CHILDREN'S MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES

Quality and Outcomes Report

Supplement

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Office of Quality Assurance for Children's Programs

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Glossary of Acronyms and Abbreviations

Table i: Glossary of Acronyms and Abbreviations

Acronym/ Abbreviation	Description
ACT	Assertive Community Treatment
ADHD	Attention Deficit Hyperactivity Disorder
APR	Automated Placement Referral
ASD	Autism Spectrum Disorder
ASO	Administrative Service Organization
BBH	Bureau for Behavioral Health
BFA	Bureau for Family Assistance (formerly Bureau for Children and Families)
BJS	Division of Corrections and Rehabilitation's Bureau of Juvenile Services
BMS	Bureau for Medical Services
BPH	Bureau for Public Health
BSS	Bureau for Social Services (formerly Bureau for Children and Families)
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Needs and Strengths
CCBHC	Certified Community Behavioral Health Clinic
CCRL	Children's Crisis and Referral Line
WVCHIP	WV Children's Health Insurance Program
CMCR	Children's Mobile Crisis Response
CMCRS	Children's Mobile Crisis Response and Stabilization
CMHE	Children's Mental Health Evaluation, being completed by West Virginia University
CMHW	Children's Mental Health Wraparound
CMS	Centers for Medicare & Medicaid Services
COMET	Communication and Operations Mobile Engagement Tool
CPA	Child Placing Agency
CPS	Child Protective Services
CQI	Continuous Quality Improvement
CSED	Children with Serious Emotional Disorder
CY	Calendar Year
DART	Document Assessment and Review Tool

Acronym/ Abbreviation	Description
DH	Department of Health
DHF	Department of Health Facilities
DHHR	Department of Health and Human Resources
DHS	Department of Homeland Security
DoHS	Department of Human Services
DUA	Data Use Agreement
DW/DSS	Data Warehouse/Decision Support System
ED	Emergency Department
EDS	Enterprise Data Solution
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ESMH	Expanded School Mental Health
FACTS	Family and Children Tracking System
FSC	Family Support Centers
FTE	Full-Time Equivalent
HCBS	Home and Community-Based Services
ICD	International Classification of Disease
IDD	Intellectual and Developmental Disabilities
IEP	Individualized Education Program
LOS	Length of Stay or Length of Service
MU	Marshall University
MAYSI	Massachusetts Youth Screening Instrument
MCO	Managed Care Organization
MDT	Multidisciplinary Team
NWI	National Wraparound Initiative
NWIC	National Wraparound Implementation Center
OCMS	Offender Case Management System
OOS	Out of State (e.g., OOS placement of children)
OQA	Office of Quality Assurance for Children's Programs
PBS	Positive Behavior Support
PCP	Primary Care Provider
PECFAS	Preschool and Early Childhood Functional Assessment Scale

Acronym/ Abbreviation	Description
PIP	Performance Improvement Project
POC	Plan of Care
PRTF	Psychiatric Residential Treatment Facility
QIA	Qualified Independent Assessment
RMHTF	Residential Mental Health Treatment Facility **Note:** RMHTF is often used as a catch-all term for residential stays, including PRTF stays, unless otherwise noted.
SAH	Safe at Home West Virginia
SED	Serious Emotional Disorder
SEER	National Institute of Health Cancer Institute Surveillance, Epidemiology, and End Results (SEER)
SMI	Serious Mental Illness
SPA	State Plan Amendment
STAT	Stabilization and Treatment
SUD	Substance Use Disorder
TLVY	Transitional Living for Vulnerable Youth
UM	Utilization Management
PATH	People's Access to Help, WV's Comprehensive Child Welfare Information System
WVCHIP	WV Children's Health Insurance Program
WVDE	WV Department of Education
WVEIS	West Virginia Education Information System
WVICCC	WV Intensive Clinical Care Coordination
WVU	West Virginia University
WVU CED	WVU Center for Excellence in Disabilities
WVU HAI	WVU Health Affairs Institute
YRBS	Youth Risk Behavior Survey
YS	Youth Services

Supplement to the Children's Mental Health and Behavioral Health Quality and Outcomes Report

This document serves as a supplement to the Children's Mental Health and Behavioral Health Quality and Outcomes Report published on October 31, 2025. Information in this document expands on topics covered in the full report and is designed to provide additional detail and context that is abridged from the main text.

S.1 Data Sources

Data and information to evaluate and monitor services and outcomes are drawn from a variety of sources, including multiple data systems, quality sampling reviews, fidelity reviews, and feedback from staff, children, families, providers, caregivers, and other stakeholders. In some cases, data sources are integrated to support program collaboration and/or reporting (e.g., child journey and outcomes reporting, WV Wraparound waitlist management). Known limitations to data may apply and have been listed, where possible, throughout the full report and in this section. Inconsistencies related to child-level identifiers may impact matching accuracy within and across systems. The timing of data pulls may also impact results or yield inconsistencies with data pulled on different dates. This can result from reasons such as data entry lag (e.g., claim runout; providers are allowed one year from the date of service to file a claim) or data quality improvement efforts (e.g., updating incomplete data, correcting quality errors identified over time). Data pull dates have been noted where relevant. Analysis strategies are designed to minimize discrepancies by allowing for adequate lag time (given intel from data lag studies) while also keeping data review time periods as timely as possible.

Data sources used to aggregate data for this report include the following:

- The West Virginia Department of Human Services' (DoHS) Bureau for Social Services (BSS) Families and Children Tracking System (FACTS) data for children in DoHS custody; this system provides a static history of active child placements prior to 2023.
- DoHS's WV People's Access to Help (WV PATH) system for children in DoHS custody, including Residential Mental Health Treatment Facility (RMHTF) placements; this system was implemented in January 2023[1] to replace FACTS. The WV PATH system also includes information on referrals to in-state residential facilities utilizing Automated Placement Referral (APR).
- DoHS's Enterprise Data Solution (EDS) system of Medicaid and WV Children's Health Insurance Program (WVCHIP) data, including data associated with Children with Serious Emotional Disorder (CSED) Waiver services; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening; Medicaid eligibility; parental[2] RMHTF placement; Assertive Community Treatment (ACT); Medicaid State Plan Children's Mobile Crisis Response and Stabilization (CMCRS); Certified Community Behavioral Health Clinics (CCBHCs); emergency departments (EDs); and claims-based mental health home- and community-based services (HCBS). This new system was implemented at the end of March 2023.

[1] Given adjustment to the new PATH system, unexpected quality errors from the time of transition may exist. Data quality and completion are expected to improve over time as staff acclimate to these changes. PATH data may show a brief lag, as field workers may not be able to update the system immediately, particularly around the exit status and timeline of child placements. DoHS is still monitoring the pattern of this lag and the impact of retroactive updating, but the initial analysis shows PATH data are stable after one to two months.

[2] EDS claims are the data source for parental placements to Psychiatric Residential Treatment Facilities (PRTFs). Claims data account for an extremely small volume of RMHTF data.

- DoHS's Bureau for Behavioral Health (BBH) grantee reporting via Epi Info System for BBH-funded CMCRS and Wraparound services. The Epi Info System was initially implemented in fall 2021. BBH rolled out a series of system updates to streamline and expand data collection for these services via Epi Info System "Version 2" (V2) in October 2023.
- DoHS's BBH grantee reporting for Positive Behavior Support (PBS) captures service utilization information for the West Virginia University (WVU) Center for Excellence in Disabilities (CED) PBS Program.
- HELP4WV – iCarol Call Reporting System for calls[3] made to the Children's Crisis and Referral Line (CCRL) and warm transfers to CMCRS; 988 data is also captured in the iCarol system.
- DoHS's BBH Assessment Pathway Portal from the contracted Administrative Services Organization (ASO) provider, Acentra Health. This data tracks family-based referral application assistance and connection to interim services, including BBH-funded Wraparound assignment and waitlist data. Tracking of this data set transitioned to Acentra in July 2024. In August 2025, data collection was converted to Acentra's Atrezzo system. Data from past collection mechanisms has been collected and aggregated in the Office of Quality Assurance for Children's Programs (OQA) data store for retrospective reporting needs.
- DoHS's Bureau for Medical Services (BMS) CSED Waiver applications data from the contracted ASO provider, Acentra Health.[4] This data set transitioned to Acentra's Atrezzo system in November 2024. Static history from previous data tracking mechanisms have been captured in the OQA data store.
- Division of Corrections and Rehabilitation's Bureau of Juvenile Services (BJS) Offender Information System captures population, screening, and commitment information for children involved with BJS.
- WV Judiciary's Division of Probation Services Offender Case Management System (OCMS) contains information for probation involvement, mental health screening, and adjudication status.
- Aetna's Quickbase system contains discharge planning reporting for children in RMHTF and shelter settings. Due to data entry lag considerations, placement information may vary from PATH information, including the limitation that children with short stays in placement may not be entered into Aetna's system.

[3] "Calls" include texts and chats unless otherwise noted. Calls include those from children, families, or advocates for a child who is in mental health crisis or who is seeking referrals to related services. Callers reporting an age over 20 were excluded from the data set.

[4] The ASO, Acentra Health, was identified as "Kepro" in some prior semi-annual reports. A merger between CNSI, a leading provider of innovative healthcare technology solutions, and Kepro was completed in December 2022, and rebranding of the name to "Acentra Health" was announced in June 2023.

- Aetna Utilization Management (UM) authorization reporting for children's Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS) history.
- CSED Waiver status, waitlist, and on-hold reporting from Aetna's CSED Roster Quickbase system.
- DoHS's BMS CSED Waiver application determination reporting from Acentra Health and the contracted assessor, Psychological Consultation and Assessment, Inc. (PC&A). In November 2024, data collection was converted to Acentra's Atrezzo system; historical data from past tracking will be maintained in the OQA data store.
- DoHS's Fostering Healthy Children Data System[5] (sourced from FACTS/PATH) that includes EPSDT screening for children in foster or certified kinship care including Child Protective Services (CPS) and Youth Services (YS). EPSDT screening in this system may vary from EDS claims.
- DoHS's Outreach and Education Tracker includes details on outreach activities conducted by DoHS.
- Child and Adolescent Needs and Strengths (CANS) Automated System, which includes CANS assessment and WV Wraparound enrollment data (includes all three payor sources), Safe at Home (SAH) Wraparound services contact data, and data to assist with Wraparound Facilitator capacity and caseload analysis. Data in EDS claims and Epi Info may vary from the CANS system due to data entry and processing lag.
- Qualified Independent Assessment (QIA) Tracking Spreadsheet, maintained by Acentra Health, includes information for children who are child welfare-involved and referred for assessment for imminent risk for RMHTF placement, including related level of care recommendations. In November 2024, data collection was converted to Acentra's Atrezzo system.
- Marshall University (MU) SAH Case Assignment and Waitlist Tracking for SAH-funded Wraparound services.
- MU Out-of-State (OOS) Case Coordination Tracking System includes placement data for children in OOS RMHTF settings as well as information on discharge planning processes, assessments, barriers to discharge, and reasons for OOS placement. Due to data entry lag considerations, placement information may vary from PATH information.
- MU Wraparound Fidelity Evaluation Report includes findings from evaluation of WV Wraparound strengths and needs to meet high-fidelity Wraparound services.

[5] The Fostering Healthy Kids data system does not include child exit date. This might make it unclear if an individual had time to be screened before exiting placement. Data may be subject to change given data entry and related claims reporting lag. Further analysis has shown greater stability in these data six months following the review period.

- WVU Children's Mental Health Evaluation Report includes results from surveys and interviews with key stakeholders (e.g., children and families, judges, school counselors) to help DoHS understand system needs and strengths.
- CPA county-level foster home and key performance indicator reporting[6] collects information on foster home capacity and retention.
- The WV Department of Education's (WVDE's) ZoomWV system is a public-facing system that provides statewide information on public education-related indicators.

DoHS has continued to develop a data store to house data from multiple sources across its child welfare and mental/behavioral health services systems, including data from internal systems as well as data third-party systems (i.e., contractors, vendors, and providers). The goal of this data store is to capture child- and interaction-level data from child-serving entities to enable aggregation, cross-systems analysis, and outcomes reporting for use in DoHS's continuous quality improvement (CQI) processes. Building out of the data store is occurring in phases, with data quality and completion integral to all steps to help ensure accuracy and sustainability of reporting mechanisms. Substantial progress has been made in the development of the data store, the addition and enhancement of child-level matching, build-out of analytic data sets, and dashboard development. The data store structure allows data groupings to be created to meet programmatic administration needs easily, such as creating age, provider, district and county, and other categorical groupings to enable a more flexible, focused approach to information shared for programmatic planning. Data store resources are often sourced from multiple originally separate data systems, which has greatly enhanced OQA's flexibility and agility in responding to key questions, understanding the child journey (i.e., populations, systems and service engagement, and outcomes), and promoting DoHS's ability to use data-informed approaches and make data-driven decisions.

[6] Data is collected in aggregate from each agency; therefore, analysis limitations exist and potential for manual entry error is increased.

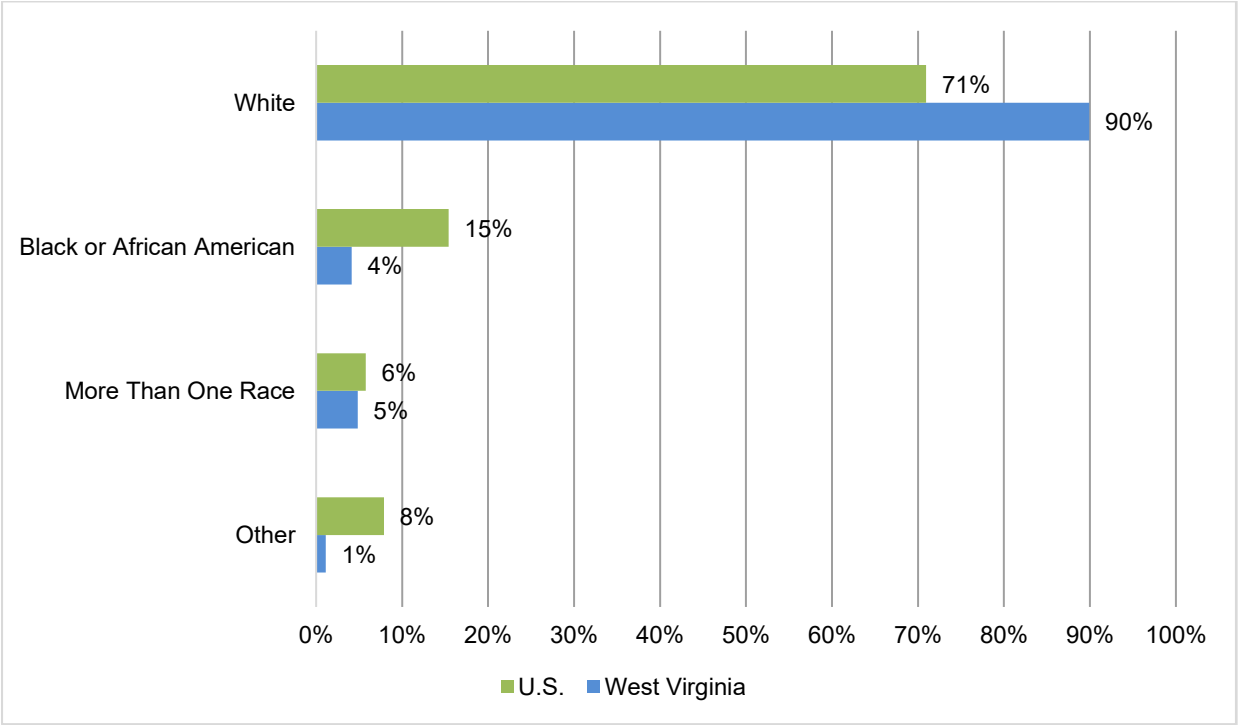
S.2 WV's Child Population and Individuals Utilizing Services

S.2.1 WV Demographics for General Child Population

WV's unique demographic and geographic makeup varies significantly from most of the United States. As DoHS examines service utilization, reference to the state's population is important to track whether the populations reached accurately represent the state's population.

As shown in Figure S.1,[7] the state has a larger proportion of white children when compared to the nation (90% in the state compared to 71% nationwide). Non-white races represent only 10% of the WV child population, compared to 29% nationally.

Figure S.1: Racial Distribution of West Virginians Less Than Age 21 Compared to the Nation

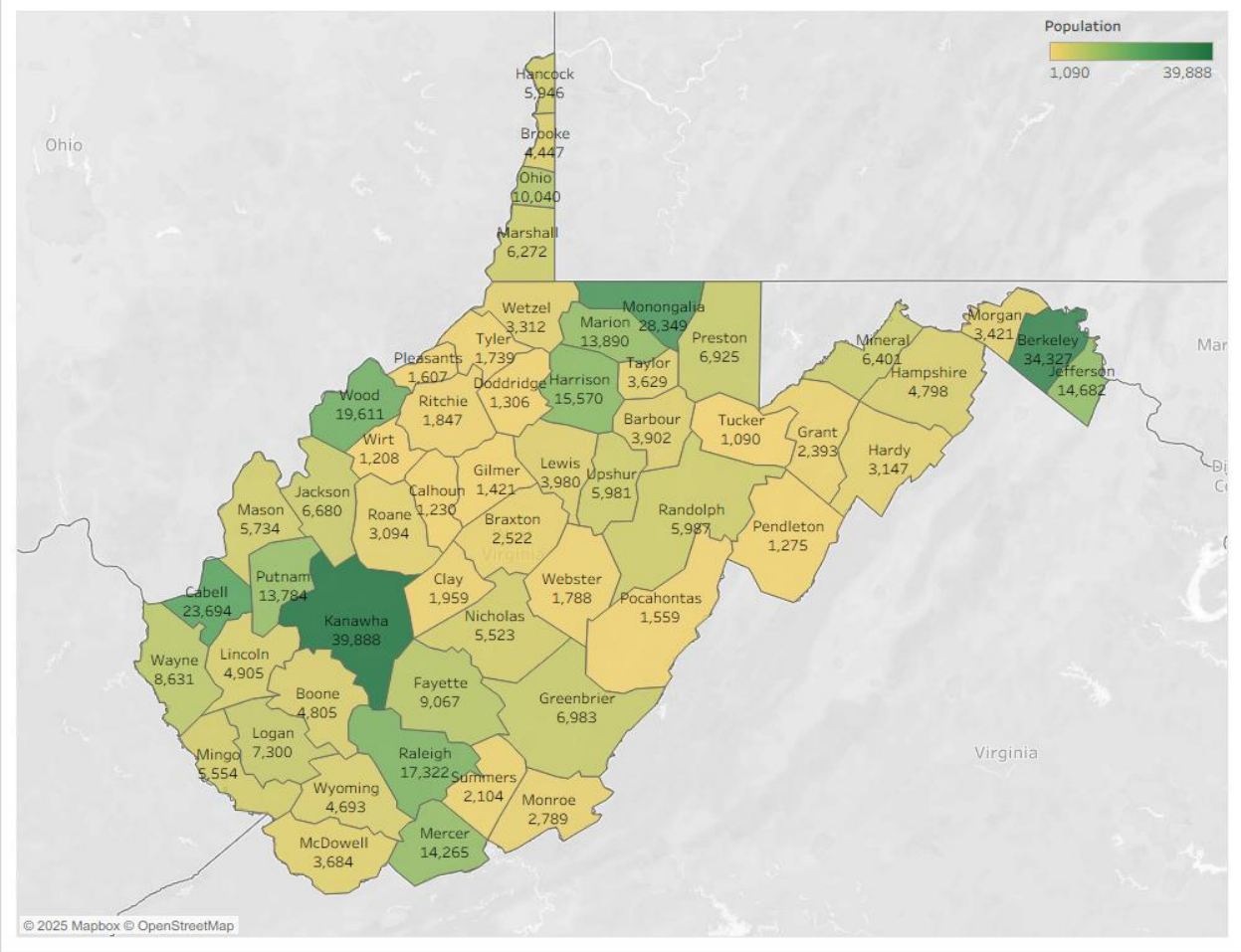


In addition to racial distribution considerations, the state's geographic makeup is also an important consideration for service utilization and outreach. According to the U.S. Office of Management and Budget, only 21 of WV's 55 counties are considered urban. Children and families who live in rural areas may have additional barriers to accessing services. Figure S.2

[7] Single-Race Population Estimates, United States, 2020 – 2022. July 1 resident population by state, age, sex, single-race, and Hispanic origin, on CDC WONDER Online Database. The 2020 – 2022 postcensal series of estimates of the July 1 resident population are based on the Blended Base produced by the U.S. Census Bureau in lieu of the April 1, 2020, decennial population count, released by the Census Bureau on June 22, 2023. Accessed at http://wonder.cdc.gov/single-race-single-year-v2022.html on May 30, 2024.

represents the population of people in each county who are younger than 21 years of age for context of service utilization as referenced throughout sections of this report.[8]

Figure S.2: WV Child Population Through Age 20 – 2022 (n = 418,238) SEER Data Single-Year Age Groups



S.2.2 Children Accessing Services Through the Assessment Pathway and Other Relevant Mental Health Programs

A full comparison of WV's general child population demographics and children accessing the various children's mental health programs and services is captured in Table S.1. In summary:

- One in four Medicaid-eligible children in calendar year (CY) 2024 had a serious emotional disorder (SED) diagnosis.
- Consistent with biological sex proportions identified in the RMHTF population, HCBS programs served more male children. Most service utilization showed to be

[8] 2010 to 2019 Intercensal Estimates of County Population by Age, Sex, and Bridged Race for Vintage 2022 Postcensal Estimates, Woods & Poole Economics, Inc., Washington D.C. February 2024. https://seer.cancer.gov/popdata/download.html

approximately 60% male, while children with Medicaid/WVCHIP and an SED were only 52% male. Exceptions to this service utilization trend were CMCRS (53% male) and readmissions to RMHTF (also 53% male). The Quality Committee previously cited that symptomology of more male-associated behaviors, such as physical aggression, may contribute to higher rates of service utilization among males. Greater readmission rates among females are described more in depth in Section *7.3 Residential Readmission*. It is unclear why CMCRS does not have a higher proportion of males utilizing the service, especially given the patterns in need among males in other populations (e.g., RMHTF, Probation Services). Children in need of a home were also more evenly distributed (49% male).

- Age has been identified as a key factor influencing a child's likelihood of being served in their home and community. Correlations between age and intensity of needed services and/or inability to maintain a child in a home have been demonstrated throughout the main report. Children in need of placement were more likely to be older (83% were 13 – 17 years old), while children in the overall child welfare population consisted of only 32% aged 13 – 17. Children with a YS case type were also more likely to be older (77% age 13 – 17).
- HCBS such as Wraparound (including CSED), CMCRS, and Behavioral Support Services, as well as the Assessment Pathway to access these services, reached a greater proportion of children in age categories 5 – 9 and 10 – 12 when compared to children in RMHTFs who skewed older. However, there were key differences between the proportion of children aged 13 – 17 served through the CSED Waiver (44%) versus the comprehensive WV Wraparound program (66%). This is largely due to the SAH payor source serving older individuals who are involved with child welfare. A new policy implemented in July 2024 intends to help ensure all children are referred to the pathway to expand utilization of Medicaid-covered Wraparound services (i.e., CSED Waiver). The shift toward younger age categorizations for most community-based programs was identified as a potential early intervention opportunity for those individuals who may have current or potential risk for placement in an RMHTF. Although this is a positive finding regarding early intervention, it may take several years to see the full impact on RMHTF services for children in these age ranges. Nevertheless, 68% of youth served through WV Wraparound were over the age of 12, indicating a key demographic overlap and an opportunity for diversion from inappropriate use of RMHTF settings.
- QIA demographic data also shows strong overlap with the RMHTF population, which provides another key opportunity to divert children with the most imminent risk from out-of-home placement.
- Most youth in RMHTF settings were in the 13 – 17 age group (77%). In review of the prioritized discharge population,[9] the age distribution shifted older, with 12% of transitional age youth 18 to 20 in this subpopulation compared to only 1% in the total

[9] Youth prioritized for discharge planning defined as in-state placements with recent CAFAS/PECFAS less than 140 who have an anticipated discharge date in the next 60 days (n = 260) for the period of July to December 2024.

RMHTF population. Further details regarding these transitional age youth are included in Section *7.0 RMHTF Services,* with considerations given to potential discharge barriers of transitional age youth that may be influencing this trend.

- Based on a comparison of statewide race distribution for children aged 0 to 20, BBH PBS showed programs serving a slightly higher proportion of Black or multiracial individuals (14%), despite Black or multiracial individuals representing a small number of the general WV population (9% reported as multiracial or Black/African American). This has been a consistent finding with the PBS program. WVU's CED provides input and training to staff for program outreach and service delivery for improved cultural competency, which may be attributable to being able to reach a higher proportion of this population of children. Wraparound (11%) and RMHTF (12%) utilization—as well as children in child welfare placement (12%) and children in need of community-based placement (15%)—also had a higher proportion of Black or multiracial children compared to the WV population (9%). Readmission rates by race had a similar representation as the WV population. Race will continue to be monitored as an important indicator for assessing equitable access to services. Review of race data will be expanded as the data store is built out and data quality improvements are achieved, in particular, using child-level unification across data systems to review race data, even when this information is not captured directly).

Table S.1: Summary[10] Comparison of Demographic Trends Across Service Types, CY2024

Area of Review	Total Number of Children	Biological Sex Trends (Percentage Male)	Age Groups				Race			
			5 – 9	10 – 12	13 – 17	18 – 20	White	Black or African American	Multiracial	Other
WV – All Children 0 – 20	418,238	51.5%	23%	14%	26%	16%	90%	4%	5%	1%
Medicaid/ WVCHIP Eligible 0 – 20	255,696	51%	25%	15%	25%	13%	--	--	--	--
Medicaid/ WVCHIP Eligible 0 – 20 With SED[11]	63,695	52%	25%	19%	35%	15%	--	--	--	--
WV At Risk 0 – 20[12]	9,413	52%	18%	15%	47%	15%	--	--	--	--
Children in Child Welfare Placement as of July 31, 2025[13]	6,049	52%	21%	13%	32%	5%	83%	11%	1%	4%
Children in Placement With a YS Case as of July 31, 2025[14]	1,114	58%	2%	7%	77%	12%	80%	10%	2%	8%
CCRL	1,092	51%[15]	23%	18%	41%	1%	--	--	--	--

[10] This summary comparison only includes relevant percentages (percentages large enough for comparison); however, the denominator for each group is inclusive of all available demographic types including those not listed (e.g., unknown biological sex, age 0 to 4, or individuals with missing data, categories with greater than 15% of information unlisted). Percentages may not add to 100% due to rounding considerations.

[11] The Medicaid/WVCHIP eligible with SED population is representative of an SED diagnosis in CY2024.

[12] The WV at-risk population is representative of CY2024. Youth identified as at risk and turned age 21 by December 31, 2024, were included in the 18 to 20 age categories to be inclusive of the whole population during the year.

[13] Of children in child welfare placement, 28% were aged 0 to 4 and 32 (< 1%) aged 21+. Children with YS case type included <1% aged 0 to 4 and 1% aged 21+.

[14] This includes any YS case type for children in placement. Children can have more than one case type. For these cases, 36% had YS as primary, 52% CPS was primary, and 12% state ward was primary case type.

[15] Approximately 11% of biological sex data was missing from calls for the CCRL; 39% of calls were recorded as being for female children.

Area of Review	Total Number of Children	Biological Sex Trends (Percentage Male)	Age Groups				Race			
			5 – 9	10 – 12	13 – 17	18 – 20	White	Black or African American	Multiracial	Other
Aggregate CMCRS Calls – Preliminary	711	53%	27%	24%	44%	2%	80%	4%	1%	6%
Assessment Pathway – Family-Driven Referrals[16]	619	60%[17]	28%	21%	41%	4%	--	--	--	--
Assessment Pathway – Aggregate Referrals[18]	2,974	59%[19]	20%	15%	54%	8%	--	--	--	--
CSED Waiver Applications	2,201	57%	20%	15%	53%	10%	--	--	--	--
CSED Waiver Utilization	1,182	57%	27%	23%	44%	4%	--	--	--	--
WV Wraparound Utilization	3,124	56%	13%	17%	66%	2%	76%	7%	4%	6%
Behavioral Support Services – BBH (PBS)	236	64%	35%	28%	31%	1%	84%	6%	8%	2%
RMHTF Services	1,783	62%	6%	14%	77%	1%	--	--	--	--

[16] Family-based referrals can originate from the CCRL, managed care organizations (MCOs), CMCRS, families, primary care physicians, mental health professionals, school personnel, or regional care coordinators.

[17] Biological sex data is only available for referrals logged in BBH's Assessment Pathway Portal, as Acentra does not track biological sex data for CSED applications. Therefore, this percentage is based on a subset of only 320 referrals with available biological sex data.

[18] WV Wraparound includes Wraparound services through three funding sources: CSED Waiver, SAH, and BBH Children's Mental Health Wraparound (CMHW). Additional details on Wraparound services and funders are included in Section 3.0 WV Wraparound Services.

[19] Biological sex data is only available for referrals logged in BBH's Assessment Pathway Portal, as Acentra does not track biological sex data for CSED applications. Therefore, this percentage is based on a subset of only 320 referrals with available biological sex data.

Area of Review	Total Number of Children	Biological Sex Trends (Percentage Male)	Age Groups				Race			
			5 – 9	10 – 12	13 – 17	18 – 20	White	Black or African American	Multiracial	Other
RMHTF Prioritized Discharge Planning[20]	260	62%	3%	6%	80%	12%	--	--	--	--
RMHTF Discharges (Full Population)[21]	413	57%	3%	11%	86%	0%	82%	11%	1%	7%
RMHTF Discharges (Readmits Only)[22]	153	53%	3%	14%	84%	0%	85%	9%	0%	7%
Youth Needing Community-Based Placement[23]	223	49%	6%	11%	83%	--	81%	13%	2%	4%
QIA	1,214	57%	5%	14%	76%	3%	74%	11%	1%	8%
CPS/YS Wellness (EPSDT) Screening[24]	3,330	52%	21%	12%	28%	0%	--	--	--	--
Screening: Probation	586	64%	0%	3%	93%	3%	86%	5%	4%	0%
Youth Adjudicated as Status Offenders or Delinquents (Probation Services)	1,052	68%	0%	8%	87%	3%	84%	8%	5%	0%

[20] The prioritized discharge planning population includes youth in active in-state RMHTF or PRTF placement with CAFAS <140 and anticipated discharge in 60 days or less, during July to December 2024. Tracking youth meeting these specific criteria did not begin until June 2024, so full CY2024 data is not available.

[21] Data is for January-June 2024. Excludes children 17 or older at discharge.

[22] Data is for January-June 2024. Excludes children 17 or older at discharge.

[23] Children in both in-state and OOS residential placements and emergency shelters who need foster or kinship care placement as of July 31, 2025. Youth ages 18 to 20 were excluded from this analysis because they do not qualify for traditional foster care. Youth in RMHTF whose discharge barrier data included behavior being unchanged or escalating, awaiting transitional living, and/or court ordered were excluded, as well as youth in emergency shelters with a barrier of awaiting transitional living.

[24] Youth placed in DoHS custody with an EPSDT screening within one year of placement from the Fostering Healthy Kids System.

Area of Review	Total Number of Children	Biological Sex Trends (Percentage Male)	Age Groups				Race			
			5 – 9	10 – 12	13 – 17	18 – 20	White	Black or African American	Multiracial	Other
Screening: BJS	1,062	--	0%	4%	88%	8%	--	--	--	--
Youth Newly Committed to BJS Custody	131	--	0%	1%	89%	11%	--	--	--	--

S.3 Intervention Opportunities

S.3.1 Mental Health Screening

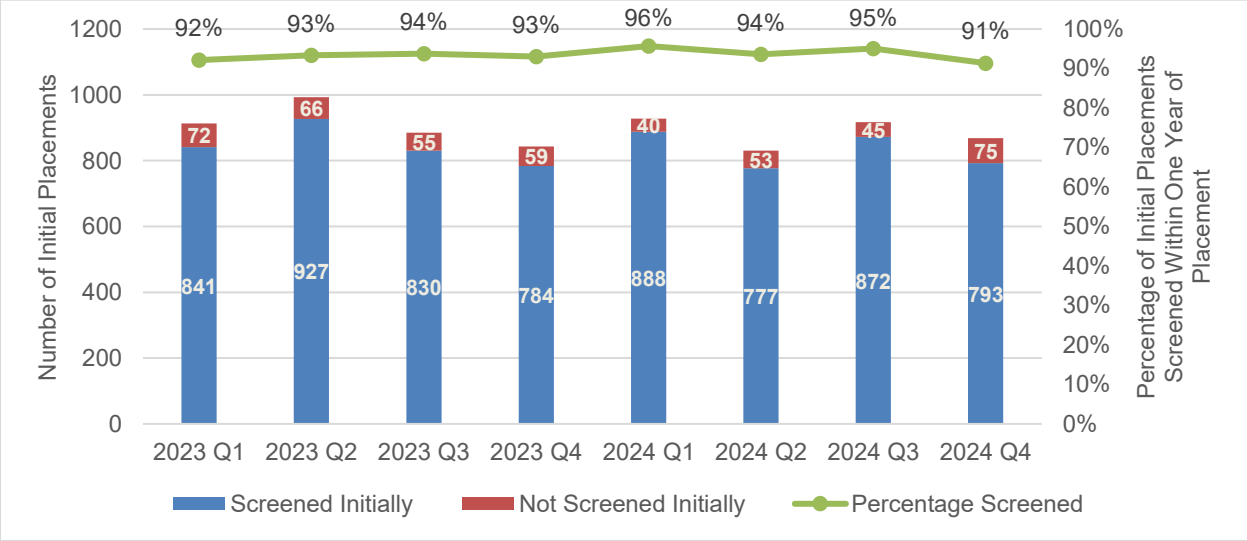
Supplemental information and figures related to screening are included below. Sections 2.1 and 2.2 in the full report contain more detailed information.

S.3.1.1 Child Welfare Screening

Screening children[25] for possible mental health needs using the Functional Assessment Screening Tool (YS) and ongoing assessment (CPS) by child welfare workers is required to be completed within 15 days of the case establishment.[26] This policy reinforces early identification of mental health needs to enable referrals to be conducted—regardless of whether the child is placed in child welfare custody or receiving home-based services. As previously stated, these efforts are in addition to those completed via the HealthCheck program to help ensure opportunities are not missed to address needs.

Figure S.3 shows the percentage of children with a screening within one year of placement by quarter from Quarter 1 (Q1) 2023 to Quarter 4 (Q4) 2024 based on the month the child was placed in DoHS custody.

Figure S.3: Initial Child Welfare Placements and Screenings by Quarter, 2023 Q1 to 2024 Q4



Data lag is expected for more recent periods because one year has not yet passed since placement, meaning some children may not yet be eligible for their annual wellness visit if they already received this visit within the 365-day period prior to placement. Also, children may be in

[25] Children in foster care or certified kinship care (includes youth in YS and/or CPS custody).

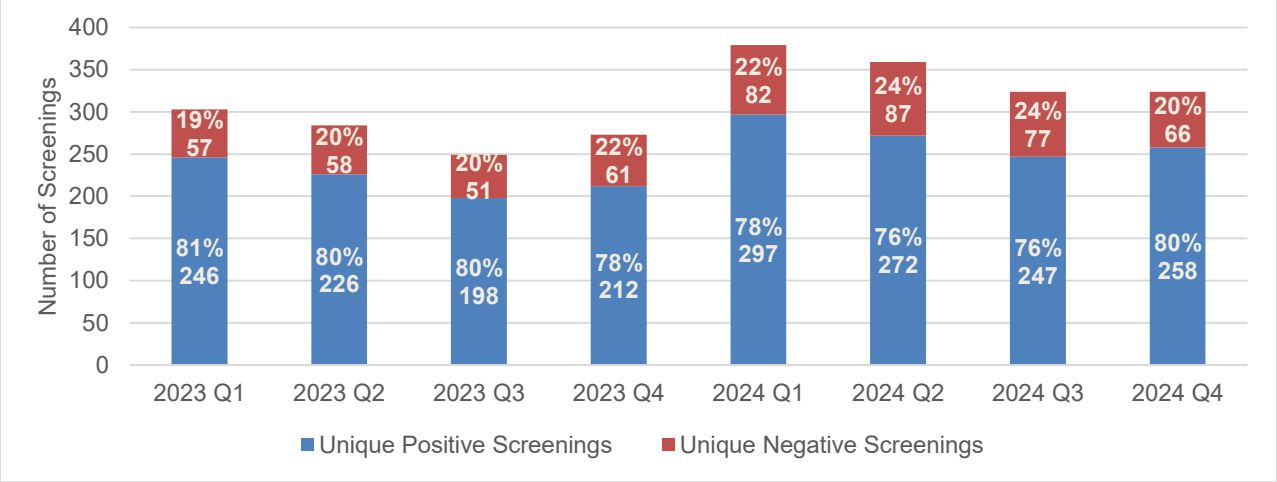
[26] CPS policy states that the ongoing assessment will be completed within the first 15 days of transfer of the case to ongoing services. YS policy states that the FAST will be completed within the first 15 days of initial contact with the family. If a child goes immediately into a shelter or RMHTF before the ongoing assessment or FAST are completed, the child welfare worker will complete referrals within 24 hours of placement.

care for a limited period of time and may not have ample opportunity for screening based on the duration of placement. Nevertheless, screening rates are high throughout the review period, ranging from 91% to 96%. Total initial placements ranged from 843 to 993.

S.3.1.2 BJS Screening

The percentage of BJS-involved youth with a positive mental health screening throughout CYs 2023 and 2024 was 76% – 80% per quarter, consistent with prior years. BJS facility-level data reviewed on a quarterly basis indicates full adoption of the BJS screening process.

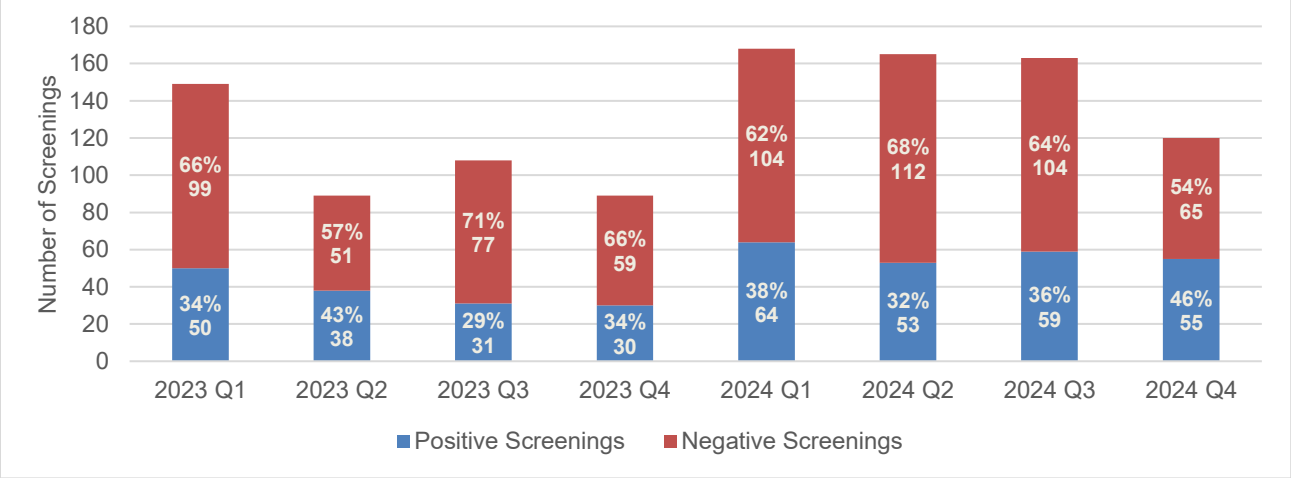
Figure S.4: BJS MAYSI-2 Mental Health Screenings, 2023 Q1 to 2024 Q4



S.3.1.3 Division of Probation Services Screening

The percentage of probation-involved youth with a positive mental health screening throughout CYs 2023 and 2024 ranged from 29% to 36% per quarter. An increase in the total number of screenings was noted in CY2024 compared to CY2023.

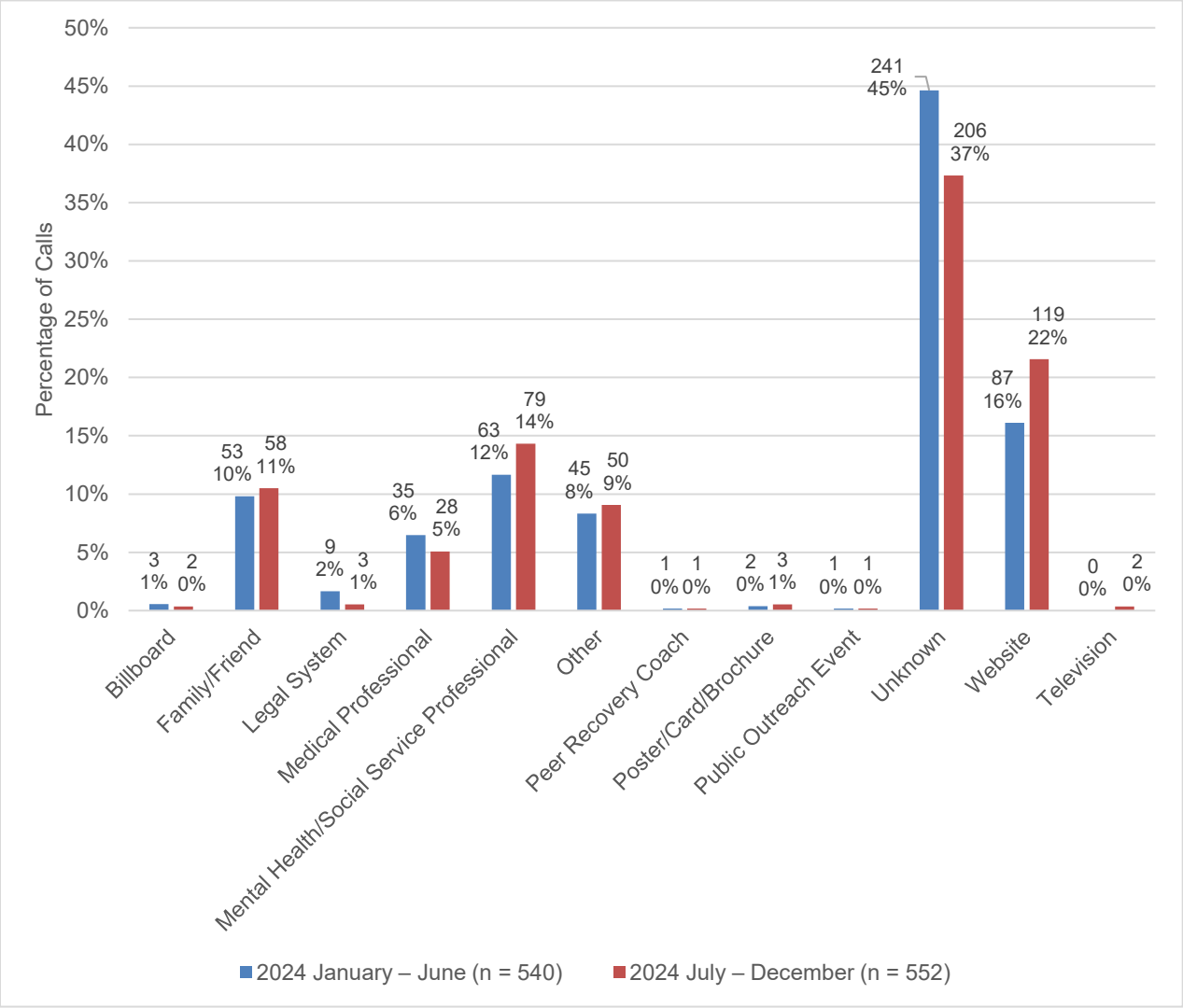
Figure S.5: Probation Services MAYSI-2 Screenings, 2023 Q1 to 2024 Q4



S.3.2 CCRL

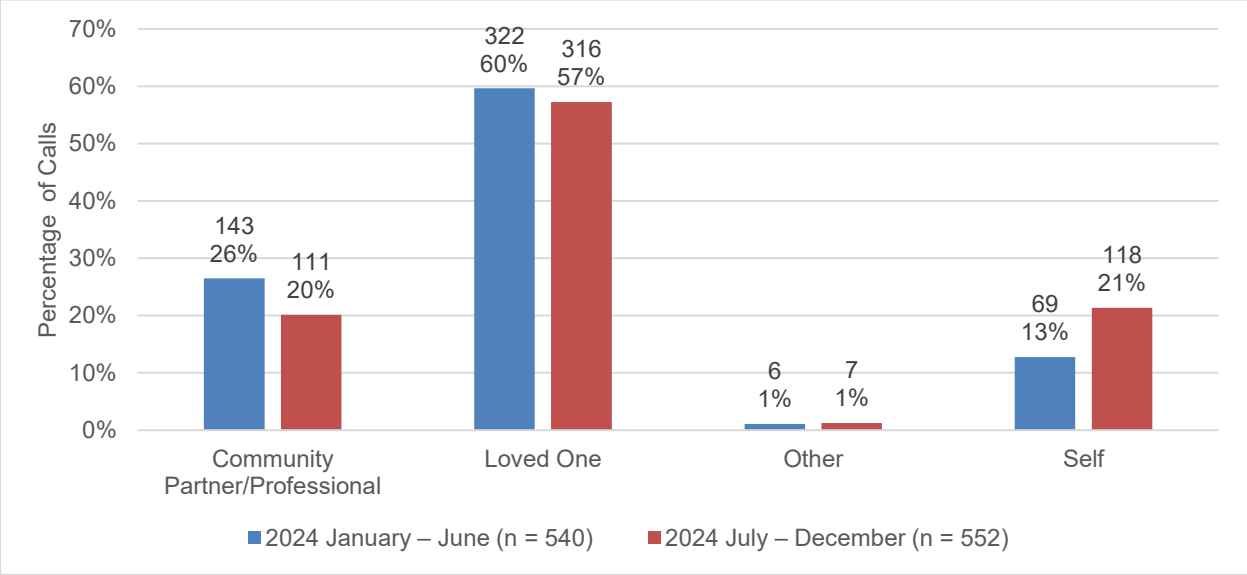
Supplemental information and figures related to CCRL are included below; Section 2.3 in the full report contains further details. The information in Figure S.6 below shows details of referral source to the CCRL comparing the first and last half of 2024. A large percentage of CCRL referral sources were unknown: 45% in January to June 2024 and 37% in July to December 2024. Among known referral sources, the CCRL website was the most commonly listed referral source in both halves of 2024: 16% in the first half and 22% in the second half.

Figure S.6: Referral Source for Call, January – June 2024 vs. July – December 2024



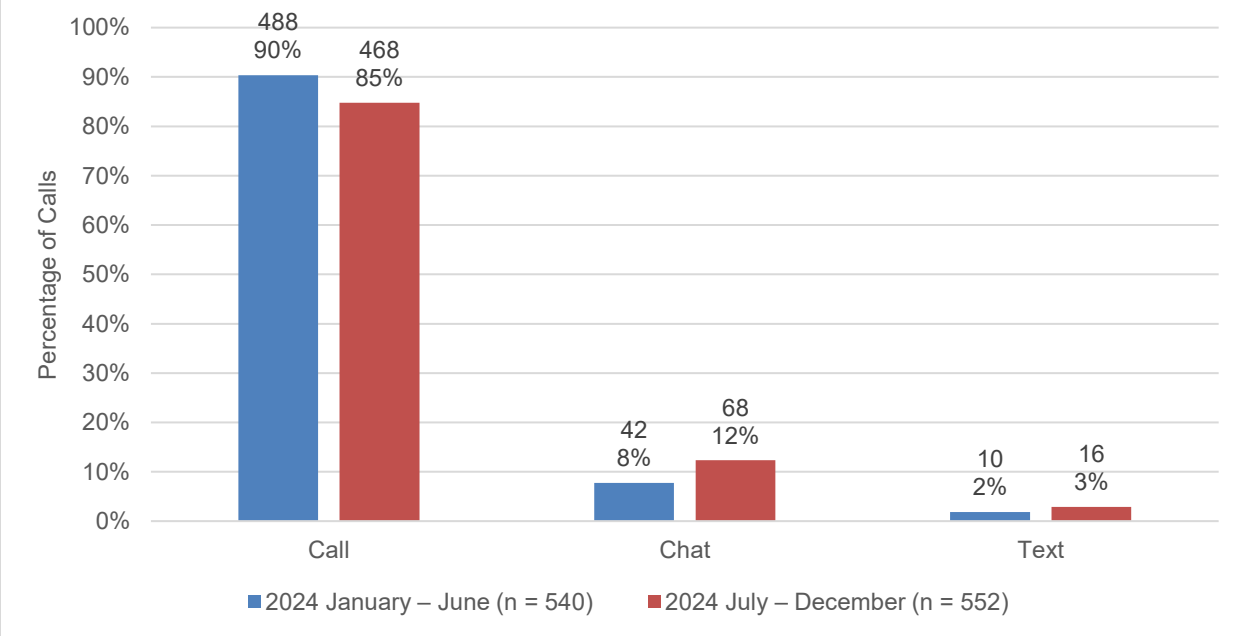
More than half of calls to the CCRL are made by a loved one: 60% in January to June 2024 and 57% in July to December 2024. Calls made by the child themselves increased from the first half of the year (13%) to the second half (21%), while calls from a community partner/professional decreased (26% to 20%).

Figure S.7: Caller Relation to Individual in Need, January – June 2024 vs. July – December 2024



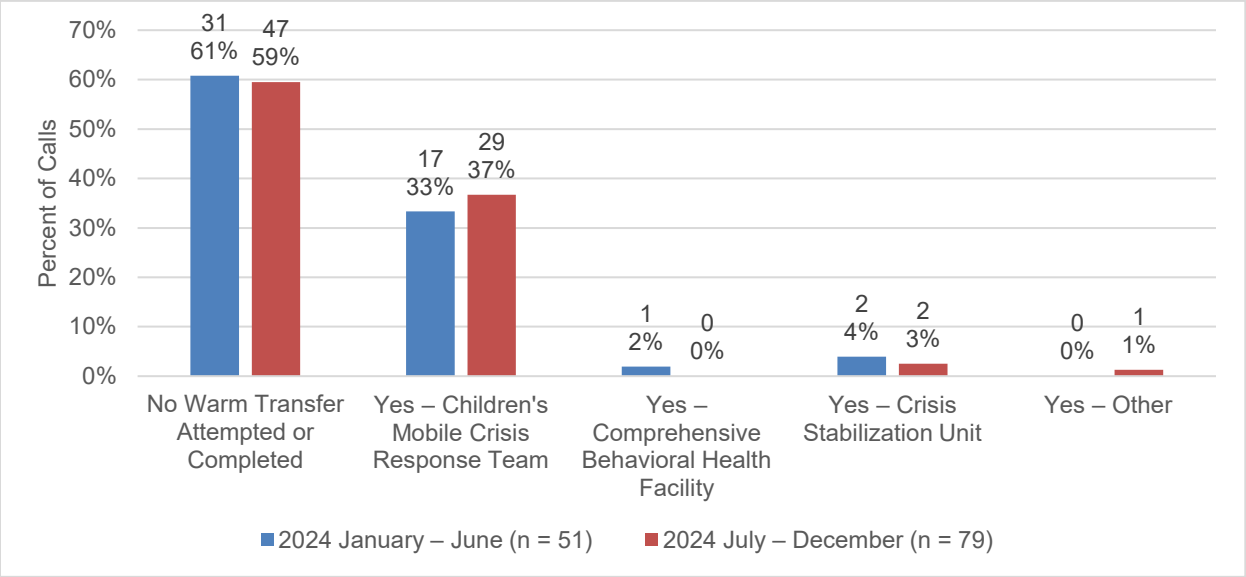
Most contacts to the CCRL are made via a traditional call (85% – 90%). Callers utilized the chat feature more in the second half of 2024 (12%) than in the first half (8%). Texts composed a similar proportion of contacts in both periods.

Figure S.8: Type of Contact, January to June 2024 vs. July to December 2024



Three-fifths (60%) of emergency/urgent/crisis calls in both halves of 2024 had no warm transfer attempted or completed. Approximately one-third were transferred to a CMCRS team.

Figure S.9: Referral Types for Calls Reported as "Emergency/Crisis/Urgent," January to June 2024 vs. July to December 2024



S.3.3 Behavioral Support Services

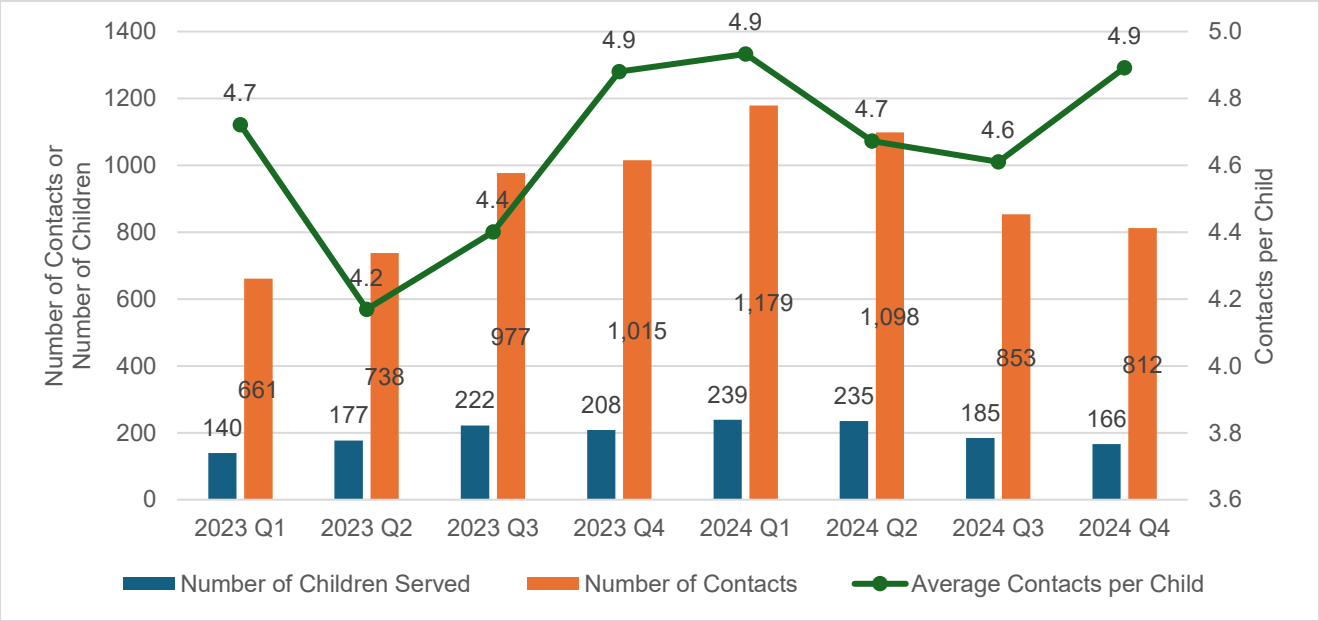
Behavioral Support Services focus on providing prevention and intervention supports for children who are demonstrating significant maladaptive behaviors, who are at risk of out-of-home placement or involuntary commitment at a psychiatric hospital or PRTF, or who are transitioning to the community from an out-of-home placement. PBS is a type of behavioral support service and is an evidence-based strategy to improve independence, decrease behavioral challenges, teach new skills, and improve overall quality of life for children experiencing significant maladaptive behavioral challenges. Behavioral Support Services are used widely, including within BBH, BSS, BMS, and WVDE programs and providers.

In addition to the BBH-funded Children's PBS program provided by WVU CED, services are also conducted through trained providers of BBH, BSS, BMS, and WVDE programs. Referrals to Behavioral Support Services may be received through the CCRL, Assessment Pathway, or community outreach efforts. Data is currently only available for direct services provided by WVU CED under the BBH PBS grant; however, BMS implemented a Behavioral Support Services modifier code that will allow Behavioral Support Services-related claims data to be captured for children receiving these services through Medicaid. Training is needed to fully implement this change which is included under proposed policy. Training will be scheduled following the approval of policy.

The number of children served by WVU CED by quarter varied from Q1 2023 to Q4 2024, ranging from 140 to 239 children served each quarter (Figure S.10). This program has limited capacity but focuses on working directly with families and children with intensive needs and provides training for parents and providers on related strategies. Of children served, 63% are between 5 and 12 years old, providing an opportunity to serve younger children and potentially divert them from more intensive out-of-home services. Despite some increases in the number of

children served in a period, the average contacts per child have been maintained (4.2 to 4.9 contacts per child each quarter).

Figure S.10: Children and Interactions, Monthly, 2023 Q1 – 2024 Q4



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

S.3.4 Assertive Community Treatment

ACT is an inclusive array of community-based rehabilitative mental health services for WV Medicaid members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization requiring a well-coordinated, integrated package of services provided over an extended duration. ACT is an option available statewide for youth ages 18 to 20 to help prevent unnecessary institutionalization. ACT services were expanded in October 2024 when CCBHCs were operationalized.

Eligible youth aged 18 to 20 are offered ACT services as they progress through the Assessment Pathway. The number of youth accessing ACT services is low, primarily due to the reluctance of youth to participate in these intensive services, but utilization was slightly higher in 2024 than in 2023 (Table S.2). Any type of engagement with ACT services introduces youth to these services, creating awareness of these services that individuals may choose to access later in life.

Table S.2: ACT Youth Utilization Comparison Across Six-Month Periods, CY2023 – CY2024

	January – June 2023	July – December 2023	January – June 2024	July – December 2024
Youth < 21	5	7	8	8

S.3.5 Referrals to the Assessment Pathway

Supplemental information and figures related to Assessment Pathway referrals are included below. Section 2.5 in the full report contains more information.

Figure S.11 depicts referral source information for the 3,376 referrals in CY2024. DoHS made slightly more than half of referrals (n = 1,798, 53.3%) (i.e., were child welfare referrals). The majority of referrals came from the DoHS (Child Welfare, n = 1798, 53.3%).

Figure S.11: Aggregate Assessment Pathway Referral Sources, CY2024 (n = 3,376)

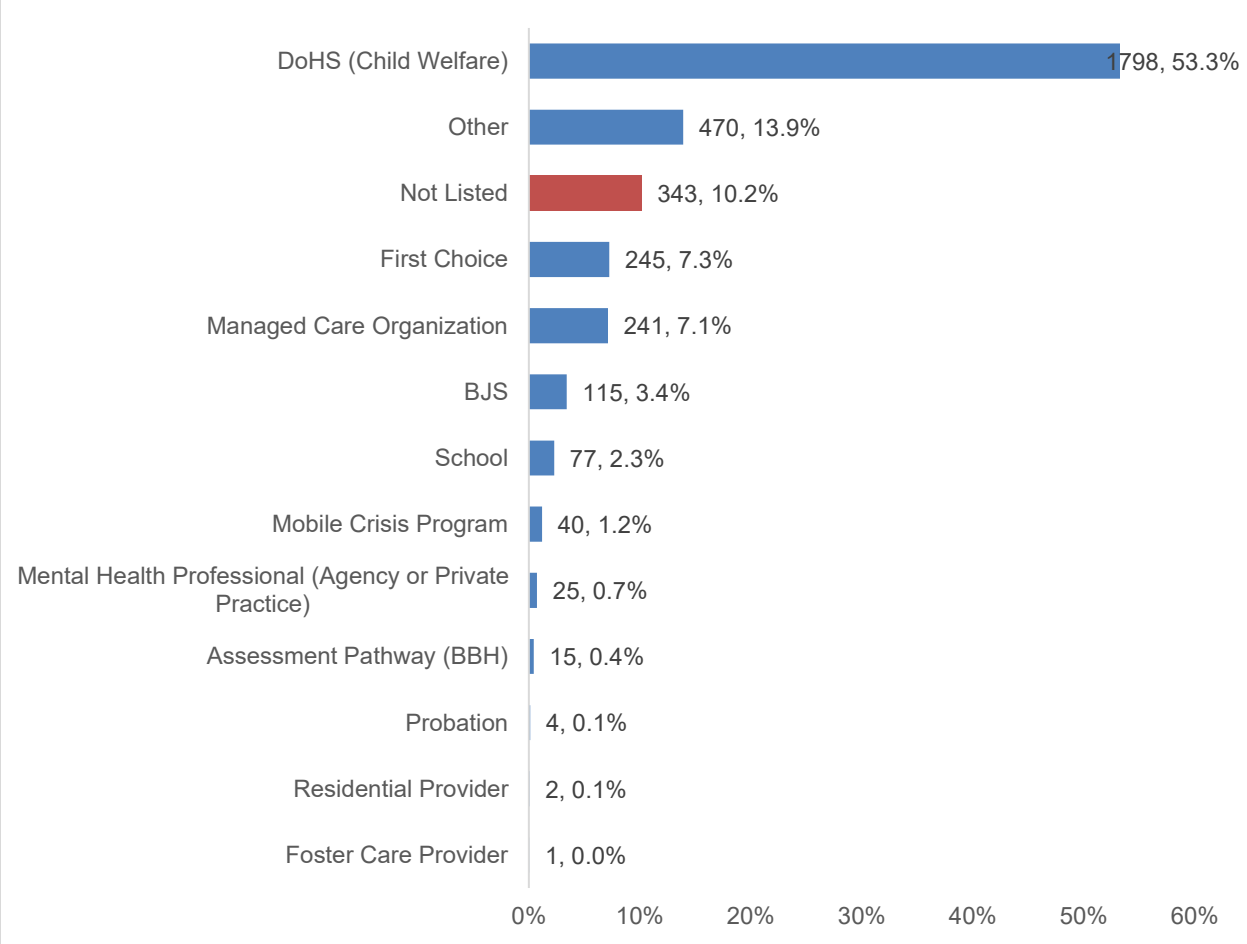


Figure S.12 shows the percentage change in county-level Assessment Pathway referral rates from CY2023 to CY2024. In total, referral rates increased by an average of 11% statewide. Most counties (41 of 55, 75%) had sustained referral rates. Ten counties increased referral rates compared to only four counties (Mineral, Tyler, Wetzel, and Wirt) that had lower referral rates in

2024. These four counties are among the least populated in the state, meaning the addition or loss of a small number of referrals can have an outsized impact on their referral rates relative to more populated counties.

Figure S.12: County-Level Comprehensive Assessment Pathway Percentage Change in Referral Rates per 1,000 Child Population, CY2023 to CY2024

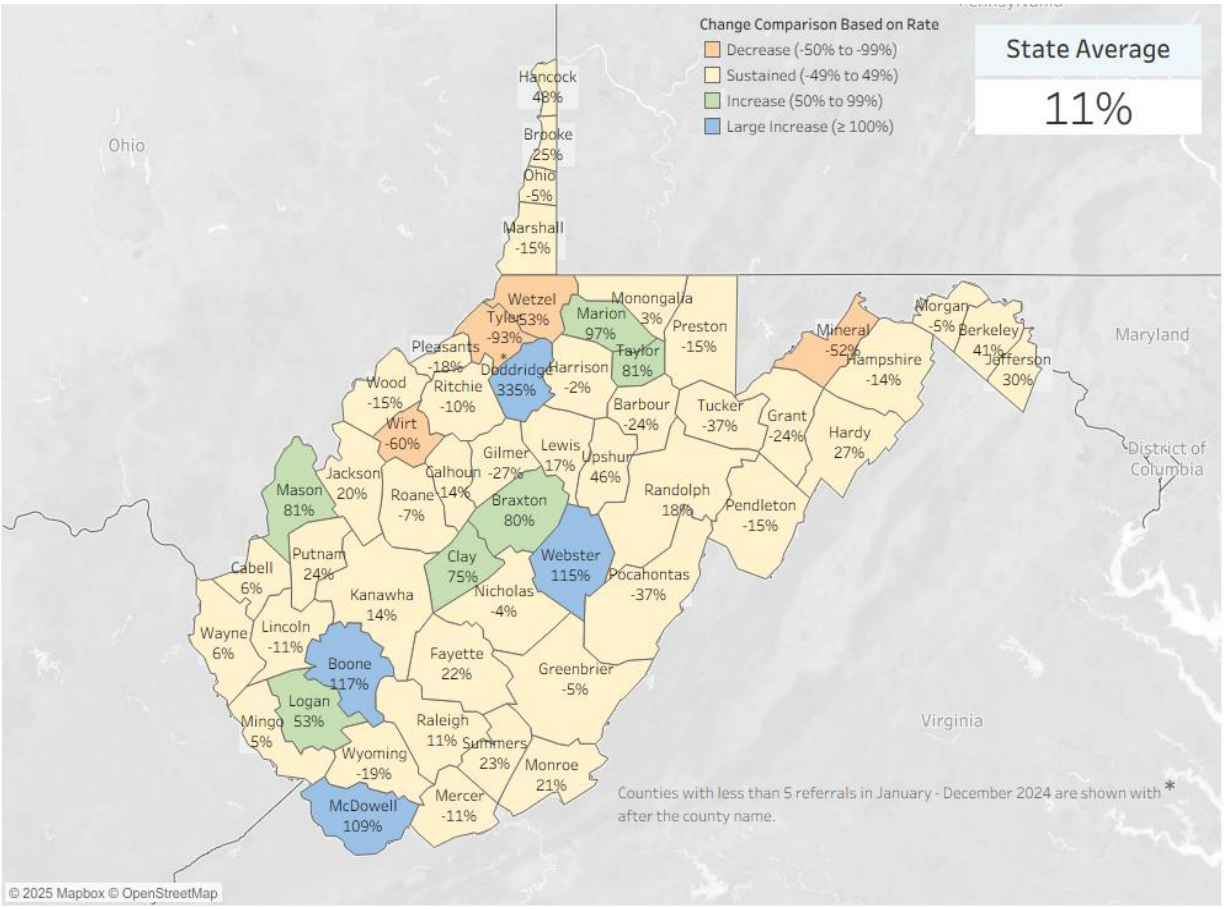
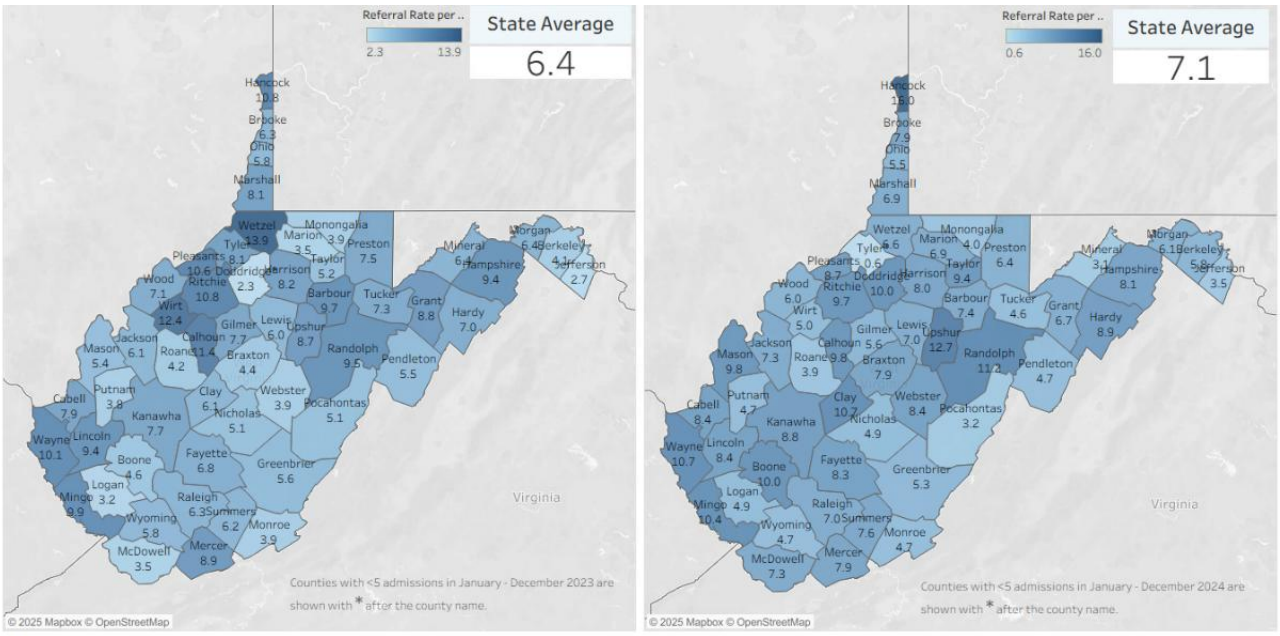


Figure S.13 shows Assessment Pathway county-level referral rates in CY2023 (left) and CY2024 (right). In 2023, the state average referral rate was 6.4 referrals per 1,000 children; this increased to 7.1 referrals per 1,000 children in 2024, an 11% increase as indicated in Figure S.12 above. Referral rates are relatively uniform statewide in both years. Information may be used in combination with other county-level considerations to determine awareness and outreach-related need.

Figure S.13: County-Level Comprehensive Assessment Pathway Referral Rates per 1,000 Child Population, CY2023 to CY2024 (Left to Right)



S.4 WV Wraparound Services

Supplemental information and figures related to WV Wraparound are included below. Section 3.0 in the full report contains full details.

The following includes updates and next steps related to the Assessment Pathway and Wraparound service process.

1. Interim Wraparound services can be provided while determining eligibility for CSED Waiver-covered WV Wraparound services, with criteria shared with BSS and BMS.
2. As of July 1, 2022, financial ineligibility will no longer be a barrier for the CSED Waiver due to an approved waiver amendment.
3. DoHS's bureaus recognize that some children may be appropriate for Wraparound even if they do not meet clinical eligibility for the CSED Waiver. Other Wraparound payor sources may enroll children in the following circumstances:
    - Significant mental health needs
    - At risk of out-of-home placement
    - CAFAS/PECFAS score of 80 OR 70 or below with current involvement by DoHS's BSS
    - Coexisting or co-occurring disorders that do not otherwise meet the criteria or eligibility for a secondary waiver, such as Intellectual/Developmental Disabilities Waiver or Traumatic Brain Injury Waiver.

CSED Waiver Services Information

Table S.3 captures six-month period CSED Waiver services utilization by service type for CY2023 and CY2024. Consistent with prior periods, the services with highest utilization are Wraparound Facilitation, Family Therapy, and Family Support. Families would like more respite services, and DoHS acknowledges the challenges of providing respite services based on provider feedback.

Table S.3: CSED Waiver Service Utilization by Service Type, Six-Month Period Comparison, CY2023 to CY2024

	January – June 2023		July – December 2023		January – June 2024		July – December 2024	
Service Description	Hours Provided	Unique Children	Hours Provided	Unique Children	Hours Provided	Unique Children	Hours Provided	Unique Children
Crisis Service: Mobile Response	29	9	12	7	N/A	N/A	N/A	N/A
Family Therapy	12,109	611	12,990	639	12,523	642	11,913	661

Service Description	January – June 2023		July – December 2023		January – June 2024		July – December 2024	
	Hours Provided	Unique Children	Hours Provided	Unique Children	Hours Provided	Unique Children	Hours Provided	Unique Children
Independent Living/ Skills Building	699	19	748	17	706	14	506	15
In-Home Family Support	3,620	264	3,637	221	3,600	209	3,299	206
Job Development	N/A	N/A	N/A	N/A	1	1	N/A	N/A
Peer Parent Support	43	17	74	22	159	37	55	22
Respite Care, In Home	854	42	672	30	900	40	997	45
Respite Care, Out of Home	1,753	68	941	49	884	47	1,133	50
Wraparound Facilitation	15,678	760	18,789	802	20,739	818	N/A	716
All CSED Waiver Services	**34,785**	**815**	**37,862**	**850**	**39,511**	**875**	**17,903**	**848**

Note: EDS data was pulled with a paid through date of June 30, 2025.

For purposes of quality improvement, understanding county-level changes and identifying where to focus efforts, DoHS continues to track CSED Waiver service utilization rates by child's county of origin. DoHS program teams recognize this data must be reviewed in the context of other data and influencing factors. The following figures capture the county-level comparison of the first and second half of 2024. Only counties with data in both time periods appear on the maps. Figure S.14 captures the percentage change in the number of unique children accessing CSED Waiver services by county; Figure S.15 shows the rate of unique children accessing services by county. Note that counties serving a small number of children may show larger percentage increases or decreases. Also, small county populations may result in large increases for a smaller number of children served.

Figure S.14: Percentage Change in Number of Unique Youth Accessing CSED Waiver Services Per 1,000 Youth Population by County, January to June 2024 vs. July to December 2024

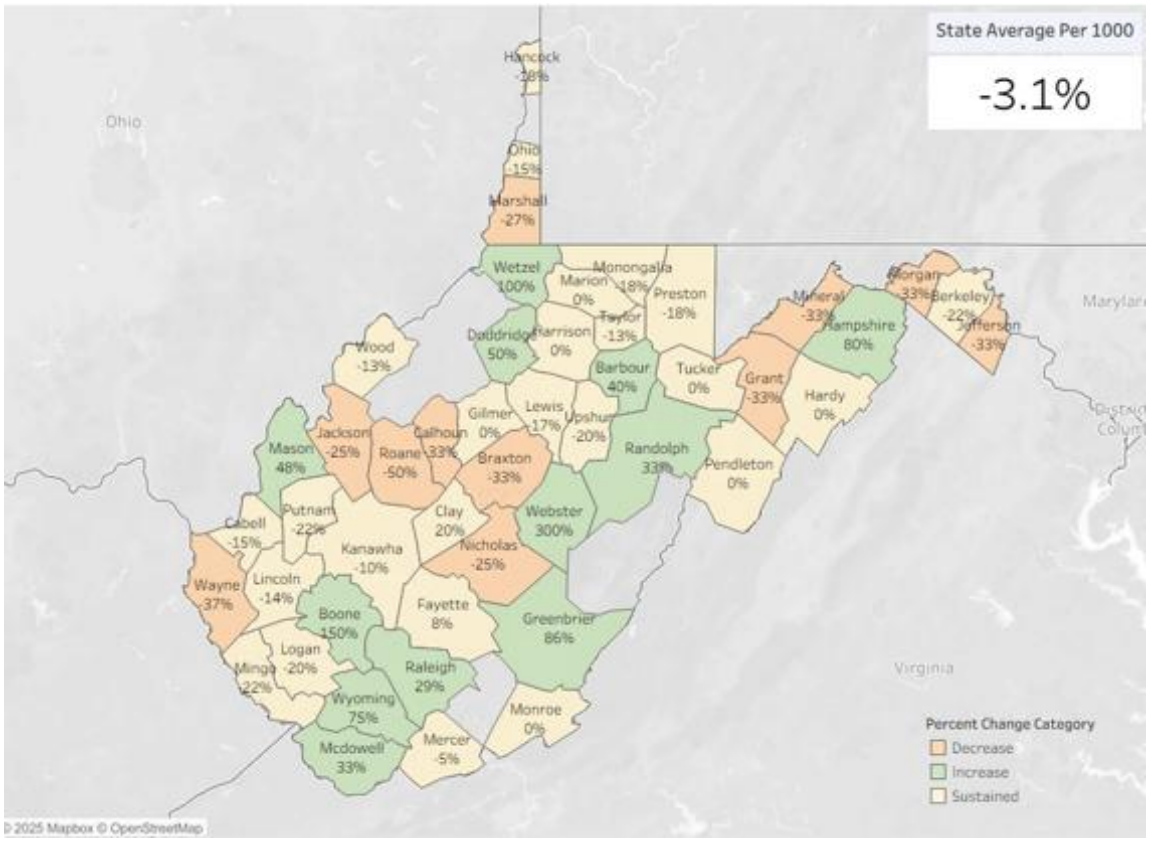
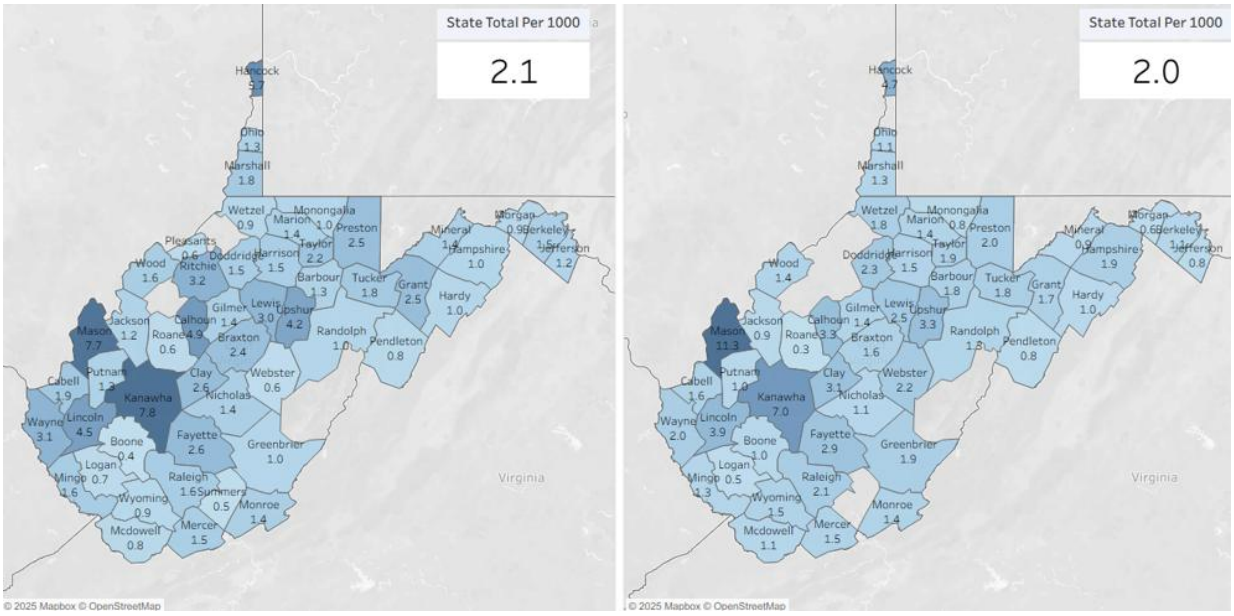
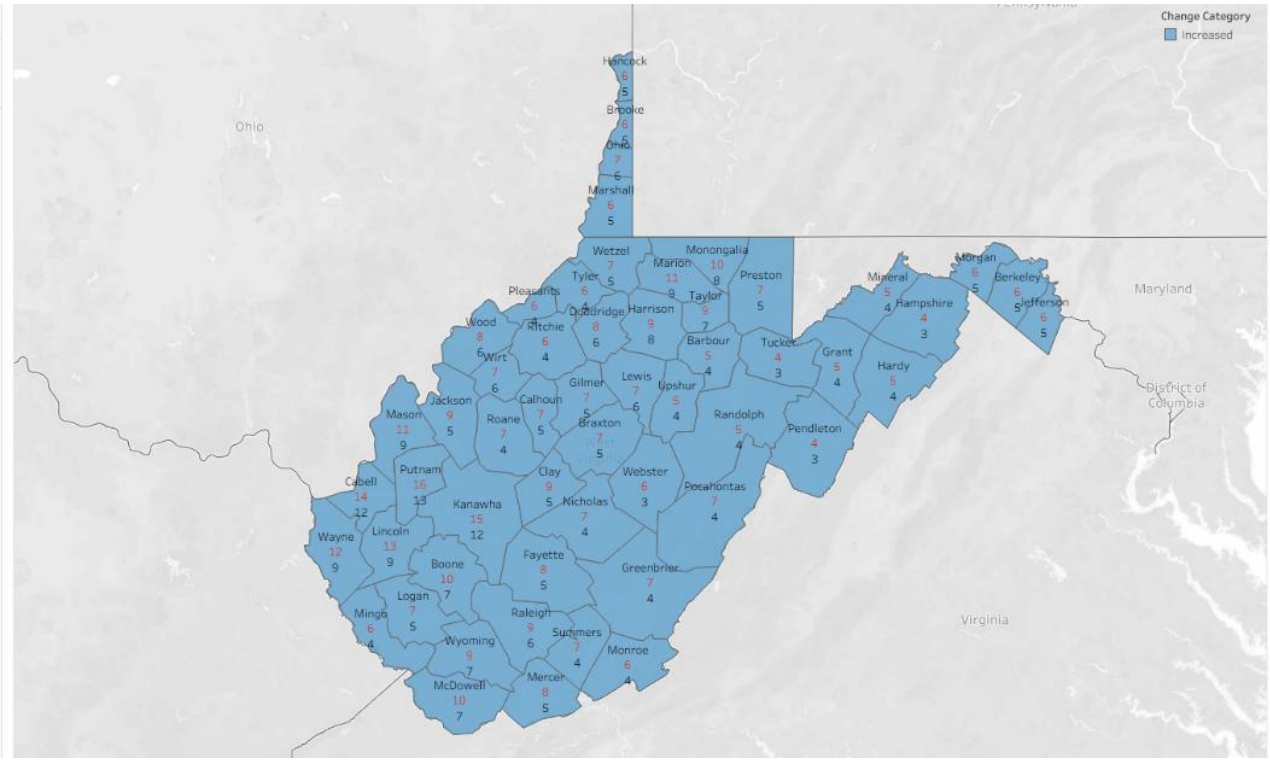


Figure S.15: Number of Unique Youth Accessing CSED Waiver Services by County, January to June 2024 vs. July to December 2024 (Left to Right)



Aetna is responsible for CSED Waiver provider network capacity and remains focused on adding providers. The number of CSED Waiver service providers expanded in all counties between March 2024 and December 2024 (Figure S.16). CSED Waiver services are available statewide.

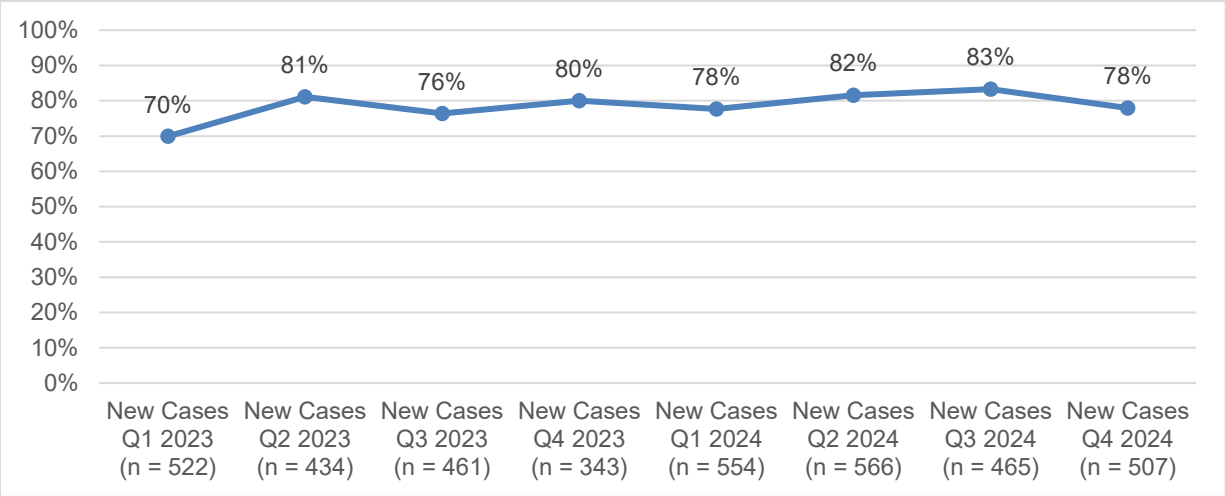
Figure S.16: Number of Provider Agencies Offering CSED Services by County, March 2024 (Black Font), and December 2024 (Red Font)



CANS Completion and Timeliness

The Wraparound Fidelity and CANS Performance Improvement Project (PIP) team reviews CANS completion and timeliness data monthly. In the second half of 2024, Wraparound program leaders began meeting with individual providers to review and follow up on their results. Through this process, the need for provider-level reporting in the CANS automated system was identified to assist with improved tracking of CANS completion as well as overall management of Wraparound cases. The development of provider-level reports was initiated in fall 2024, with the reports operationalized in August 2025. While outside the review period for this report, results for Q1 2025 showed an improvement in CANS completion in the last 90 days for children enrolled in Wraparound services (89%, the highest compared to all previous periods). Programmatic intervention with providers has helped drive this improvement. Improved accountability through the new provider-level reports is also expected to enhance caseload management, facilitator capacity, and improved Wraparound fidelity through use of the CANS.

Figure S.17: Aggregate Wraparound CANS[27] Completion and Timeliness by Quarter – Children With CANS Completed in Last 90 Days (% of All Children Enrolled 30+ Days), Q1 2023 – Q4 2025



[27] CANS data is as of Julye 31, 2025.

S.5 Systems Engagement and Outcomes

Supplemental information and figures related to systems engagement and outcomes are included below. Section 4.0 in the full report provides further detail.

The following tables show detailed results from the logistic regression models described in Section 4.4. Some results that were not statistically significant have been excluded from these tables for relevance and brevity. The full report includes the full list of indicators and a detailed methodology. Each age group was compared with children aged 15 – 16 to produce odds ratio results, given they are the group with the greatest representation in RMHTF settings. Tables S.4 – S.7 are color coded for statistically significant factors: green for protective factors and red for predictive factors. A p-value of 0.05 was used to determine statistical significance.

Table S.4: Model 1 Summary Details, Outcome: Out-of-Home Placement Grouped[28] Definition

Variable	Odds Ratio	95% Confidence Interval	P-Value
Age Group 5 – 7*	0.18	(0.12 – 0.27)	< 0.001
Age Group 8 – 9*	0.27	(0.18 – 0.41)	< 0.001
Age Group 10 – 12*	0.46	(0.35 – 0.62)	< 0.001
Age Group 13 – 14*	0.85	(0.64 – 1.12)	0.25
Age Group 17+*	0.45	(0.3 – 0.67)	< 0.001
Male Sex	1.07	(0.87 – 1.31)	0.55
CAFAS 140+	1.77	(1.44 – 2.17)	< 0.001
Wraparound Three Months Plus	0.74	(0.59 – 0.92)	0.01
ED Utilization	4.13	(3.24 – 5.27)	< 0.001

[28] Out-of-home placement was defined as any of the following occurring after the assessment pathway/CSED application was submitted: RMHTF admission, acute hospitalization, new YS placement episode, or BJS placement.

Table S.5: Model 2 Summary Details, Outcome: RMHTF Placement

Variable	Odds Ratio	95% Confidence Interval	P-Value
Age Group 5 – 7*	0.14	(0.07 – 0.29)	< 0.001
Age Group 8 – 9*	0.27	(0.14 – 0.53)	< 0.001
Age Group 10 – 12*	0.33	(0.2 – 0.56)	< 0.001
Age Group 13 – 14*	0.7	(0.42 – 1.17)	0.17
Age Group 17+*	0.31	(0.12 – 0.82)	0.02
CAFAS 140+	1.71	(1.19 – 2.46)	< 0.001
ED Utilization	4.38	(2.94 – 6.51)	< 0.001

Table S.6: Model 3 Summary Details, Outcome: RMHTF Placement (Includes Only Children Age 13+)

Variable	Odds Ratio	95% Confidence Interval	P-Value
Male	1.19	(0.93 – 1.52)	0.17
CAFAS 140+	1.52	(1.19 – 1.94)	< 0.001
Assessment/Evaluation HCBS Only	0.33	(0.12 – 0.85)	0.02
Wraparound Three Months Plus	0.62	(0.47 – 0.81)	< 0.001
ED Utilization	1.45	(1.11 – 1.91)	0.01

Table S.7: Model 4 Summary Details, Outcome: RMHTF Placement (Includes Only Children With Wraparound for Three Months+)

Variable	Odds Ratio	95% Confidence Interval	P-Value
Age Group 5 – 7*	0.09	(0.03 – 0.29)	< 0.001
Age Group 8 – 9*	0.11	(0.03 – 0.37)	< 0.001

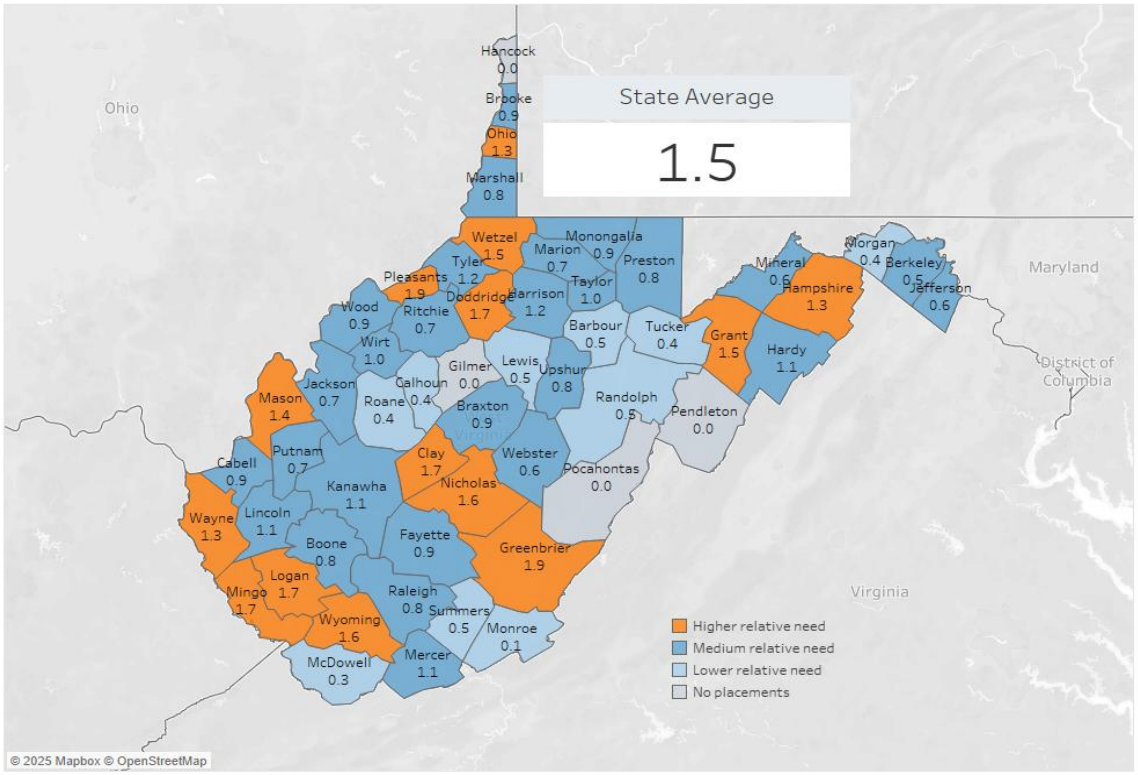
Variable	Odds Ratio	95% Confidence Interval	P-Value
Age Group 10 – 12*	0.46	(0.26 – 0.83)	0.01
Age Group 13 – 14*	0.94	(0.54 – 1.62)	0.82
CMCRS Utilization	0.35	(0.13 – 0.93)	0.04
ED Utilization	2.00	(1.25 – 3.2)	< 0.001

***Note:** Children aged 15 – 16 were used as a reference group for age, as they are the group with the greatest representation in RMHTF settings.

S.6 Community-Based Placement Capacity

A ratio of the average number of certified homes compared to therapeutic foster care and emergency shelter placements within a county provides an approximate view of levels of need for an area. A higher ratio indicates a greater need for additional foster homes, given that, in realistic circumstances, an open and active home does not necessarily indicate a placement would be accepted. Figure S.18 depicts this ratio for youth of all ages, while Figure S.19 depicts the ratio for youth 13 and older. As indicated in Figure S.18, the state average ratio of placements to homes for all ages was 1.5 from July to September 2024. The ratio should ideally be less than 1 to accommodate appropriate matching considerations for placements and foster families. Greenbrier County had the highest placement-to-home ratio, with approximately two children in foster or shelter placements for every one foster home available. While volume impacts should be considered related to counties with small populations, counties in orange may be considered for more targeted outreach due to the need for additional foster families.

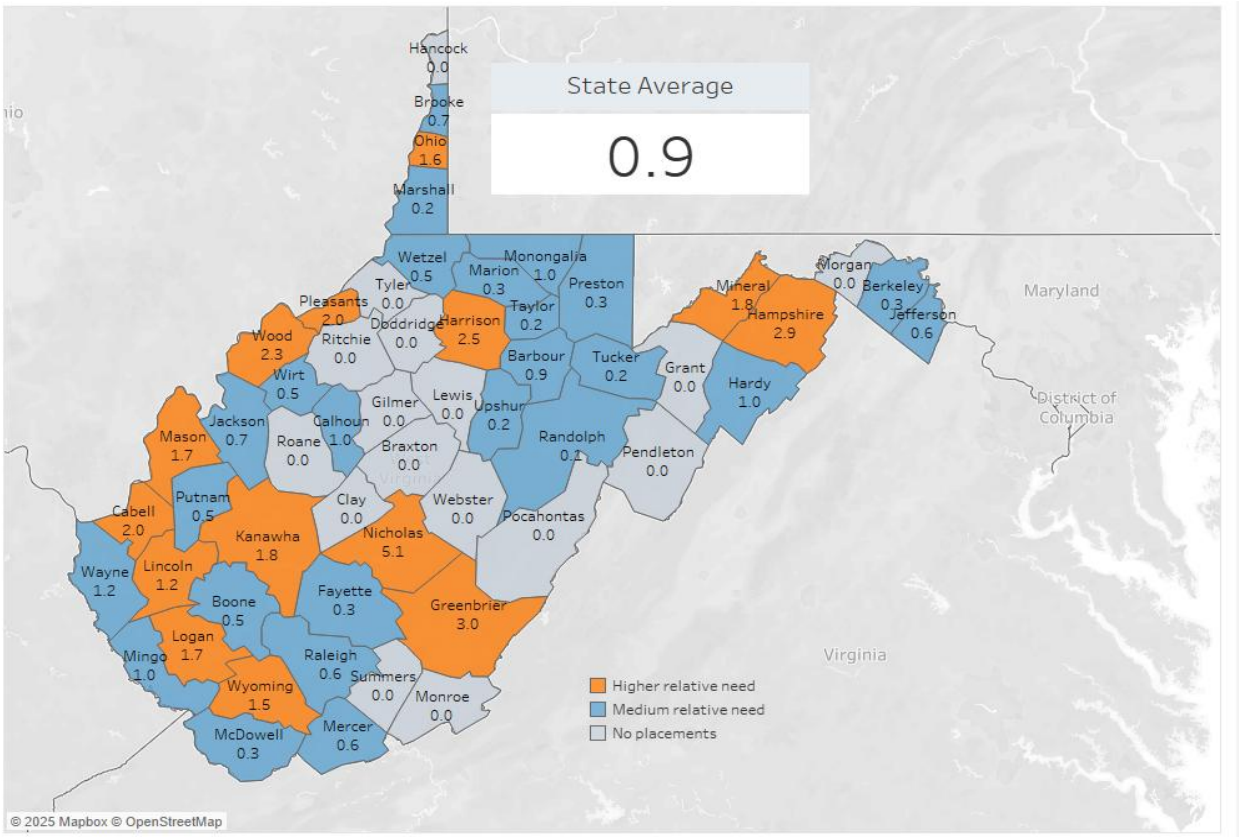
Figure S.18: Ratio of Average Therapeutic Foster Care and Emergency Shelter Placements per Foster Home, All Ages, July to September 2024[29]



[29] July to September 2024 was used to avoid considerations around holidays, which can skew these ratios, to provide a more accurate picture of what placement and home ratios may be at a typical point in time.

The state average ratio for children age 13+ and homes willing to accept children age 13+ was 0.9 (Figure S.19). While it seems promising that the ratio for older children is less than the overall average ratio of 1.5, more flexibility in available homes is needed for teens. Family matching and supports and skill levels often needed for older youth should be considered for adequate capacity. The counties in orange have the greatest need for foster homes compared to children in placement (relative need), with Nicholas (five placements for every one home) and Greenbrier (three placements for every one home) among the highest ratios. Notably, some of WV's population centers varied in ratio. Kanawha (1.8), Cabell (2.0), Harrison (2.5), Wood (2.3), and Ohio (1.6) Counties had higher placement-to-home ratios, while Monongalia (1.0) and Berkeley (0.3), Raleigh (0.6) were among the lowest. Improving placement-to-foster-home ratios in population center counties may have larger impacts statewide.

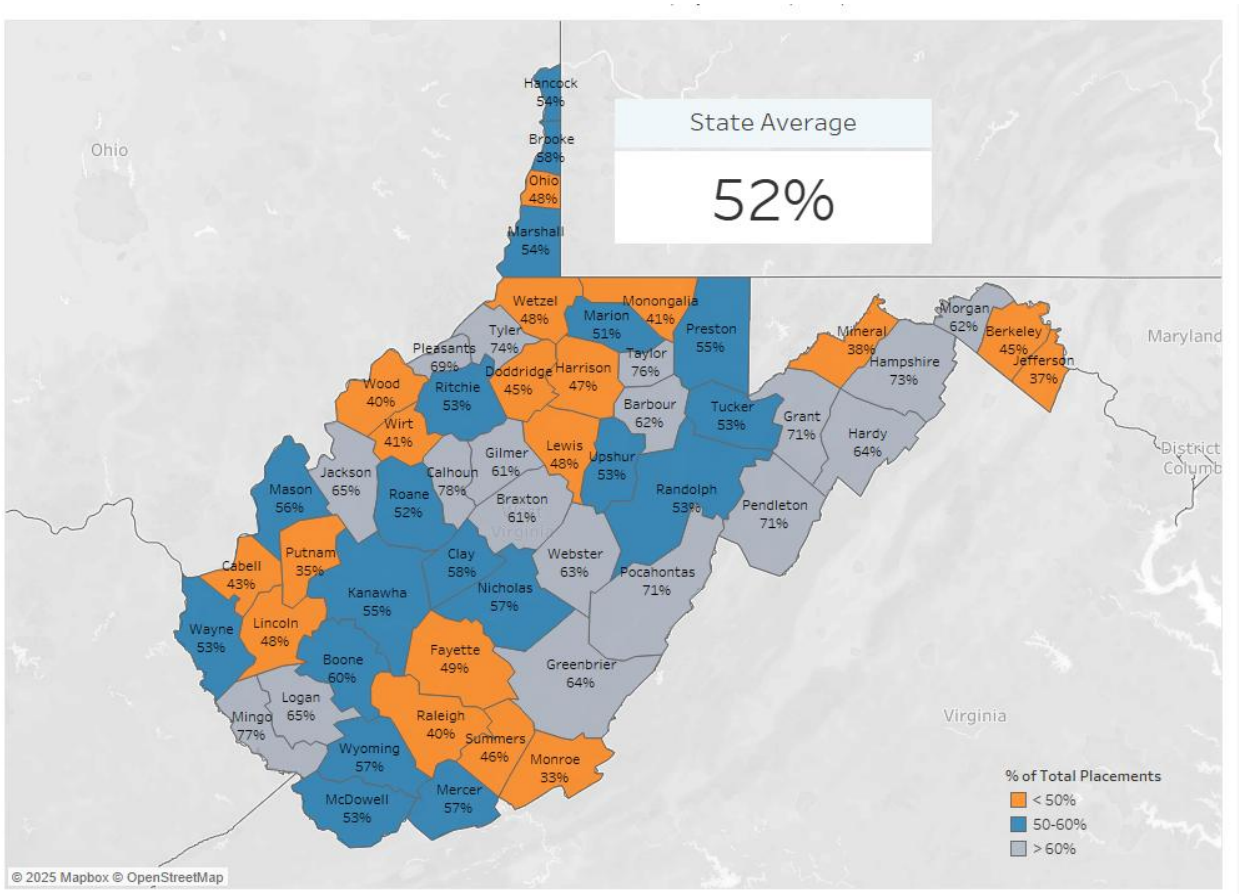
Figure S.19: Ratio of Average Therapeutic Foster Care and Emergency Shelter Placements per Foster Home, Age 13 and Older, July to September 2024



WV has been a leader in kinship care across the country. Several counties with higher foster placement ratios—such as Kanawha, Mason, Hampshire, Morgan, Grant, Wetzel, Ritchie, Greenbrier, Logan, and Mingo—seemed to compensate for this with higher rates of kinship placement (greater than 50% of foster placements in kinship care; Figure S.20). Furthermore, members of the Quality Committee compared counties with low kinship placement rates to counties with high placement-to-foster-homes ratios, identifying counties with the greatest overall need for community-based placement availability. Wirt (41%), Wood (40%), Ohio (48%), and Cabell (43%) Counties were among the lowest in WV for percentage of placements located

in kinship-type homes and were also identified as high need for foster homes. Because of the low rate of kinship placements in these counties, additional focus should be considered for family-finding activities and expanding available foster homes.

Figure S.20: Percentage of Kinship Foster Placements* by County (Average), July to September 2024

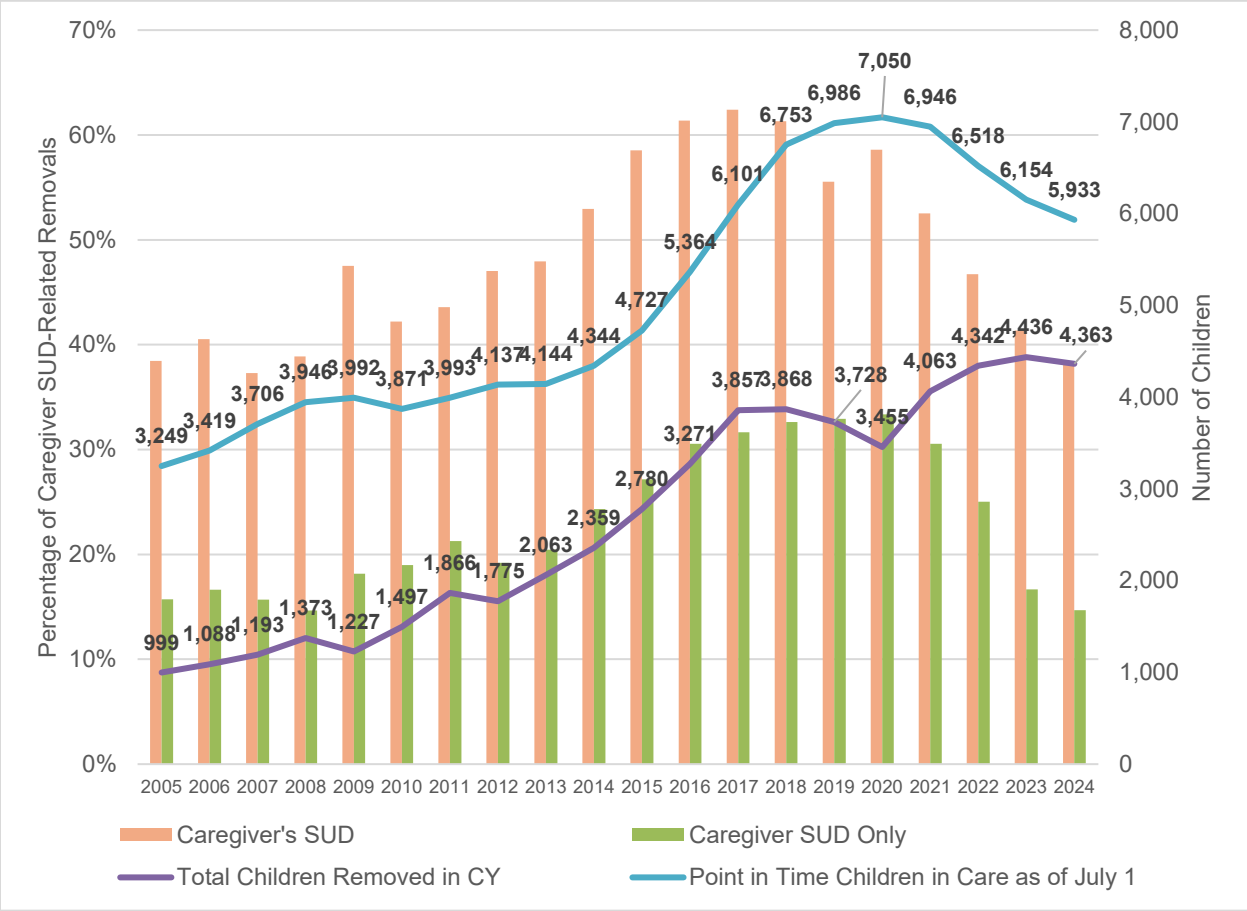


***Note:** This map is inclusive of certified and non-certified kinship homes.

In addition to overdose deaths, the opioid epidemic has impacted the child welfare system. Over the past two decades, children removed from the home due to a caregiver's substance use disorder (SUD) grew to over 60% of removals, peaking in 2017 (Figure S.21). Starting in 2021, the volume of children in care began decreasing, resulting in over 1,000 fewer kids in care on July 1, 2024, compared to four years earlier. Children with a removal reason[30] due to a caregiver's SUD has also decreased to 38% of removals, equivalent to the rate in 2005. While progress and positive outcomes have been demonstrated in response to the devastation caused by the opioid crisis, DoHS does, however, expect a "ripple effect" in mental health needs in the coming years due to increased trauma and substance exposure among children.

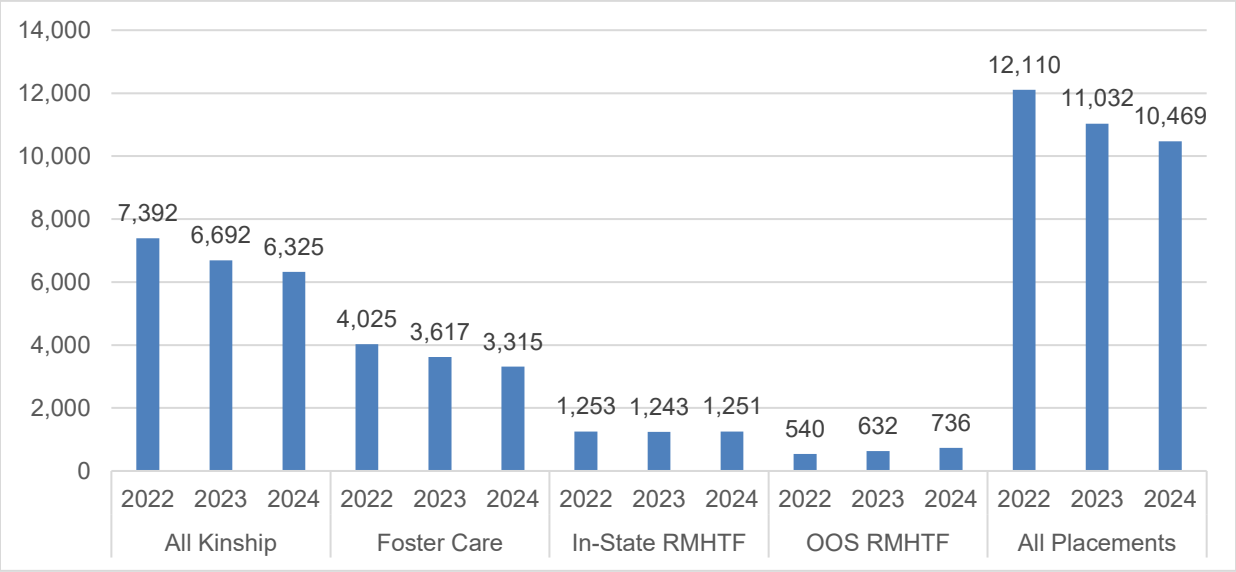
[30] Children may have multiple removal reasons for the same case.

Figure S.21: Removal Reason Related to Caregiver's SUD and Number of Removals for Children Removed in CY; Point in Time as of July 1, Number of Children in Child Welfare Placement, CY2005 to 2024



Out-of-home placements settings vary based on the needs of the child. Figure S.22 shows decreases in community-based placements such as kinship and foster care from FY 2022 to 2024. Overall placements have decreased by 14%, with in-state RMHTF/PRTF placements remaining relatively stable, and OOS residential placements having a 36% increase. As referenced in Section 6.3 Out-of-State Risk, in-state capacity for some specialized needs is insufficient at this time for the volume of youth with those needs.

Figure S.22: Key Placement Type Volume, Median Time in Placement (LOS), Trend Comparison Fiscal Year (FY) 2022 – 2024



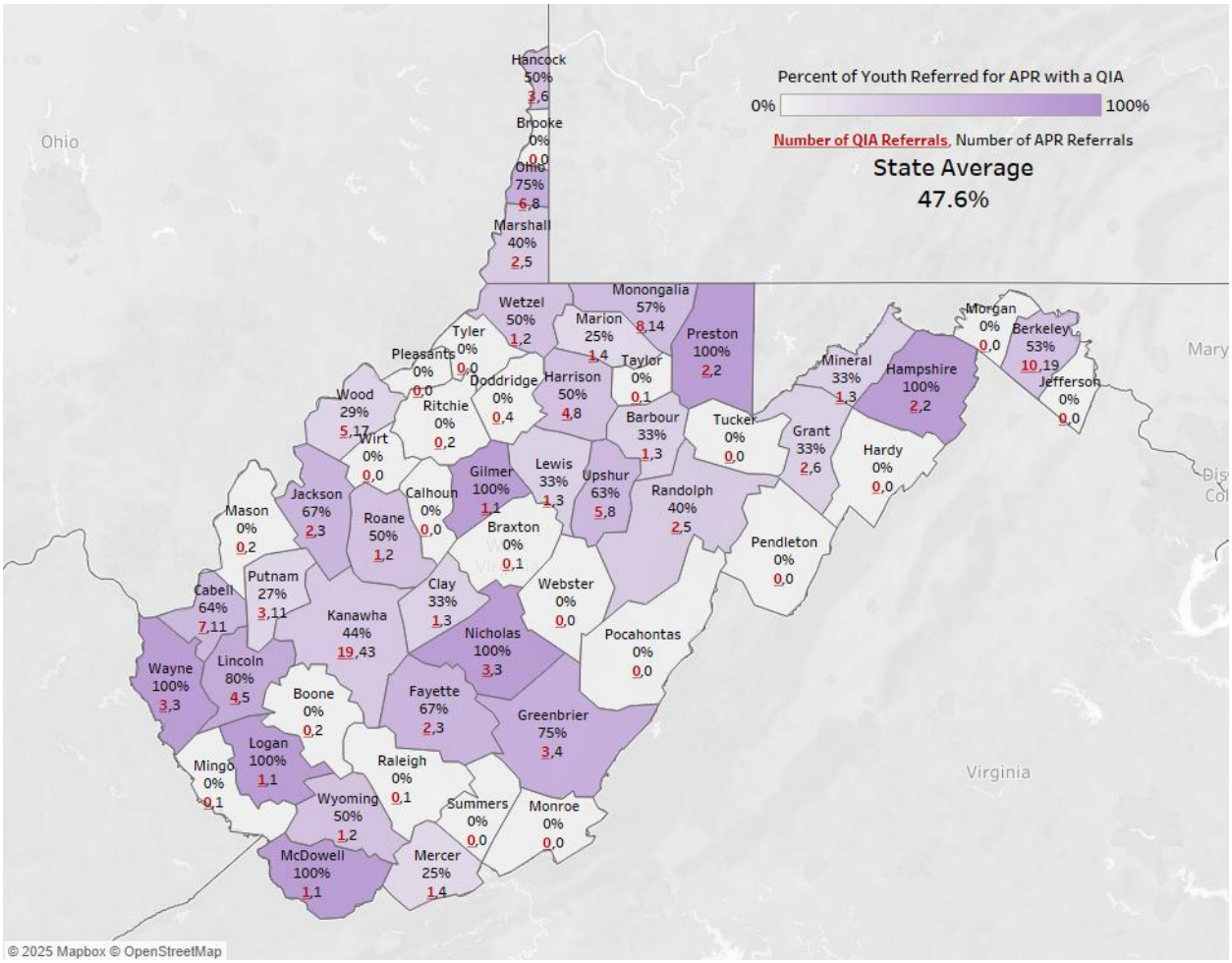
S.7 Imminent Risk of Residential Placement

Supplemental information and figures related to Systems Engagement and Outcomes are included below. Section 6.0 in the full report contains further detail.

S.7.1 QIA

Figure S.23 shows the rate of youth being referred for APR in August 2025 with a prior QIA referral up to one year prior. It is ideal that youth have a QIA prior to an APR submission to verify that residential placement is recommended. BSS shares updates on APR-related indicators monthly with social service managers for review and technical assistance opportunities. BSS leadership believes this metric can be highly influential to impact timely strategic response to inadequate referrals.

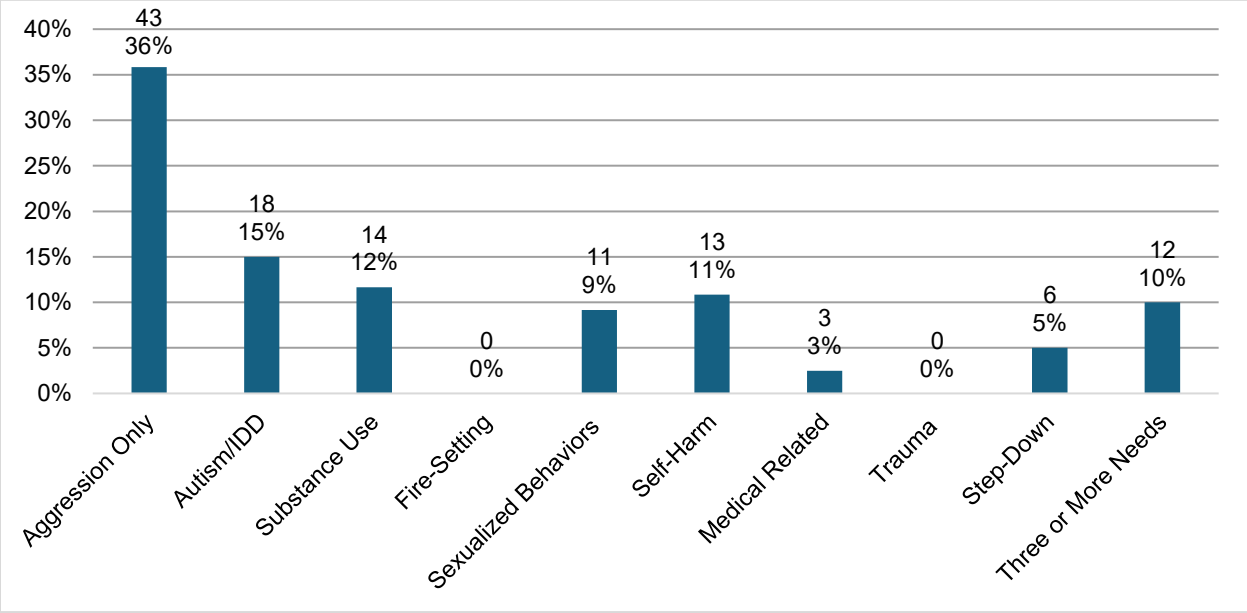
Figure S.23: Youth Referred for APR in August 2025 With a QIA Referral in Previous 365 Days (APR: n = 229; QIA, n = 120)



S.7.2 OOS Risk

Figure S.24 displays the needs of 120 children approved for OOS placement who exhibited aggressive behaviors from January to June 2025. For 36% of youth (n = 43), aggression is their only need that cannot be met in state, while the remaining 64% have aggressive behaviors and at least one other need. Indications of aggressive behavior most frequently occurred in those who also had an autism spectrum disorder (ASD)/IDD diagnosis (15%, n = 18).

Figure S.24: Co-Occurring Needs With Aggression That Cannot Be Met in State, January to June 2025



S.8 Residential Mental Health Treatment Facility Services

Supplemental information and figures related to Residential Services are included below. Section 7.0 in the full report contains further details.

Parental Placements in Residential Treatment

Parental placements make up only a small portion of the overall residential census. The number of parental placements decreased during the review period: there were only 10 parental placements in December 2024 compared to 35 in December 2023. By comparison, there were 27 parental placements in January 2022.

County-Level Residential Treatment Utilization

For purposes of quality improvement, understanding county-level changes and identifying where to focus efforts, DoHS continues to track residential placement rates (defined as unique children who were in an RMHTF at any time during the period per 1,000 children aged 20 and under) by the child's county of origin. Figure S.25 shows the percentage change in RMHTF unduplicated headcount by county, comparing CY2023 and CY2024. Specific rates by county for these two CY periods are shown in Figure S.26. The overall statewide average decreased slightly (-1.1%) between 2023 and 2024, indicating that census has remained stable.

Positively, eight counties (highlighted in green in Figure S.25) had greater than or equal to a 25% decrease in utilization, while only five counties (highlighted in orange) had an increase greater than or equal to 25% between the two periods. The remaining counties had sustained rates, except two (Tucker and Pendleton) that were excluded due to having a headcount of fewer than five children. Of note, many counties in WV are rural with smaller child populations, so small changes in headcounts can greatly influence changes in rates.

Figure S.25: Percentage Change in RMHTF Unduplicated Headcount per 1,000 Children Under 20 by County of Origin, CY2023 vs. CY2024

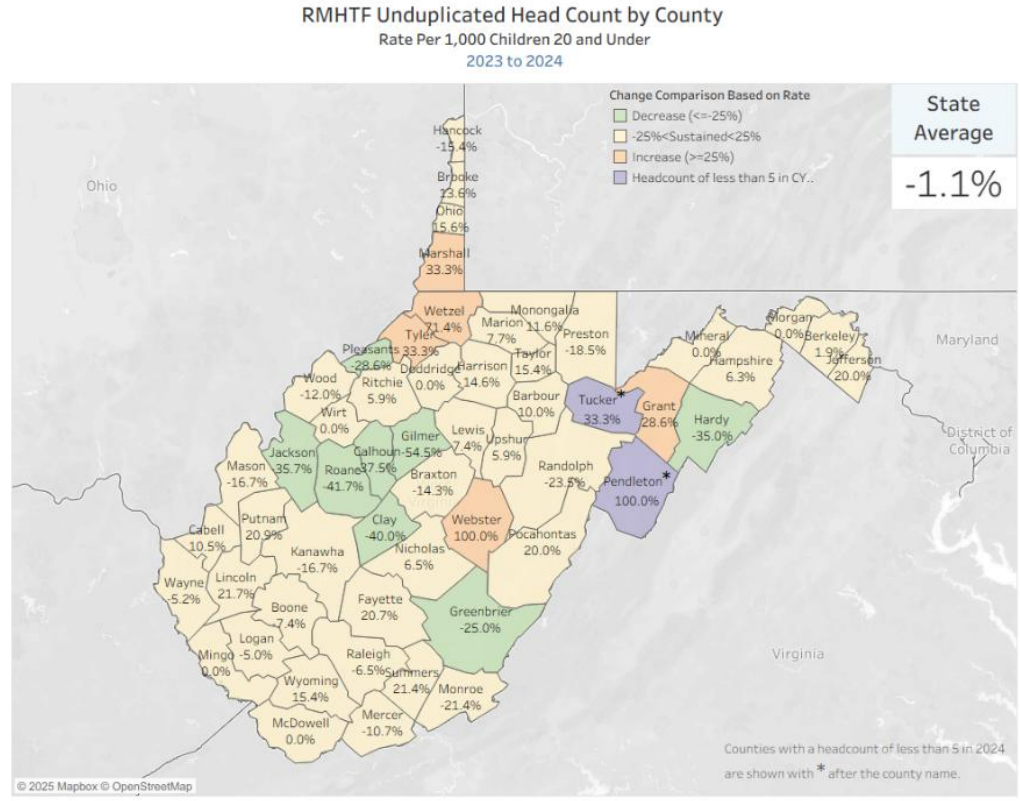
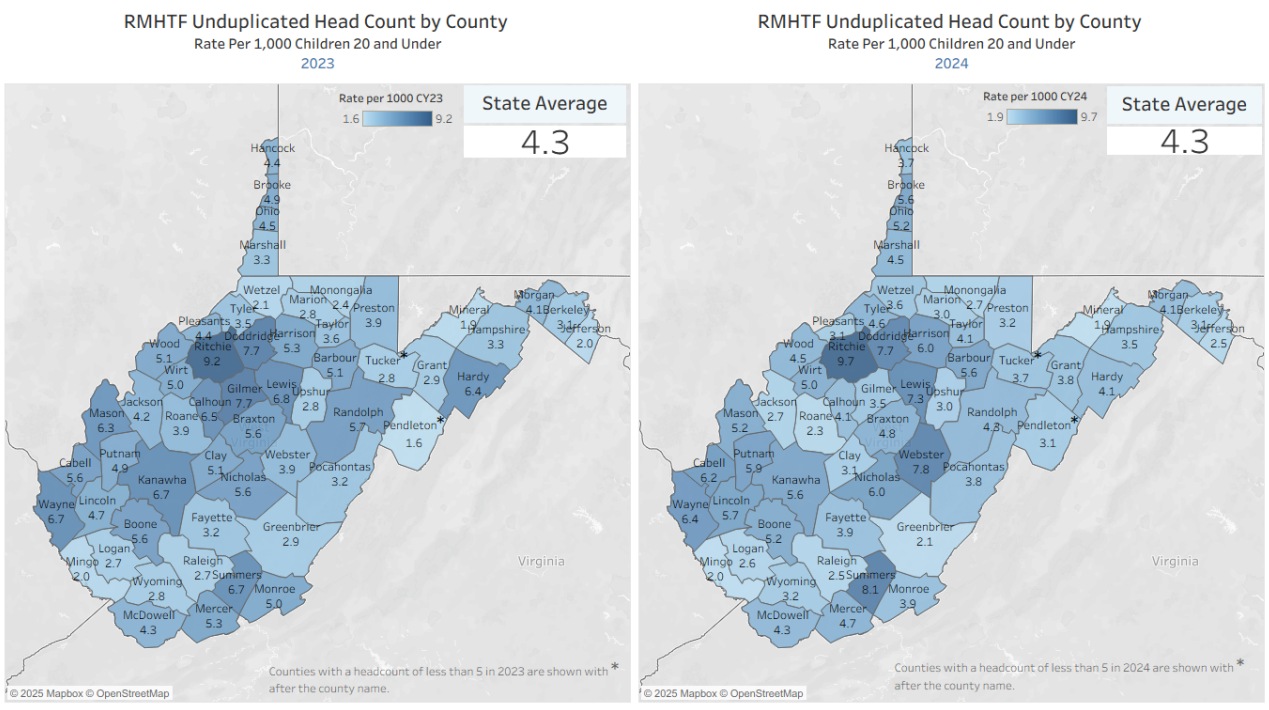


Figure S.26: Placement Rate Comparison, CY2023 vs. CY2024 (Left to Right)



S.9 Additional Information

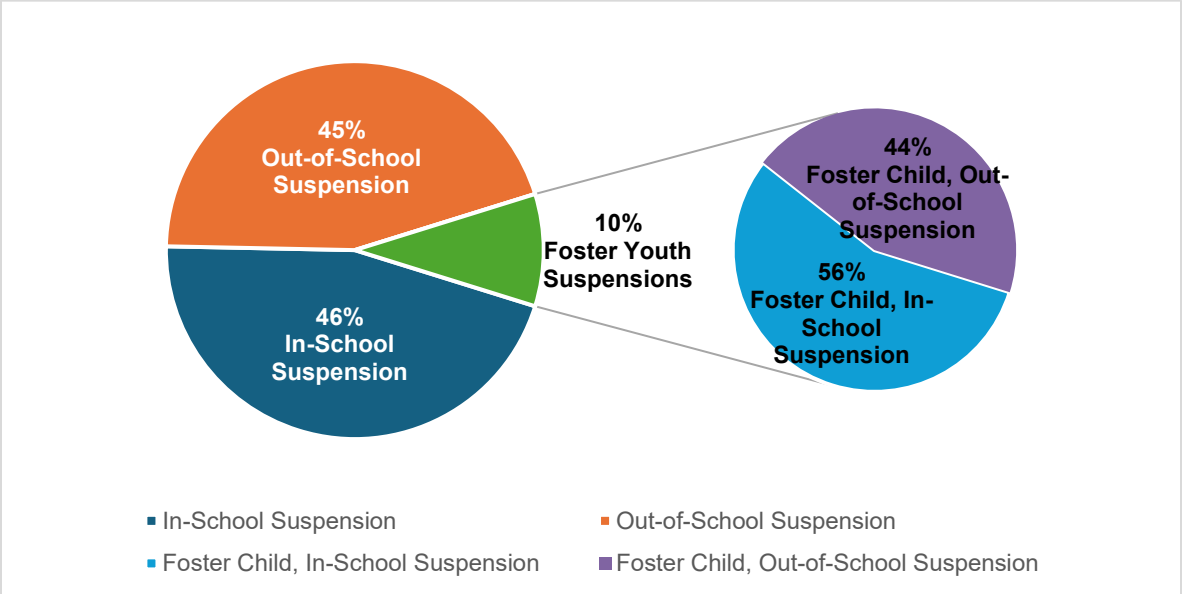
S.9.1 School Performance

As part of the greater collaborative started in December 2022, DoHS is working with the WVDE. A data use agreement (DUA) is in place that will enable sharing and reviewing educational data for the at-risk population. These data will be used to reduce disciplinary action for students residing in foster care and form trauma-informed approaches. A second DUA for matching data from the West Virginia Education Information System (WVEIS) to improve understanding of child outcomes over time is also in place. Data collected from WVEIS will allow tracking of student progress and need indicators—such as attendance, school performance, disciplinary actions, and educational accommodations (i.e., 504, Individualized Education Program (IEP))—which will become part of the data store for review of cross-systems-related outcomes. DoHS is currently coordinating with WVDE to establish formal and routine data transfer processes, which have been delayed due to other prioritized needs.

DoHS has conducted outreach to the education community throughout 2024 and the first half of 2025, such as attending the WV School Counselor's Association Conference. Many attendees indicated they were unaware of services they could be utilizing for students, such as the CCRL, but were enthusiastic about the availability of these services. Educating stakeholders within the school system about available HCBS and their ability to make referrals for students and families has been a key outreach point for DoHS.

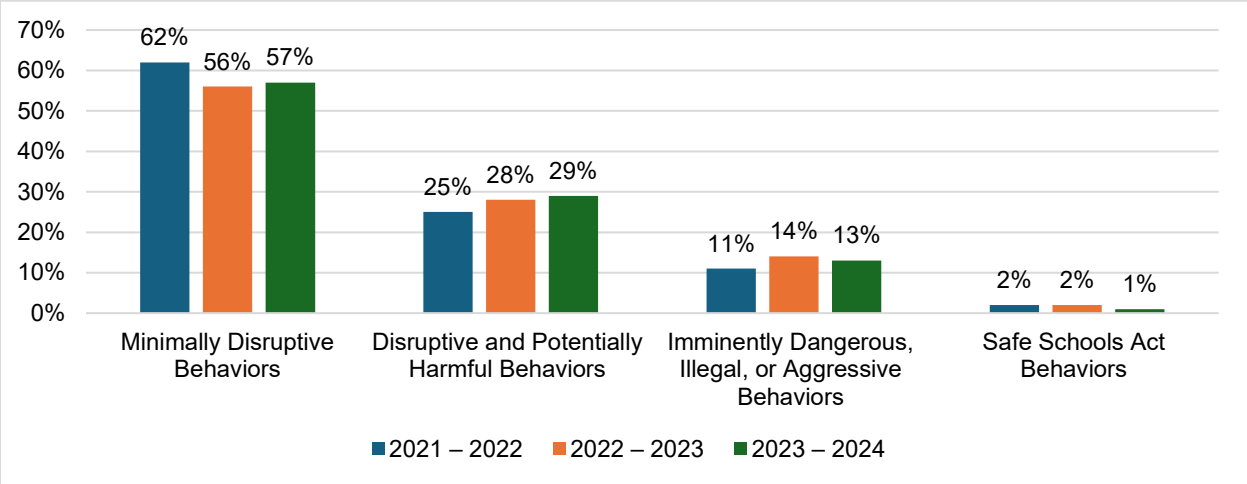
School data from WVDE's ZoomWV system showed little fluctuation from previously reported data. Figure S.27 shows that foster youth represent a large portion of youth disciplined via suspension. However, a shift was observed from the previous report with more foster youth having in school suspension rather than out-of-school suspension.

Figure S.27: 2023 – 2024 School Year Suspensions by Type (n = 66,999)



Level of incident behavior, as depicted below in Figure S.28, has shown little fluctuation since the previously reported year. Positively, there has been a decrease in Safe Schools Act behaviors (including battery of school employees, felony crime, illegal substance-related behaviors, and possession or use of dangerous weapons), which require an out-of-school suspension by law. Students expelled for their behavior dropped to 413 in the 2023 – 2024 school year, representing a 19% decrease from the previous school year.

Figure S.28: Level of Incident Behavior by School Year



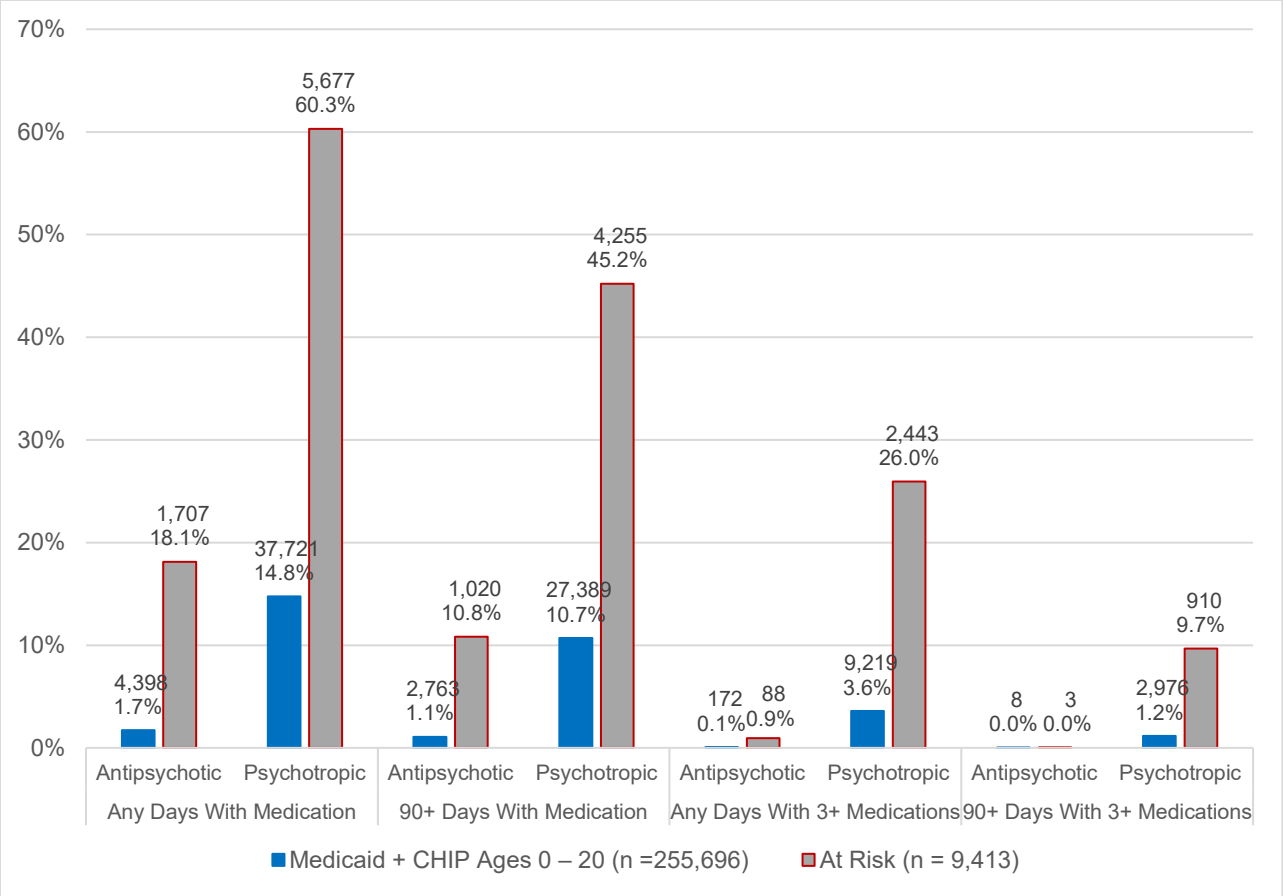
S.9.2 Polypharmacy Utilization

Polypharmacy analyses using pharmacy claims data to compare the general population to those at risk of residential placement did not identify significant numbers of Medicaid children with three or more psychotropic medications, which included use of antipsychotic medications. Per Figure S.29 below, in CY2024, only 3.6% (n = 9,219) of this population utilized three or more of these medications for at least one day. The rate of utilization was higher among the at-risk population:[31] 26.0% (n = 2,443). Only 1.2% (n = 2,976) of the general Medicaid population and 9.7% (n = 910) of the at-risk population utilized three or more psychotropics for at least 90 days. Fewer than five at-risk children used three or more antipsychotics for 90 days or more. There was an observed shift in both the overall Medicaid and at-risk populations in the polypharmacy analyses from the last time this data was pulled for the January 2024 Semi-Annual report. Previously, data included youth from January to June 2023—a six-month period as opposed to the full CY included in this report. Also of note is that the continuous Medicaid eligibility put into place during the COVID-19 pandemic ended in March 2023, thus accounting for decreases in the Medicaid population.

[31] At-risk children were identified for each quarter in 2024, defined as those children (under age 21) with an SED in the most recent 12 months (where an SED is defined as ICD-10 diagnosis codes in the psychiatric range, or F-range [that is, starting with F] *except* for: the F1, or SUD, range and F55 [also a SUD diagnosis], and the F70-F80 range of IDDs during CY 2021) AND meeting any of the following criteria in most recent three months: Medicaid/CHIP member with an emergency room visit for a psychiatric episode, Medicaid/WVCHIP member with a psychiatric hospitalization episode, Mobile Response, children who are in child welfare custody because of CPS or YS involvement, OR children with SED in the first three diagnosis positions and a CAFAS/PECFAS > 90.

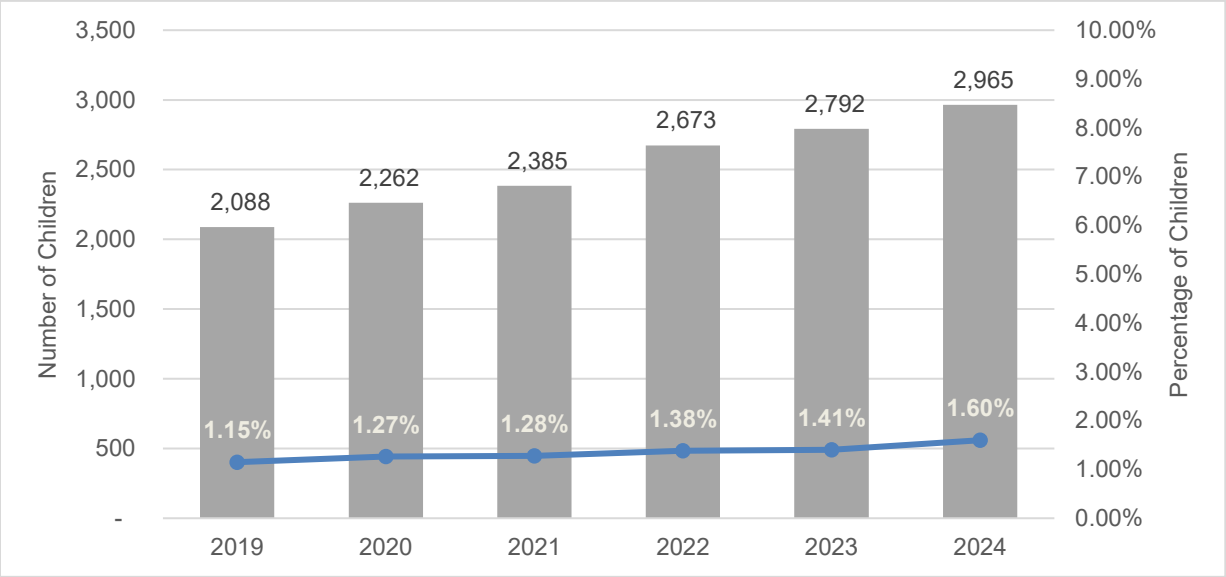
It was noted that some children considered to be on “maintenance medications” for continued mental health treatment may not be included in the at-risk population despite polypharmacy use, as the child did not flag for at-risk indicators (e.g., child welfare involvement or recent identification of functional impairment or mental health crisis service engagement). BMS has policies and processes in place to flag any child for whom polypharmacy may be an issue, enabling intervention when necessary.

Figure S.29: Psychotropic and Antipsychotic Utilization Among Children With WV Medicaid and Children at Risk for Residential Placement, CY2024



The COVID-19 pandemic impacted healthcare significantly. WV Medicaid’s extended eligibility for individuals enrolled in Medicaid ended in March 2023. Increased allowances for telehealth services have improved access for some populations who have reliable phone and internet connectivity. Figure S.30 shows the number and percentage of Medicaid children aged 6 to 20 with three or more psychotropic medications for 90+ days from 2019 to 2024. Utilization has trended upward over the last six years, likely another indicator of increased acuity of need, from only 1.15% (n = 2,088) in 2019 to 1.60% (n = 2,965) in 2024. DoHS will continue to monitor this to help ensure prescriptions, including polypharmacy utilization, remain appropriate.

Figure S.30: Utilization of Three or More Psychotropic Medications for 90+ Days for Medicaid and WVCHIP Children Aged 6 – 20, CYs 2019 – 2024



The WV Medicaid Pharmacy Program has several procedures and policies in place to help prevent inappropriate utilization of psychotropic medications, including prospective drug utilization review edits. Claims are reviewed for appropriate age, dose, therapeutic duplication, and potential drug-drug and drug-disease interactions. When claims are denied, prescribers are required to complete prior authorization and justify the prescription. These requests are reviewed by a child psychiatrist available through a contract with MU. Metabolic laboratory tests and an involuntary movement scale are required for continued prior authorizations. At this time, no major concerns were identified with current practices—given the established checks and balances infrastructure. WV will continue to monitor this and expand these analyses as needed to understand influences of the child journey and mental health system engagement.