West Virginia
KidsThrive
Collaborative

Reducing the Reliance on Residential Services for Children

August 17, 2023

WEST VIRGINIA Department of Health & Human Resources

Agenda

1. Outline of Goals
2. Children's Mental Health and Behavioral Health Services
3. Qualified Independent Assessment (QIA)
4. Remodeling Residential Treatment Interventions
5. Updates from the U.S. Department of Justice (DOJ)

West Virginia KidsThrive Collaborative

West Virginia Department of Health & Human Resources

Outline of Goals

- Serve children with serious emotional disorders in their homes and community settings
- Reduce West Virginia's reliance on residential treatment facilities
- Reduce West Virginia's reliance on out-of-state residential treatment facilities

To achieve these goals, West Virginia's communities must have strong and sustainable community-based mental and behavioral health services for children.

Children's Crisis and Referral Line (CCRL)

The CCRL is available statewide 24 hours a day, 7 days a week.

- **844-HELP4WV** (844-435-7498)
- Connects youth and families with children's mobile crisis response and stabilization (CMCRS) teams and other home- and community-based services (HCBS), including WV Wraparound
- Families, youth, and those who work with them call, text, or chat with the CCRL 24/7
- Most services outlined today accessible through CCRL
- https://www.help4wv.com/ccl

WV Wraparound

Network of providers that offers services for children with serious emotional disorders or serious mental illness

- Serves ages 3 to 21 and their families
- Adheres to the National Wraparound Initiative (NWI) fidelity standards
- Wraps the child and family with supports
- Prioritizes family “voice and choice”
- Consists of four phases: engagement, planning, implementation, and transition
- Accessed through **844-HELP4WV** primarily or by applying for the Children with Serious Emotional Disorder (CSED) Waiver with Acentra Health, or Mobile Crisis Response team referral
- Referred through children’s mental health screening by the primary care provider (PCP) or other systems-level entry points

WV Wraparound (continued)

Children with Serious Emotional Disorder (CSED) Waiver

- Implemented by DHHR's Bureau for Medical Services (BMS) in March 2020
- From July – December 2022, 583 children accessed services
- Currently, 731 active participants
- Capacity to serve a total of 2,000 participants
- Approved to continue HCBS effective February 1, 2023
- Monitoring (July – December 2022):
  - Time from application to eligibility determination
  - Wait time from eligibility determination to first date of services
  - Fidelity to NWI standards

WV Wraparound (continued)

Assessment Pathway Initial Outcomes

Early data points toward positive outcomes for youth and families interacting with the Assessment Pathway. Data reviewed for children ceasing participation:

- Approximately 200 youth ceased participation in 2022, about 20% of referrals
- All youth with referral to pathway receive immediate mental health resources while waiting for Wraparound assessments and determination
  - Some families cited community resources were able to meet needs
  - Only one in every 20 youth entered residential placement after this interaction
  - Only one in every 20 youth accessed emergency department care for mental health needs post pathway

Takeaway: Preliminary findings point toward youth and families interacting with pathway receiving needed information to remain in their home and communities.

DHHR will continue to evaluate this as more data becomes available for youth accessing longer term high intensity services in the home or community.

WV Wraparound (continued)

Children's Mental Health Services (DHHR's Bureau for Behavioral Health [BBH])

- Serves ages 0 – 21 with mental health diagnosis, or intellectual or development disability (I/DD) combined with serious behavioral health or mental health concern
- From July to December 2022, 60 individuals served

Safe at Home (SAH) West Virginia (DHHR's Bureau for Social Services [BSS])

- Serves youth ages 9 – 18 in child welfare system and covers interim Wraparound for youth ages 3 – 21 awaiting CSED Waiver determination
- From July and December 2022, 1,134 children served by SAH, including Wraparound for youth awaiting CSED Waiver determination

Children's Mobile Crisis Response and Stabilization (CMCRS)

- Pilot began in 2017, first formal reporting in 2018, and fully statewide in May 2021
- **844-HELP4WV** can connect youth up to age 21 and their families to CMCRS services through a warm transfer to the regional Mobile Crisis Response and Stabilization (MCRS) team nearest them
- MCRS team speaks with youth or family and responds in person based on preference
- After de-escalating crisis, MCRS team completes crisis plan and links youth or family to appropriate community-based services to help them stay in their communities
- Six regional providers cover services statewide
- Increased awareness – 617 calls to the CCRL between July – December 2022
- Data points being monitored:
  - Ability to connect from CCRL to MCRS teams
  - Where referrals and calls come from
  - By phone vs. in person
  - Acuity (e.g., referral for information, community connection, or emergency)

Other HCBS

Regional Youth Services Centers (RYSCs)

- Statewide network serving youth, families, and communities
- Ages 12 to 25
- Six RYSCs promote positive outcomes through evidence-based programs and practices
- Access through **844-HELP4WV** or an RYSC directly

Expanded School Mental Health (ESMH) Services

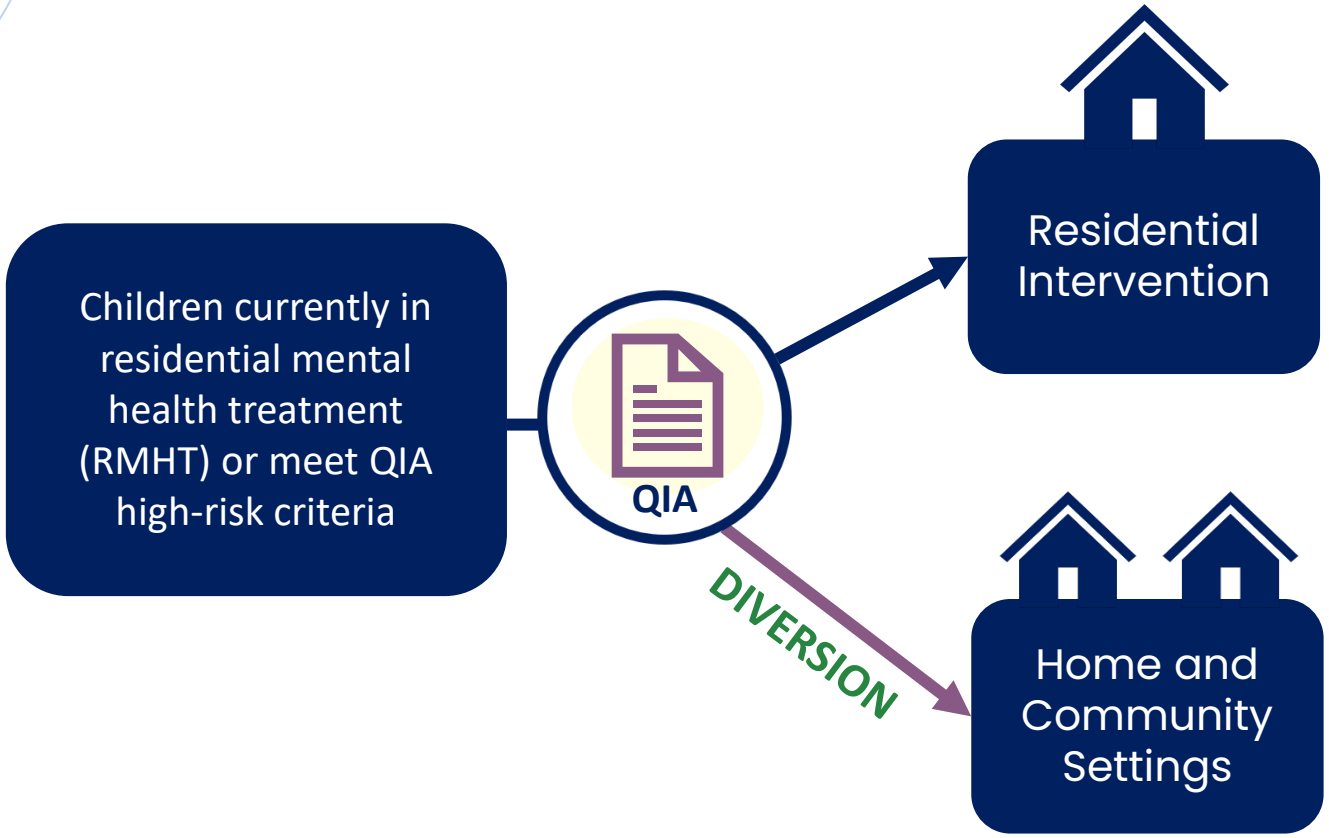
- Support system of schools, families, and community partners that enhances students' mental health in schools
- Serves 82 schools statewide, began with 12 schools in 2015
- BBH and SAMHSA funding
- To learn more: https://wvesmh.org/

Children's Mental Health and Behavioral Health Services

DHHR Semiannual Quality and Outcomes Report – July 27, 2023

- Input from service and child-level data
- Feedback from providers, facilities, youth, and caregivers
- Goal to advance and strengthen current systems through collaborative, strategic, and timely decision-making and action
- Capture results of DHHR's collaborative quality reviews and recommended next steps
- Data period of July 2022 – December 2022, including utilization trends July 2021 – December 2022 and exceptions for newly implemented services
- Of 166 children in prioritized discharge planning population anytime between January – June 2022, 109 (66%) since discharged from RMHT
- Located on the WV Kids Thrive Collaborative website: https://kidsthrive.wv.gov/DOJ/

Qualified Independent Assessment (QIA)



Assessment information used to identify qualified, least restrictive residential intervention

HCBS, including CSED Waiver Wraparound, help avoid unnecessary residential intervention

QIA (continued)

Purpose

- Third-party professional uses evidence-based assessment tool and decision models to provide recommendation on appropriate level of intervention and least-restrictive service setting

Procedure

- Referral made to Acentra Health
- Acentra Health assesses child using:
  - Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS) score
  - Child and Adolescent Needs and Strengths (CANS) assessment
  - CANS Decision Support Model for recommendation
  - Recommendations provided to the Court when applicable, and provided to the worker and Aetna, as part of the child's team, to ensure the child's needs can be advocated

QIA (continued)

Who requires a referral?

If a child meets any of the following criteria, they are at High Risk of placement and must be referred:

- Judicial involvement that indicates the child may need residential care or requests residential placement options and/or requests referral made to residential treatment facilities.
- The child is not cooperative with the court's requests.
- The child is disrupting or has disrupted from other arranged placement such as a kinship/relative home or foster home and no other options are available.
- The child's family requests removal from the home, or the home is unsafe and no alternative family settings are available.
- The child has no stable family home or other living arrangement.
- The child requests placement in a residential mental health facility.
- The child has been adjudicated as a status or delinquency offender.
- The child has been referred to a stabilization and treatment (STAT) home within the past 90 days.
- The child has been previously adopted and the adoption is at risk of disruption.
- The child is a danger to themselves or others.

QIA (continued)

Definition and data

- CAFAS/PECFAS score is functional assessment

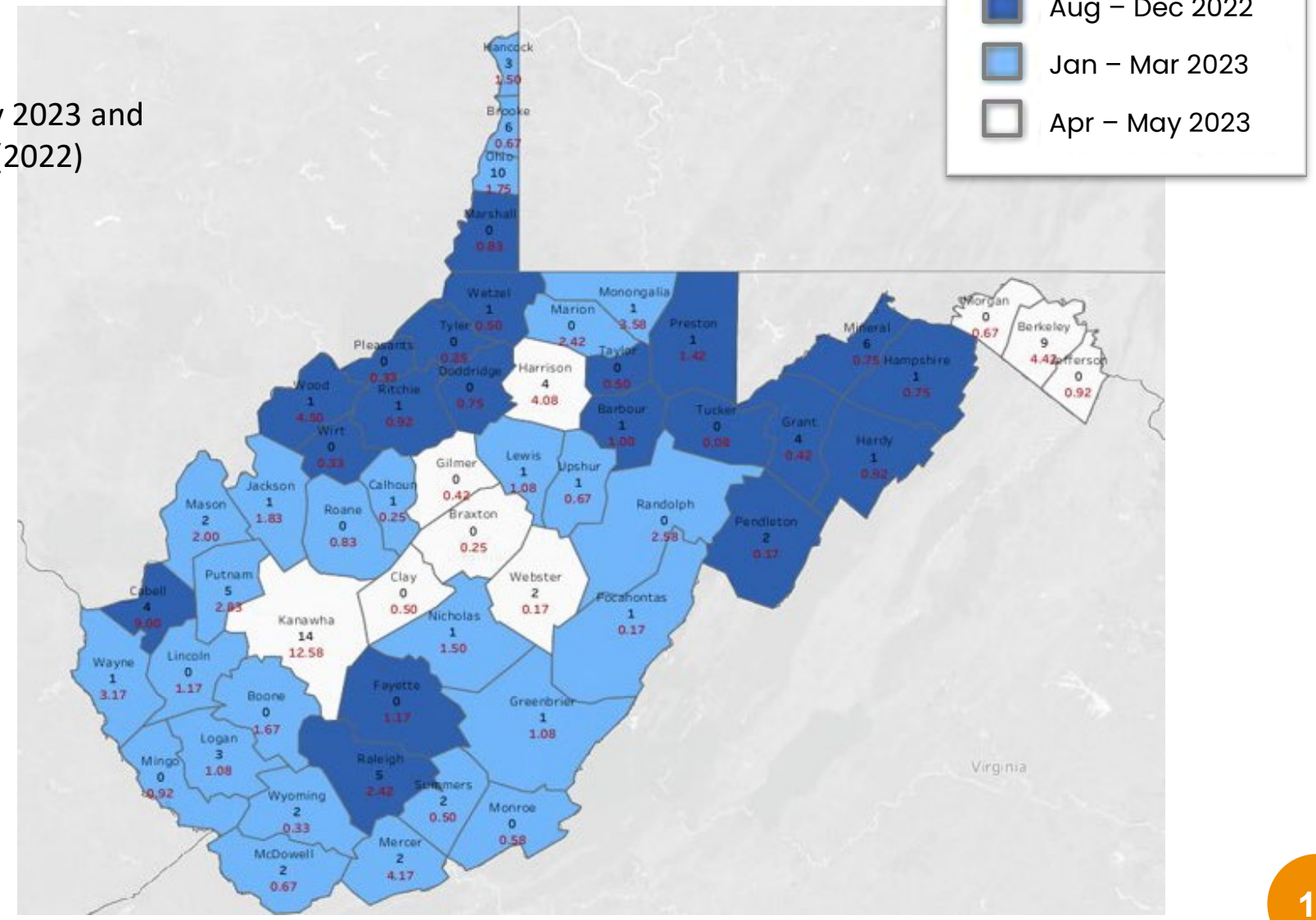
8 Scale Sum	***Level and description of overall dysfunction based on youth's total score***
0-10	Youth exhibits no noteworthy impairment
20-40	Youth likely can be treated on an outpatient basis, if risk behaviors are not present
50-90	Youth may need additional services beyond outpatient care
100-130	Youth likely needs care that is more intensive than outpatient and/or includes multiple sources of supportive care
140 and above	Youth likely needs intensive treatment, which would be shaped by the presence of risk factors and the resources available within the family and community

- CANS Decision Support Model for recommendation
- August 2022 – April 2023: 125 children referred to QIA
- Of the 125 children, nearly 70% received HCBS recommendation
- 64% of recommendations delivered within 30-day goal

QIA (continued)

Data Map

Number of QIAs signed in May 2023 and
Average Monthly Admissions (2022)
by Rollout Year and County



Remodeling Residential Treatment Interventions

Review of group residential provider network

- Number of providers statewide: 23
- Number of facilities statewide: 46
- Number of children served in group residential facilities in-state: 511
- Number of children served in group residential facilities out-of-state: 280

Demand pressures

- Increase in volume of children and youth in need of in-state residential and support services.
- Children and youth are traveling out-of-state for residential treatment facility services.

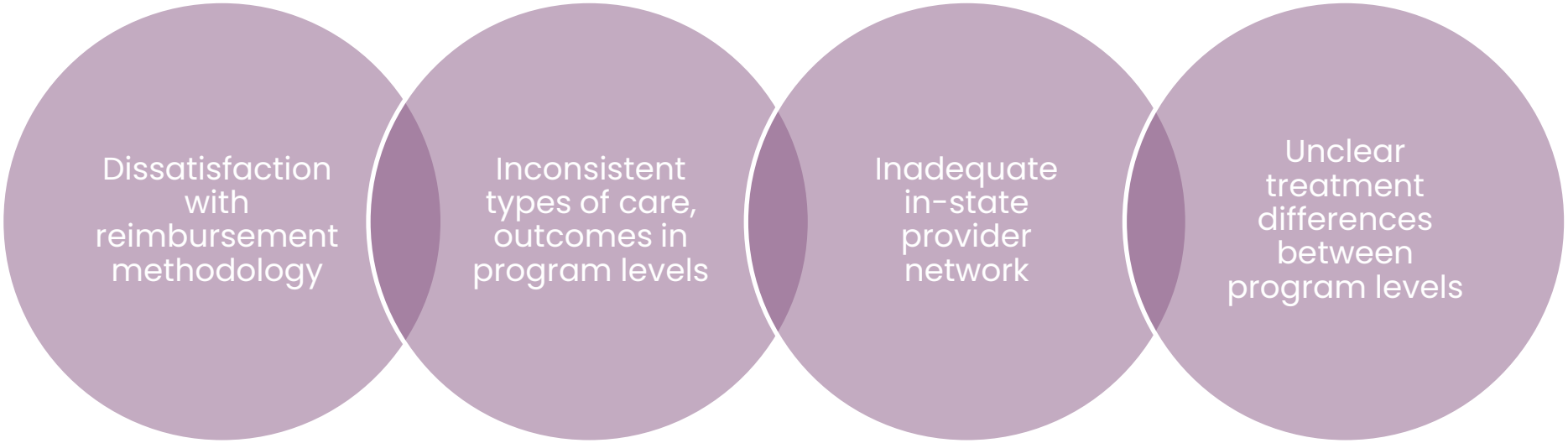
Remodeling Residential Treatment Interventions (cont.)

Review of current program structure

Level 1	Settings where children attend public school and have minimal supportive services and behavioral interventions
Level 2	Settings where children have moderate to severe adjustment difficulties and are served by a multidisciplinary team (MDT)
Level 3	Settings where children with intense, severe, and unpredictable behavior have 24-hour supervision in highly structured treatment program
Level 3.5	Blended level in which children have a level of need higher than typical Level 3 setting
Level 4	Crisis/emergency shelter

Remodeling Residential Treatment Interventions (cont.)

Review identified areas of concern in current structure



Remodeling Residential Treatment Interventions (cont.)

Review of residential mental health treatment (RMHT) levels

- Myers and Stauffer, LC (MSLC) compared cost reporting information and rates between providers in the same level and across levels.
  - Overall rate totals for each provider were compiled for analytical purposes.
  - Rate components were analyzed.
- Levels 3.5 and 4 providers were excluded from the analysis due to being less comparable to other levels.

Remodeling Residential Treatment Interventions (cont.)

Review of RMHT levels (continued) – Current rate methodology

The rate paid for RMHT services is the total of three components:

- Room and board costs are converted to a per resident per day (PPD) basis. These allowable PPD expenditures are fully reimbursed up to the level of established ceilings (standards) for these services.
- There are three distinct parts to the rate setting calculation for room and board: basic operations costs, capital costs, and incentives.
- Supervision is a set number of hours based on the level.
- Treatment is the residual cost after accounting for room and board and supervision.

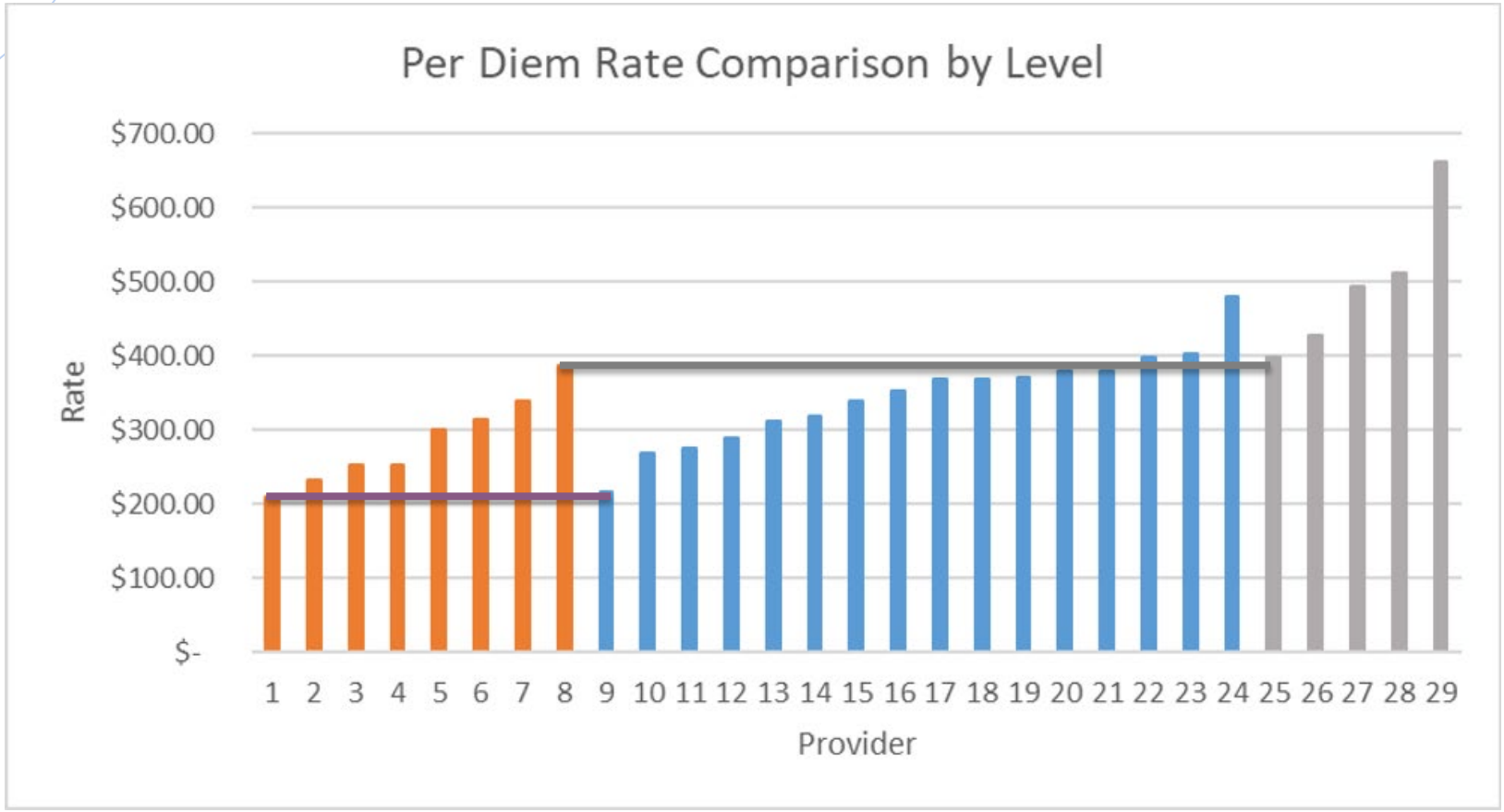
Remodeling Residential Treatment Interventions (cont.)

Review of RMHT levels (continued)

MSLC compared the total RMHT rates by provider.

- In a leveled rate structure, it is generally the case that rates increase with levels.
- There might be some overlap, but the majority of a level's rates should be higher than the level below it.
- However, the RMHT rates do not follow those guidelines:
  - Level 1 rates are generally not distinguishable from Level 2.
  - The lowest Level 2 rate is comparable to the lowest Level 1 rate.
  - The highest Level 1 and 2 rates are comparable to the lower Level 3 rates.

Remodeling Residential Treatment Interventions (cont.)



Remodeling Residential Treatment Interventions (cont.)

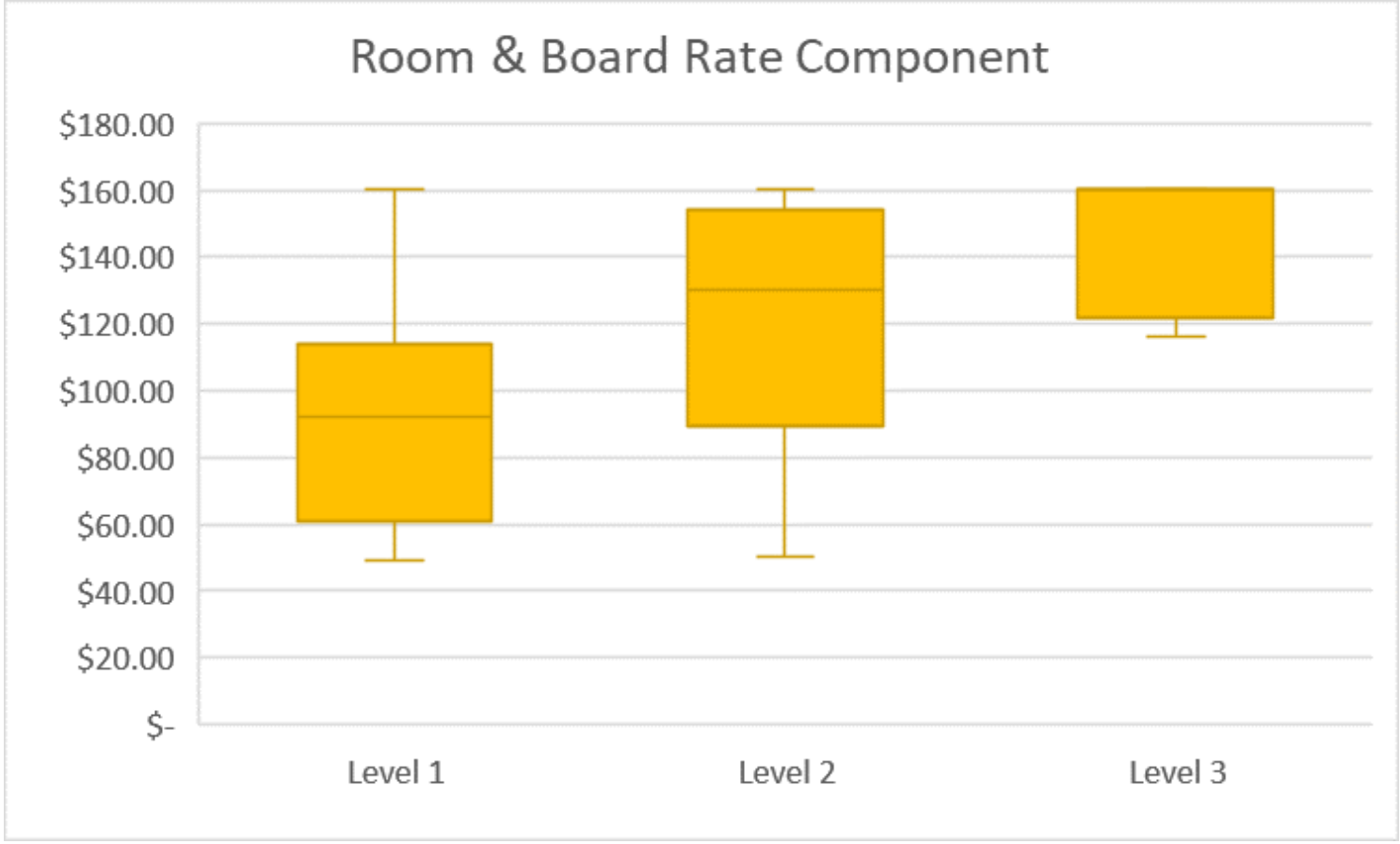
Review of RMHT levels (continued)

Costs associated with each component:

- Treatment: Includes the psychiatric treatment services for patients
- Supervision: Includes the service hours for care of patients
- Room and board: Includes housing and food costs for patients
    - Capital costs: Includes depreciation, interest, and rent; capital is a component of room and board but is shown separately to aid in review

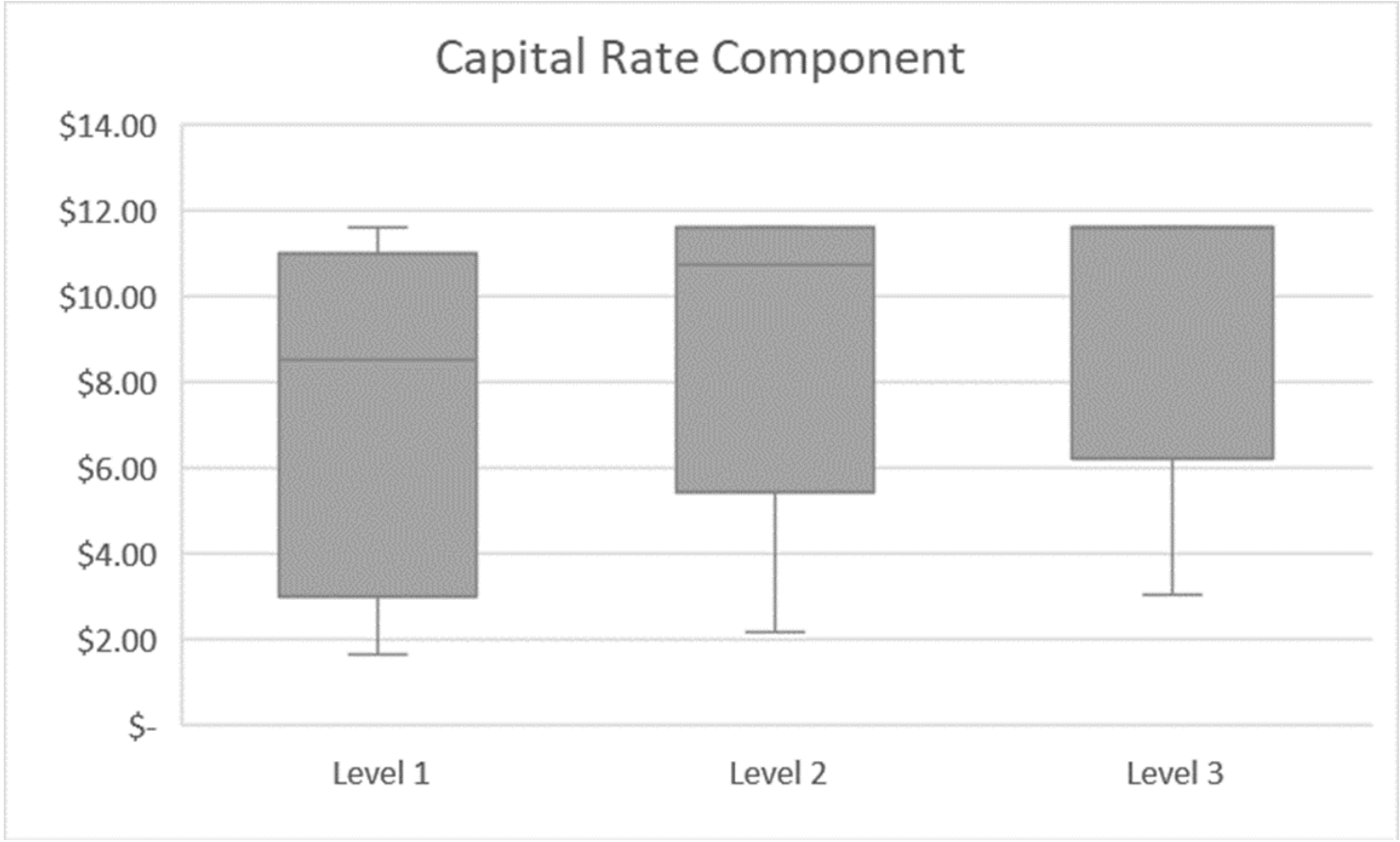
Remodeling Residential Treatment Interventions (cont.)

Program service level provider costs and rate comparisons



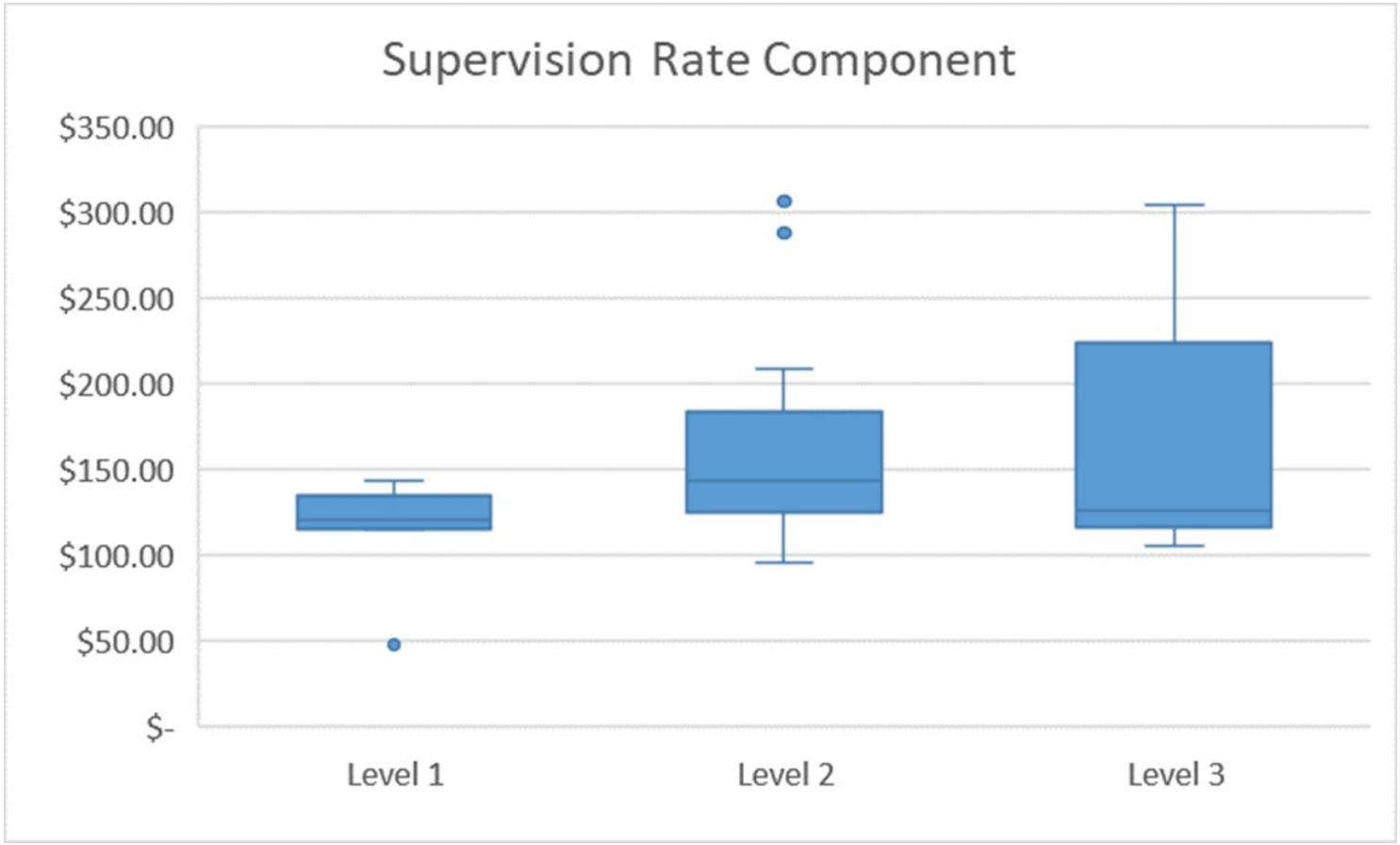
Remodeling Residential Treatment Interventions (cont.)

Program service level provider costs and rate comparisons (continued)



Remodeling Residential Treatment Interventions (cont.)

Program service level provider costs and rate comparisons (continued)



Remodeling Residential Treatment Interventions (cont.)

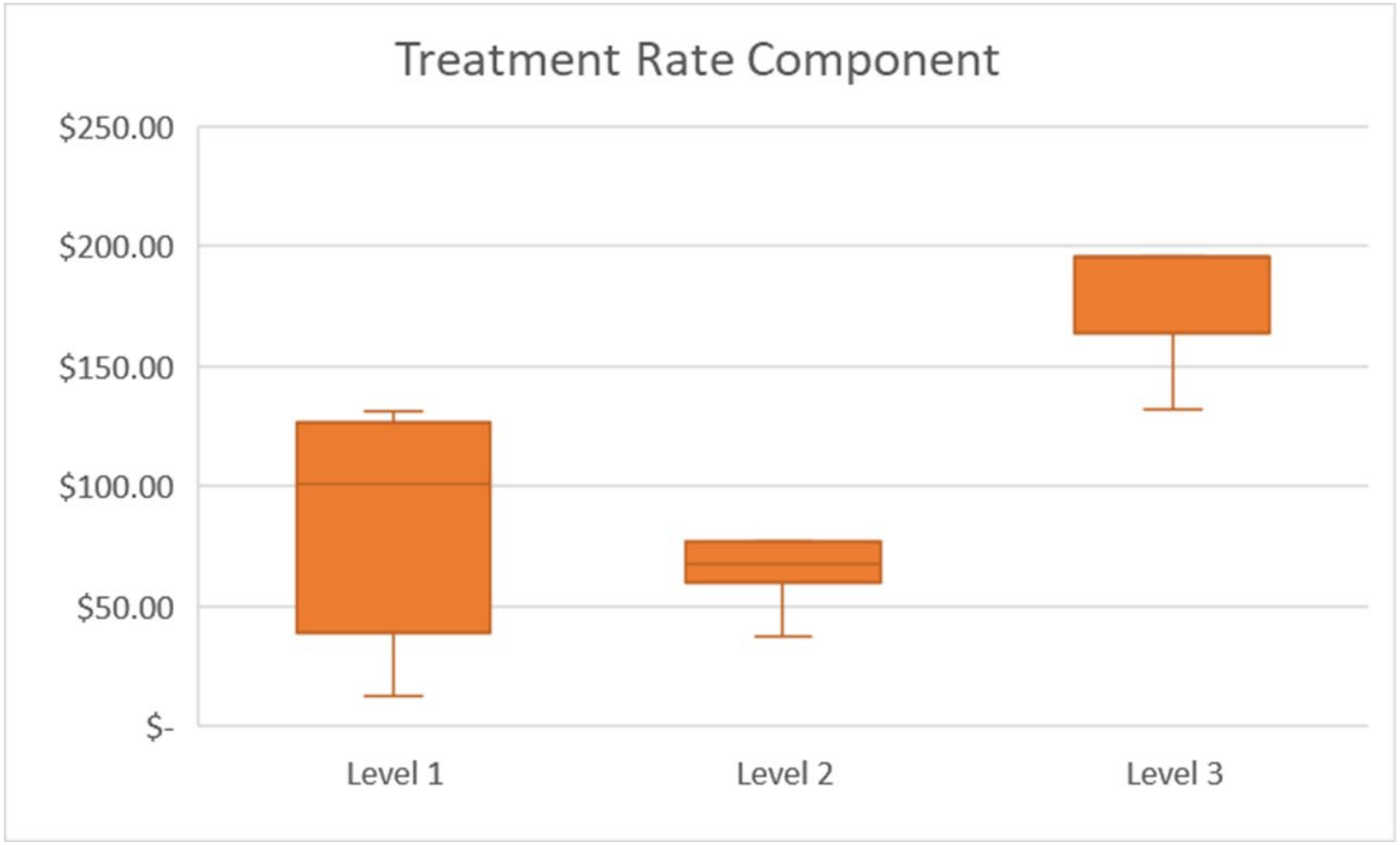
Supervision matrices

Levels 1-3 (1:6)		
1-6 Beds	16+8	24
7-12 Beds	32+8	40
13-18 Beds	(16*3)+(8+8)	64
19-24 Beds	(16*4)+(8+8)	80
25-30 Beds	(16*5)+(8+8+8)	104
31-36 Beds	(16*6)+(8+8+8)	120
37-42 Beds	(16*7)+(8+8+8+8)	144
43-48 Beds	(16*8)+(8+8+8+8)	160
49-54 Beds	(16*9)+(8+8+8+8+8)	184
55-60 Beds	(16*10)+(8+8+8+8+8)	200

Level 4 (Emergency Shelters)		
1-5 Beds	16+8	24
6-10 Beds	(16*2)+16	48
11-15 Beds	(16*3)+24	72

Remodeling Residential Treatment Interventions (cont.)

Program service level provider costs and rate comparisons (continued)



Remodeling Residential Treatment Interventions (cont.)

Program service level provider costs and rate comparisons (continued)

Remodeling Residential Treatment Interventions (cont.)

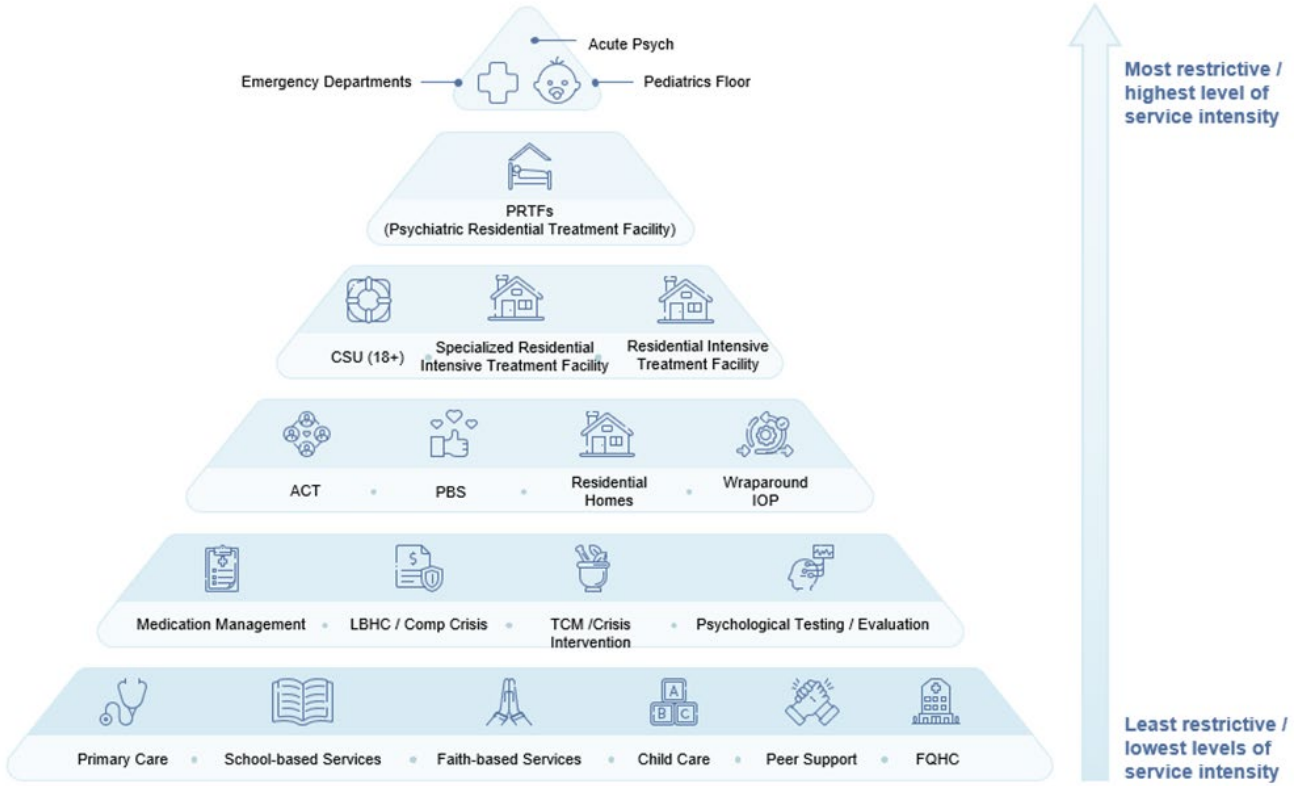
Program service level provider costs and rate comparisons (continued)

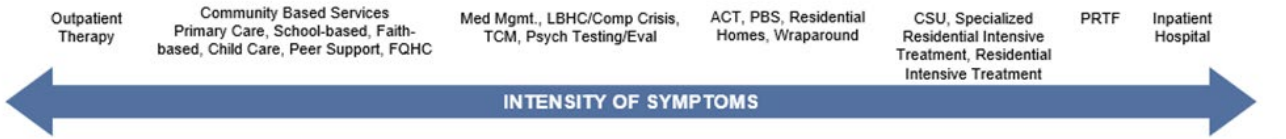
Key findings:

- The current levels produce rate components that do not directly increase with service level complexity.
- Provider service level classification may not reflect the level of child/youth they serve.

Remodeling Residential Treatment Interventions (cont.)

Intensity of services





PRTF – Psychiatric Residential Treatment Facility
CSU – Crisis Stabilization Units
ACT – Assertive Community Treatment
PBS – Positive Behavior Support
FQHC – Federally Qualified Health Center
TCM – Targeted Case Management
Wraparound IOP– Intensive Outpatient Program
LBHC/Comp Crisis – Licensed Behavioral Health Center

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Remodeling Residential Treatment Interventions (cont.)

Proposed program structure: Settings (continued)

Residential Homes	• Focus on achieving a permanent family placement • This type of setting would have community-based treatment services and children would attend public school
Specialized Residential Intensive Treatment Facility	• Focus on particular groups depending on specific treatment needs who have historically been sent out of state for care (e.g., sex offenders, autism spectrum with major behavior challenges) • This type of setting would have a specific treatment requirement
Residential Intensive Treatment Facility	• Offer the highest level of treatment services • This type of setting would have a treatment requirement
Emergency Shelters	• Short-term care settings which provide a residence for children and youth who cannot return to their home, typically because of a court decision or foster care placement change

Remodeling Residential Treatment Interventions (cont.)

Proposed rate structure overview

	Room and Board	Supervision	Treatment
Residential Homes	X	X	Outside of Per Diem
Specialized Residential Intensive Treatment Facility	X	X	X
Residential Intensive Treatment Facility	X	X	X
Emergency Shelters	X	X	X

Remodeling Residential Treatment Interventions (cont.)

Proposed rate structure

- Rates proposed will not be site-specific
- Rate would be established at the service program category level using a formal rate build-up process
- Rates to fluctuate with needs of the child/youth served
- Rate structure continues to include the three long standing components:
  - Room and board, supervision, and treatment

Remodeling Residential Treatment Interventions (cont.)

Proposed rate structure (continued)

Room and board costs

- Development of a standard rate for each provider service category
- Values derived from:
  - Provider cost reports
  - Subject matter expert (SME) feedback
  - Provider feedback
  - Inflationary considerations

Remodeling Residential Treatment Interventions (cont.)

Proposed rate structure (continued)

Supervision costs

- Staffing ratios and supervision hours based on needs of the child/youth
- Specialized providers may have unique supervision ratios or requirements
- Data would come from:
  - Provider cost reports/wage surveys
  - Bureau of Labor statistics data
  - Other wage/benefit sources
  - SME feedback
  - Provider feedback

Remodeling Residential Treatment Interventions (cont.)

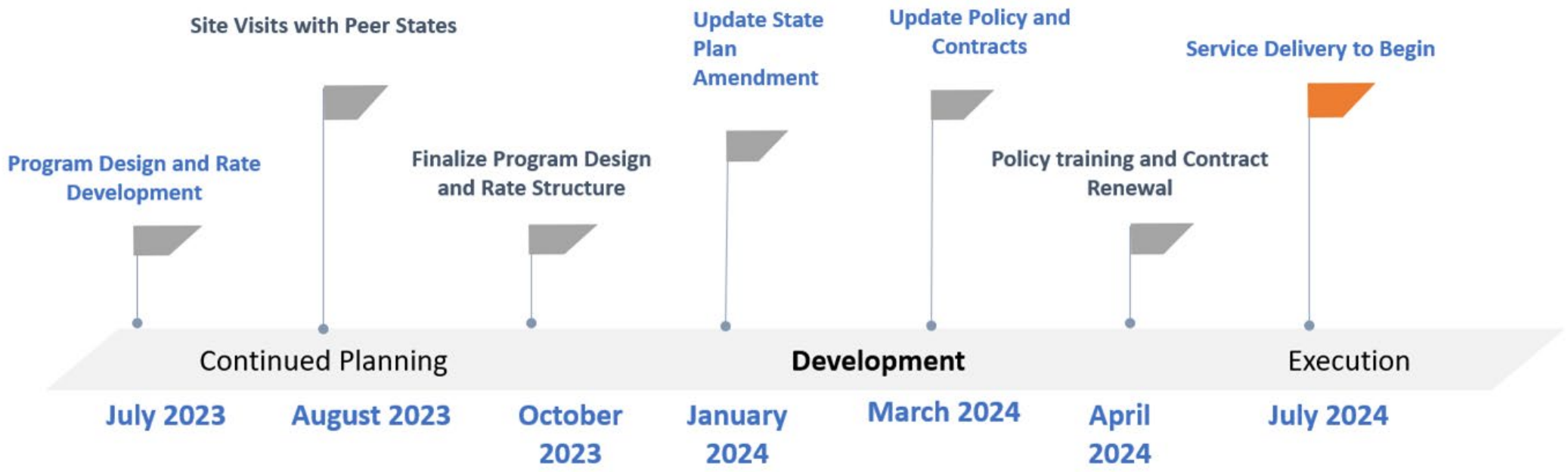
Proposed rate structure (continued)

Treatment Costs

- Clinical standards for minimum treatment requirements will be established
- Treatment rates would increase for higher needs children/youth
- Clinical standards would be determined through collaboration of state subject matter experts and provider feedback
- Cost values derived from:
  - Provider cost reports
  - Provider wage survey
  - Bureau of Labor statistics data
  - Data from similar state service types or peer states
  - Other identified sources

Remodeling Residential Treatment Interventions (cont.)

Project timeline



Remodeling Residential Treatment Interventions (cont.)

Upcoming activities

- Rate development
- Latent class study
- Model development
- Ongoing provider meetings

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Updates from the DOJ

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Thank you!

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