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

Report by Subject Matter Expert

June 2023

UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK

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1. Introduction

1.1 DOJ/WV Partnership

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

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

1.2 Report Methodology and Structure of Each Review Area

This report is divided into sections according to content areas as outlined in the Agreement. Each requirement of the Agreement is scheduled for compliance review in phases through the fall of 2023, when all Agreement requirements will be rated for compliance. Two areas (Outreach & Education and Workforce) are not due for rating until fall 2023.

Agreement Categories	Spring 2022	Fall 2022	Spring 2023	Fall 2023
Assessment	X	X	X	X
Wraparound	X	X	X	X
Assertive Community Treatment	X	X	X	X
Quality Assurance & Performance Improvement System		X	X	X
Screening		X	X	X
Target Population		X	X	X
Children's Mobile Crisis Response		X	X	X

Agreement Categories	Spring 2022	Fall 2022	Spring 2023	Fall 2023
Residential Reductions			X	X
Behavioral Support Services			X	X
Therapeutic Foster Care			X	X
Outreach & Education				X
Workforce				X
All Other Provisions				X

For each area, we include the following sections:

1. *Agreement Provisions*. This includes the relevant requirements from the Agreement, as well as a basic description of the area itself.
2. *Historical Review*. This provides an overview of findings and observations from the previous six SME reports.
3. *Review of Current Documentation, Activities, and Accomplishments*. This section provides an overview of the information the SME received regarding DHHR's progress toward compliance with the relevant provisions during the reporting period. A full list of these documents is provided in Appendix A. Throughout this report, several conventions are used to refer to the documents received that were common across agreement areas:
    a. January 2023 WV DHHR Children's Mental Health and Behavioral Health Services: Quality and Outcomes Report—referred to as *The January 2023 Semi-Annual Quality Outcomes Report*.
    b. March 10 and 27, *2023 WV DHHR Deliverables Summary* to SME—this is the report the SME received from BerryDunn Consulting in March 2023 with updates in April 2023 that summarized all documents shared.
    c. Implementation Plan for the Memorandum of Understanding Between the State of WV and the U.S. Department of Justice, Year 4, January 17, 2023—referred to as the *Year 4 Imp Plan*.
4. *Compliance Rating and Justification*. This section shares information about the current compliance ratings, based on criteria in Appendix C.
5. *Recommendations to Achieve Compliance*. This section imparts the SME recommendations, outlined primarily in table format to share three components: the recommendations themselves; the action steps required for those recommendations; and the compliance category of the Agreement that the recommendation addresses. The SME, working from the Agreement, identified nine possible categories: Statewide Capacity; Timely Provision; Access to Service; Accessible Information; Mutually Agreed Delivery by Provider and Family; High Quality Service; Quality Assurance; Data Collection & Monitoring; and Workforce Readiness.

In the review, there are several overarching considerations the SME wishes to highlight that apply across Agreement areas:

- *Implementation.* When creating systems change, it is helpful to have a guiding implementation framework. The SME recommends adopting and/or clarifying the States' implementation strategies, which will be particularly helpful in scaling up evidence-based interventions for

Wraparound, MRSS and ACT to address and assess whether interventions are reaching the intended target population and statewide sustainability throughout clinical and community settings. Several frameworks like University of Colorado's RE-AIM, National Implementation Research Network (NIRN), Oregon's Social Learning Center's Stages of Implementation Completion (SIC), Active Implementation Research Network (AIRN), or California Evidence-Based Clearinghouse adopted Exploration, Preparation, Implementation, Sustainment (EPIS) can be considered. This type of framework should be supported by a robust workgroup structure. See Appendix D for an analysis of workgroups and meetings held between October 2022 to March 2023.

- *Data.* Throughout the report, recommendations appear related to data sharing, data dashboards, and data dissemination. The details of data reporting and sharing are captured in DHHR's Continuous Quality Improvement Plan, Key Performance Indicator Tables Working Document, and QAPI Suite of Reports and Quality Review Schedule. DHHR publishes the Children's Mental Health and Behavioral Health Services Quality and Outcomes Report on a semiannual basis in January and July each year. Additional program and service specific reports are developed for use in DHHR's internal CQI processes. Overall, the SME believes that, with additional sharing of data, it will be much easier to rate movement towards compliance. At a minimum, routine quarterly data reports should be shared with the SME in each service area. While these reports issued for DHHR's internal use will not be made publicly available, they will assist the SME with evaluating compliance. While the SME is not suggesting the use of numeric metrics or benchmarks to define compliance, the SME does believe more access to data will allow for easier tracking of progress towards compliance.
- *Provider Buy-In.* The SME wishes to stress the importance of increasing provider engagement and would like to learn more about DHHR's strategy to engage with and support alignment with providers in each service area. The SME recommends convening provider learning communities.

For reference, commonly used abbreviations throughout this report are included in Appendix E.

2. SME Compliance Agreement Review Area

2.1 Assessment

2.1.1 Service Description

Agreement Requirements 24, 26, 28, 32, 35, 36, 40, and 52. For children and youth whose screening indicates a need for further evaluation, or who are recommended for or placed in a RMHTF, or who have received mental health crisis intervention, the Agreement requires the State to provide timely, face-to-face intake and assessment, delivered at times and locations mutually agreed upon by the provider and child and family. The Agreement also requires that a qualified individual use the CANS assessment tool (or similar tools) to identify needs and assist the child and family team in the development of an individualized service plan. Lastly, the Agreement requires DHHR to provide the child's assessment to the MDT.

2.1.2 Historical Review

The first six SME reports document the following points of consideration and progress.

Building the Assessment Pathway. DHHR created the Pathway to Children's Mental Health Services (Assessment Pathway), which according to the *Year 4 Imp Plan,* "streamlines access points for assessment of children's mental or behavioral health service needs and provides assistance in linking children and families to services while the assessment process is being completed". DHHR has put in place the necessary policies and procedures regarding the Assessment Pathway, and the Assessment Pathway is being rolled out in phases: Phase 1 started with a focus on direct referrals from children, youth and families, PCP referrals, and CMCRS provider referrals; Phase 2 focused on BSS staff. DHHR has determined key performance indicators for the Assessment Pathway such as referral rate and timeliness and has begun reporting and reviewing that data on a quarterly and monthly basis. One of the challenges with the Assessment Pathway is the lack of availability of data aggregated across sources and providers that would show the whole pathway of services. Another challenge is that children need to be assigned an interim WF who provides support while the CSEDW application is being processed, but there is a waitlist for that service and limited information regarding the funding source and the amount/duration of the interim service. DHHR is working on collecting this data and hopes to include it in future reports.

Utilizing the CANS. Prior to the Agreement, BSS was using the CANS in its Title IV-E Waiver program, SAH, and has a CANS Automated System for entering CANS data. Now, CANS is being used in WV Wraparound services, and MU has trained and certified Wraparound staff in using the CANS. Additionally, DHHR has had ongoing conversations with MU and WVU to develop CANS data reports and discuss meaningful use of CANS data. DHHR has also developed a CANS decision support model for use in the QIA process.

Utilizing additional assessments. DHHR is using the CAFAS and PECFAS to determine CSEDW eligibility. These assessment tools are also used by DHHR to help define the target population for the Agreement.

2.1.3 Review of Current Documentation, Activities, & Accomplishments

Assessment Pathway. DHHR has continued to utilize its Assessment Pathway to assess and connect children in need of mental or behavioral health services. The SME commends DHHR for the concerted effort to track and review data about the Assessment Pathway. Based on data in the *January 2023 Semi-Annual Quality Outcomes Report*, there were 447 referrals to the Assessment Pathway in January-June 2022. There has been an increase in the number of counties who are participating and submitting referrals since the last semi-annual report; only 8 out of 55 counties did not make referrals. The SME will continue to look for expansion to statewide referrals. Data indicating the source of referrals showed that half of referrals (51%) came from Kepro, and the remaining referrals came from FirstChoice, BBH, and CMCRS. Additionally, there were 729 CSED Waiver referrals submitted directly to Kepro. The main referral sources included DHHR, Aetna, the Assessment Pathway, and court systems. BJS has also begun sending referrals to Kepro and is expected to appear as a referral source in future reports.

DHHR has set four key indicators to measure timeliness for the Assessment Pathway:

- Step 1: Initial contact with family after receiving the referral. This step was completed in 2.1 weekdays on average, meeting the target of 5 weekdays.
- Step 2: Complete and submit the CSEDW application. This step was completed in 8.6 weekdays on average and does not have a target goal.
- Step 3: Complete the CAFAS/PECFAS. This step was completed in 6.7 weekdays on average, which did not meet the target of 4 weekdays.
- Step 4: Assign an interim WF if child is not receiving Wraparound. This step was completed in 9.2 weekdays on average, which did not meet the target of 5 weekdays. The delay in this step seems to be caused due to an increase in service demands and some provider capacity limitations.

In total, it took an average of 30 days from initial referral to assignment of an interim WF. In the December 2022 SME report, the SME recommended adding a Step 5, which would be the family's first face-to-face appointment with a provider. That step is particularly important for meeting the Agreement requirement, which specifies providing a timely, face-to-face meeting with a provider. That information was not included in the *January 2023 Semi-Annual Quality Outcomes Report*, so the SME reiterates the need for this metric.

DHHR conducted additional analyses to better understand the Assessment Pathway, looking at progression through the Assessment Pathway, reasons that families decline participation, and time on the waitlist. The *January 2023 Semi-Annual Quality Outcomes Report* showed that there were 120 children (26.9%) who did not participate after being referred because the family failed to respond or declined further participation. The most common reason for declining participation was (perceived)

Medicaid/income ineligibility. There were 144 children placed on the WF waitlist and they waited for an average of 30 weekdays. DHHR acknowledged that increased timelines and waitlists are due to increased service demands and limited provider capacity. This data can help DHHR identify where there may be barriers or gaps that need to be addressed, and hopefully lead to improved timeliness and services.

CANS data. DHHR provided its first review of CANS data in the *January 2023 Semi-Annual Quality Outcomes Report*. The SME recognizes that CANS data reporting is still in the early stages of development and DHHR has made strides to reach this point. Initial CANS data showed that 84% of newly enrolled youth (in SAH, an RMHTF, CSEDW, or BBH) had at least one CANS completed, and 56% had their CANS completed within 30 days of enrollment. These initial data points are a good first step in understanding CANS completion rates. DHHR is working with MU, WVU, and the University of Kentucky to develop CANS data analyses and reports which will be available in the future. DHHR is also planning to expand the use of CANS in the following ways:

1. As of March 1, 2023, CSEDW providers are required to enter CANS information into the State's CANS automated system. Having the provider CANS data in the State's system will be helpful for providing a better picture of children's needs across the State and allow for more real-time monitoring by the State.
2. DHHR has contracted with MU to have a CANS completed for all children in out-of-state placements, with an update every 60 days.
3. In-state RMHTF staff are expected to update CANS monthly for youth in their care, per *BSS Pathway to CMHS*.

QIA. DHHR has developed a QIA process to assess children and youth who are at high-risk for or currently placed in a RMHTF. As of March 1, 2023, DHHR has trained on and begun implementing the process in 40 out of the 55 WV counties. Based on the *QIA Training* and *BSS Pathway to CMHS* documents, the eligibility criteria for QIA have been established along with the referral steps for staff to follow. The QIA process utilizes the CANS assessment and CAFAS/PECFAS assessment, and results in a recommendation on intensity of intervention based on the WV CANS decision support model. There is a benchmark of 30 calendar days for referral and assessment, and data will be reviewed to compare the recommended versus actual levels of care that children receive. The QIA process is still in the beginning stages of implementation, so the SME looks forward to seeing progress in future reports, particularly with a completed QIA SOP and implementation data. During the monthly meeting with DOJ and DHHR on May 3, 2023, DHHR provided updates on the QIA process and shared preliminary data on referrals received. There were some questions raised by DOJ and the SME about the overlap between the CSEDW and QIA process, the QIA criteria for high risk of residential placement, and the unintended consequences of creating a pathway to residential placement. DHHR was receptive to the needs that were raised and has already planned next steps that address many of these concerns.

MDT interaction. DHHR provided two documents sharing guidance on how assessments should be shared with the MDT. The *MDT Desk Guide* references assessments in the following places:

- The list of items to "Gather and Review Information Concerning Child/Family" includes assessments, CANS, and QIA.
- The child welfare worker will distribute all assessments and records related to the child and family during the MDT meeting.
- The child welfare worker will include information in the MDT report regarding CSEDW assessments, evaluations, and reports that have been shared and discussed with the MDT.

The *MDT Participants and Confidentiality Statement* has space to indicate what assessments were reviewed during the meeting. The SME commends the State for providing documentation of the process for information sharing, as requested in the previous SME report.

A link to the *Court Improvement Program Webpage* was provided as part of this reporting period. It was mentioned that an R3 MDT subgroup was implemented through this collaboration and more information at the next period would be helpful to further understand Assessment Pathway education and coordination developments with WV's courts.

2.1.4 Compliance Rating and Justification

Agreement Requirements 24, 26, 28, 32, 40, and 52. Compliance Rating: Partial Compliance Justification: These requirements pertain to timeliness and state-wideness of assessment, leading to a timely face-to-face meeting with a provider. The State has shown that they are actively trying to address this requirement by: 1) establishing and monitoring KPIs to track timeliness of Assessment Pathway steps; and 2) meeting one out of three timeliness targets. However, data on time to a face-to-face meeting is missing from the analysis and there's only one measure of referrals by county, so the level of state-wideness is unclear and seems to fall short of statewide reach.
Agreement Requirements 35. Compliance Rating: Partial Compliance Justification: This requirement centers around having qualified individuals utilize the CANS and/or other tools to develop service plans. The State has implemented use of the CANS in Wraparound and has plans to assess children in other settings (youth out-of-state; RMHTF). As of now, the State is still rolling out the QIA process which will use CANS and CAFAS/PECFAS. Also, the State is still in the early stages of collecting and reporting CANS data.
Agreement Requirements 36. Compliance Rating: Partial Compliance Justification: This requirement involves sharing assessments with the MDT. The State has provided documentation showing that the expectation for information sharing is in place. To ensure full compliance, the State should provide data showing that this is actually being completed by teams.

2.1.5 Recommendations to Achieve Compliance

DHHR has put considerable effort into building the Assessment Pathway and is taking the right steps toward collecting and reviewing data elements that will help with monitoring the process as referrals increase. There are still some elements, such as QIA and CANS data analysis, which are in the early stages of implementation, and the SME looks forward to seeing progress on those tasks in the future.

Data on workforce capacity was not provided and therefore not discussed here, but it is a key element of conducting timely assessments that should be reviewed. Recommendations are presented in the following areas: 1) monitoring assessment capacity; 2) improving timeliness and tracking of Assessment Pathway referrals; 3) continuing to develop policies and data reports for CANS; 4) establishing policies and data reports for CAFAS/PECFAS; 5) clarifying and providing additional documentation for the QIA process; and 6) monitoring whether assessments are being regularly shared with MDTs. Some of these recommendations have been suggested in prior SME reports. The SME intends to meet with DHHR to discuss ways to achieve compliance as related to current recommendations.

RECOMMENDATIONS	ACTION ITEMS	COMPLIANCE CATEGORY
Monitor and improve data on assessment capacity.	-For all of the assessments (QIA, CANS, CAFAS/PECFAS) continue to: • Regularly review the number, location, and capacity of assessors. • Increase the accessibility to and availability of assessors throughout the State.	-Statewide Capacity -Timely Provision -Data Collection & Monitoring -Workforce
Increase referrals, improve timeliness, and reduce drop-offs in the Assessment process.	-Include time to the first face-to-face appointment as part of the Assessment Pathway timeliness data. -Create a target goal for time from referral to first face-to-face. -Continue to monitor the steps where the timeliness target was not met. Continue to investigate reasons for not meeting the target, and develop, implement, and measure a strategy to improve timeliness. -Continue to review data on interim Wraparound services (see recommendations in Wraparound section 2.2.5) and develop, implement, and measure a strategy to reduce time on the waitlist. -Continue to investigate why families "drop off" the Assessment Pathway and develop, implement, and measure a strategy to improve engagement. For example, if families decline services because of a misunderstanding of eligibility criteria, determine if staff need a different approach or more training on how to explain the criteria to families.	-Timely Provision -Access to Service
Continue to develop policies and data reports for CANS.	- Continue to collect and monitor CANS data from all applicable sources (e.g., out-of-state placements; RMHTF). -Monitor provider participation in entering CANS data into the CANS automated system, being mindful of whether this will cause duplicative data entry for providers and addressing that as needed. -Measure how well the needs and strengths identified on a child's CANS matches with their ISP (called plan of care (POC) in WV).	-Data Collection & Monitoring

Establish policies and data plans for CAFAS/PECFAS.	-Provide clarity about the purpose of the CAFAS/PECFAS versus the CANS, and how information from one assessment is incorporated into the other. -Develop metrics/data reports to review the number of youth receiving CAFAS/PECFAS and provide outcome measures.	-Data Collection & Monitoring
Clarify the QIA process and provide additional documentation.	-Continue collecting and monitoring data regarding the QIA process. -Provide revised QIA SOP for SME review. -Explain how the results of the CAFAS/PECFAS factors into the QIA's recommendation. -Explain how assessment results are shared with the child and family.	-Access to Service -Data Collection & Monitoring
Develop a process to ensure that assessments are shared with MDTs.	-Create KPI that indicates the percentage of MDTs that receive a child's assessment. Describe a plan/ venue for reviewing this data (for example- which work group might monitor this).	-Data Collection & Monitoring

2.2 Wraparound

2.2.1 Service Description

Agreement Requirements 12, 16, 21, 22, 24-28, 33-36, 40, 41c. The Agreement requires that there is statewide access to Wraparound for children and youth needing in-home and community-based mental health services with a CFT coordinating and managing the care of each child. Wraparound must function with high fidelity to the NWI model. The CANS assessment (or another tool) is used to inform an ISP for each child. And, finally, if a child has an existing multidisciplinary MDT, the Wraparound screening, assessment, and ISP must be made available to the MDT (See the Assessment section for additional information).

2.2.2 Historical Review

The first six SME reports document the following points of consideration and progress:

Wraparound model alignment statewide and implementation. When the SME began its analysis of Wraparound in WV in 2019, there were three distinct Wraparound programs operating in the State. The first few steps recommended by the SME were to align the three programs into one uniform practice, develop a plan to apply fidelity to the model, and monitor pathways and referrals to Wraparound. Additional recommendations focused on aligning Wraparound policies and procedures, setting uniform terminology and language, and developing consistent outreach and education. As alignment continues, the SME has looked for continued statewide streamlining, finalization of the *WV Wraparound Manual*, an understanding of how the State will continue to work towards fully compliance to the model, increased access, coordination with MDT, and improved clarity of data collected. Recommendations are still being made by the SME to fine tune the mechanics of how WV Wraparound is implemented, and data is collected.

Funding sources. The funding stream and eligibility for this service include: BBH Children's Mental Health and BSS Safe at Home Wraparound facilitators provide interim services for children with a CAFAS/PECFAS of 90 or greater until the CSED Waiver application is approved. If the child does not meet the criteria for CSED services, the child can continue services with either the BBH or BSS funded Wraparound services.

CANS and MCO roles. There has been discussion about the use of CANS and the role of MCOs in supporting referrals and pathways to access Wraparound. WFs need to be trained in CANS, and the use of CANS data has been recommended to identify red flags and course correct throughout Wraparound implementation.

CSEDW approval. By June 2020, the CSEDW was approved, naming Wraparound as a pivotal care coordination practice and service in WV. Alignment of the three Wraparound programs was still underway and the need to obtain real time data for review remained a recommendation. By the end of 2020, a leading recommendation was to strengthen and increase referrals to youth in the CSEDW.

Evaluation partner. WVU was hired to conduct an evaluation of services in WV, and the SME requested the opportunity to review the evaluation plan to ensure Wraparound and other services were captured effectively.

High-fidelity implementation and evaluation. Beyond the high priority of alignment, the DART was selected to measure fidelity, and there was a focus on setting Wraparound metrics to include in the QAPI report. Initiation of WV's contract with MU to conduct fidelity and CQI reviews was recognized as a step forward to help collect and analyze fidelity data at regular intervals to include statewide provider understanding of fidelity. MU's contract includes individual provider reports to support improved provider performance.

Wraparound driving transformation. Through Wraparound alignment considerations, a decision was made to use Wraparound as a vehicle to drive access to home and community services as well as to guide residential services reduction. As a result, all children in WV with SED, including those in child welfare, would receive one streamlined Wraparound approach, with services guided by a single assessment tool.

High-fidelity evaluation. Initiation of WV's contract with MU to conduct fidelity and CQI reviews by a research team was recognized as a step forward to help collect and analyze fidelity data at regular intervals and generate provider reports to support improved provider performance.

New training center. MU has a new training center to support the needs and pace of training in WV.

2.2.3 Review of Current Documentation, Activities, & Accomplishments

*Accomplishments***.** DHHR's *Year 4 Imp Plan* produced in January 2023 includes a section on Wraparound. Much progress has been made in this service area. The main accomplishments described by WV DHHR in the *Year 4 Imp Plan* include the following:

- finalizing the first draft of the *WV Wraparound Manual*;
- initiating Wraparound training;
- implementing a training and TA Plan for WFs;
- monitoring ongoing fidelity review;
- identifying KPIs and data collection related to WF; and
- completing Wraparound provider capacity analysis.

The SME has seen evidence of several of these items completed and will look in the next period for additional documents to support the implementation of comprehensive training and TA plans for Wraparound. Monitoring of fidelity and completion of the provider capacity analysis.

The Plan addresses the ongoing needs to work towards the following: clearer operating procedures; fidelity achievement; provider capacity assurance; sharing knowledge with community partners and families about Wraparound; development and dissemination of reports to monitor utilization; formalization of CANS utilization; and Assessment Pathway analysis. The SME will be looking for

updates on these open tasks in the next reporting period, along with additional recommendations made at the end of this section.

*Fidelity***.** The first *West Virginia Wraparound Fidelity Report,* produced by MU utilizing the DART, was finalized in December 2022. The data contained in the report was reviewed in August and September 2022 across 17 providers. This data was intended to obtain a baseline fidelity rating in advance of training, TA and coaching provided by NWIC as the State works towards fidelity. The data covered three DHHR Bureaus including BSS, BBH and BMS, however the data was not separated by funding source for purposes of this report. The new Wraparound plan of care went into place October 1, 2022, across three funding sources as the State is working towards Wraparound alignment in statewide practices. The SME looks forward to seeing how this translates into uniform practice statewide. The next review should convey more results by funding source to assess for any variance as the State continues with uniform and statewide training and adherence to fidelity standards. Appendix B of the *West Virginia Wraparound Fidelity Report* was very useful since it outlined all the 2022-2023 Wraparound Trainings that have taken place over this past year. MU meets monthly with the University of Washington Wraparound Evaluation and Research Team (WERT) to address data analysis and fidelity plan implementation.

A sample of youth enrolled in Wraparound between October 2021 and March 2022 was reviewed as part of the above report to assess baseline. Wraparound training started in February 2022. The sampling was pulled from the WV CANS System, and the DART was applied to the sampling to inform this report. At this time, many of the Wraparound providers were still unable to access the CANS automated system, which impacted the sample of youth that were available to be selected. The DART assessed adherence to fidelity, including looking at Wraparound principles and practices through a review of documentation collected during the Wraparound process. The DART is scored in six main areas:

1. Timely Engagement,
2. Wraparound Key Elements (meeting attendance, driven by strengths and families, natural and community supports, and needs-based),
3. Safety Planning,
4. Crisis Response,
5. Transition Planning, and
6. Outcomes.

Thirty-seven youth were reviewed in this report sample, which was adequate to conduct a fidelity review designed to analyze the general process. Once all the data was collected on these 37 youth, the information was loaded into WrapStat and Qualtrics for analysis. Ideally, the sample size will increase in the next report to allow for more strength and generalizability in the findings across funding sources—verifying consistency in the Wraparound model across providers.

The DART analysis showed that prior to NWIC training, these three new standards were a few of the fidelity elements noted as challenges in the baseline report:

- inclusion of family stories;

- at least quarterly updates to youth strengths; and
- natural supports participation.

The SME will be looking for improvements in these areas in the next fidelity review. Additionally, further training on other new standards related to crisis responses should also yield improvements in the next review. The new crisis incident standards related to Wraparound include: 1) updating a crisis plan 24 hours after an incident and 2) convening a CFT team meeting within 72 hours.

As a result of the baseline findings in MU's *West Virginia Wraparound Fidelity Report*, the OQA recommended that a Wraparound PIP team be established in early 2023. This committee began meeting in early 2023 to address the findings, but the SME has not received any updates during this review period related to this effort. Additionally, MU will complete the next round of fidelity reviews by summer 2023, followed by annual fidelity reviews and reports.

Data/CQI. The MU report identified 11 recommendations, all of which were excellent suggestions and included in the recommendations section of the SME report, below, unless already put in place. The SME applauds WV for acting on the recommendation to create a CQI committee dedicated to Wraparound and a statewide oversight workgroup that will include the voice of youth, families, and providers. The State reported the committee is meeting weekly to monitor and address barriers related to Wraparound. The SME will look forward to learning more and reviewing documentation, policy changes, data and other outcome information related to the committee's efforts as the PIP team started meeting weekly in early 2023. Also, the MU recommendations all pointed towards expanding WV's Wraparound infrastructure by adding more resources to dedicate to this large scale and important implementation in WV.

The *January 2023 Semi-Annual Quality Outcomes Report* contained a section on WF data from the three available funding sources. Additionally, a driving aim of MU's Wraparound fidelity report is to ensure wraparound facilitation services are implemented with fidelity. As Wraparound utilization grows and more data is collected there is a great opportunity to learn more about the characteristics of children in WV to continue to understand, shape and transform WV's mental health system.

One specific goal for WF services, noted in the report and applicable across all agencies, is "to reduce the number of children removed from their homes due to SED and SMI". This is a reduction metric that could be closely tracked; if SED and SMI are the only reasons considered for child welfare removal. HCBS and WF are specifically designed to stabilize placements and address the behavioral health needs of a youth that may be causing family disruption. Paired with crisis services, HCBS and WF should be able to make progress towards the goal of keeping children at home and also address their mental health needs. The SME looks forward to future data that supports this benchmark.

As DHHR continues to train all WF providers with the same NWI model and curriculum, data collection will improve to allow for evaluation of WV Wraparound as one streamlined service and boost the ability to conduct analyses across funding sources. The SME looks forward to the next assessment of fidelity by MU, as well as WVU's overall evaluation, both expected within the next six months.

*Utilization***.** The *January 2023 Semi-Annual Quality Outcomes Report* captured the following utilization data during this period. SAH WV providers' data was not provided. The SME looks forward to full collection and reporting of data in the next semi-annual report to understand the full utilization picture. WV recently reported (through the *January 2023 Semi-Annual Quality Outcomes Report)* that, as of March 1, 2023, all Wraparound providers are required to enter CANS assessments into the online CANS database. The SME is looking forward to seeing how this information will be used to evaluate WF caseloads and drive workforce forecasts.

Table 1. Wraparound Utilization January – January 2022

FUNDING SOURCE	NUMBERS SERVED	DATA SOURCE
BBH	161	System of Care Epi
SAH WV providers	Data not available	CANS automated system
CSED Waiver	298	DW/DSS

With respect to utilization, 161 individual youth were served through BBH from January – June 2022, which created a solid foundation for analysis. There was mention that LGBTQ+ service utilization data, although a small number, was closely reviewed internally. The SME applauds the need for and importance of giving this vulnerable population particular attention.

The State identified that the patterns of utilization are consistent with the seasonal changes; as schools let out for the summer, utilization goes down. The SME will look for future applications of trending data to align with other implementation areas such as outreach and education.

Two hundred and ninety-eight individual youth were served through the CSED Waiver from January – June 2022, which also provided a robust sample for analysis. DHHR continues to prioritize and monitor the timeline of the eligibility determination from the date of first CSED Wraparound services. This is very important to continue to track**.** See intensity of service recommendations in CSED Waiver Section 3.3.

The average length of Wraparound was 9.3 months, with a median of 8 months, with a majority (73%) receiving services up to 1 year. The State identified the need to continue to look at those outliers being served for longer, some youth as long as 2 years. SME commends WV efforts to understand their data to inform practice.

Provider capacity and training. With respect to provider capacity, according to the *January 2023 Semi-Annual Quality Outcomes Report*, the number of WFs increased 16.9% from 142 to 166 from January – June 2022. Additionally in November 2022, it was assessed that the number of WFs had increased to a total of 187 as referenced in the *DHHR November 2022 WF Capacity* document. Therefore, the growth overall from January – November 2022 represented a total 31.6% increase which is commendable. To ensure access is within reach of families, will require ongoing assessment and monitoring of provider capacity.

DHHR is aware that to measure true capacity as relates to manageable caseloads, the FTE status of WF personnel must be known and factored in, since many are part-time employees. DHHR recognizes the NWI best practice standards for caseload ratios. The SME will look forward to reviewing

additional data related to this analysis and how the State is forecasting the need for WF recruiting and building provider capacity with respect to demand. Additionally, the State is reviewing the rate structure to aid recruitment and retention of WFs, pivotal to their HCBS workforce and in response to increased CSED Waiver applications.

The SME reviewed the *Forecasting Demand for CSED Waiver Wraparound Facilitation Services* slide deck which included preliminary workforce projections for the next 6-12 months and used existing data with respect to referrals, applications, eligibility determination, length of service and utilization services. Analyzing this data and sharing findings with Aetna, Kepro and providers will allow partners to plan for demand. This collaboration and use of initial data is a promising step forward for WV and will serve as a good model for other services. Also, BMS is considering a rate restructure for Wraparound, which will hopefully boost recruitment efforts. The SME will continue to track this development and its impact.

MU has established a contract with UCONN to provide the Wraparound training and TA to providers and to certify MU staff as Wraparound trainers. The SME looks forward to seeing the train the trainer plan to fully understand how this transfer of knowledge and training will be established and sustained to support providers ongoing in WV.

Overall implementation. The SME requested an update on the *WV Wraparound Manual,* a valuable tool to guide providers with statewide implementation and adherence to fidelity. The SME was informed no new edits have been added to the original Manual finalized in September 2022 nor has it been distributed and socialized with Wraparound Providers. There is an immediate need to revisit the *WV Wraparound Manual* to further develop and edit its contents and create a training and TA plan to support its implementation.

The initial Manual drafted is a good start, but the Manual requires considerably more content, detail, and expansion, addressing important information to support providers to deliver Wraparound. The SME will be looking for the next steps to enhance and disseminate the Manual to address operational requirements and practice expectations in the delivery of Wraparound services in WV. Many of the details may appear in provider contract language, but it will be beneficial to pull in the comprehensive Manual to guide consistent practice across providers. Examples of other well-developed Wraparound manuals include those in New Jersey, Louisiana, Massachusetts, and Washington.

It was also reported (through the *March 2023 SME Deliverables Summary*) that the CSED Waiver has been approved for an additional five years, which creates a long-term sustainability mechanism for this service. This is very good news with respect to the financing of this service.

The *WVU Evaluation Report* from June 2022 shares initial baseline findings focused on basic characteristics of children and youth receiving WF, along with community and family awareness and workforce issues. These are the rudimentary questions that are important to ask at the start of implementation, but as WF utilization increases, the sophistication of the data captured and analyzed should follow. Along with continuous assessment of fidelity to the model, the services (beyond WF) should be captured and analyzed to understand a youth's complete picture and dose of interventions accessed. The evaluation plan can also evolve to focus on the outcomes that result from the WF

process, coordination, and utilization of services. Increasing access to and timeliness to WF is critical, and planning for the analysis capturing all services a child receives is important.

2.2.4 Compliance Rating and Justification

Agreement Requirements 16, 24-28, and 40. Compliance Rating: Partial Compliance Justification: 16. WV is committed to providing a comprehensive ISP for each child. SME requests documentation (such as ISP templates) to review if the ISP fully complies with the components laid out in paragraph 16; and further data to demonstrate that ISPs as laid out in paragraph 16 are consistently completed and implemented. 24-28. Wraparound as an intervention meets the requirements for a HCBS as laid out in the Agreement. SME requests documentation regarding how fidelity to Wraparound is ensured. 40. Wraparound is a practice and process that supports a children's individualized needs. However, WV needs to further address the following: assessing statewide service needs to ensure access and build capacity; training the workforce in Wraparound principles; determining if linkages are being made to community services; and verifying the amount, location, intensity, and duration of these services for the target population.
Agreement Requirements 12, 21, 22, 33-36, 41c Compliance Rating: Partial Compliance Justification: 12, 21-22. WV needs to continue with best practice training to work towards full Wraparound fidelity and ensure the workforce is demonstrating full competency in core model areas in practice. 33. Statewide access needs to be documented with stronger and more specific data to ensure that those children identified for Wraparound are accessing this service in a timely manner. 34. Through ongoing training and coaching, and coordination with NWIC Wraparound, high fidelity to the model is in progress and is in the initial stage of implementation in WV. 35. CANS is the chosen tool being trained and implemented in WV, but the workforce still needs continued training and coaching on rating, completion, and data entry and integrating CANS into the Wraparound process at the practice level. 36. Further data is needed to ensure that Wraparound screening, assessments and ISPs are provided to social service MDT convenings. 41c. Further details are needed on the implementation plan and steps to evaluate the fidelity of CFT teams to the NWI model.

2.2.5 Recommendations to Achieve Compliance

As indicated by findings in MU's first baseline *Wraparound Fidelity Report f*inalized in December 2022, the State needs to address many areas to work towards fidelity. It will take time to reach full fidelity, but with a strong continuous quality improvement framework and continued training and coaching at the provider-level, fidelity will improve, and Wraparound will grow. Development of an ongoing Wraparound training and TA plan, refining the quality improvement processes, engaging with

providers and enhancing content and detail in the existing *WV Wraparound Manual* are critical next steps.

The SME recommends next steps in the following areas: 1) further assess, build and monitor program/provider capacity; 2) continue and support outreach to low WF enrollment counties, 3) expand and operationalize the *WV Wraparound Manual* and disseminate and train on WV-specific Wraparound tools/documents statewide; 4) continue to train and coach programs/providers in Wraparound curriculum and CANS; 5) provide systems orientation and training to the community; 6) work towards and monitor high fidelity; 7) refine data collection (WF enrollment and youth level service utilization levels); 8) improve and support data system input; and 9) grow and dedicate statewide resources and infrastructure to Wraparound implementation.

RECOMMENDATIONS	ACTION ITEMS	COMPLIANCE CATEGORY
Further assess, build, and monitor program/provider capacity.	-Continue review of whether existing providers are actively enrolling children in Wraparound services. A continued review of data is needed to assess whether WV has sufficient capacity to provide services to children currently enrolled, as well as expand services to meet projected need. -Continue analyses of enrollment into the CSEDW and Wraparound along with looking at service intensity (i.e., hours per month). Continue assessing if the existing provider pool can offer the amount of service expected, and potentially needed, to each child and family is critical.	-Statewide Capacity
Continue outreach to counties with low referrals to the Assessment Pathway, with additional focus on areas with limited CSEDW referrals and higher rates of residential placements.	-Continue outreach plan to achieve this goal and recommendation.	-Access to Service
Expand and operationalize the *WV Wraparound Manual* and disseminate and train on template Wraparound tools/documents statewide.	-The *WV Wraparound Manual* needs to be further edited to include considerably more detail, along with a training and TA plan. The Manual details should include: the role of WF and CFT Team; expectations regarding interagency collaboration; operational aspects of Wraparound; staffing and supervisory ratios and respective expectations; roles/job descriptions; integration of Wraparound within operations in WV; the process of submitting care plans to Aetna; service authorizations, coordination with other providers); process to address disagreements among the CFT team; expectations for inclusion of natural supports; how the providers interface with Aetna for service approvals; if CFT is	-High Quality Service -Workforce Readiness -Accessible Information

	determining medical need for services, or how disagreements between Aetna's medical need determinations and the CFT are resolved; how Wraparound interfaces with other systems and providers, including child welfare caseworkers and MDTs, court systems, schools/IEP issues; how Wraparound providers support the participation of other behavioral health providers in CFTs; and a description of the types of services and supports that Wraparound providers are expected to engage. -Disseminate and train statewide on streamlined documents to support high-fidelity Wraparound practice.	
Train and coach programs/providers in Wraparound curriculum and CANS.	-Continue to refine the train the trainer plan for upcoming trainings to practitioners/supervisors in key Wraparound principles and roles and track these trainings and participants attending. -Continue to build CQI processes, to use preliminary data collected as well as data in MU reports to train and coach at the provider and systems level. -Continue to train/coach the workforce on CANS rating and completion, integrating into the Wraparound process at the practice level.	-High Quality Service -Access to Service -Data Collection & Monitoring
Provide cross bureau training, technical assistance using CQI practices specific to Wraparound.	-Continued outreach/education on the Wraparound model to partners (such as other bureaus). -Continue regular meetings with representatives that can make high level decisions from all bureaus, provider agencies and family and youth advocates.	-Statewide Capacity -Timely Provision -Access to Service -QA -Data Collection & Monitoring -Workforce Readiness
Monitor ongoing fidelity of Wraparound services to NWI model. In response to fidelity monitoring reports, develop and implement needed program changes, provider training or other interventions recommended to attain fidelity.	-Continue with plan to review ISPs as part of quality oversight and Wraparound fidelity reviews to ensure NWI standards, which includes individuation of each plan of care for each child; this type of data would be used to support fidelity efforts to ensure that services are individualized to the youth and family. -Align all DHHR policy with NWI standards. -Continue to provide PIP updates in the semiannual reports	-High Quality Service
Refine data collection.	-Continue to provide a clear analysis encompassing enrollment, unique children served, and the amount of service each child is receiving to improve analysis around access, intensity, and timeliness of service provision. -Continue to include unique utilizers, timeliness of receipt of services, and amount and duration of services received. Data should be disaggregated by provider, age, region, and length of stay, in addition	-Statewide Capacity -Timely Provision -Access to Service -QA -Data Collection & Monitoring -Workforce Readiness

	to a total or statewide aggregated reporting. Data should be stratified by providers to support quality oversight, inform an understanding of system strengths, and identify challenges that require training, support, or policy revisions. -To fully understand the intensity and duration of services a child receives, it is critical to be able to capture and analyze all services the child is receiving; that is, services provided under the CSEDW, Medicaid State plan services, and BBH-funded services. This is planned as part of the data store buildout, and the SME looks forward to future reporting of this data. -DHHR's QA Team should continue to formalize and apply data analysis related to Wraparound service utilization, waitlist, Assessment Pathway, provider capacity forecasting analysis and monitoring to assist with ensuring statewide accessibility to Wraparound services as referrals to the Assessment Pathway increase. -Provide information reported from the unique utilizer perspective as opposed to solely by-service.	
Promote consistent, centralized data entry for CQI and evaluation and formalize CANS data analysis and outcomes reporting.	-Continue to monitor data entry into WV CANS System and build into existing data dashboard.	-QA -Data Collection & Monitoring
Grow and dedicate statewide resources and infrastructure to Wraparound.	-Hire a WV State Wraparound Program Director, preferably with authority to oversee all child-serving bureaus and oversee all aspects of Wraparound implementation). - Continuation of efforts by the PIP team that was formed in early 2023, which uses a CQI framework to drive and improve Wraparound quality and fidelity. - Clarify and develop WV's strategy for addressing Wraparound waitlist across CSEDW, SAH, and BBH.	-Statewide Capacity -Timely Provision -Access to Service -Accessible Information -Mutually Agreed delivery by provider & family -High Quality Service -QA -Data Collection & Monitoring -Workforce Readiness

2.3 Assertive Community Treatment

2.3.1 Service Description

Agreement Requirements 24, 25, 26, 27, 28, 36, 39, 40, 41, 52. The Agreement requires that the State ensures that ACT is available statewide to young adults in the target population aged 18-20. This service should be delivered at times convenient to youth and families so that it meets their individualized needs. The agreement permits ACT teams to substitute for child and family teams through Wrap, provided they have an individualized service plan and access to home and community-based services, as needed. This same service is also available through adulthood, past the target population age range, which makes it a unique service among the children's behavioral health service array.

2.3.2 Historical Review

The first six SME reports document the following points of consideration and progress.

Initial ACT implementation. ACT was included in 2003 in WV's SPA and operates out of BMS to provide an array of inclusive community-based mental health services for young adults 18 to 20 with serious and persistent mental illness. The inclusion of ACT in the SPA predates the Agreement.

Statewide expansion. WV has been working over the last two years towards statewide implementation. ACT was expanded in November 2021 through a BMS contract with Mountaineer Behavioral Health to provide services in regions two and four.

Reach to transition-aged youth population. Under the Agreement, DHHR included ACT for young adults, as an alternative to Wrap, with the belief this age group may benefit from either service. There was concern in the last SME reports that youth need to "fail up" to access ACT services, suggesting this service is potentially only being offered to youth aging out of residential placements.

Utilization. The ACT model is only intended for adults, making a fraction of the Agreement target population eligible for this service. However, the utilization of this service has remained very low for eligible young adults since inception.

Freedom of choice between care coordination services. Previous reports clearly state that youth and families that fall within this age range should have freedom of choice between ACT and Wrap. As mentioned, ACT is included in the SPA, and Wraparound is a part of the CSED Waiver, so they are supported with different sustainability mechanisms. However, both services cover the same population age range with similar behavioral health case management type needs.

Areas of improvement. Ongoing recommendations include the need to: address workforce shortage concerns; expand ACT eligibility criteria; establish a retrospective review process with increased frequency; clarify which data source provides the most accurate and real time data; reach statewide coverage; establish and ensure freedom of choice between ACT and Wraparound; continue communication plan efforts using the state's *Resource Rundown* mechanism to reach families with older

children and youth; and continue refining fidelity reviews of ACT services as delivered by Kepro, the State's ASO.

2.3.3 Review of Current Documentation, Activities, & Accomplishments

The *Year 4 Imp Plan* outlines one goal related to ACT: to increase capacity and address any ACT provider workforce capacity issues to ensure that the service is available statewide and that services are delivered in a timely manner. While this is a solid goal and well-connected to the aim of the Agreement to ensure capacity and access, it does not address efforts to outreach to the oldest range of the target population.

Two accomplishments are noted in the *Year 4 Imp Plan* that address ACT expansion statewide as well as improvements to oversight and monitoring. These two actions demonstrate progress towards Agreement compliance and evidence was provided to support these accomplishments:

1) Initiation of a newly procured ACT vendor contract in the Eastern Panhandle, and
2) Through the QAPI team, identification of KPIs, data collection, and reporting specific to ACT services.

The agencies involved in addressing and improving services for ACT include BMS, BBH, and QA staff. Open tasks indicated in the *Year 4 Imp Plan* include undertakings and outcomes related to clear operating procedures, quality monitoring and oversight, statewide access, and the availability of routine reports to analyze and improve services and provider network capacity building. The action items are in line with the needs to effectively implement ACT. The SME will be seeking updates and tracking the progress of the established action items over the course of the next six months through workplan documentation and use of real time data.

Two documents from EastRidge Health Systems demonstrated progress in expanding ACT to the Eastern Panhandle, where there has been a gap in service. The documents included a proposal and an email from the VP of Outpatient Services from provider EastRidge Health Systems, including a brief narrative, a start-up budget from January 1 through September 30, 2023, and documentation of progress related to building capacity for ACT in the Eastern Panhandle. This documentation also included an email from the provider which shared a relatively brief and informal update depicting the ACT startup process. On March 1, 2023, the VP reported on hiring, building construction, potential client/referral lists and training updates. These updates appear to indicate the proposal was awarded with the goal to go live with ACT services early to mid-April. Updates from the provider indicate workforce remains an issue, but construction of the new building will not impede implementation since an interim space is available. For the SME team to monitor future progress, the following information would be useful:

- The method to obtain the potential ACT client list.
- Drafted marketing materials and process to obtain community referrals.
- A more detailed implementation plan from EastRidge Health Systems to allow the State to better track progress, barriers and developments related to hiring, training, the referral process and go-live status.

The first two recommendations above apply to all ACT providers to ensure marketing and recruitment efforts are underway and ongoing to reach WV's target population.

ACT Monthly Provider Discussion Notes further showed that ACT implementation discussions are underway. These notes included BBH grantee call and meeting summaries related to ACT from July 2022 to January 2023. These notes were very minimal in content, providing one or two bullets of what was covered without any references, indication or detail who was present at these meetings. The SME will be looking for more detailed notes to be taken at meetings, including thorough sign-in sheets documenting who (e.g. name/roles of providers) is in attendance and what agendas items and topics are addressed along with outcomes and next steps.

The ACT Retrospective Review Tool designed to guide Kepro in quality assurance efforts is a very important development. The tool was finalized and approved in December 2022. Kepro began using the tool in January 2023. This tool is used by Kepro staff to assess providers against ACT fidelity standards. The SME will seek additional information on Kepro's workflow of the new tool as well as information on the other MCO's utilization review processes to assess quality.

The PRTF Policy available on BMS' website provides evidence that effective January 1, 2023, BMS Chapter 531 in the "Psychiatric Residential Treatment Facility Services" (page 36) and the "PRTF Provider Agreement" (page 2) include this identical language in the discharge sections: "Discharge planning for any members 17.5 – 21 years of age must include consideration, education, and referral to Assertive Community Treatment (ACT) Program. Criteria must be reviewed and discussed with the member and/or family." It was indicated that provider training is conducted in the spring and fall each year. The SME would like to further understand how this new ACT discharge explanation is communicated in trainings through a training plan to ensure that there are clear processes in place for providers to explain to youth and families the availability of and linkage to ACT and right of refusal to engage in Wraparound instead, upon discharge back into the community.

As indicated in the most recent *January 2023 Semi-Annual Quality Outcomes Report,* for the reporting period January – June 2022, the enrollment in ACT was very low and only included three youth ages 18-20. This is a decrease from the prior six-month period, when five youth were served. Discharge or decline reasons were not available. Critical information missing includes how many youth declined ACT services, which would show how many young adults were offered or referred to the service in the first place. The SME understands that freedom of choice is now available between Wraparound and ACT as a matter of policy, but the SME needs further information and data to understand whether and how the choice is being offered. The SME understands that the State expects ACT services to increase due to new policies put in place to communicate ACT to families upon discharge from PRTFs. Understanding and capturing how many families receive this information at discharge from PRTFs will be important data to track.

The new Freedom of Choice form now allows youth and families to consider and choose between Wraparound and ACT services. The SME would like to see how this form is communicated across workgroups, bureaus and to families, documenting use of the form and collecting data around how many and which individuals within the target population access or decline either service.

As mentioned in the *January 2023 Semi-Annual Quality Outcomes Report*, the Quality Review Committee wants to further explore ACT utilization in other states, as well as further explore utilization of services among the oldest youth in the target population. DHHR has shared with the SME their interest in identifying gaps in services for the older population but has not seen anything formal in writing. The SME will look for more intentional strategies and practices to link young adults with community services, such as identifying and intervening with youth with high and frequent ED and inpatient hospitalization admissions. Where ACT teams substitute for the Child and Family teams, the ACT teams shall develop the ISP; and provide or ensure access to needed in-home and community-based services. Since the 18-20 age range is included in the target population and therefore within range of the Agreement, understanding how this age group transitions to the adult behavioral health system is critical. Also, as mentioned in DHHR's last *Semi-Annual Quality Outcomes Report*, there is merit in looking at national data related to transition-aged youth population to help the State fully understand the prevalence and marketing strategies of young adults accessing ACT across the country.

According to the WVU's *Children's In-Home and Community-Based Services Improvement Evaluation Baseline System and Community-Level June 2022 Report,* providers focusing on children's services were least aware of ACT in the WV service array (17% were aware, compared to 83% aware of residential treatment). Providers were defined as organizational leaders and administrators of agencies offering children's mental or behavioral health services, healthcare and mental health providers, law enforcement officers, judges, attorneys, probation officers, DHHR workers, and school administrators.

Additionally, the State's *CQI Plan* and *KPI Tables* include these measures and indicators below being captured for ACT. The indicators in addition to demographics, include the following:

- Number of ACT referrals by referral source,
- ACT length of service,
- Number/proportion of eligible youth enrolled in ACT services,
- ACT service utilization,
- Timeliness of ACT enrollment after initial referral, and
- ACT provider capacity.

The *KPI Tables* further outline which data sources will be used to pull this data. Some data sources are still being explored, such as the number of ACT referrals proposed to collect via the Aetna Discharge Planning data set. The SME will look for further refinement of the *KPI Tables* and future receipt of ACT Services Reports. DHHR's regular review of ACT data is captured in the QAPI Suite of Reports and Quality Review Schedule.

Lastly, the State indicated that the *Resource Rundown* webpage will post information related to ACT and that materials are being developed. The SME looks forward to seeing these materials. Also, archived and "What's to Come" sections may be helpful for this webpage, so that as new materials are developed, both new and old resources can be accessed by new viewers more easily.

2.3.4 Compliance Rating and Justification

ACT is a unique and critical benefit under the Agreement, serving as a gateway service that can be accessed during the upper years of the target population and past age 21. This means even if a youth does not access the service before age 21, communication to young adults and families is critical to educate them about ACTs potential benefits and how to access this service.

Agreement Requirements 24, 39, 52. Compliance Rating: Partial Compliance Justification: Although the State is moving towards statewide availability of ACT, WV is currently in early implementation with a newly identified provider in the Eastern Panhandle. Additionally, more thorough data needs to be collected and refined to capture those referred to ACT, those enrolled in the service, and fidelity to the model to better understand how the young adult population aged 18 to 20 is being served.
Agreement Requirements 24, 25, 26, 27, 28, 36, 40 and 41. Compliance Rating: Partial Compliance Justification: Additional improved data collection and analysis are needed to track and ensure that individuals are receiving timely, statewide access to ACT in the most integrated setting, at mutually agreed upon times and locations. Further data is needed to ensure that ACT screening, assessments and ISPs are provided to social service MDT convenings. Quality assurance practices to confirm ACT is delivered with high quality standards and addresses individualized needs should be further assessed. Implementation should be supported with more detailed plans at the provider and DHHR level. Additionally clear and thorough documentation of meetings and progress is needed along with validation of effectiveness of this program to reach the target population.

2.3.5 Recommendations to Achieve Compliance

Since ACT can reach the young adult population that may have ongoing behavioral health needs, the State should prioritize connecting families to ACT as a long-term home and community-based service as they exist the target population range. ACT is both a gateway and longer-term service to help youth with clinical, rehabilitation, supportive and case management services through their adulthood. ACT has the potential to address symptom management, and improved social, family, and environmental function for young adults with significant mental health needs in their community environment. Wraparound is a valuable alternative; however, WV should also strive to increase ACT enrollment through marketing to young adults with ongoing mental health concerns. ACT is unique in that this service is available throughout adult years.

Given that ACT is a service offered to a relatively small and finite portion of the Agreement target population (ages 18-20), the opportunity to fine tune how this service is implemented creates real opportunity. Since enrollment data is not unwieldy, ACT can serve as an example to the State of how this implementation can be approached and translated to other services. Recommendations below include: 1) revisions to BMS Chapters 503 and 531 and associated trainings to providers, 2) finalization of ACT retrospective tool, 3) collaboration with new Eastern Panhandle provider, 4) growth in ACT data collection, analysis and quality assurance processes reviewing both local and national data, 5) completion of provider capacity needs analysis, 6) increased ACT public awareness, and 7)

coordination and communication of freedom of choice ACT v. Wraparound and pathway to either service.

RECOMMENDATIONS	ACTION STEPS	COMPLIANCE CATEGORY
Complete Chapter 503 updates.	-Complete Chapter 503 Appendix F updates for group residential services to require freedom of choice between ACT and Wraparound for eligible youth discharging from group residential. -Create an Appendix to Chapter 503 to describe requirements for Certified Community Behavioral Health Centers (CCBHCs) since ACT will be a required service. -Amend/update the eligibility criteria for ACT.	-Accessible Information -Mutually Agreed Delivery by Provider & Family -Statewide Capacity -Workforce Readiness -Access to Services
Complete Chapter 531 updates and PRTF Provider Agreements to require the choice of ACT versus Wraparound for eligible youth discharging from PRTFs.	-Add freedom of choice language to Chapter 531.	-Accessible Information -Mutually Agreed Delivery
Complete provider trainings related to the changes in Chapters 503 and 531.	-Draft training plan for providers and other relevant community members.	-High Quality Service -Workforce Readiness
Finalize and implement changes to the ACT Retrospective Review Tool and process.	-Continue review of data from newly changed 12-month review cycle with 100% of ACT recipients and draft QA report template to address findings.	-High Quality Service -QA -Data Collection & Monitoring
Collaborate with the Eastern Panhandle provider to begin ACT services and track implementation progress.	-Seek more detailed implementation plan from new provider and track progress.	-Statewide Capacity -Access to Service -High Quality Service
Grow data collection, analysis, and QA process for ACT and use local and national data to understand and strategize reaching TAY population.	-Continue to implement program-level data collection, review and reporting for ACT services applying KPIs outlined in the *CQI Plan* and expand KPIs. -Improve quality review process and presentation of preliminary data to monitor fidelity to the ACT model, and provider-specific reports and expand data collected. -Create intentional TAY strategic plan to better understand the clinical needs and outcomes of the State's young adult population. -Review both local and national trends of ACT services, particularly 18-20 population. -Request support from university partners on national TAY research.	-Data Collection & Monitoring -Access to Service -High Quality Service

Complete provider capacity needs review, as reflected in DHHR's *CQI Plan* and recruit for additional providers, if needed.	-Create accessible and ongoing provider network information.	-Statewide Capacity & Access
Increase ACT public awareness to young adults and families to increase referrals and utilization.	-Include future *Resource Rundown* topics that address ACT to communicate, explain and market the purpose and benefits of ACT to families and community members. -Draft ACT content, include and streamline on the *Resource Rundown* platform.	-Accessible Information
Coordinate communication of Freedom of Choice form and pathway across workgroups and bureaus.	-Establish a coordinated effort across workgroups (beyond the PRTF provider network) and through the pathway document to include detail on 1) how youth would be determined to meet eligibility for either service, and 2) how a youth eligible for both would be offered choice between the two services. -Finalize pathway and develop a SOP describing how a member will be offered choice.	-Accessible Information

2.4 Quality Assurance and Performance Improvement System

2.4.1 Service Description

Agreement Requirements 28, 48, 49, 50, 51. The Agreement stipulates that for all children screened, assessed, and receiving services under the Agreement, DHHR is required to collect and analyze data to assess: service delivery (including whether children are unnecessarily institutionalized); measurement of improved positive outcomes and decreased negative outcomes; changes in functional ability; fidelity to the NWI model; and timeliness of crisis/urgent services. The Agreement requires WV to perform quality sampling reviews of a statistically valid sample of youth to identify areas of strength and areas for improvement, with related steps towards improvement reported in the semi-annual report.

QAPI is a cross-bureau system for supporting data-driven decision making and improving timeliness, effectiveness, and efficiency. These are intended to support the transition to compliance as well as sustainability through an evolving CQI effort. A centerpiece of this effort is a data store bringing together multiple streams of data spanning services (including timeliness), screenings, outcomes (including functioning, juvenile justice, school, and CPS), fidelity, and RMHTF population characteristics. This data store, and the internal and external reporting, are overseen by the OQA.

2.4.2 Historical Review

A culture of data-driven decision making is clearly implied in nearly every aspect of DHHR's objectives. Consistent with this vision, the previous SME team provided substantial TA to DHHR on the development of the infrastructure that promotes this culture. DHHR is to be commended for generally following through on these recommendations in a timely manner, involving interested/affected members at numerous points in this process; developing new data sources to improve timeliness; establishing and growing a data store and an internal data dashboard; undertaking evaluation tasks specifically mentioned in the Agreement; improving the documentation and transparency of KPIs; and disaggregating these KPIs on key demographics. The OQA has been established and staffed to help institute roles and responsibilities and to ensure an infrastructure that supports all bureaus and service aims.

2.4.3 Review of Current Documentation, Activities, & Accomplishments

Overview. Quality improvement pervades all services covered in this report. As a cross-bureau, cross-service effort, findings related to individual services, including benchmarks that are or are not met and trends that indicate specific service provisions, are described more fully in the sections describing those services. This section focuses on overarching aspects that pertain directly to the development, implementation, and sustainability of a data-driven decision-making process, and the infrastructure necessary to ensure adherence to high quality standards.

DHHR has provided 5 key documents that describe their CQI process:

1. *CQI Plan*
2. *Data Store Buildout Timeline*

3. *KPI Table*
4. *Suite of Reports*
5. *January 2023 Semi-Annual Quality Outcomes Report*

These documents describing the steps being taken to continue to build and improve data systems have been updated recently and demonstrate responsiveness to the compliance ratings and recommendations of prior SME reports (e.g., ensuring KPIs are documented and transparent.)

Although these documents show clear evidence that DHHR is making progress in this area, most notably on development, it is not yet clear to us that this process has been implemented at scale or in a way that is sustainable without continued technical assistance from the SME or other partners. To be clear, we are not indicating that scale and sustainability have not been reached in certain areas; rather, we are indicating that more evidence supported by an implementation framework is needed to support an informed compliance rating. On the positive side, we have seen that there is encouraging momentum in this regard on several services (e.g., foster home capacity issues identified and discussed by quarterly committees) independent of the TA provided directly by the SME, which does suggest a shift towards sustainable data-driven decision making.

Commitment to quality. The following information comes from the *January 2023 Semi-Annual Quality Outcomes Report* unless otherwise stated. DHHR continues with phased implementation of both QA (backward-facing) and CQI (forward-facing) processes.

- A key piece of QA, the baseline *Wraparound Fidelity Report*, was issued during the current cycle, and revealed that critical standards in the NWI model were not being adhered to.
- DHHR followed through on prior recommendations to dig deeper into current data sources, such as the RMHTF population data, which has revealed that much work still needs to be done to ensure that only children who require residential treatment are in residential treatment, and only for as long as it is needed.
- Indicators for all relevant services have been established and included in the *CQI Plan* and further detailed in the Key Performance Indicators Working Document.

The SME will look for full execution of the established *CQI Plan* and documentation of key indicators to include data collection, analysis and application.

Overall, quality is managed through the following processes:

- The OQA and the committees—both standing and (as-needed) PIP teams;
- Contracts with providers and vendors (e.g., Kepro, which undertakes the QIA) to collect data and contracts with two universities to conduct evaluations;
- Data collection and the data store, which synthesizes the data from these sources to form the backbone to the QAPI data dashboard and reporting, which are then fed back into reports;
- Internal and external reporting through dashboards, and periodic and ad hoc reports;
- Responsiveness to data quality issues; and
- Utilization of data to track compliance and promote sustainability by identifying critical needs.

Documentation is regularly updated to reflect the data sources, indicators, and reports that are being planned and implemented.

OQA and committee structure. This is outlined in the *January 2023 Semi-Annual Quality Outcomes Report*, unless otherwise stated.

- The OQA provides the structure for coordinating data-related tasks that span multiple bureaus and services and takes responsibility for the semi-annual report (*Year 4 Imp Plan*).
- Standing "Quality Committees" for each service, consisting of all bureau and program teams, meet on a regular quarterly schedule and make data and service recommendations towards removing silos and encouraging accountability and transparency. For example, the *January 2023 Semi-Annual Quality Outcomes Report* noted that an October quality review included a focus on foster home capacity, recommending actions be taken to improve recruitment and retention.
- Interdisciplinary, cross-bureau, and cross-function quality reviews occur on a regular schedule to review data, identify areas of strength and document and follow-up on opportunities for improvement. At the program, service, and workgroup levels these meetings occur monthly; at the department level they occur quarterly. Quarterly data reviews are completed with BJS and Probation Services.
- PIP teams are formed and meet as needs or opportunities emerge. One key example is a PIP team for Wraparound intended to address issues identified in the baseline *Wraparound Fidelity Report*.

The SME will be looking for future documentation of ongoing monthly and quarterly data review meetings.

Data store build and reporting. As noted in prior SME reports, DHHR has published a detailed timeline for the modules to be made available in the data store (also see *QAPI Data Store Buildout Timeline Projection March 2023*), with target release dates for as-yet unreleased data modules spanning from April 2023 to April 2024.

- CSEDW-eligible population and utilization data constituted two data modules that were recently made available.
- Modules that will become available during the next cycle include Child CAFAS History and Discharge Planning.
- A detailed schedule in the *QAPI Suite of Reports and Quality Review Schedule March 2023 Update* indicates the reporting status and frequency (monthly, quarterly, semiannual, or ad hoc basis).
    - DHHR is to be commended on the contract with Kepro for a QIA of children at high risk of residential placement. Although in the early stages, this information will likely provide insights into bottlenecks and failure points, provider- and region-specific trends, and opportunities for system improvement.
- Timelines for phased roll-out and incorporation of QIA into the data store and reporting have been provided.
- OQA will be hiring a second analyst to support adherence to these schedules and continued implementation of CQI processes (*March 2023 SME Deliverables Summary*).

Data utilization and quality. DHHR is making considerable efforts in this area, as noted in the *January 2023 Semi-Annual Quality Outcomes Report.*

- Several data systems are currently available in the data store while others are being phased in, sometimes with significant lag behind the implementation of their related programs (*QAPI Data Store Buildout Timeline Projection March 2023*).
    - For data not yet integrated into the data store, reports are made available on a recurring basis manually.
- Although results from these quality efforts are still early, evidence supports the importance of the quality efforts for program improvement and adherence to standards (e.g., the *Wraparound Fidelity Report.*)
- DHHR has leveraged data for semi-annual reporting, revealing opportunities for addressing barriers and improving service delivery.
    - For example, BBH staff have suggested that they would like to examine outliers in crisis service utilization to better understand youth who are frequent users.
- DHHR has also begun to analyze these data more thoroughly, examining KPIs for different groups of children, and the results of these efforts have the potential to have an immediate impact. Some examples include impacts on discharge timeliness and warm transfers between CCRL and CMCRS; as well as longer-term impacts on transition-age youth.
- DHHR is commended for using data to identify high-need counties to focus the initial roll-out of QIA.
- As noted in the most recent Semi-Annual report:
    - DHHR has identified sources for several outcomes that are required, such as arrests/detentions, commitment to BJS or DHHR, and suspension/expulsion from school. In the case of the school data, DHHR has indicated that a data sharing agreement will be needed. Further, the KPI table specifically identifies commitment to BJS or DHHR as indicators.
    - The CANS assessment data pertaining to youth functioning, which is planned for integration into the data store in July 2023, has been subjected to a quality and completeness review by DHHR.
    - The January report notes that BMS already monitors for polypharmacy, and the KPI table indicates that number/proportion of prescribed "psychotropic" (not specifically or limited to antipsychotic) drugs will be part of the semiannual reporting process.
- DHHR is also commended on decisions to disaggregate on indicators that suggest areas of concern (e.g., the plan to examine characteristics of those who quickly discharge vs. those who do not; or the rich descriptive data of youth in residential care who have CANS or CAFAS scores under 90).
- Some of the data suffers from imperfections that DHHR acknowledges are problematic and is making plans to address, including high rates of non-response and missing values.
    - The SME notes in the *Wraparound Fidelity Report* that one provider did not participate in data collection.
    - The most recent semi-annual report indicates that efforts are underway to respond to a prior SME recommendation and include contract review as part of the quality infrastructure to ensure that providers and vendors are full participants in the data

collection and quality process. DHHR program leadership and quality teams are actively engaged with third party vendors to address data collection and data quality issues.

2.4.4 Compliance Rating and Justification

Agreement Requirements 28, 48, 49, 50, 51. Compliance Rating: Partial Compliance

Justification:

These requirements pertain to:

28. *Ensure timely provision of mental health services to address any urgent need for services.* As this requirement pertains to quality, DHHR is making efforts to collect data that will allow them to be more responsive. DHHR should continue efforts to identify measures for daily or weekly review and ensuring these reviews are conducted.

48. *QAPI development, including data needs and dashboard development*. Multiple documents describe extensive plans for data build, including a timeline that is partially complete, on-time as of the most recent revision, and is scheduled to reach completion in April 2024. *Measurement of unnecessary institutionalization*. Analysis of the Assessment Pathway through a QIA process (which will be conducted by Kepro), as well as analysis of discharge data will continue to help DHHR understand opportunities for both diversion and discharge.

48a. *Semi-annual reporting, analysis of cross-bureau implementation quality, including measures of remaining or returning home, failure of foster home placement, institutionalization, arrest, or involvement with juvenile or criminal justice system*. OQA continues to meet the requirement for semi-annual reporting, using a data store and dashboard built from cross-bureau data; recent planning meetings (with WV DHS, the court system, and WV DOE) have served to further the goal of incorporating cross-agency data in the data store; several of the noted indicators are currently or slated to be included in the data store and will be featured in future reports.

48b-c. *Analysis of implementation across critical youth-serving agencies and bureaus and analysis of data to assess impact on children in the target population.* Implementation data will necessarily follow implementation by a substantial lag, particularly if using Medicaid claim data. At the present time, most of the data is being generated manually, although all DOJ related services data are within the projected timeline for integration into the data store. The *January 2023 Semi-Annual Quality Outcomes Report* contains an extensive analysis on CSED waivers.

49a-b. *Child screening, dates of screening, service engagement, and receipt of services including type and amount.* As noted in the *January 2023 Semi-Annual Quality Outcomes Report*, screening data are currently limited to a recent period of time and remain siloed, pending incorporation into the data store. Nevertheless, the siloed data are proving to be actionable, with improvements to data quality and screening processes.

49c. *Residential stays and admissions, including admission dates, length of stay, and number of prior residential placements*. RMHTF stays and stay or admission characteristics are an integral part of the data store and numerous reports, including a sophisticated MU report (*Youth in Group Residential and Psychiatric Residential Treatment Facilities*) on an empirical classification of youth based on need, have helped to clarify this population; at present DHHR is focused on the QIA and ensuring all youth have a discharge plan (discharge planning data are to be incorporated into the data store prior to the next semi-annual report.)

49d-e. *Outcomes of children in the target population including child functioning, prescribing patterns (or 3 or more anti-psychotic medications), juvenile services, and arrests or detainments; and how DHHR will utilize data to address problems and improve services*. DHHR has made progress on developing many of these outcomes (arrests/detentions; commitment to custody; suspensions and expulsions). For functioning, plans call for the CANS assessment to be integrated into the data store in July 2023. Only youth identified with three or more prescriptions for psychotropic drugs (which includes anti-psychotic medications) were included in reporting reviewed during this cycle; however, DHHR has included more specific indicators around youth with three or more anti-psychotic medications in the more recent July 2023 Outcomes report, while continuing to report on youth's psychotropic use.

49f. *Fidelity of child and family teams to NWI model.* A baseline report, prepared by MU, was issued in November 2022, and utilized data that revealed gaps in fidelity.

50.1-50.3 *Annual quality sampling reviews of a statistically valid sample of children in the target population; identification of strengths and areas for improvement from these reviews; and the steps taken to improve services accordingly will be reported in the semi-annual report*. DHHR has contracted with WVU to conduct the quality sampling review; the next report of those efforts will be released in Fall 2023.

51. *Addressing problems through the analysis of data*. DHHR is beginning to collect and align data with best practice (e.g., they responded to the SME recommendations to follow up on the failures of warm transfer between CCRL and CMCRS).

2.4.5 Recommendations to Achieve Compliance

RECOMMENDATIONS	ACTION STEPS	COMPLIANCE CATEGORY
Real-time (daily or weekly) data review.	-DHHR should continue to document how they use such data to inform real-time improvements (e.g., including documentation regarding data review at workgroup and quality meetings as well as next steps, lessons learned, and planned improvements.) -Data with a brief lag and high responsiveness to bureau or provider actions should be prioritized. This will help ensure contractual obligations are met and identify concerning trends that can be headed off more quickly. This will also help identify breakdowns in the pathway, bottlenecks in service delivery. -DHHR should continue in the direction of quick turnarounds for problems identified through either technical assistance or their own data analysis.	-Data Collection & Monitoring
Undertake rapid cycle improvements.	-Although the "rapid cycle improvements" suggestion of prior SME reports were not addressed directly by name, some PIP teams may be prepared to handle this	-High Quality Service

	task if the timeline for convening, studying, acting, and resulting improvement is brief enough (3-4 months.) -Rapid cycle improvement requires examination of highly responsive short-lag data on a daily or weekly basis.	
Ensure vendor and provider contracts stipulate expectations about supporting quality efforts.	-The importance of stressing quality improvement efforts as a contractual obligation of all providers and vendors has been noted in earlier SME reports. DHHR has begun to respond to this recommendation, but further details on these efforts are needed. -Providers and vendors should continue to be expected to assist not only in compliance with the Agreement, but with ongoing accountability efforts. -DHHR should continue to clearly communicate their expectations for providers and vendors.	-Data Collection & Monitoring
Child-focused reporting.	-It is important to go beyond silo-oriented reports of service receipt and timeliness to report on the progress that children experience in the Assessment Pathway and subsequent services received, identifying potential bottlenecks and delays experienced by individual children and families as they move from one service (and the responsibility of one bureau) to another. DHHR has begun to respond to this recommendation, but further details are needed. For example, in the section on CSEDW Utilization, the *January 2023 Semi-Annual Quality Outcomes Report* refers to a time when "the data store is expanded to allow alignment of child-level data across systems" (p. 65) but this refers to collection and synthesis, and not analysis. Further, it lacks specificity (what data elements will be included) and a timeline for implementation. -Averages may not provide sufficient evidence for identifying problems in this area; DHHR should continue to look for outliers (similar to the plan to examine repeat users of crisis services) or set benchmarks and look for records that exceed or underperform these benchmarks. -For example, CCRL and CMCRS are child-focused practices and child-focused reporting will support efforts to customize these HCBS to the needs of specific children and families, including ascertaining whether youth were stabilized in their treatment, and diverted from the ED.	-Data Collection & Monitoring

Data quality.	-DHHR should continue building and revising documentation of KPIs and other data across all services and activities such that metrics, time periods, and other essential characteristics, from diverse sources of data, are transparent and concise. It will be helpful to create an SOP that details a process for who collects the data, with what frequency, and how the data will be used to inform services. (The data buildout tables contain part of this information.) -DHHR should continue to improve the utility of the data that are collected by eliminating vague or un-actionable response options where this is possible. -DHHR or their contractors should continue to investigate sources of missing data and non-response and undertake efforts to reduce these problems. -Periodic data quality review should continue to be conducted (e.g., of CCRL and CMCRS data). -In survey data collection, efforts should be made to follow up with providers to minimize non-response.	-Data Collection & Monitoring
Increased disaggregation of data as appropriate.	-Key indicators should be disaggregated to the provider and region level to identify discrepancies that may be specific to one or more providers. DHHR indicates internal analysis of county and provider level data is occurring, and the SME looks forward to seeing this data in the future. -As outlined in DHHR's CQI plan and KPI Tables documents, key indicators should also be disaggregated on child characteristics to ensure these problems are not disproportionately impacting specific groups of children. -Include specific county-level data for services that are currently expanding statewide. While this data is currently used by DHHR internally, sharing county and regional level data with the public could be a strategy to increase calls to certain areas and help providers set specific goals and areas of growth, address training needs and continue to move to best practice.	-Data Collection & Monitoring
Mapping.	-Continued use of maps is recommended, particularly related to recruitment of providers and homes. Understandably DHHR would not map the exact locations of (for example) the STAT caregivers, but some county-level indicators could be mapped, helping to understand number of caregivers in each county or region.	-Data Collection & Monitoring
Improved use of specific data sources.	-DHHR should provide further details on how the QIA and/or CANS data could be combined with other data in the data store to support improvement efforts (including how these data might be leveraged for child-focused reporting.)	-Data Collection & Monitoring

2.5 Screening

2.5.1 Service Description

Agreement Requirements 31, 32, 48, and 49. The compliance agreement requires the State to ensure that all children and youth who are eligible to receive mental and physical health care and services through DHHR are screened to determine if they should be referred for mental health evaluation or services and that DHHR adopt a standardized set of mental health screening tools. Additional provisions require the screening of children entering child welfare and juvenile justice, as well as screening if the child or family requests it, as well as outreach and training on the use of the screening tools for physicians of children who are Medicaid-eligible. Fifty-two percent of Medicaid-eligible children who are not in the Youth Services, child welfare, or juvenile system systems shall be screened with a mental health screening tool annually.

2.5.2 Historical Review

Over the course of the SME reports so far, there has been substantial progress in determining and documenting which screening tools are being used by various agencies, as well as in expanding and supporting the use of HealthCheck (WV's EPSDT[1] program) among Medicaid MCO and other primary care providers. As in other agreement areas, there are acknowledgements throughout the reports of the impact of the COVID-19 pandemic and the need to continuously adjust timelines in terms of goals for assessing gaps in screening and putting new policies and practices into place.
The first six SME reports document the following points of consideration and progress.

Screening protocols. Throughout the course of the Agreement, WV has made great progress in establishing screening protocols across agencies. The following protocols are in place:

- DHHR policy requires that all children placed in DHHR custody via the child welfare system, including Youth Services and CPS, receive an EPSDT screening, which includes mental health screening, within 30 days of placement (as documented in the *Foster Care Policy Manual,* updated June 2023).
- BSS uses the FAST (Youth Services) and the Ongoing Assessment (Child Protective Services) as an early screening opportunity in addition to the EPSDT screening.
- BJS and Probation Services use the MAYSI-2. This process is in early implementation.

Tracking screening. There are two primary avenues for tracking screening rates: 1. assessing EPSDT behavioral health screening rates among primary care doctors for Medicaid-eligible youth via an MOU with the OMCFH, and 2. reviewing policies and data on tracking behavioral health screening performed by BJS and Probation Services. Tracking and monitoring is clearly outlined. In some cases, DHHR is working with relevant entities to address data quality issues. Overall screening rates are included in the data store build out.

[1] EPSDT is Medicaid's comprehensive and preventive child health program for individuals under the age of 21.

The goal of 52% of Medicaid eligible children who are not in youth services, child welfare, or juvenile justice will be screened with the mental health screening tool annually had not been met as of the most recent SME report, though there was a question about accuracy of the data[2]. This data methodology has since been revisited to ensure accuracy and consistency. DHHR is working toward achieving the 52% goal for Medicaid eligible children who are not in youth services, child welfare, or juvenile justice. According to the *January 2023 Semi-Annual Quality Outcomes Report*, DHHR is reviewing this data and has plans to continue to implement several strategies to increase both wellness screening generally and the proportion of screenings that include standardized mental health components. According to the Suite of Reports Publication, DHHR plans to review preliminary data quarterly to address this goal.

EPSDT and the HealthCheck form. The EPSDT benefit for Medicaid is one substantial avenue for screening in the state, using the HealthCheck form. However, one ongoing issue is that the EPSDT report of screening rates captures all screenings and is not specific to behavioral health. While managed care organizations do share monthly reports on EPSDT screens and the reports do include mental health categories, the last time this data was mentioned in an SME report, only one of four MCOs was actually populating that data field. OCMFH undertook a significant effort to retrospectively determine screening rates using a hybrid auditing process, the first round of which was completed in December of 2020. In 2020, the population audited included children ages 0-20 and the rate was nearly 80%. The goal would be to automate some of this process to lighten the workload moving forward; the SME has recommended accomplishing this at least partly through the addition of a code modifier to more accurately identify behavioral health screening as part of EPSDT screening. There was also a suggestion that the Medicaid External Quality Review vendor Qlarant could assist with this monitoring work.

Outreach and education. More work is needed to increase awareness and engagement of primary care providers in using screening as part of a continuum of care. One effort previously mentioned by the SME was for HealthCheck program specialists to meet with primary care providers. The SMEs are waiting for data to review from the Bureau for Medical Services on its efforts with MCOs to improve screening rates.

2.5.3 Review of Current Documentation, Activities, & Accomplishments

The most recent SME Deliverables Package highlighted three main areas of progress:

- DHHR has moved towards clarification of which tools are being used by each bureau/agency, as DHHR has adopted a standard set of mental health screening tools, including operating procedures, which include: HealthCheck screenings within 30-days of removal for children placed in the custody of DHHR, which includes Youth Services and CPS; MAYSI-2 for the

[2] From the December 2022 SME report: "Using data in DHHR's semi-annual report, it would appear DHHR has not met its benchmark of 52% at time of this report. Given DHHR had met this benchmark previously, DHHR was going to review its data to ensure its accuracy. When pulling publicly available CMS Form 416 data for the most recently available year (2020) overall EPSDT screening rates, which include screening for more than just mental health, met the 52% benchmark. As such, the SME recommends that DHHR, DOJ, and the SME review this requirement, discuss what DHHR learned after it completes its internal validation of the data in its semi-annual report. Depending on the timing of this discussion, OMCFH's next HealthCheck quality review report may be available and may provide more up-to-date information on 2021 HealthCheck screening rates."

State Division of Probation and the BJS; and EPSDT for primary care providers. The BJS protocol for MAYSI-2 utilization remains under revision but changes include referring youth to the Pathway at the time of screening to ensure that services are available to them shortly after discharge.

- The State's DPS updated its policy to include expanding screening to include select pre-adjudicatory youth (no additional information is provided as to what defines the subset). The policy was updated in September 2022 and was provided to DPS staff.
- BMS has engaged in efforts with the MCOs to improve screening rates for EPSDT, including monthly discussions with MCOs to emphasize the importance of improving the rates of screening; continued provider training sessions; and outreach to encourage wellness visits and screenings. (This area cross references to Outreach & Education.)

The *Year 4 Imp Plan* describes goals related to screening for 2023. The plan specifies that the following entities complete screenings: YS; CPS; WV Division of Corrections and Rehabilitation, BJS; and DPS. In line with the compliance agreement, the stated goal is for a mental health screening using an approved screening tool be completed for any child not already known to be receiving mental health services when the child enters YS, the child welfare system, or the juvenile justice system; or when the child or family requests mental health services or that a screen be conducted. Additionally, no less than 52% of WV Medicaid-eligible children who are not in the YS, child welfare, or juvenile justice systems will receive annual trauma-informed psychosocial screening. The plan also highlights work on data collection for screenings and the distribution of flyers to PCPs with a QR code and URL to make referrals online via JotForm (an electronic referral form): https://hipaa.jotform.com/PGHN/help4wv-PCP-referral. Additionally, progress has been made in using the EPSDT mental health screening modifier code; and in DHHR gaining access to reports to be able to monitor screening practices. Open tasks in the Implementation Plan include:

- Providing TA to YS and CPS staff on screening, making referrals, and completing data collection.
- Completing PCP training and implementing a survey of PCPs to evaluate their understanding of referring to the Assessment Pathway and the availability of HCBS. No additional information was received about the nature of these trainings or surveys.
- Continuing implementation of program-level data collection, review, and reporting for screening KPIs as outlined in the *CQI Plan* and *Key Performance Indicators* (working document).

The *January 2023 Semi-Annual Quality Outcomes Report* shares the following screening updates:

- In 2021, WV had 106,184 Medicaid members aged 0 – 20 with at least 90 days of consecutive eligibility who received HealthCheck (EPSDT) screening during well-child visits. This represents 46% of Medicaid-eligible children aged 0 – 20 with at least 90 days of consecutive eligibility (n= 229,908 total eligible children). This overall screening rate has remained stable since 2020.
- The retrospective analysis of medical records linked to administrative claims for 2021 found that 83.3% of children's medical records indicated a mental health screening was included during the primary care provider exam, an increase from 79.5% found in the 2020 chart review. Extrapolating from the chart review results, this means an estimated 38.5% of Medicaid

eligible children aged 0 – 20 with at least 90 days of consecutive eligibility received an EPSDT with mental health screening in 2021, an increase from 36.5% in 2020.

- There are many implemented and planned activities with MCOs, including monthly meetings, quality related capitation withholding measures, adding structure to the MCO care manager call process, and training with PCPs.
- Roll out of data review of the FAST for use in early screening for YS is being conducted on a phased county-by-county rollout, and there are clear issues with data quality and completion. Focused TA was piloted in Cabell County resulting in improvement in data collection. This TA is expected to roll out to additional counties, but no clear timeline is presented.
- All children placed in DHHR custody are required to receive an EPSDT screening during a well-child visit, including mental health screening, within 30 days of placement with CPS. However, since exit data is not available, it is currently unclear if these children have an EPSDT screening during a well-child visit before exiting placement. There is the opportunity to use data to tell a more complete story about the screening experiences of the CPS population.
- For BJS screening, there was an average of 105 unique screenings per month. Because each child should be screened at intake and whenever they transition within BJS facilities, the number of screenings per month should equal or exceed the number of intakes. The number of unique screenings per month exceeded the number of intakes for 7 of the 10 months represented with the exceptions occurring in May, September, and October (for all three months, the number of screenings almost reached the number of intakes). This is a positive sign indicating that screenings are taking place as expected.
- Looking at DPS, the screening and referral process is still early in implementation, and data only represents 27 counties. Effective February 2023, recurring quarterly reviews have been scheduled to review and evaluate Probation Services screening and referral data at the county level. Quarterly reports will be shared with the chief probation officers to assist with making continued improvements at the county level.
- Provider capacity remains a concern. Outreach to PCPs is increasing, but child welfare staff vacancies continue to be a concern.

2.5.4 Compliance Rating and Justification

Agreement Requirements 31, 32. Compliance Rating: Partial Compliance

Justification:

These requirements call for a standardized set of screening tools for all eligible children and that all children who meet criteria are screened. DHHR continues to make progress in rolling out these tools across agencies. However, work remains to reach uniformity in implementation and tracking across bureaus and agencies and to increase reach to all children who need to be screened. More training and outreach are necessary to reach all parties who will eventually be responsible for conducting screenings when the screening system/network is operating as intended. Specific areas where increased screening could be supported by more training and outreach, include Medicaid-eligible children. Additionally, the 52% goal for Medicaid-eligible children has not been reached.

Agreement Requirements 48, 49. Compliance Rating: Partial Compliance
Justification: These requirements relate to quality assurance and data collection. There is still work to be done to give DHHR access to data which will allow for screening monitoring with limited lag in reporting. Something akin to a screening data dashboard that encompasses all agencies could provide a clear snapshot of how DHHR is performing regarding screening rates. Integration of data in the data dashboard according to the referenced data store plan will move the state towards meeting this requirement.

2.5.5 Recommendations to Achieve Compliance

The recommendations in this area fall into several key categories. First, WV still needs to increase total screening levels for all eligible children. Increasing screening has several components, including workforce capacity building and outreach to MCOs and PCPs who provide screening. There is also a strong need for more unified, less siloed data for screening. The SME strongly believes that a clearer implementation plan overview is necessary to better understand current screening activities and future progress.

RECOMMENDATIONS	ACTION ITEMS	COMPLIANCE CATEGORY
Increase screening for all eligible children.	-Increase screening levels across all entities responsible for providing screening. Specifically, WV still needs to meet the Agreement requirement that 52% of Medicaid eligible children who are not in youth services, child welfare, or juvenile justice will be screened with the mental health screening tool annually. -While the SME commends DHHR for its high mental health screening rates as part of its well-child visits, the SME recommends that additional strategies be added to address the low occurrence of well child visits among older youth.	-Access to Service
Work with MCOs to improve screening.	-Documentation is required to show efforts with MCOs related to TA provided on improving screening.	-Access to Service
Training and TA for PCPs.	-The SME would like to review more documentation on work and collaboration with physicians to increase screening rates.	-Access to Service -Workforce Readiness
Increase data monitoring of screening rates.	-DHHR must implement an oversight process to ensure that all youth entering a state agency are screened upon entry. -The creation of more uniform data collection strategies and dissemination tools across agencies will allow for easier and more effective oversight.	-QA -Data Collection & Monitoring

2.6 Target Population

2.6.1 Service Description

Agreement Requirement 23. The Agreement states that the target population include all children under the age of 21 who: a) have a Serious Emotional or Behavioral Disorder or Disturbance that results in a functional impairment, and (i) who are placed in a Residential Mental Health Treatment Facility or (ii) reasonably may be expected to be placed in a Residential Mental Health Treatment Facility in the near future; and b) meet the eligibility requirements for mental health services provided or paid for by DHHR.

2.6.2 Historical Review

The first six SME reports document the following points of consideration and progress.

Setting target population parameters. In the SME August 2021 Report, the SME first reviewed the state's translation of the Agreement target population into operational parameters for data reporting and compliance oversight purposes. The operational parameters were proposed to be able to apply the definition to pull, analyze, and report data from DHHR's various data systems, and conduct the evaluation. DHHR indicated from the start that this analytic translation of the target population definition would only be used to pull data for reporting and would not be used to determine service eligibility or medical necessity criteria for services defined in the Agreement.

Target population proposal and testing. Once the parameters were drafted, the State, DOJ, and the SME actively discussed the State's proposed approach to define the target population for data reports and the evaluation. As discussions continued, the State proceeded with testing the definition. The SME supported the State's plan to enter a testing phase of its proposal.

First target population analysis. DHHR's first analysis of data was presented to DOJ and the SME in January 2022 to determine the "at-risk of residential" subpopulation focused on diagnostic categories. The State pointed out that functional data from the CANS or CAFAS/PECFAS was not available, and that service utilization data for certain services in the proposed definitions such as CMCRS were not yet available. DHHR specified that analysis of functional need from standardized tools and service utilization will be performed when that data is available.

Recent steps and standing recommendations. Most recently, meetings dedicated to target population development were held in June and September 2022 with the SME and DOJ to further discuss the initial analysis. DHHR was responsive to the concerns raised at these meetings. One area of concern involved defining how long a youth stays in the data set. DHHR in turn confirmed youth will stay in the target population until their 21st birthday. Additionally, DHHR agreed to remove 1) the exclusion of children with ADHD to align with the federal definition of SED and 2) the provision for children who were "expected to need residential within the next 30 days" (which was a duplicative requirement that would be met through CAFAS scoring). The SME made several recommendations that are still being discussed. They involve including youth that access Agreement services in the target population data set even if they do not meet at-risk criteria; defining a look-back methodology; and including

further analyses on primary SUD diagnoses. The parties agreed that until the data store is built out further and more data is available (targeted for late 2023 and into 2024), little movement and compliance evaluation can be made in this area. More data and time are needed to enable WV to test and validate the parameters established to capture children in their data set as relates to the Agreement.

2.6.3 Review of Current Documentation, Activities, & Accomplishments

DHHR has worked over this last year to establish criteria to translate the target population definition into operational parameters for data reporting and compliance oversight. Since WV's operational definition of their target population was presented in January 2022, DHHR made recommended revisions in May 2022, as outlined below. This is the agreed upon definition among the parties. Given the data warehouse is still under development, no new information or data analysis was provided to the SME related to the target population in this reporting period.

Current Operational Definition to Define Youth At-Risk of Residential from Claims or Administrative Data Sources		
Children under 21 with an **SED** and a CAFAS/PECFAS score greater than or equal to 90 (≥90).	OR	Children under 21 with an **SED** and one of the following in the past 90 days: ☐ Incidence of acute psychiatric care hospital stay ☐ Incidence of ED visit for psychiatric episode ☐ Mobile Crisis Response Incidence ☐ In state's custody due to CPS or YS involvement.
Definition for Serious Emotional Disturbance (SED): Children with ICD-10 F Diagnosis Codes, excluding the following standalone diagnoses. ☐ F10 –F19, F55 (SUD) ☐ F70 –F80 series (neurodevelopmental disorders) ☐ 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)		

2.6.4 Compliance Rating and Justification

Agreement Requirement 23. Compliance Rating: Partial Compliance
The target population definition has been drafted and subsequently amended based on SME recommendations, which demonstrates the DHHR's active progress in establishing a consistent definition. The data to do the full analysis of functional need on youth in the target population is still unavailable as the data warehouse continues to be built and data inputted. Until the complete set of data is available, the effectiveness of this definition cannot be fully validated.

2.6.5 Recommendations to Achieve Compliance

The SME recommends the following 1) moving forward with current data collection and analysis with existing definition, and 2) expanding analyses.

RECOMMENDATIONS	ACTION ITEMS	COMPLIANCE CATEGORY
Continue moving forward with collecting data and conducting current analyses using the target population operational definition.	-Share data with the SME to demonstrate that the target population is receiving home and community-based services as intended. -Continue building out the data store, with projected completion date of 2024.	-Data Collection & Monitoring -Access to Service -QA
Expand analysis.	-Include analyses to evaluate whether youth in the target population are receiving services.	-Data Collection & Monitoring -Access to Service

2.7 Children's Mobile Crisis Response and Stabilization

2.7.1 Service Description

Agreement Requirements 13, 15, 24, 26, 29, 30, 40, 41, 48 and 49. The Agreement requires the State to develop CMCRS statewide for all children, regardless of eligibility, to prevent avoidable higher levels of care and connect with community services. The CMCRS must operate 24/7, via a toll-free number and must have plans to respond to crises by telephone or in-person and to collect and report data to track timeliness of response and family engagement in HCBS following a crisis.

2.7.2 Historical Review

The first six SME reports document the following points of consideration and progress.

Design. CMCRS was initially piloted with a great deal of installation pre-work to understand the financing, current crisis model, and reasons CMCRS is requested. Capacity and growth plans were also developed. CMCRS services are funded by BBH as well as through the CSEDW.

Implementation of CCRL. CCRL is a statewide call center established in 2020 and dedicated to responding to children and families calling for assistance. CCRL was created by BBH and is part of WV's larger Help4WV call line. Based on children's and families' self-reported behavioral health needs, triage and warm hand-offs are made by CCRL to local CMCRs service providers occur, while resources and referrals for non-urgent behavioral health concerns are provided.

Implementation of CMCRS. CMCRS has been available statewide since 2021 and is supported by CCRL. WV has seven CMCRS providers that cover six regions in the state.

Training. CMCRS initially went live without standardized training, but since then a CMCRS curriculum to train providers and work towards consistency and best practice statewide is being supported by a contract with UCONN TA and trainers.

Operationalizing. Development of the *CMCRS Manual (*first draft finalized January 2023) and policy and procedures were recommended to further standardize and align bureaus, create consistency with crisis response and improve workflow between CCRL and CMCRS and adhere to MRSS best practice specific to children and families.

Data collection. Basic indicators for CCRL and CMCRS have been established in the *CQI Plan* to support initial data collection.

QA. Past recommendations have been made to conduct a quality review of CCRL and CMCRS to identify and address areas for improvement. The SME will seek information on whether quality reviews are planned and underway.

2.7.3 Review of Current Documentation, Activities, & Accomplishments

Summary. CMCRS services have been available in WV since May of 2021. Although implementation has been underway for approximately two years, in many ways it is still in the beginning stages. As WV builds their statewide crisis response system for children and families, the first edition of the Manual, shares basic implementation strategies, but there is not a more comprehensive plan that outlines all the implementation details and moving parts. There are three core components to a full crisis system that includes: a single access CCRL and a warm transfer to mobile response, followed by an interconnected, when needed stabilization component. Although the second two components (mobile response and then stabilization) are provided by the same provider, very little information has been provided to the SME regarding the stabilization component of CMCRS and it remains in development.

Training. The SME is pleased to learn that WV seamlessly contracted with UCONN (since staff transitioned from UMB) for their expertise to provide MRSS training, TA and coaching to WV providers. The *March 2023 SME Deliverables Summary* indicated that CMCRS provider training commenced in December 2022 and will continue through June 2023. This same document indicated that 90% of providers have been trained, but no specific evidence was provided to support this claim. It is difficult to understand what staff from which providers in which regions received the training, beyond the one *MRSS Training Completion* form provided. (This document did not clarify where this training occurred.) There was mention in the *March 2023 SME Deliverables Summary* that participants from the homeless shelter and local law enforcement attended. Little information was provided to give the SME context who attended and where in the state. The SME would like to obtain a better understanding as to who is targeted and prioritized for WV's CCRL/CMCRS trainings. MRSS curriculum training and coaching to crisis line, crisis response field workers and supervisors is critical and clearer, centralized tracking and presentation of a training plan would be valuable for the SME to evaluate at the next review. A comprehensive database of training completed with names, roles and associated providers would be helpful to follow how WV is meeting workforce training needs.

The SME received two UCONN training curriculums, the *MRSS Intro Manual Winter 2022* and *MRSS Supervision Module 1 Participant Manual*. The SME understands UCONN is providing the initial training to all staff and training MU through the train the trainer methodology. MU conducts coaching with UCONN support when needed. MU will provide the MRSS training independently to WV providers as of September 2023. The SME did not receive any updates for the CAT. The MU Training website platform does outlines the MRSS training schedule at MU's Wraparound and Mobile Response Training Assistance webpage. The SME is unclear where the CAT training plan or schedules are posted. The SME will look for more information at the next review period to demonstrate development in centralizing training and a training plan.

Implementation. The *CMCRS Manual* begins to define the purpose and process for WV's crisis system customized to children and families but requires considerably more detail. Of particular note is the name change of the service to CMCRS which now integrates the S for the stabilization intervention component into the name, which is a great step forward. The SME will look for this name change in all documents moving forward. Also, the member service flow in the *CMRCS Manual's Appendix A* is helpful to begin to map out the process when a child calls the crisis line. The selection and integration

of the CAT is commendable to help workers systematically use a standard assessment tool statewide. This streamlined tool will allow for greater analysis of youth touched by the crisis system.

It was mentioned in the *March 2023 SME Deliverables Summary* that an additional child-focused manual will be developed in 2023. The SME is unclear what additional content will be included in the second manual. Expansion of the current manual may be a better approach to improve communication and dissemination of information. However, the SME would like to learn more about WV's intent. Additionally, the *March 2023 SME Deliverables Summary* provided an update that BBH Mobile Crisis is providing stabilization for families while they await HCBS. The SME would like to understand the State's plans to clarify the definition of the stabilization service for both BBH and for use across the entire crisis system. The SME also looks forward to reviewing the CCRL Desk Guide targeted for completion summer 2023 and intended to strengthen the "warm transfer" process from CCRL to CMCRS.

CQI. The *CQI Plan* along with its associated *KPI Tables* outline the measures for both CCRL and CMCRS. However, the SME would like to see an expansion of indicators for these services beyond basic data collected and movement towards capturing outcomes specific to youth, such as if youth were stabilized in their current placement or if youth were diverted from the ED. Strong and more detailed metrics will allow QA staff and providers to understand the impact and effectiveness CMCRS can have on children and families in the immediate and long term.

The *CMRCS Manual* appropriately distinguishes Initial Response from Follow-up Services (stabilization) in its definition, and is mentioned in the flowchart, however the SME does not see any corresponding or specific KPIs that distinguish these two components. Furthermore, the manual does not address the many partners-schools, law enforcement, hospitals-and their involvement, investment, and much needed collaboration in further building out a robust crisis system that meet the unique needs of children and families. A holistic approach (involving all interested/affected groups) is critical to improve community awareness, provider buy-in, triage and intake expectations, the actual crisis intervention, discharge (transition) planning, available follow-up community linkage and services. WV should be praised for building the foundation of a crisis system over the last few years. The SME will look for growth and improvement in the details to ensure the clinical intervention is done with best practice; families are satisfied with CCRL contact and CMCRS response; and the behavioral health needs of children and families are addressed and stabilized through WV's crisis system.

As mentioned, WV's coordination of CCRL and CMCRS is well underway, and the *Year 4 Imp Plan* indicates several accomplishments including: finalizing the CMCR manual; use of data to coordinate and educate contracted vendors; collaboration with the QAPI team on identifying CMCR KPIs and review of CMCRS provider capacity. That said, the SME only received documentation of the new manual and listed KPIs. The SME looks forward to receiving more evidence, including the efforts and process to discuss data with the crisis vendors and the provider capacity analysis.

CCRL public awareness and utilization. The most recent publicly available data is reported in the *January 2023 Semi-Annual Quality Outcomes Report,* with preliminary data reported in the Quarterly Quality Committee presentation. Activities in this review period (January – June 2022) included efforts to increase awareness and utilization and address data with the CCRL provider. The SME recognizes DHHR current efforts to collect, report, and act upon data findings. DHHR has begun to collect and

use basic measures that will inform timely statewide access. CCRL data is reviewed quarterly with volume of calls reviewed monthly with respect to quality and access to the call line. WV remains focused on outreach and knowledge of the CCRL line as expansion continues.

Table 2. County Reach Across Three Reporting Periods

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

The SME notes that the last publicly available data indicates that 41% of the county level data is missing which makes obtaining a picture of statewide access difficult.

With further respect to public awareness and outreach, the *January 2023 Semi-Annual Quality Outcomes Report* did not include specific county-level data due to small numbers when the data is broken out at the county level. DHHR reviews county-level data internally. Sharing county and regional level data with the public could be a strategy to increase calls to certain areas and help providers set specific goals and areas of growth, address training needs and continue to move to best practice.

The SME is satisfied that the counties without documented calls were listed in this report as prioritized outreach counties. The SME also notes an increased sophistication in analysis, as these preliminary data slides analyze the greatest calls per capita, which will help with forecasting workforce needs.

The SME will look forward to comparing call volume in future report periods and hopes as WV's system develops, contact to the CCRL line will increase.

Table 3. Six Month CCRL Call Volume

Reporting Period	CCRL calls
January – June 2022	494

Connection between CCRL and CMCRS. Figure 56, in the *January 2023 Semi-Annual Quality and Outcomes Report* begins to capture what types of referrals a youth receives from a coded "emergency, crisis or urgent" call and is compared to the preliminary data in the *Quarterly Quality Review Slide Deck* for the next six months. There were fewer emergency calls, but there was a higher percentage of mobile responses. The SME also will be looking for future reports on emergency/urgent/crisis data, to track whether urgent calls are decreasing or increasing going forward.

Table 4. Warm Transfer, Attempted or Completed, of Calls Reported as "Emergency/Crisis/Urgent" and had a Response Listed for Referral

	July-Dec 2021	Jan-June 2022
Referral Type	**Percentage (N=63)**	**Percentage (N=99)**
Short- or Long-Term Treatment	Not reported	1% (1)
Crisis Stabilization Unit	2% (1)	2% (2)

Comprehensive Behavioral Health Facility	Not reported	4% (4)
Children's Mobile Response Team	41% (26)	25% (25)
No Referral Listed/No Warm Transfer Attempted	55% (35)	68% (67)
Other	Not Reported	Not reported
911	2% (1)	Not reported

The outcomes of calls are very important to capture in order to understand how the call center is applying the MRSS curriculum and its customization and handling of calls specific to children and families. With continued training, call specialists should see that a call that involves a child and family should be handled differently than one for an adult. Equally significant is collecting and understanding the data and outcomes of calls made directly to the crisis line numbers at the seven CMCRS providers. The SME will look for this data in the future to gain a comprehensive picture of calls to the main statewide CCRL line and to the local provider lines.

With respect to deployment of mobile response teams, data in the *January 2023 Semi-Annual Quality Outcomes Report* indicated a trend downward from 41% to 25% in this reporting period. The SME will look for an upward tick in future review periods. One would expect as the CCRL vendor and MRSS providers are trained in national best practice, the use of mobile response teams would increase. As indicated, the preliminary data for July-Dec 2022 showed a slight uptick in percentage of calls that were referred to mobile response, but the overall call volume was down considerably. Additionally, one would expect less bypassing of mobile response to short- or long-term treatment, a BH facility or a crisis stabilization unit. (Also, the SME is unclear what short- or long-term treatments refer to as a referral category). Quality reviews could be conducted to understand why so many calls are being resolved by phone. The *January 2023 Semi-Annual Quality Outcomes Report* also noted, for 68% of calls, the referral was unknown or no warm transfer was attempted. In essence two thirds of the referral information is missing. Since CCRL is the gateway to the crisis system, the SME would expect further training to call specialists both in the MRSS model and data collection protocols and strengthening of CQI practice to improve data collection. While providing information and referrals is a very good use of the CCRL line, it is also important to ensure mobile response is deployed according to best practice for children and families. When a family calls a crisis line, the best practice default is generally to send out a mobile team to assess the situation in-person. The SME would like to better understand who is making the calls to CCRL and the nature and outcomes of the calls. The SME will also continue to look for an upward trend of mobile response dispatches.

According to the *January 2023 Semi-Annual Quality Outcomes Report*, data capturing the timeliness of warm transfer to mobile response indicated 50% of calls were connected in less than 5 minutes and 37% in under a minute, with the remaining data missing. Capturing this data is important, and the SME looks forward to reviewing this ongoing data benchmark to track progress and will particularly look for an increase in data completion rates.

Although progress is being seen, the data collection indicators could be strengthened to add depth to the data that is being collected. Well-developed crisis response systems like those in Connecticut and New Jersey have been gathering robust data for decades and could be very good examples to look at to further refine and build data collection measures and reporting to support implementation of a best practice model of mobile response services for children and families in WV. The SME would welcome

offering further TA in this area to help WV build a stronger data collection and a quality improvement in this area.

CMCRS data. The *January 2023 Semi-Annual Quality Outcomes Report* indicates that the mobile response provided through BMS's CSEDW is not included in this report. Consideration and plans to integrate this data could be explored to build a fuller picture of CMCRS utilization in the State. This report shared preliminary data that 604 children received CMCRS services across the 6 regions in this reporting period January through June 2022. The SME is interested in the data available at the next reporting period to look for growth. The SME again notes that there is no distinction whether a child continues with stabilization services beyond the initial response provided. It will be important to clarify data points going forward to determine which youth get a CCRL call only; initial mobile response only; or are referred onto CMCRS' stabilization component which can last up to eight weeks. At this point, it is not clear how or how many youth move from the initial 72-hour response to the 8-week stabilization service.

CMCRS could benefit from a devoted statewide and oversight program manager and QA support. Formalizing the structure and frequency of reports will enhance data collection and quality improvement. The SME looks forward to seeing the future reports referenced in the *CQI Plan – KPI Tables* including the Children's Crisis and Referral Report and the CMCRS Report and expansion of its indicators.

Purpose and reach of CMCRS. The *January 2023 Semi-Annual Quality Outcomes Report* shares that the State is giving particular attention to connecting CMCRS to marginalized youth and families which is commendable. The use of CMCRS can provide intentional and much needed support to vulnerable populations and the State could consider protocols specific to child welfare populations. For example, providing CMCRS at the time of foster care placements, especially in kin arrangements, can help stabilize these placements and provide resources to these families. The use of CMCRS to connect youth and families to longer term and supportive services is an excellent goal and one that the State should be tracking moving forward. Also, the State has identified the need to look at repeat callers, which is a good measure to review and address. As the crisis system evolves in WV, the State will continue to see the opportunities and value in tracking intercepts and touch points to their CMCRS system.

Provider network. The SME was pleased to see the reporting of CCRL and CMCRS provider capacity in the *January 2023 Semi-Annual Quality Outcomes Report*. Continued tracking of workforce vacancies as well as forecasted staffing needs will continue to be important to track to ensure statewide access is available. With only one of the two crisis counselors hired at the vendor, the SME is interested in seeing policy to understand what types of cases get elevated to a counselor and if not available, what is the result of the call to address any immediate clinical needs. Also, the state recognized the need to offer CMCRS provider TA and coaching to improve both practice and workforce hiring concerns.

CMCRS awareness. Baseline data reported in WVU's *Children's In-Home and Community-Based Services Improvement Evaluation Baseline System and Community-Level June 2022 Report* indicated providers statewide have close to 50% awareness of CMCRS. The SME looks forward to seeing updated figures a year later to see if marketing and outreach efforts have impacted awareness statewide.

Although an effort is being made to advertise that all calls are funneled through the CCRL line, it is reported by the State that some calls are made directly to the seven CMCRS providers. It would also be important to capture the volume of those calls received directly by those regional providers to gain a complete picture of crisis calls received statewide. Also, the State recognized ongoing needs to reach interested/affected community groups such as schools and emergency departments to increase education and calls to CCRL. Marketing through *Resource Rundown* of a CMCRS dedicated webpage could increase CMCRS communication. Lastly, the SME is interested in understanding the role 988 plays in WV CMCRS system going forward.

2.7.4 Compliance Rating and Justification

Agreement Requirements 13, 15, 24, 26, 29, 30, 40. Compliance Rating: Partial Compliance Justification: 13 and 15. The CMCRS as described in policy complies with the Agreement requirements. More data is required to determine if the service as currently delivered meets the requirements (for example meets target population and best practice customization for children and families). 24. WV has established a statewide crisis line and CMCRS providers that cover all six regions in the state and therefore has initiated implementing this activity. To reach full compliance, much data is still needed to ensure timely access and that this service enables a child to stay in their home setting. 26. Given that mobile response deployment numbers remain relatively low, and much of the crisis calls are handled over the phone, WV needs to still demonstrate that CMCRS is being delivered at times and locations mutually agreed on by the provider and family. 29. CMCRS should be available to all children regardless of eligibility through a hotline and through mobile teams with staff trained in responding to children in crisis. The implementation of these requirements is underway through establishment of a toll-free crisis line and teams, but they are still in early stages of implementation. 30. CCRL protocols and desk guides are still under development to guide decisions by crisis line staff to resolve handling a crisis by phone or dispatch mobile response teams. 40. Further data and information is needed to assess and validate that CCRL and CMCRS are providing timely and individualized services to meet the child's needs and through best practice.
Agreement Requirement 41, 48, 49. Compliance Rating: Partial Compliance Justification: 41. Improved completion of data and details in data collection, with respect to both crisis line and mobile response outcomes are needed to better evaluate the implementation of WV crisis system for children. 48. More sophisticated quality assurance measures are needed to measure impact and outcomes of children in the community after CCRL and CMCRS interventions. 49. More data is needed to determine the impact on children. This should include data on encounters with the crisis line, crisis response, timeliness, and connection to ongoing services via crisis response.

2.7.5 Recommendations to Achieve Compliance

Developing a comprehensive crisis system is a complicated multi-system undertaking that spans collaboration with multiple systems, including health and mental health care systems, emergency/urgent care systems, schools, and law enforcement. When crisis systems are designed, setting metrics to capture the current and future target is extremely important. Many of the recommendations below involve collecting data and tracking progress towards building a high quality, person-centered, accessible, and equitable crisis system. These recommendations will assist WV to work towards full compliance and include: 1) increasing community knowledge of the statewide crisis system for children and families; 2) adhering to national MRSS best practice; 3) further developing and training the CCRL workforce to ensure call center customization and principles specific to children and families is understood and in practice; 4) strengthening CCRL and CMCRS data collection and CQI processes; and 5) increasing collaboration between the CCRL vendor and seven local crisis providers.

The SME stresses and reiterates the importance of CMCRS since it is both a universal service and one that has low barriers to access. For these reasons, continued focus on building a robust CMCRS system has great value and will serve WV in the long run to reach more children and families, help connect them with services and ultimately achieve Agreement goals.

RECOMMENDATIONS	ACTION ITEMS	COMPLIANCE CATEGORY
Increase community knowledge of WV crisis response system for children and families.	-Develop clear outreach and education plans, for example, to schools and emergency departments to bolster service recognition and branding of CCRL and CMCRS in WV. -Expand and repeat content on the *Resource Rundown* to reiterate purpose, intent, and expectations to families.	-Accessible Information
Adhere to national best practice, such as timely access to the crisis lines, increased mobile response dispatches and delineation between initial mobile response and stabilization service components, and warm hand off practices.	-Further refine the CMCRS manual and use across seven vendors to support crisis response system best practice for children and families. Specifically edits to the workflow are needed since some steps appear to be missing in the CMCRS manual. One is the step to move from initial response to the stabilization component and another is the jump to PRTF, skipping over other formal resources and communities in the community. Added infographics and flowcharts to help lay out how CMCRS works together across community partners and how it connects to a larger HCBS service array system in the State can be an ongoing task. Including WV's specific values through a consensus process with interested/affected groups such as reducing trauma, more mobile specific metrics, increased individual, family, and community satisfaction geared specifically to the	-High Quality Service -Workforce Readiness -Access to Service

	uniqueness of the children and families in your State could be of great value. -Further define the stabilization (follow-up) CMCRS service by developing this component into a distinct service and track transition from initial mobile response, when recommended. Specify details, both in process and practice under the eight-week stabilization (follow-up) component of CMCRS. Current data does not include this level of specificity and as such does not provide an understanding of any ongoing follow-up to CMCRS service provision. Given that CMCRS services have up to eight weeks of stabilization, it will be important to understand stabilization utilization, and if any of the youth with repeated calls received CMCRS stabilization services, and any challenges the CMCRS had in providing or connecting youth and families with stabilization services. -Ensure warm-handoff data is being collected and analyzed and policies and procedures are established between CCRL and CMCRS providers. -Address when a warm transfer was attempted but did not occur as well as conduct a retrospective quality review of previous warm transfers that did not occur, and based on findings, implement quality improvements plan to address any statewide, systemic, or provider-specific challenges.	
Further develop and train the CCRL workforce to ensure call center customization and principles specific to children and families are understood and in practice.	-Continue to address the volume of calls resolved with telephonic support only, along with repeat calls to ensure that calls are receiving the appropriate level of intervention needed. -Provide the SME with the specific training requirements, credentials, and staff experiences for staff of the CCRL. -Continue to collect data on the presenting concerns and the outcomes of the calls to ensure staff are trained in youth-specific concerns to ensure appropriate referrals & resources when mobile response is needed or when a 911 intervention may be required. -Draft CCRL desk guide for use across CCRL vendor and seven CMCRS vendors.	-High Quality Service -Workforce Readiness
Strengthen CCRL and CMCRS data collection and CQI processes.	-The SME looks forward to seeing monthly reports outlined in the *CQI Plan* to be generated including the: 1. Children's Crisis and Referral Line Report 2. CMCRS Report -Beyond monthly reports, the SME recommends formalizing quarterly and annual reports that	-Data Collection & Monitoring -QA

	would summarize indicators of access, service quality, performance and outcomes. -For data reported: a. Continue to improve completion rate of data, including demographic data. b. Continue to monitor regional and county variation, and through CQI processes, address any disparities. c. Specific to outreach and education, continue efforts with CCRL and CMCRS providers to promote the availability of CCRL and CMCRS with strategies refined based on data analysis such as regional/county variation, and for DHHR to continue to report on these efforts in its semi-annual reports.	
Increase collaboration between CCRL and CMCRS providers.	-Consider running a quarterly statewide learning collaborative hosted by DHHR along with MRSS TA experts including the CCRL vendor and seven local crisis providers and other interested/affected groups to connect practice and data across the state.	-High Quality Service -Workforce Readiness -Data Collection & Monitoring -QA

2.8 Residential Reductions

2.8.1 Service Description

Agreement Requirements 32, 35, 41, 52. WV must achieve a reduction in the number of children living in RMHTFs (based on the census of June 1, 2015 of 1096) to 822 (a 25% reduction) by December 31, 2022, and a further reduction to 712 youth (35% reduction) by December 31, 2024. DHHR is taking steps to ensure that residential programs serve only youth who require that level of supervision and care for safety or flight reasons, and that all youth who enter an RMHTF have a discharge plan that stipulates the conditions under which the child should be discharged to a foster placement or permanency setting.

Table 5. Foster Care Placement Report, June 2015[3]

Facility Type	Youth in an In-State Facility	Youth in an Out-of-State Facility	Total Youth in Any Residential Placement
Group Care	678	174	852
Psychiatric Facility (short-term)	63	86	149
Psychiatric Facility (long-term)	28	1	29
Parentally placed in a psychiatric facility**			66[5]
2015 Totals	769	261	1096
Goal 25% Reduction by December 31, 2022			822*
Actual Census of December 31, 2022 (% reduction)			781 (29%)
Goal 35% Reduction by December 31, 2024[6]			712*

*Rounded to the nearest whole child.

2.8.2 Historical Review

The first six SME reports document the following points of consideration and progress.

Consultation. Reducing reliance on residential care is the central aim of the Agreement. DHHR has received considerable TA from the SME team, as well as support from other organizations such as Casey Family Programs, on approaches to reducing use of residential care. This includes consultation on data needs and data utilization for understanding the heterogeneous populations of youth admitted to RMHTFs and at risk for admission, as well as development of residential KPIs. The consultation provided is robust such that reduction efforts are approached from multiple angles: implementing diversionary HCBS; promoting the discharge of youth already admitted who do not (or no longer)

[3]As discussed in the SME's third reported dated December 2020, the State has proposed reductions for additional years of the Agreement, including a 35% reduction compared to the 2015 date by 2024 and a commitment to propose further goals for reductions beyond the Agreement.

meet the criteria for an RMHTF stay; and identifying youth at risk of admission and providing appropriate HCBS before they are admitted.

Appropriate use of residential care. The result of these efforts has been a notable decline in the census of youth in RMHTFs, as well as a decline in the number and percentage of children placed with out-of-state providers, during a time when foster family capacity has remained constant. DHHR recognizes that residential care is therapeutic, not simply an alternative placement setting. The SME has recommended decoupling of facility or place from intensity of need; youth admitted to residential facilities must meet certain criteria for their safety or the safety of others but that is not necessarily indicative of the intensity of their behavioral health needs.

Much of the work done over the last three years in consultation with the SME has been related to the identification of and intervention with existing pathways to residential placement, including recent efforts undertaken with the court system and youth-serving agencies. This effort has also led to development of the Assessment Pathway that helps ensure treatment through HCBS when possible while allowing for cases where there is a clearly recognized need, based on valid and reliable assessment instruments, for the specific services and oversight that residential care provides. Many of the recommendations made by the SME have led to implementation of approaches that have recently been phased in (e.g., the Assessment Pathway and outreach efforts with interested/affected groups), and efforts to inform other child-serving professionals (e.g., judges) about HCBS alternatives to residential care. With the on-boarding of the Assessment Pathway, WV is building the capacity to address the needs of all youth regardless of the "door" they come through, whether it be child welfare, juvenile justice, or voluntary placement. Although much work remains to be done to achieve across-the-board compliance, DHHR has begun to implement a significant number of service changes in a relatively brief period of time.

Data use. Data and analysis have been central to this work. MU conducted a sophisticated cluster analysis that revealed some insights about the heterogeneous populations of youth in these facilities. Further, DHHR is using data at multiple stages to better understand the youth who are admitted despite not having sufficient need, and to plan for programs that can both satisfy the capacity needs and directly address behavioral and life skills training needs for youth.

2.8.3 Review of Current Documentation, Activities, & Accomplishments

DHHR is undertaking several actions that will build on the success they have had in reducing the residential census and in sustaining this reduction. The SME again commends DHHR on the actions they have already undertaken, including building, and analyzing a robust set of disaggregated data on the RMHTF census. Unless otherwise noted, the source for the following data is the *January 2023 Semi-Annual Quality Outcomes Report*.

DHHR continues to broaden efforts to reduce the number of children admitted to, served in, and readmitted to RMHTFs.

- To increase awareness of alternatives to RMHTFs, DHHR has made some efforts to inform the public, physicians, and court officials of the Assessment Pathway using wallet cards.

- An effort is underway to begin monitoring of foster home capacity to ensure that sufficient statewide and accessible capacity exists to support the placement needs of youth who are not eligible for admission to RMHTFs under the strict criteria that should now be in place.
- DHHR plans to undertake an analysis of youth experiencing RMHTF readmissions, including the youths' characteristics and other factors that are driving these readmissions. This report, which will be completed in partnership with OQA, will take place in late 2023.
- DHHR plans to focus on the average LOS for children in residential care.
- DHHR has recently added language to *Chapter 531 Psychiatric Residential Treatment Facilities Services (Effective Date: January 1, 2023)* regarding assessment requirements (including CAFAS and PECFAS.)
- DHHR has provided an updated decision support document called *CANS residential decision support model (revised March 2023)* that describes how the CANS will be used to help determine which of five levels of care children should receive. These are based on numeric ratings from the CANS instrument and provide some explanation for future residential admission decisions.
- DHHR has contracted with Kepro to implement a Qualified Independent Assessment (QIA) of all children at high risk of or referred to residential placement and defined "high risk" as related to numerous legal, family, safety & stability, and case history characteristics (page 117 of Semi-Annual Report). 22 referrals have been received from the 20 counties active in the phased rollout as of late 2022.
- DHHR intends to implement this QIA process for all new referrals to residential facilities, though the implementation has experienced delays pending some capacity issues at Kepro, which they hoped to have resolved in early 2023.

DHHR continues to take steps to discharge youth from RMHTFS into appropriate settings.

- In March 2023, DHHR distributed to licensed providers *Request for Proposal: Transitional Living for Vulnerable Youth Residential Programs* to have 70 beds (35 each in the northern and southern parts of the state) converted to specialized transitional living for older youth 17-21 who are unable to be served in their own homes or in a foster home.
- The *Foster Care Policy* (revised May 2022) includes a requirement for MDTs to meet every 90 days regarding the progress of children in residential care (also see *March 2023 SME Deliverables Summary*). (Also see the Assessment section for more information on MDTs).
- DHHR acknowledges that the reduction in census is not linear and that in fact the trend is subject to periodic fluctuations that adhere to a seasonal pattern.
- DHHR has conducted extensive analysis of youth with CAFAS scores under 90 to prioritize discharge planning of this group; this includes reporting by gender, age, functional ability, and diagnosis. DHHR has also begun an analysis of discharge barriers.
- DHHR is partnering with Aetna to address adherence to the requirement that all youth in residential care have a discharge plan in place, including taking these steps: 1) ensuring discharge plans are in place for all youth in residential with CAFAS < 90; 2) implementing a requirement that residential providers file a monthly reauthorization for all youth in in-state residential process, including a review of the discharge plan; 3) increasing licensing visits to two unannounced and one planned visit per year, including a review of discharge plans; 4)

continuing to provide training on discharge planning, through MHP, for MHP care managers, BSS staff, and residential providers (expected for 2nd quarter of 2023). A training program, developed and implemented by MHP, has been provided to hundreds of staff, and retraining was underway or planned for mid-2023.

DHHR has recognized a need to reduce out-of-state admissions and has taken steps to build capacity for youth to remain in-state. This includes converting in-state capacity to meet the specialized needs of youth that are currently provided out of state; a draft SOP for out-of-state admissions indicates that as part of the process of sending a youth out of state, it will be necessary to document that all in-state options have been exhausted.

Implementation of the Assessment Pathway widely and across the various youth-serving systems, and the QIA of youth at high risk of or referred to residential placement, to be undertaken by Kepro, suggest further opportunities for reductions in RMHTF admissions.

2.8.4 Compliance Rating and Justification

Agreement Requirements 32.2, 35.3. Compliance Rating: Partial Compliance
Justification:
32.2. *It is presumed that all children who reside in a Residential Mental Health Treatment Facility on the Effective Date, or who are placed in a Residential Mental Health Treatment Facility after the Effective Date, need in-home and community-based services.* DHHR continues to make progress on (a) preventing unnecessary admissions; (b) identifying youth eligible for discharge; and (c) discharging youth who do not meet or who no longer meet the criteria for RMHTF admission.

35.3. *Individualized service plans will include discharge planning for children in residential mental health treatment facilities.* DHHR is aware that many youth do not have discharge plans, but efforts are underway to ensure that 100% of currently admitted youth have discharge plans, and that all youth admitted in the future have discharge plans filed in a timely manner.

Agreement Requirement 52. Compliance Rating: Compliance as to the December 2022 target in 52 (c). Not compliant/unrated as to the remaining provisions.
Justification:
52c. This concerns a benchmark that DHHR must reduce the RMHTF census by 25% to 822 by December 31, 2022.

52d. This concerns the assessment of all youth residing in an RMHTF on December 31, 2024, specifically that they be assessed by a qualified professional and that the residential setting is found to be the most integrated and appropriate setting for their individual needs. This will not be assessed for compliance at this time, though the QIA process being implemented by Kepro suggests progress is being made.

2.8.5 Recommendations to Achieve Compliance

DHHR has been responsive to numerous suggestions made in prior reports, but some concerns across several domains remain. Additionally, some of these recommendations may address challenges that are now coming into focus as certain system constraints, such as TFC/STAT

capacity and foster home capacity for taking older children in the Target Population, have been identified. Recommendations concern the essential task of reducing admissions and discharging youth who do not meet admission criteria, working with out-of-state providers, ensuring the availability and use of evidence-based practice, leveraging data, and improving workforce capacity.

RECOMMENDATIONS	ACTION ITEMS	COMPLIANCE CATEGORIES
Reduce admissions.	-DHHR should continue to work closely with courts, judges, and attorneys to ensure that every child receives a QIA that recommends RMHTF admission before any such admission occurs. -Source of referral to QIA and RMHTFs are planned as KPIs to be incorporated into the data store in October 2023; the SME recommends DHHR include reason for referral and that these data be used to plan and implement diversion interventions. -The Transitional Living for Vulnerable Youth Residential Program, for which an RFP was distributed in March 2023, should be clarified to indicate whether it will only serve youth (of the stipulated ages of 17-21) being discharged from RMHTFs or whether it will be made widely available to all youth meeting the stated criteria. Further, DHHR should clarify how these facilities will function differently from RMHTFs, including clarifying the goals and scope of the services provided in these facilities (besides simply relieving RMHTFs of older youth with lower CAFAS scores), and how they will meet best practices guidelines for TAY. -BSS should continue to work with their own caseworker staff to improve adherence to the Assessment Pathway. -Admission reduction efforts can be aided through targeted (geographic) recruitment and certification of new foster homes; finding and licensing homes that will take older youth and youth with behavioral health needs; and overall ensuring that currently slack capacity is utilized as-is or converted to specialized homes (e.g., STAT.) -There should be more clarity on how the levels of care and placements will be determined and differentiated. All references to RMHTFs should clarify that youth will only be admitted if such a placement would be most appropriate given their specific needs.	-Access to Service
Discharge youth who are appropriate for community-based services.	-DHHR must continue to prioritize discharge planning and follow-through within this group, which includes but is not limited to youth with CAFAS < 90.	-Access to Service

	-Ensure that youth discharged from RMHTFs are not "stepped down" to lower levels of (still intensive) care but are discharged to permanency or a lower-tier foster placement. -DHHR should provide data that providers are implementing the 30-day reauthorization process. -The SME agrees with the Quality Committee that formal periodic quality reviews of discharge plans should be undertaken; and that discharge planning be formalized as a requirement for all out-of-state providers. - DHHR should clarify its approach to developing new placement options for TAY and the ways in which these facilities (which, per the RFP, are to come from the current population of RMHTF providers) are different from RMHTFs in meaningful ways.	
Work with out-of-state providers to reduce unnecessary placements in RMHTFs.	-Through the use of contract renewal, require out-of-state providers to adhere to the same stipulations required of in-state providers on factors that are crucial to reducing admissions and readmissions as well as ensuring the discharge of youth not in need of residential care. This includes requiring CAFAS and PECFAS implementation. -Continue the work on a prior SME recommendation to compare in-state and out-of-state youth to begin to understand whether the longer average LOS is due to greater intensity or severity (or the extent to which the longer stays are due to other factors such as discharge planning). Completing this will be aided by availability of reliable and valid CAFAS/PECFAS scores. -Ensure the SME has the most up-to-date and complete version of the Out-of-State SOP (last one dated August 2022), that the final version reflects the recommendations above, and that there is follow-through on prior recommendations regarding clarification about 1) why conduct disorder results in automatic denial, 2) the role of child and family teams, and 3) the role of child welfare consultant. Further, add this process to the Assessment Pathway flow chart.	Access to Service
Use evidence-based practice to improve services.	-Although promoting RMHTF efficacy and programming is not directly addressed in the agreement, it is another potential approach for reducing the population of RMHTFs by helping to reduce lengths of stay. Critically, it may have the most promise for youth with more intensive need. -DHHR should clarify with providers that RMHTF care is intended to be an effective treatment stay. (The revised Chapter 531 on PRTF Services does indicate that these facilities should use evidence-based	-Access to Service -High Quality Service

	practices and treatments such as behavior management and active family engagement.) -Although the cluster analysis revealed that the population of RMHTFs was heterogeneous, and identified specific clusters of youth, a common thread running through nearly all of the groups was "anger and oppositional behavior." This suggests a possible approach to contracting with providers and specialists who treat using approaches shown to work effectively for youth with aggression, disruptive behavior disorders, and externalizing disorders; and it directly addresses RMHTF diversion given the criteria for admission including risks to the safety of youth or the people around them.	
Leveraging data.	-Continue weekly monitoring of the RMHTF census, with comparisons made to the same time period in one or more prior years. This should include the disaggregated data by youth characteristics and geographic areas, as shown in the most recent semi-annual report, such that priorities and trouble areas can be identified and responded to quickly. -Consider reporting average LOS using the median rather than (or in addition to) the mean. Median lengths of stay are less prone to the impact of youth with very long LOS. To the extent that some youth with high LOS have more intense needs, this may bias the measure in a way that is contradictory to the aims of reduction, which are to eliminate unnecessary admissions and reduce LOS to spells that satisfy youth needs. -Figure 74 of the *January 2023 Semi-Annual Quality Outcomes Report*, according to the text (page 131), "summarizes the number of prior RMHTF stays…" but in fact the numbers are percentages. It would be helpful to have raw numbers. -DHHR should deepen their analysis of discharge barriers, disaggregating these data by child characteristic and systemic factors. Qualitative data collection could help reveal the systemic factors that are salient to providers and children/families. -Analyze existing data to ascertain where youth who are discharged are subsequently placed, and specifically whether they are "stepped down" to lower levels of residential care, which the SME has recommended against. -Analyze youth with CAFAS 90 or above, including comparisons to those below 90, in order to identify unique characteristics of these youth.	-QA -Data Collection & Monitoring

	-When the census is reported for tracking and compliance purposes, report the breakdown by in-state and out-of-state for the same time frame.	
Focus on improving workforce capacity.	- Given the workforce and recruitment challenges that DHHR already faces, it is incumbent that DHHR maintain relationships in good standing and be responsive to providers. The SME is sensitive to the pressure that providers must feel that they are under as DHHR undertakes such rapid and far-reaching changes, and DHHR must be sensitive to this as well, while also maintaining expectations of these providers that are in alignment with the agreement. The SME recommends a provider learning community to address provider concerns and implementation support.	-Statewide Capacity

2.9 Behavioral Support Services

2.9.1 Service Description

Agreement Requirements 11, 24, 25, 26, 27, 28, 37, 40, 41, 48, 49, 50, 51, 52. The Agreement requires the State to implement statewide Behavioral Support Services, which include mental and behavioral health assessments, the development and implementation of a positive behavioral support plan as part of the individualized treatment plan, modeling for the family and other caregivers on how to implement the behavioral support plan, and skill-building services.

Behavioral Support Services is an approach that is used widely within BBH, BSS, BMS, and WV DOE programs and providers. PBS is a type of Behavioral Support Services and is an evidence-based strategy to improve independence, decrease behavioral challenges, teach new skills, and improve overall quality of life of children who are experiencing significant maladaptive behavioral challenges.

2.9.2 Historical Review

Over the course of the SME reports so far, the two largest accomplishments have been the creation of the Positive Behavior Support (PBS) Program at WVU CED, along with contracting with CU to provide PBS training, with the former more responsible for direct service and the latter addressing workforce capacity building. Also, while not discussed originally in the agreement, there has been the emergence of a discussion of Behavioral Support Services both as a service to be delivered and as a philosophy.

The first six SME reports document the following points of consideration and progress.

Pathway to services. There is a continuing discussion of the need to and difficulty in understanding how children and families are made aware of available Behavioral Support Services. There is also a question with respect to defining the decision-making criteria for need determination. One recurring area of concern involves referrals from schools. In previous SME reports, there are questions about whether or not students who are referred through the schools (51%) are being connected to Wraparound and to the larger continuum of care. Tracking referrals from schools remains an ongoing issue.

Tracking service provision. There are ongoing challenges with tracking exactly who is receiving services. This is partly due to the fact that it is difficult to determine with the WVU CED if the services they provide are direct services and, if not directly billable, then determining how they can be monitored. This issue applies to both training and to direct services.

Service provision data. When data was originally shared with the SME, the WVU CED reported 692 interactions with 37 clients, with 7 receiving PBS plans. The second mention of data documented 32 clients each month receiving services and 39 consultations related to the needs of other youth, reaching 103 professionals/month. An additional data report shared that the number of children served monthly increased from 21 youth in 7/20 to 41 in 6/21. It is unclear what type of quantitative reports are being created that can facilitate action planning.

Waitlist. In the most recent reports, it has emerged that there is a waitlist for services at the WVU CED. There was a recommendation to assist waitlisted children by consulting with their current provider.

Medicaid and billing codes. To assist with Medicaid billing, the SME provided the State with examples of Medicaid service descriptions, medical necessity criteria, and provider qualifications from Georgia, Maryland, Oklahoma, and Virginia. However, there is continuing challenge with tracking delivery of services outside of Medicaid claims. If there is not a specific billing code for PBS and Behavioral Support Services, then it is unclear how the state will ensure it meets its goal of increasing by 50% PBS services to children, youth, young adults, and their families through both direct implementation and training in homes. Billing codes remain a concern throughout the SME reports. There has also been an ongoing request to review the draft of the changes to the provider billing manual. The addition of modifiers to Medicaid billing codes was expected to be activated no later than 7/1/22, but this appears to remain an ongoing issue.

Workforce capacity/training. A key goal is building workforce capacity, and that involves monitoring provider recruitment, retention, training and supervision. There was one recommendation for a needs and gaps assessment, but there is no documented follow-up. Progress with the work of CU appears to be moving more slowly than originally anticipated, perhaps because of a delay in awarding the grant. The SME requested previously to review CU's training plan & online training platform.

Risk of out-of-home placement. In a prior SME report a question emerged about the parent-reported "risk of out of home placement" question that appeared in the data that was shared with the SME. No explanation thus far has been provided explaining how that data is used.

2.9.3 Review of Current Documentation, Activities, & Accomplishments

The *Year 4 Imp Plan* highlights goals around PBS, an evidence-based strategy to serve individuals who are demonstrating significant maladaptive behaviors, making them at-risk for negative outcomes, including residential placement. The State is committed to making PBS available through a variety of methods to increase accessibility. The WVU CED is the main provider of PBS, both providing services to individuals and building workforce capacity and system capacity. Key efforts highlighted to achieve the main goal in this topic area involve the work with CU to train the workforce and build capacity and the efforts around drafting and implementing a Chapter 503 modifier to existing behavior management codes to distinguish PBS services. In collaboration with the QAPI team, efforts have also been made to identify KPIs and support data collection and reporting around PBS services.

The deliverable report highlighted two main areas of progress:

- The first training and credentialing cohort was held by CU in the fall of 2022 and completed in December 2022 with 29 providers. The next training was scheduled for March 27, 2023, and the SME looks forward to seeing evidence and feedback as relates to this training.
- The Medicaid modifier code is still expected to be implemented in 2023.

The *January 2023 Semi-Annual Quality Outcomes Report* shares the status of Behavioral Support Services efforts in the following areas:

- The WVU CED provided PBS services to 108 youth from January – June 2022, with an average of 49 children served per month. During this period, 1,085 total services were conducted. The most common services provided to individuals were PBS plan writing (51%); brainstorming, a service typically done with lower-need cases to provide ideas and support for families (25%); and person-centered planning (14%). Intensive services are also a service provided, but it is not clear what percentage they represent (11% were listed as service type unknown). HCBS such as Wraparound and Behavioral Support Services served a greater proportion of children in age categories 5–8 and 9–12 compared to youth in RMHTF.
- WVU CED continues to experience workforce shortages. As of December 2022, there was a waitlist of 14 children for PBS services, but families were prioritized based on need, and BBH continued to meet regularly with the provider to troubleshoot workforce shortages and hiring barriers.
- The BBH PBS program through WVU CED has nine full-time equivalent staff and four vacancies, which will be reduced to two vacancies following onboarding of individuals recently accepting offers for the openings for behavior specialists. WVU CED continues to be actively focused on recruiting to fill current vacancies.
- While CU has begun training, the WVU CED also continues to provide training on PBS, training an average of 333 individuals each month from January to June 2022.
- The WVU CED PBS program provided consultation for an average of 33 youth per month compared to the previous 6-month period of 42 youth per month as shown in Figure 47. This decrease in consultations may have been due to staffing shortages during the period.

The *January 2023 Semi-Annual Quality Outcomes Report* notes that State Plan Behavioral Support Services data are unavailable, but implementation of the modifier code will help with this process. Next steps identified include:

- Monitoring WVU CED data to track needs.
- Assessing missing service indicators to provide TA to providers for improved data collection.
- Continuing outreach to BIPOC communities with initiatives such as the Transformation Transfer Initiative grant. (It was noted that BBH-funded PBS and Wraparound services tended to serve a slightly higher proportion of BIPOC individuals compared to the general population. However, due to the low number of BIPOC individuals in WV, there is fluctuation which may not be significant.)
- Once it is available, using the modifier code to assess to 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)
- Continuing work with CU on training and credentialing.

2.9.4 Compliance Rating and Justification

Agreement Requirements 11, 24, 25, 26, 27, 28, 37, 40. Compliance Rating: Partial Compliance
Justification:
These requirements involve making BSS available throughout the state to help improve outcomes for children and youth and help them either stay in or return to their home and communities. The implementation of the modifier code will make it much easier for the state to determine where it is meeting these goals and where it is falling short.

Agreement Requirement 41. Compliance Rating: Partial Compliance
Justification:
This requirement involves the availability of services statewide. The work with CU in training and credentialing has begun to address this need, as well as WVU CED hiring additional staff to fill workforce shortages. However, both efforts must expand, perhaps with the addition of additional training opportunities to meet the need.

Agreement Requirements 48, 49, 50, 51, 52. Compliance Rating: Partial Compliance
Justification:
These requirements involve data reporting and service utilization tracking. The implementation of the modifier code will be a considerable help in making these efforts more comprehensive and making the data more available and actionable.

2.9.5 Recommendations to Achieve Compliance

DHHR has demonstrated considerable commitment to ensuring that children and youth in WV have access to Behavioral Support Services. Overall, progress depends on the building of infrastructure, both to increase capacity to provide services with trained professionals and, through the new modifier code, through better data availability. Because this is the first time that Behavioral Support Services has been under compliance review, this is the time to set expectations. The SME would like to see a clearer data picture about who is being referred for services, who is receiving services, and the workforce being developed to provide those services. As this picture becomes clearer, it will become more possible to recognize and address the gaps in coverage.

Recommendations remain in the following areas: finalizing the PBS training plan; finalizing the PBS credentialing plan; finalizing Chapter 503 revisions; completing implementation and training on use of PBS modifier code to allow for additional monitoring of service utilization; continue program-level data reviews and follow-up action on published reports for PBS services; addressing workforce capacity issues; addressing children and families on the waitlist; understanding how referrals are working; and reaching a better understanding of outreach efforts.

RECOMMENDATIONS	ACTION ITEMS	COMPLIANCE CATEGORY
Finalize PBS training plan.	-The SME understands that CU received a new contract in March 2023. The SME requests access to existing or planned/draft training plans and materials from 2022 and 2023, including all training curricula, trainer qualifications, pre- and post-testing materials, information on participants (type such as parent, professional, etc.; pass/fail rate) for review and discussion, and plans for participant feedback. -The SME would like to review outreach/recruitment planning for future training.	-Statewide Capacity -Workforce Readiness
Finalize PBS credentialing plan.	-As with the training plan, the SME requests to review the credentialing plan.	-Workforce Readiness
Finalize Chapter 503 revisions	-Send to the SME for review prior to finalization.	-Data Collection & Monitoring
Complete implementation and training on use of PBS modifier code to allow for additional monitoring of service utilization.	-Overall, the SME would like to see more data on service referrals and utilization, understanding that the modifier code will help with this. -The SME would like to see the plan for training on the new modifier code.	-Data Collection & Monitoring
Continue program-level data reviews and follow-up action on published reports for PBS services.	-The SME would like to see how data is used regularly for quality assurance and program monitoring. -The SME would like to understand the utilization of the workgroup for this purpose.	-QA -Data Collection & Monitoring
Addressing workforce capacity issues.	-Complete review, as reflected in DHHR's *CQI Plan*, of provider capacity to meet needs. -If applicable, recruit additional providers to meet needs, as more information becomes available through credentialing. -As described above, the SME would like to see recruitment materials for trainings.	-Statewide Capacity -Workforce Readiness
Address children and families on the waitlist.	-The SME would like to see more documentation about consultation being offered to these families.	-Access to Service
Reaching a better understanding of how referrals flow.	-The SME understands that referrals from schools are occurring in a regular manner but still requests documentation of tracking of these referrals.	-Access to Service
Reaching a better understanding of outreach efforts.	-The SME would like to see more about outreach efforts to families in general, specifically what type of outreach efforts are being made to families in BIPOC communities.	-Access to Service -Accessible Information

2.10 Therapeutic Foster Care

2.10.1 Service Description

Agreement Requirements 6, 20, 24-28, 37, 38, 40. The Agreement stipulates that DHHR "shall develop Therapeutic Foster Family Homes and provider capacity in all regions and shall ensure that all children who need this service are timely placed in a Therapeutic Foster Family Home with specially trained therapeutic foster parents, in their home community whenever possible."

2.10.2 Historical Review

Development of STAT home model. In response to these requirements, DHHR has developed a new program called Stabilization and Treatment (STAT) that supplements the existing tiered system of foster homes. The three legacy tiers of care include: 1) Tier 1 – traditional foster care; 2) Tier 2 – treatment foster care for youth with mild to moderate trauma, behavioral problems, or emotional dysregulation; and 3) Tier 3 – intensive treatment for youth with moderate to significant trauma, behavioral problems, or emotional dysregulation. STAT goes beyond this; it is an intensive family-based treatment setting that extends intensive services to higher needs youth who would have previously been placed in an RMHTF. This placement is an HCBS while in foster care that will keep the youth in the community and will be provided on an as-needed temporary basis, with the expectation that youth will return to their prior placement as soon as possible. The STAT Home SOP indicates that need is determined by "imminent disruption" due to behavioral challenges that the foster care parents are no longer able to address, but that such disruption is not accompanied by a serious risk to the child or others, or a flight risk (beyond that which could be managed through a safety or flight risk plan.) STAT parents will be trained to support active participation in home, school, and community and support efforts to ensure therapeutic services are provided. Therapeutic services will be provided by HCBS such as Wraparound (and ACT, for those over 18.) There can be only one qualifying child in a STAT home. The STAT home SOP delineates the characteristics of these homes in comparison with Tiers I, II, and III.

Accomplishments based on TA. The first several SME reports indicated that substantial technical assistance was provided for therapeutic foster care, and highlighted questions about the planning and implementation, including how it would align with an existing tiered foster care structure. Milestones and themes include:

- A legislative change (HB 4092) supported higher payments to foster caregivers providing care to youth with SED and IDD.
- Numerous recommendations were made with regard to regional capacity, alignment with need, and recruitment of homes in this context; current utilization, surveillance and KPI development; and against the use of TFC as a step-down from restrictive placement settings.
- A recurring theme throughout these reports concerned the eligibility of youth for TFC, with the SME recommending all youth in the target population, not just those entering through the CPS gateway, be eligible.
- Another theme emerged related to ensuring that placement changes occur only in the best interest of the child and not to the benefit of the providers.

STAT development. The April 2022 SME Report highlighted the following information about STAT, the newly developed intensive TFC program, specifically:

- The focus of STAT is on short-term efforts at stabilization; youth who are successfully stabilized will return to a tier I-III home and resume efforts towards permanency.
- This focus (and name) was decided upon after consultation with CPAs. STAT is a home-grown program that was developed after discussions with other states (New Jersey and Oklahoma are mentioned in an earlier report).
- "STAT" is used rather than "TFC" through all documentation from this point forward, and there were concerns that with the emphasis on STAT, Tiers II and III would be somewhat neglected (largely related to the interconnectedness of these three levels of care in the context of need and capacity or recruitment.)
- There is continuing debate over which children would be provided TFC services, and whether it would be limited to children in CPS custody.

Despite the improved clarity, numerous questions were raised across the SME reports (such as regarding the definition of "disruption" for identifying eligible children), but most of these appear to have been answered by the most recent SME Report. There was a much briefer set of recommendations in the December 2022 SME report, largely related to the SOP and recruitment approaches; differentiating the criteria for placement with STAT home vs. placement in other tiers; engagement with families and children in quality improvement; and that foster care status should not determine eligibility for STAT. We address responses to these recommendations below, as well as raise some additional recommendations based on further details that have been provided.

2.10.3 Review of Current Documentation, Activities, & Accomplishments

Overview. The *STAT Home SOP Manual* provides details on the process of eligibility, the roles of each party involved in the child's care, the differences between the tiered placements and STAT, and specific scenarios under which a STAT Home should call CMCR**S**. In particular, the SME would like to extend praise for being explicit that STAT Homes are expected to participate in evidence-based approaches to behavioral health care, and that psychotropic drug prescribing will be tracked. To date only one STAT home has been recruited and trained and no children meeting STAT criteria have been placed in this home.

Eligibility. The *STAT Home SOP Manual* outlines that STAT Home placement is intended for youth, age 3-20 who are in state custody and who are receiving CSEDW services who meet an "imminent disruption" criterion:

- "Notification to CPA (by foster parents, WF, other CPA, DHHR case worker) that the child's behavior appears to be more than the parents are equipped to manage"; and
- "The child is creating safety concerns in the home for themselves or others, and foster parents have asked for child to be removed from the home."

Based on document review and recent discussions (e.g., March 29 site visit) DHHR indicates that when STAT Homes become available, they will be used only for children in state custody, which includes children served by child welfare as well as BJS-involved children who are placed in state custody.

Services. The *STAT Home SOP Manual* outlines the following criteria for services:

- An example provider contract addendum shows that clear training expectations are being established. Further, the contract requires homes to use trauma-informed disciplinary measures.
- Placement will be reviewed at least every 30 days (placements can end before 30 days). If the child has not returned home after 90 days, the child will either remain in the STAT home or be considered for RMHTF admission.
- In addition to the responsibilities of tiered system foster parents, STAT home parents are trained in advanced crisis prevention and intervention and implementation of complex treatment plans for addressing behavioral health needs.
    - The training curriculum, which is facilitated by the STAT Home provider (the CPA), includes trainings on Children with Exceptional Needs and PBS.
    - These foster parents are also trained in: crisis prevention, intervention, and de-escalation tactics; advanced trauma symptoms and parenting strategies; childhood disorders and treatments; anger management; and mental health issues. These trainings will be facilitated by the STAT Home provider.
- STAT home parents will receive education or training regarding the child's condition and how to support community treatment.
- STAT home parents will not provide therapeutic interventions but will rely on HCBS providers and work in partnership with CSEDW services, Wraparound (or ACT), as well as the prior placement or home of origin to provide: daily supervision, food, clothing, shelter, and school supplies, personal incidentals, liability insurance, and relevant travel expenses (for example, to the child's prior home for visitation, for school, for participation in development of Child and Family Service Plan). Services covered by other HCBS providers are noted, although not consistently:
    - CSEDW will provide in-home family support and therapy, job development, supportive employment, specialized therapy, assistive equipment, community transition support, and peer parent support.
    - In a document labeled *STAT Home Training*, certain responsibilities are intended to be shared by STAT Home caregivers and CSEDW services, including caregiver respite, independent living/skills building, crisis (mobile) response, and WF; however, in the SOP, many of these (except caregiver respite) are listed as strictly CSEDW services.
- Given that therapeutic services will be provided by HCBS programs, the success of STAT is heavily dependent on successful deployment and efficacy of Wraparound and ACT and the coordination of these services with STAT Home parents and providers.
- CMCRS can be provided when behavior escalates beyond that which a trained STAT Home parent can handle.

Capacity, recruitment, and retention. Unless otherwise noted, the following information comes from the *January 2023 Semi-Annual Quality Outcomes Report.*

- STAT Home training for BSS staff has been offered by DHHR since December 9, 2022, and was anticipated to be complete in February 2023 (with over 700 staff completing the training as of January 2023, as indicated in the Deliverables Summary).
- The M*arch 2023 SME Deliverables Summary* indicates that 10 CPAs have agreed to offer STAT. DHHR is actively supporting these CPAs in the recruitment of STAT homes, focusing on homes with tenure as foster families and aiming for recruitment across all regions.
    - CPAs have indicated that recruitment will target homes that currently serve other children within the tiered system.
- DHHR reports that as of January 2023, 14 families, statewide, have expressed interest in being STAT home providers, with 3 families nearly complete with training. No children have been placed in a STAT home thus far.
- Although some agencies have homes that have completed the trainings, these homes have current child placements that have to be resolved before they can accept children meeting STAT home criteria (as relayed at the site visit on March 29, 2023).
- Statewide, one family is currently ready to provide services under this model.
- DHHR acknowledges that statewide availability and provider capacity remain open tasks that will be ongoing.
- One noted aim of DHHR, given that STAT home placements will only be temporary, is to recruit families interested in providing only temporary care for children (Site Visit March 29, 2023).
- In section 1.02 of STAT Home Provider Contract, labeled "Foster Family Care Recruitment & Training" the training requirements are described, but recruitment expectations or requirements are not.
- In sum, the documentation suggests that DHHR recognizes that recruitment may become a significant bottleneck in compliance with this service. Recent reports indicate that there has been a recent plateau in recruitment in general, as the number of foster homes entering and leaving the tiered system are about equal. The number of homes recruited so far (and trained) suggests that this will be a challenging program to scale up to a meaningful statewide diversion program and it is not clear what the timeline is for recruitment to readiness.

Differentiating STAT from TFC Levels II and III. The SOP and other documentation largely focus on the new STAT Home model; less is said about the existing Tier II and III therapeutic homes and how they can serve the effort to reduce residential placements, but as noted above, eligibility has been clearly defined. According to the STAT Home SOP, Tier II (treatment foster care) and Tier III (intensive treatment) are both home settings for youth with higher levels of trauma or behavioral or emotional dysregulation (mild to moderate, and moderate to significant, respectively.) Tier II may also include youth with medical needs or conditions beyond routine or preventive care, and pregnant or parenting teens; Tier III may also include infants who have been exposed to drugs, medically fragile youth, youth engaging in high-risk behaviors, those experiencing difficulty in school/home/community, and those stepping down from a more intensive or secure level of care. Very little is said about ensuring that Tiers II and III offer evidence-based approaches to care that

may be effective at diverting children from higher levels of care (which would include STAT homes, which will not be widely available for some time.)

Quality improvement including engagement with children and families. Data needs for forecasting, data collection and reporting of KPIs, and evaluation of performance are upcoming tasks in the implementation timeline. Quantitative data pertaining to STAT implementation will have to wait for wider rollout, though plans are being made to work with youth and families on qualitative data collection.

- STAT home KPIs include admissions and discharges (to lower and higher intensity settings including RMHTFs), and length of stay; recruitment and capacity; as well as overall RMHTF admissions by time and county of origin.
- Reporting of quality will be initiated after STAT homes have been operational for a sufficient length of time.
- The implementation plan suggests that STAT will be evaluated, in partnership with youth and families, to measure performance and seek feedback.

2.10.4 Compliance Rating and Justification

Agreement Requirements 24-28, 37, 38,40. Compliance Rating: Partial Compliance
Justification:
These requirements pertain to TFC as part of the HCBS array of services being offered statewide that will help children to remain in or return to their homes. DHHR has developed an intensive and temporary TFC placement called STAT Homes, and has undergone efforts to plan, train, contract, and recruit for these homes.

Agreement Requirement 38. Compliance Rating: Partial Compliance
Justification:
This requirement involves the availability of services statewide. As of now, the number of CPAs agreeing to offer STAT homes, the number of families agreeing to participate in the STAT home service, and the number of families trained and ready to take children, and the number of children receiving the service, fall substantially short of statewide access.

2.10.5 Recommendations to Achieve Compliance

DHHR has built a home-grown program to fill an HCBS gap between existing therapeutic or treatment foster care and residential placement. The SME is making several recommendations regarding eligibility standards and developing STAT into a high-quality evidence-informed service, clarifying certain roles, responsibilities, and expectations of STAT homes vis-a-vis other HCBS, ensuring sufficient capacity to meet need for Tier I-III and STAT, and differentiating between these levels of care.

RECOMMENDATIONS	ACTION ITEMS	COMPLIANCE CATEGORY
Ensure services offered meet high standards.	-Based on experiences evaluating other existing intensive TFC programs, the SME offers the following ranked recommendations from most ideal to least: 1) the state consider adopting one of these established evidence-based programs (e.g., TFC Oregon); 2) the state consider contractual language that stipulates STAT Home providers should use an existing evidence-based program model; 3) the state conduct a thorough "common elements" review that compares STAT Home services with selected evidence-based program models on key dimensions of care (e.g., maximum number of children placed; responsibilities of caregivers; interfacing with HCBS) to understand alignment and identify any differences in approach that might provide opportunities to further improve the STAT model. -Consistent with our above recommendation, if DHHR is unable to deliver STAT home services statewide and as needed in the target population, DHHR will need to revisit its approach toward complying with this part of the agreement. -DHHR should clarify that one child in a STAT home means one eligible child, and no other foster children, but does not directly limit the number of children (natural born or adopted) in the household.	-High Quality Service
Clarify roles, responsibilities, and expectations among STAT Home and other HCBS.	-The example Foster Family Care Provider Agreement, although it specifies "trauma-informed" disciplinary measures be used, does not provide any details on expectations for what this means. We recommend that this expectation be made explicit.	-High Quality Service
Ensure sufficient homes to meet and sustain capacity.	- A STAT home recruitment effort is underway, and DHHR will support CPA recruitment. The nature and extent of support provided to CPAs should be clarified. - Recruitment expectations or requirements should be made explicit in the contract addendum, such as under section 1.02, labeled "Foster Family Care Recruitment & Training." -Data should be collected on "what works" in recruitment efforts. For example, it has been noted that because lengths of stay in STAT Homes are intended to be shorter, this may	-Statewide Capacity

	engage different families than those interested in the tiered system. -The SOP mentions placement proximity to home of origin; the SME suggests DHHR should map derived statistics (e.g., ratio of children to available beds) by region, rurality, or county. -If recruitment approaches differ across CPAs, DHHR should consider acting as a clearinghouse to distribute information on what works. -DHHR and CPAs should cast a wide net; although recruiting from the existing pool of tiered foster system families may speed up recruitment and training, The SME is concerned that excessive targeting of these existing homes may lead to capacity shortages in those tiers, with challenges in identifying suitable replacements. This approach may also curtail efficacy as these existing homes will be replaced by inexperienced new homes. In particular, the SME wants to ensure an adequate provision of Tier III homes as the "last stop" prior to residential eligibility and use of this more intensive service level as a diversion from residential placement. -DHHR should assess children currently served in the tiered system for STAT Home eligibility, as a crucial first step in mapping recruitment needs, and obtain feedback from CPAs on what information may be useful for forecasting STAT Home need geographically. For ongoing responsiveness to changing demands, "leading" indicators such as the number of children going through the assessment pathway and entering lower tiers of care at various CANS/CAFAS score levels may be informative of recruitment targeting. -DHHR should clarify whether STAT homes will be used in other ways (e.g., as a standard Tier I foster home); i.e., whether homes trained in a STAT level of care will be taking on children who do not need that level of care. (This is not about the presence of other children in a STAT home while a STAT placement is active, but about using slack STAT capacity to serve as other tiers of care.) -DHHR should explain what will happen if a STAT Home bed is needed but unavailable.	

Differentiation and relationship between STAT and tiered levels.	-DHHR should provide a clearer understanding of the preceding placement's role in care when the child is moved to the STAT Home, including the following considerations: whether that bed will simply not be filled as long as the child is in STAT, such that the bed is ready when the youth is ready to return; whether and under what circumstances the preceding parent can opt to discontinue working with this child; the extent of those caregivers' participation in the care of the child sent to the STAT home under either of these scenarios; who would fill the role of the parent or caregiver in the event the preceding placement declined to continue working with the child; and whether the preceding caregivers will still be reimbursed for care of this child while the bed is being held for the return of this child.	-Statewide Capacity -Timely Provision -Access to Services

3. Other Areas of Progress in Meeting DOJ Agreement Requirements

3.1 Outreach & Education

3.1.1 Service Description

Agreement Requirements 31, 37, 40, 41F, 42, 48b 54, 67. The Agreement requires the State to: 1) conduct outreach to and training for physicians who serve children who are Medicaid-eligible on the use of the screening tools; 2) develop outreach tools for medical professionals who treat Medicaid-eligible children; 3) develop an outreach and education plan for interested/affected groups in the State of WV on the importance of the stated reforms prescribed in the Agreement; 4) provide timely, accurate information to families and children regarding the in-home and community-based services that are available in their communities; and 5) collaborate with the WV DOE and the WV DHS around care for the target population.

3.1.2 Historical Review

The first six SME reports document the following points of consideration and progress.

Physician outreach regarding screening. Outreach to physicians has been covered in the Screening section of previous SME reports. To better understand needs and gaps around mental health screening by county, WV developed a heat map to track the percentage of EPSDT exams that include mental health screenings. This tool has since been used as a communication tool with providers and regional leadership to identify opportunities for improvement and to educate PCPs about regional differences with mental health screenings.

Outreach tools for medical professionals. No activity has been noted for this category.

Outreach and Education Plan. WV created the *2020-2024 Outreach and Education Plan*, a comprehensive living document. Some of the plan items and achievements are:

- WV noted that it would create an educational toolbox. The SME recommended that this toolbox be updated regularly and added to the Kids Collaborative website.
- Creation of the Kids Thrive Collaborative website. DHHR significantly improved their website, moving from the *West Virginia Child Welfare Collaborative* to the *West Virginia Kids Thrive Collaborative,* which SME noted was much more user-friendly. The SME recommended that DHHR continue to fine tune and make improvements to the website, such as by having a broad range of educational resources.
- Kids Thrive Collaborative virtual meetings. These meetings are conducted quarterly and open to the public.
- Creation of a list of interested/affected groups.
- Aetna has completed trainings to the judiciary regarding Agreement services. The SME recommended ensuring that Aetna's messaging was consistent with DHHR's messaging.

- Many meetings with interested/affected groups have occurred, including (but not limited to) a Pediatric Mental Health Outreach and Communication Focus Group, a Primary Care Provider Outreach group, a CSEDW Policy Clarification Conference Call, and judiciary outreach including, at a statewide judicial conference.
- DHHR developed an outreach data tracker to track activities that are "associated with services for children with serious emotional disturbance, including encouraging use of home and community-based services and diverting children from residential placement," as noted in the April 2022 SME Report. This outreach tracker allows the State to report outreach and education efforts and detail how they are specific to the Agreement with the "purpose of outreach" field.

Information to families and children. When WV contracted with Aetna to create MHP, they included language that required Aetna to conduct outreach and education to clients. Direct action contained in this language includes MHP sending out postcards, texts and case manager outreach with reminders about EPSDT exams (that include mental health screening). The SME suggested that Aetna explicitly state that the EPSDT includes a mental health screen. (See also the Screening section.) SME also recommended ensuring that the State monitors these activities to ensure that MHP is completing its intended outreach.

WV created a listserv to announce upcoming meetings and events, such as the Kids Thrive Collaborative Meetings. The State also created the *Resource Rundown* as a means to share information. They are planning to develop and host a version specific to youth.

The SME has recommended that WV ensure two-way communication methods with youth and families, as through surveys, focus groups, and interviews to better understand the needs and challenges they may face in accessing services and experiences with services; and recognize families and youth as the key partners, as by including them in workgroups. The SME recommended DHHR utilize the *WV Foster Adoptive and Kinship Parents Network* document that included a range of methods to engage youth and families to generate engagement ideas. Some of the ways that the State has thus far elicited public comment includes releasing its implementation plans for public comment and submitting questions and comments on the *Resource Rundown.* The SME has encouraged WV to share the comments it received and incorporate feedback.

The State contracted with the WVU Office of Health Affairs to "implement a public education initiative aimed to raise awareness of HCBS." The SME had requested an update regarding these efforts.

The SME recommended that the State ensure that topical subject matter experts review communications and that the State formally document its communication processes to create, review and distribute materials. In response, WV created two memos that were: 1) directed to DOJ to create a process for DHHR to review relevant public-facing DOJ communications; and 2) addressed to DHHR leadership outlining outreach and education expectations across the department to align with the Agreement implementation team. WV later created a document entitled *Internal Communications Standard Operating Procedure*.

Collaboration with DOE and DHS. The SME recommended including more detailed plans and updates as to how DHHR has engaged and collaborated with various interested/affected groups including judges, DOE and DHS.

3.1.3 Review of Current Documentation, Activities, & Accomplishments

Physician outreach regarding screening. WV provided an updated training presentation, entitled *O & E HealthCheck PCP MH Referral Training.* This training is for all HealthCheck EPSDT health providers and office staff to provide 1) information on mental health screening rates completed by region; 2) additions made to preventative health screening forms to increase mental health screening; and 3) information regarding the CCRL. They also created a comprehensive and easy-to-read *Referral Desk Guide* for PCPs, which includes a QR code to make a referral to CCRL. SME applauds WV's efforts to provide brief informational resources for PCPs and related staff to support referrals to CCRL and underscore the importance of MH screening. WV notes that the trainings will be distributed statewide via HealthCheck specialists by the end of June 2023. Looking ahead towards compliance, it will be important for WV to update the SME with some process measures regarding dissemination of this training (i.e., number and percent of PCPs who received the training, number or referral desk guides disseminated, and % of PCPs/ office staff/ provider agencies the desk guide was disseminated to).

The outreach tracker data provided by WV also noted multiple instances of outreach to PCPs and other health care providers to address screening such as a video conference (August 25, 2022) regarding the Assessment Pathway to children's mental health services and mental health screening.

Outreach tools for medical professionals. No updates were provided.

Outreach and Education Plan. WV submitted their *Outreach and Education Plan Draft Revised March 2023*. Of note they have detailed their open tasks, including improved communication and collaboration among child-serving agencies (i.e., DHHR, DOE and DHS), and continuing to ensure that families and interested/affected groups have information regarding services and a "means to provide feedback." SME agrees that these are priorities, and that the State has made significant in-roads along these lines, as described below.

One outstanding question is the role of the communication toolbox described in Appendix A of the *Outreach and Education Plan Draft Revised March 2023,* described as a resource for internal and external community partners to utilize with children and families. The SME wonders whether this toolbox refers to their plans for "outreach tools for medical professionals" and requests to hear more about their plans.

WV submitted their outreach tracker data, detailing outreach and education activities. The SME commends WV for creating a way to document their outreach activities (including the purpose of the outreach, the audience, and the county). This will be an excellent way to both track outreach and to plan for needed outreach if gaps are identified. Some highlights of their outreach include: 1) outreach to a wide variety of stake holders including (but not limited to) PCPs, DOE, provider agencies,

families, probation staff and advocates; and 2) outreach at multiple venues including conferences and meetings.

Information to children and families. WV noted that BMS continues to work with MHP to update their messaging and materials to families to "include language on the importance of getting a child screened for mental health needs."

DHHR has continued the *Resource Rundown,* along with including a recorded *Resource Rundown* on their website. The SME recommends updating messaging around the timing of these events. They are noted to be bi-weekly on the website, but it looks like the next registration date is in July.

WV responded to a previous SME recommendation that they ensure Aetna complies with Outreach and Education activities by noting that they work with a vendor (Myers and Stauffer) to monitor MHP compliance.

DHHR created a "Did you know" campaign directed towards teens posted on YouTube, Facebook, and Twitter. They will also be adding it to the Kids Thrive Collaborative website. These short videos offer information regarding a DHHR program for teens to privately chat, text or talk with someone regarding bullying or any mental health concerns.

Collaboration with DOE and DHS. WV responded to the SME's previous asks to indicate collaboration with DOE and DHS by noting that they have set up quarterly meetings with leadership from DOE and DHS and have drafted a data sharing agreement. There were also instances of reaching out to DOE and DHS on the outreach tracker data including 1) a virtual video conference to the State's school psychologists regarding community mental health services for children (September 14, 2022); and 2) collaboration between the BBH and DHS around school threat assessments and contributing information regarding the CCRL and other community-based services (October 5, 2022).

3.1.4 Compliance Rating and Justification

Outreach & Education will be rated for compliance in Fall 2023.

3.1.5 Recommendations to Achieve Compliance

SME commends WV for their overall Outreach and Education efforts. As noted in this chapter, they have made many strides with 1) physician training around screening; 2) creation of DHHR's Outreach and Education Plan and implementation of parts of that plan; 3) providing information to family and children; and 4) and just recently solidifying their collaboration with DOE and DHS.

Looking ahead towards the compliance rating, WV should continue to address the latter four categories. For the Agreement category, "physician outreach regarding screening," documentation around trainings (i.e., process measures) will be important to provide. For the Agreement category, "outreach tools for medical professionals," it will be important to demonstrate completed or planned activities and any process measures collected. For the Agreement category, "information to family and children," WV can provide updates on initiatives and plans for continued outreach. Finally, for

the Agreement category "collaborating with DOE and DHS," WV can provide updates and relevant data regarding these collaborations.

RECOMMENDATIONS	ACTION ITEMS	COMPLIANCE CATEGORY
Physician outreach regarding screening.	-Document the *O & E HealthCheck PCP MH Referral Training,* including collecting data on the number and percentage of PCPs who received this training. -Document dissemination of the desk guide, including collecting data around the number (and percentage) of *O & E HealthCheck PCP MH Referral Desk Guides"* disseminated.	-Workforce Readiness
Updating the Outreach and Education Plan.	-Submit any changes made to the plan with tracked changes.	-Accessible Information
Improving information to children and families.	-Continue to update the Kids Thrive Collaborative Website. Update the calendar so that it notes upcoming events, and ensure messaging is consistent around when the *Resource Rundown* occurs. -In the "How do I" section, a suggestion is to provide a number to call for CSEDW (as opposed to a weblink). -As WV has provided in previous reports to the SME, provide number of postcards/phone calls/texts/case manager outreaches by MHP regarding mental health screening. -Provide an update as to whether MHP has added more explicit language to their postcards about mental health screening. -Provide an update/plan as to how families and youth are included in workgroups and avenues for two-way communication. The SME understands that ways to elicit feedback from families and children will be an ongoing process and recognizes that WV has made in-roads here as through the *Resource Rundown* and providing means for public comment. The SME encourages WV to continue to consider strategies to incorporate families and children. As an example, we noticed the Family Advisory Board and the Aetna Member Advisory Committee mentioned on the Kids Thrive Collaborative website. These seem like potential avenues for further collaboration and input from families and children. -Provide an update on the *Resource Rundown* for youth that is in development. -Provide an update around collaboration with WVU Office of Health. WV previously noted this	-Accessible Information

	collaboration would "implement a public education initiative aimed to raise awareness of HCBS." This sounds like an important and valuable effort. - Provide an update on the communication toolbox.	
Further develop collaboration with DOE and DHS.	-Provide any updates. -Provide relevant data such as meeting dates, data sharing agreement, agenda items/ next steps from meetings.	-Accessible Information

3.2 Workforce

3.2.1 Service Description

Agreement requirements 41d, 41e. The Agreement requires the State to: 1) address workforce preparedness to deliver services; 2) ensure availability of sufficient providers; and 3) address any workforce shortages. Inherent in fulfilling the Agreement is the need to understand current capacity; and to recruit, retain, train, and coach a behavioral health workforce to support WV's vision for reforming its system and delivering services to children and families as outlined in the Agreement.

3.2.2 Historical Review

The first six SME reports document the following points of consideration and progress.

Preparing the workforce. WV has engaged in multiple activities to prepare the workforce to meet the Agreement requirements.

- Workforce training initiatives: DHHR has invested considerably in the development of infrastructure to train, coach, and assess skills among the workforce (CANS delivery, Wrap, CMCRS, BSS). These efforts have been documented in service specific sections within the SME reports. For example, DHHR partnered with MU to create a workforce training center called the *West Virginia Behavioral Health Workforce and Health Equity Training Center* with a focus on Wraparound and CMCRS. The State also continued its contract with WVU CED PBS Program. DHHR also entered into an agreement with CU to support the development of a behavioral support services-related training and certification program. The SME has commended the considerable investments WV has made in service specific workforce capacity (reported on in individual sections of SME reports). The SME recommended continuing along this path of planning advanced trainings and modifying existing trainings, based on feedback from providers, children and families (from provider evaluations, WVU evaluations and DHHR quality and fidelity reviews).
- Residential facilities: DHHR partnered with Casey Family Programs and Chapin Hall to improve quality of care among residential facilities.
- American Rescue Plan Act (ARPA) funding: WV last provided an update around these initiatives in *WVU ARPA Projects Update September 8, 2022,* which were last reviewed in the SME's December 2022 report. These initiatives are inclusive of (but not specific to) children's behavioral health, such as trauma-informed trainings for Medicaid home and community-based services front line workers, and training for law enforcement around working with people with intellectual or developmental disabilities, and with behavioral health disorders. SME recommended that WV provide updates regarding the learning generated from ARPA-funded investments, and how WV plans to modify or expand these efforts based on the learning.
- Other workforce enhancement strategies recommended by the SME have included:
    - Work with the state licensing board to broaden scope of practice language to be more inclusive so that practice-based expertise, training and other education can be recognized.

- Develop a certification program for persons with relevant work experience to be credentialed to provide certain services with CMCRS, Wraparound, Behavioral Support Services and in-home therapy approaches.
- Develop a supervisory infrastructure to support effective supervision.
- Work with WV higher education to develop curriculum that prepares workforce to provide HCBS services (such as CMCRS, Wraparound, and Behavioral Support Services).

Analysis of the workforce. Multiple activities are underway to address workforce capacity across multiple areas of the Agreement.

- Wraparound capacity: Addressing SME's recommendation to quantify providers one service at a time, DHHR chose to focus first on Wraparound (because that workforce is essential to reducing residential interventions). DHHR developed an Excel spreadsheet tracking individual Wraparound facilitators by bureau, number of children served by each facilitator, and child's county of residence. This tool allows DHHR to understand Wraparound service provision by looking at: when individual facilitators are working across multiple bureaus, individual facilitator caseloads, and providers that are not yet offering CSEDW services. DHHR reports that this data is updated monthly. The SME recommended WV group data by the numbers of providers below the 1:10 provider to client ratio, at the 1:10 ratio (considered best practice) and above the 1:10 ratio. For ratios that exceed the 1:10 ratio, the SME recommended a rapid cycle improvement effort to reduce this number.
- CSEDW provider capacity: To expand the number of CSEDW facilitators, DHHR required that SAH programs become CSEDW providers. SME understands that BBH providers will also be required to enroll as CSEDW providers.
- Plan to Assess Service Capacity & Workforce: DHHR submitted to the SME a *Plan to Assess Service Capacity & Workforce* (Sept. 8, 2022). The document lays out a process to analyze service capacity. This was a response to the SME's request for information about how DHHR will monitor capacity.
- Plans for data collection: The SME noted in the December 2022 report that they looked forward to discussing with DHHR: plans to account for low utilization of specific services; potential inclusion of behavioral service utilization data outside of the CSEDW (such as BBH and SAH data); potential use of CANS and CAFAS data; and projecting service use that is consistent with best practice.
- Other data to collect: In addition to working on other workforce domains (other than Wrap) SME recommended assessing the current workforce that only accepts third party insurance and address refusals to accept Medicaid.

Incentives to the workforce. WV State Loan Repayment Program (STLR): WV implemented a loan repayment program, that targeted priority workforce areas including child psychiatry and children's mental health clinicians (first award cycle: 23 early career practitioners, second award cycle: 23 early career practitioners). Recipients receive $20,000 to cover student loan expenses in exchange for a two-year service obligation with a qualified State employer. Priority is given to candidates with lived

experience, and those willing to work in areas most impacted by workforce shortages and underserved rural areas.

3.2.3 Review of Current Documentation, Activities, & Accomplishments

Preparing the workforce. In the *January 202 Semi-Annual Quality and Outcomes Report* WV described that they continued provider education and training on Wraparound and CMCRS by MU (in partnership with UCONN).

Analysis of the workforce. A main focus continues to be understanding WF capacity (as described in a SME and WV meeting on March 30, 2023). For example, they are working to understand how a child's acuity level might impact caseload capacity.

WV provided Wraparound data (services current on November 2022) to the SME using their detailed Excel spreadsheet that they had developed to track individual WFs by bureau, entitled *DHHR November 2022 WF Capacity*. The documentation showed provider information and the number of children and youth enrolled in each provider, by bureau. (County data was also provided in this Excel spreadsheet.)

Review of Data provided in the *DHHR November 2022 WF Capacity* Spreadsheet:

- Only one Wraparound provider is not offering CSEDW (down from six providers not offering CSEDW noted in the December 2022 SME Report).
- There were 187 individual WFs.
- Additional information included preliminary facilitator to client ratios and additional details on methodology and caveats to the data that are still being worked through.
    - *Other provider capacity monitoring*: Throughout the *January 2023 Semi-Annual Quality Outcome Report* it is stated that provider capacity is being monitored "to better understand workforce needs, including workforce shortages, high-intensity clients impacting expected ratios, and potential regional concerns (pg. 58)".

Having focused on WF capacity, DHHR reported to the SME in a meeting (March 30, 2023) they intend to focus on understanding the capacity of the therapeutic workforce.

Incentives to the workforce. A new master's mental health counseling program was announced on February 10, 2023, at West Virginia Wesleyan College. This program was made possible by a $1.2 million investment by Aetna Better Health of WV and Community Care of WV. Enrollment is projected to begin 2023-24. In addition, Community Care signed an MOU to support the program and offer positions to each student who completes the degree after accreditation approval.

Monetary incentives. Aetna offered monetary incentives to providers to enhance the provider network, in anticipation of increased demand for CSEDW services. DHHR has added 48 CPS positions since 2018 and increased workers' salaries by 20% starting July 2022.

ARPA funding. ARPA Funding was secured to continue the STLR Program. WV summarized the three rounds of STLR awardees: 1) Round 1: 22 master's level therapists; 2) Round 2: 44 early career

therapists or counselors; and 3) Round 3 is currently underway and it is anticipated that there are 60 awardees including both master's level therapists and child psychiatrists and nurse practitioners. After Round 2, WV received feedback that the $20,000 received to pay back educational expenses in Rounds 1 and 2 was insufficient incentive. WV responded to this feedback by increasing the incentive to $35,000 for master's level therapists and $100,000 for psychiatrists and nurse practitioners.

3.2.4 Compliance Rating and Justification

Workforce will be rated in Fall 2023.

3.2.5 Recommendations to Achieve Compliance

The SME commends WV for their overall Workforce efforts. As noted in this section, they have: 1) worked on preparing the workforce through trainings and securing ARPA funding to conduct trainings; 2) done an exceptional job collecting comprehensive WF data; and 3) incentivized the workforce as through the STLR program, Aetna monetary incentives, and university partnership programs.

Looking ahead towards the compliance rating, WV will want to: 1) describe how they are using the WF data to impact practice; 2) describe their plans for looking at capacity in the other workforce domains of the Agreement; 3) continue to provide updates around trainings and future trainings; 4) discuss ways to expand workforce through creating positions that are more inclusive of a range of skills and abilities; and 5) provide updates on current and planned monetary incentives to the workforce, and university partnership programs.

RECOMMENDATIONS	ACTION ITEMS	COMPLIANCE CATEGORY
Explain how DHHR is using the WF data to inform practice.	-DHHR will continue to review and address caseload ratio data to understand the ratio differences among providers. (i.e., is it related to child acuity level?); -In addition, if not yet completed, DHHR can create a process for how they use their Wraparound data on a monthly basis (i.e., share data at specific meetings, create action steps). This process can then be applied to other workforce domains as they collect capacity data.	-Data Collection & Monitoring
Plan for data collection in all the workforce domains of the Agreement.	-WV created a *Plan to Assess Service Capacity and Workforce*. SME can support WV by discussing this plan's components. With the next report, it will be important to see any updates or actions taken to implement this plan.	-Data Collection & Monitoring

Provide updates on current and planned trainings offered across workforce domains.	-Document any trainings and assessments completed around the trainings, and planned trainings. -Provide an update on ARPA funding initiatives and how these trainings touch on specific issues around children and youth (or plan to address children and youth); and any plans for using what they learned/next steps.	-High Quality Service -Workforce Readiness
Discuss ways to expand the workforce to be more inclusive of people with a range of skills and abilities.	-Develop a plan for increasing provider inclusivity, such as: • Work with the state licensing board to broaden scope of practice language to be more inclusive so that practice-based expertise, training and other education can be recognized. • Consider creating or expanding credentialing programs (such as peer recovery support specialists).	-Statewide Capacity -Workforce Readiness
Provide updates around workforce incentives and university partnerships.	-Provide details on the monetary incentives offered by Aetna and any updates regarding university partnerships to train the behavioral health workforce.	-Data Collection & Monitoring

3.3 CSED Waiver

3.3.1 Service Description

Agreement Requirements 24, 26, 28, and 37. CSEDW is a Medicaid-funded program. It provides HCBS (with a foundation using the Wraparound care coordination model developed by NWI) to children and youth aged 3 to 21 with an SED. CSEDW prioritizes children with SED who are: in residential treatment facilities, or Medicaid-eligible and at risk of institutionalization.

3.3.2 Historical Review

Over the course of the SME reports, the greatest accomplishments have been the establishment of the CSEDW program (along with a commitment by BMS that services to be evidence-based); and the rapid expansion of CSEDW in the past year. Specific state efforts that have supported this expansion include:

- The State's CSEDW amendment (approved June 3, 2022). Highlights of this amendment include (but are not limited to) the expansion of CSEDW eligibility and the expansion of the workforce pool to include non-licensed clinicians.
- The State's outreach and engagement efforts (with eligible families and providers), which have led to CSEDW applications increasing.
- The State's efforts to determine CSEDW eligibility prior to youth's discharge from residential services. In addition, the CSEDW amendment included an extension of the hold timeframe from 180 days to 365 days. This has enabled WV to complete the CSEDW application at admission to residential services and then initiate a hold to ensure there is a more seamless transition to CSEDW services upon residential discharge.

Previous SME reports commended the State's intention to monitor hours of service provision to: 1) inform needed provider recruitment; and 2) compare utilization with child outcomes.

The first six SME reports document the following points of consideration and progress.

Data collection and monitoring. WV has reported on the number of children accessing CSEDW services annually, along with the type of CSEDW services accessed (including assistive equipment, WF, community transition, in-home family support, in-home family therapy, mobile response, peer parent support, respite, specialized therapy, supported employment, and transport).

The SME recommendations have included collecting and reporting data about families that decline CSEDW and reporting data by service hour instead of unit, which WV has addressed in their latest reports.

Timely provision. One of the CSEDW data points that WV has reported on is the time to eligibility determination and time between eligibility and provision of services. The SME noted that WV had halved the time of eligibility determination from 68 to 34 days, and that on average time between determination of eligibility and WF (as funded through CSEDW) is 58 days. The SME

recommendations have included increased understanding of delays with 1) time to eligibility determination, and 2) time between eligibility determination and provision of services.

High quality service. The SME has raised the concern that hours of service provided per child have been relatively low. To address this concern and ensure that the CSEDW services are of high-quality, the SME recommendations have included: requiring the State's vendor to monitor underutilization of service; monitoring low hours of service provision per child within CSEDW services; and determining whether plans of care are individualized, to ensure children receive services based on need.

Statewide capacity. An ongoing concern raised by WV has been challenges hiring and retaining a sufficient behavioral health workforce. The SME recommended WV review provider recruitment and retention strategies to ensure that the provider pool is sufficient for CSEDW need.

3.3.3 Review of Current Documentation, Activities, & Accomplishments

CSEDW Data Collection & Monitoring

WV provided CSEDW service use data from January 2021-June 2022 (paid through October 2022) in their *January 2023 Semi-Annual Quality and Outcomes Report.* (Note: recent data are preliminary and subject to change based on service providers having up to a year for claims submission).

CSEDW application data. The following data represents the time period of January 2022-June 2022, as of September 2022:

- 729 applications received,
- 496 (68%) applications approved,
- 59 (8%) applications denied,
- 160 (22%) applications closed, and
- 14 (2%) applications pending,

Of note:

- Over two and a half times more applications were submitted in the 6-month period of January 2022-June 2022 as compared with July 2021-December 2021. WV speculates that this is due to improved screening and referral processes and increased general awareness of the CSEDW program.
- 95% of children referred to Kepro for evaluation have a CAFAS/PECFAS score greater than or equal to 90 (indicating CSEDW is attracting its target population).
- Most referrals (51%) are coming through DHHS agencies, such as CPS and YS, followed by Aetna (13%) (representing children discharging from residential settings).
- WV is monitoring time from receipt of CSEDW application to eligibility determination (42.3 days), which is an increase of seven days as compared with the previous six-month period (July-December 2021). WV attributes this rise to the increased applications received during this time period. WV has stipulated that the max eligibility determination time period is 45-

days. To address this challenge, Kepro has hired staff to conduct CAFAS/PECFAS assessments, and PC&A (the vendor managing the Independent Evaluator network) is working to expand the network of Independent Evaluators.

- WV has put policies in place to establish a child's eligibility for CSEDW upon entry into residential settings to ensure ease of transitioning to CSEDW upon residential discharge.
- Reported challenges include the existence of a waitlist (due to limited workforce and a rapid increase in applicants).

CSEDW service utilization data. The following data represents the time period of January 2022-June 2022.

- 410 children accessed services (nearly double the previous six-month period).
- 315 children had paid claims for independent evaluations but did not access services.
- The predominant diagnosis for children accessing CSEDW is ADHD (46%; note this diagnosis could co-occur with other diagnoses).
- CSEDW service utilization per hour: Average number of hours of CSEDW service utilization decreased in this period (9 hours per month per child) as compared with July-December 2021 (12 hours per month per child). At the same time, WF increased (from 4 to 5 hours per month per child) perhaps due to focus on WF capacity). WV hypothesizes that this decrease in utilization may be related to provider capacity, a broader range of client acuity levels, and/or the influx of children who recently joined CSEDW (CSEDW service utilization for those recently admitted may be less than for those who have been in the CSEDW program for a longer duration).
- Time to CSEDW service provision from eligibility determination: WV analyzed data from January 1, 2022- March 31, 2022. Of the 55 children who had active eligibility status and were not on hold (for example, due to being in residential treatment), the average time to service provision was 62 days. This does not capture the timeline to interim services. WV will be adding interim services to the data collection to better understand time to services.

Provider capacity. Eighteen providers offer CSEDW services (up from 12 noted in the December 2022 SME Report). Four providers are in the process of becoming certified. There is at least one CSEDW service provider in each county. Providers report staffing challenges due to the pandemic and national labor shortages. The MCO has offered monetary incentives to providers in an effort to enhance the provider network.

CSEDW provider capacity forecasting. In the *Year 4 Imp Plan*, WV has identified an open task as "collaborating with MCO to continue expansion of the provider network to meet the increase in CSEDW applicants". To understand the amount of expansion called for, WV has stated it plans to use referral and application trends, and utilization rates. Preliminary forecasting was discussed in the October 2022 Quality Committee reviews, with WF, family therapy, in-home family supports, and respite identified as forecasting priorities.

CSEDW outreach. WV has collected preliminary data around counties that have low CSEDW use and high residential placement. According to communication between the SME and WV, they will be using this data to inform targeted outreach. In addition, WV has stated in multiple meetings with the SME

that they intend to increase focus on CSEDW outreach to children who are at-risk of, but have not yet been placed in, a residential setting (as most of their previous focus has been on CSEDW outreach to the population of children at residential facilities to enroll upon discharge).

3.3.4 Compliance Rating and Justification

CSEDW is not a service in itself, but rather a mechanism to provide Agreement services, it is not rated on its own terms, but is analyzed as it is relevant to Agreement requirements.

3.3.5 Recommendations to Achieve Compliance

The SME commends WV for the CSEDW expansion, efforts to monitor CSEDW service applications and utilization, and increased outreach. With CSEDW's rapid growth in applications, there is the need to better understand children's needs and provider capacity to better target outreach and services. The recommendations below are in an effort to support the priorities in the key areas of data collection & monitoring, timely provision, and statewide capacity. In terms of data collection and monitoring, WV can provide more detail in terms of their process for using data to inform CSEDW practices, and collect other relevant data items, described below. In terms of timely provision, WV can provide data on interim services that family and youth receive while awaiting CSEDW determination and service provision. Finally, in terms of statewide capacity, WV can report on their collaboration with the MCO to forecast provider need.

RECOMMENDATIONS	ACTION ITEMS	COMPLIANCE CATEGORY
Use CSEDW data to inform quality services.	-Continue to document the process by which WV is using data to inform quality services, and the results of that process. For example, recent concerning trends include time to eligibility determination increasing, and total number of service hours per child decreasing. -Continue to understand the data and use it to improve service provision. (An example could be meeting with groups interested in/affected by CSEDW to discuss the data and then creating action steps to address the data findings).	-Data Collection & Monitoring -Timely Provision
Collect demographics for CSEDW applicants who were denied or refused services.	-Add item to QAPI KPI Table.	-Data Collection & Monitoring
Collect data on interim services children and youth receive while awaiting CSEDW eligibility determination.	-Continue efforts to report data around what services children and youth receive while awaiting CSEDW determination. If this data does not exist, provide a plan to better understand what families experience during	-Data Collection & Monitoring -Timely Provision

	this interim period and what services are provided.	
Utilize data on low CSEDW service usage/ high residential placements by county to inform outreach.	-WV has already collected this data. The next step would be to create an outreach plan, based on the data collected. This is related to recommendation one (having a process for applying data collected).	-Data Collection & Monitoring -Statewide Capacity
Understand and address CSEDW service provision needs per child.	-Continue to report on utilization of services to better understand low utilization. (it may be that certain outlier cases are driving these numbers down). -To address the need to increase service intensity, consider additional methods to better understand low billing (i.e. provider reviews, individual review to see whether children are getting all services listed on ISP, median service utilization by service, utilization in first months of CSEDW enrollment vs last months). -Continue to report on service-hours per-month and provide a discussion of the factors that may be impacting fluctuations and plan to address any gaps. - Ensure that interventions are based on the severity and type of child need.	-Data Collection & Monitoring -High Quality Service
Identify ways to increase CSEDW referrals for children that are at high-risk for residential placement.	-WV has identified this as a priority. Please create an outreach plan or describe the next steps.	-Access to Service
Report on collaboration with MCO to support provider forecasting efforts.	-Provide an overview and update of this collaborative effort, with details around how WV is using: 1) referral and application trends; 2) current and expected utilization; and 3) any additional factors, to complete the forecasting.	-Statewide Capacity

4. Overall Conclusion and Next Steps

DHHR continues to progress on meeting the Agreement requirements, including reducing reliance on residential treatment. To sustain its achievements and address remaining Agreement requirements, WV should continue to develop services still in initial implementation phases, refine their data collection processes, and increase service utilization. DHHR recognizes that to reach full implementation, children and families must access and benefit from these interventions; CQI practices must become routine; and the State needs to see improvements in overall outcomes. WV is making numerous efforts, at all levels, to achieve system transformation. This includes efforts to learn more about the youth admitted to RMHTFs and ensure that requirements such as discharge plans are in place for all youth. At the same time, DHHR is taking essential steps to reduce new admissions to RMHTFs through the implementation of formal services, the processes embedded in the Assessment Pathway, and critical outreach efforts to gatekeepers (such as judges). The SME looks forward to working with WV to provide support and TA to move forward on these initiatives.

Implementation of the aforementioned services, such as Wraparound in alignment with NWI standards, has revealed new challenges that DHHR will have to address. The SME notes that DHHR is building a culture that is focused on data and quality improvement (QAPI and CQI) and that in this last reporting cycle DHHR undertook numerous quality-improvement efforts informed by data analysis. These CQI efforts are strengthened by using current data to inform implementation and practice, as well as utilizing an implementation framework and developing provider learning communities, as referenced in previous copies of internal preliminary reporting provided during past SME reviews. DHHR has begun phasing in quality reviews of services with some siloed preliminary data being used while the data store is being built up. However, the SME requires evidence that these reviews are being undertaken effectively. As noted in prior SME reports, engagement with youth and families remains critical. Further, some evidence suggests that additional provider outreach and engagement may be needed to assuage provider concerns and align with WV's strategic plan to continue to improve their behavioral health system for children, youth and families. Provider concerns may relate to buy-in with respect to WV's transformation efforts, reaching fidelity and best practice in service areas, and staffing time needed for QA and data collection efforts. WV's *Resource Rundown* webpage can continue to be an effective means to communicate pertinent trainings and developments, to interested/affected community groups ranging from families, providers, and courts. The SME expects strong work planning practices supported by WV's overarching implementation plan to stay on course to further develop its children's behavioral health system and achieve compliance in all Agreement areas.