CHILDREN'S MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES

Quality and Outcomes Report

Reporting Period: January 2024 – December 2024

Trend Review Period: January 2023 – December 2024

When kids and families thrive, West Virginia thrives.

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Office of Quality Assurance for Children's Programs

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Thank you, "WV team," for all you do and continue to do.

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, 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
DART	Document Assessment and Review Tool
DH	Department of Health

Acronym/ Abbreviation	Description
DHF	Department of Health Facilities
DHHR	Department of Health and Human Resources
DHS	Department of Homeland Security
DoHS	Department of Human Services
DUA	Date 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
FOC	Freedom of Choice
FSC	Family Support Centers
FTE	Full-Time Equivalent
HCBS	Home and Community-Based Services
ICD	International Classification of Disease
IDD	Intellectual and Developmental Disabilities
LOS	Length of Stay or Length of Service
MH	Mental Health
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)
SEO	Search Engine Optimization
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
TANF	Temporary Assistance for Needy Families
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

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1.0 Executive Summary

Since 2019, the West Virginia (WV) Department of Human Services (DoHS)[1] has been working diligently to reform mental and behavioral health services for children[2] with serious emotional disorder (SED) and their families across WV. Consistent efforts and collaboration with community partners and stakeholders have helped to develop a system where children and their families can thrive in their homes and communities. Through documented outcomes, this report will demonstrate DoHS's commitment to affording every child the opportunity to live in the most integrated setting that meets their safety and clinical needs. This report summarizes information primarily for calendar year (CY) 2024, with efforts and data for other periods described as relevant. The continuous quality improvement (CQI) review processes in place provide DoHS with insight into the strengths and areas of need in the current system, enabling strategic intervention to address needs.

WV's mental health services system for children with SED is designed to:

- Identify children's mental health needs
- Provide families with timely and smooth connections to services
- Transition children currently placed in residential settings back to their family homes or other more integrated settings

The entry way into this system of care, commonly referred to as the Assessment Pathway,[3] creates a "no wrong door" approach to streamline and facilitate access to assessment and connection to home- and community-based services (HCBS) for children and families. Children and families often enter the Assessment Pathway via a screening and/or referral process, which may be initiated or conducted by one of several entities, including call lines, primary care providers (PCPs), social service workers, probation officers, residential facilities, juvenile services, and schools.

One entry way—which is accessible to children, families, and advocates in seconds—is the Children's Crisis and Referral Line (CCRL). The CCRL is a resource for children and families in crisis to access needed support (including mobile response)[4] that creates an avenue for *anyone* seeking information regarding available services and supports. Services were expanded for

[1] On January 1, 2024, the West Virginia Department of Health and Human Resources (DHHR) became the WV Department of Health (DH), DoHS, and the WV Department of Health Facilities (DHF). Under this new structure, the Office of Quality Assurance for Children's Programs (OQA), Bureau for Behavioral Health (BBH), Bureau for Medical Services (BMS), and Bureau for Social Services (BSS) now operate under DoHS. The Bureau for Public Health is now part of DH. Given the bureaus primarily involved in this work, this report will refer to DoHS for time periods before and after the transition.

[2] For purposes of this report, unless otherwise noted, children are inclusive of youth through age 20.

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

[4] Also referred to as "Children's Mobile Crisis Response and Stabilization," or CMCRS.

mobile response in 2024, beyond grant-covered services, to allow Medicaid to cover immediate response to crises in the home and community, creating sustainability and further availability for response. The CCRL is available 24 hours per day, seven days per week, with calls answered within 13 seconds, on average. The line can be reached through call, chat, or text. Families can be screened into the Assessment Pathway by simply connecting with the CCRL.

Once connected to the Assessment Pathway, children and families are assessed for, and given the option of, applying for WV Wraparound. This program, available statewide, provides service coordination for intensive treatment and helps connect children and families to supportive services in a home- and community-based setting, including Wraparound Facilitation for children with SED. The Wraparound Facilitator, in partnership with the care team, has the primary role of identifying needs and connecting children and families with resources and services, helping ensure they are "wrapped" in the supports needed to improve their outcomes.

The Assessment Pathway also offers families the opportunity to connect with other HCBS, such as Behavioral Support Services (also referred to as Positive Behavior Support (PBS)), Assertive Community Treatment (ACT), recently added Certified Community Behavioral Health Clinic (CCBHC) services, and other locally available services to meet their needs. Families are also given information about mobile response services for crisis needs. Wraparound, ACT, PBS, and CMCRS are all available to provide HCBS statewide.

The mental health system for children with SED also helps ensure children already in residential facilities have effective discharge plans in place—incorporating family needs and input—which supports the child to reacclimate quickly to the family setting once treatment concludes and successfully remain in the community.

DoHS's CQI strategy incorporates service- and child-level data as well as feedback from providers, facilities, youth, and their caregivers to advance and strengthen current systems through collaborative, strategic, and timely decision-making and action. One of the pillars of DoHS's approach to CQI is the DoHS Quality Committee, which comprises administrative leaders from bureaus across DoHS as well as representatives from Aetna, the Bureau for Public Health (BPH), and other supportive affiliates. The DoHS Quality Committee meets multiple times per year to review data and other information that guide strategic planning.

In CY2024, DoHS further evolved its CQI strategy to understand interactions and outcomes in greater detail by focusing analyses on key populations and systems engagement at various intervention points. Through review processes, the WV team has been able to assess whether systemic needs are being met by attempting to answer if the system is reaching:

- The "right children"
- With the "right services"
- At the "right time"
- With the "right amount" of intervention

Through the availability and use of the Office of Quality Assurance for Children's Programs' (OQA's) expanded data store in 2024 and 2025, DoHS has gained greater insight and flexibility to understand the system's needs through the perspective of the child and family journey. This knowledge has helped guide policy and practice enhancements and helped ensure the mental health system can meet families where they are while emphasizing that services should be driven by assessment/clinical necessity and help children receive services in their home or, when necessary, as close to their community as possible.

1.1 Summary of Key Results, Accomplishments, and Next Steps

Through CQI-related analyses reviewed in the last half of 2024 and the first half of 2025, several key themes emerged, including the following:

- **WV Wraparound services have shown efficacy, regardless of age**, in improving functional ability for children and preventing out-of-home placement, especially placement in residential facilities.
- **WV Wraparound achieved high-fidelity status in outcomes measures** and an improved overall score, indicating "adequate" overall status in fidelity to the national model, demonstrating improvements in adherence to the integrity of the program.
- **Timely service engagement with HCBS helps promote positive outcomes** and keeps children in their communities when clinically appropriate.
- **Mobile crisis services have been underutilized.** However, identifying this need presents an **opportunity for further outreach to increase utilization** which, in turn, can **help meet immediate needs and drive diversion/stabilization efforts**.
- **Mental health acuity appears to be increasing.** Currently, one in four children in the Medicaid population age 0 – 20 has a diagnosis associated with SED. Placement types for children in child welfare custody must be equipped, supported, and willing to meet these needs, whether the placement be a kinship home, foster home, or residential facility. Expansion of supports, services, and placement options is needed to meet these growing needs.
- For children requiring residential treatment, **having thoughtful and timely discharge plans in place, including a plan for aftercare, is critical to long-term success** of treatment and helping prevent readmission.

Level of Acuity and Placement Needs

The Youth Risk Behavior Survey (YRBS) indicates that trends for mental health indicators have been increasing since 2011, which is likely associated with the opioid epidemic; this has resulted in rising numbers of overdoses and child welfare cases. The COVID-19 pandemic has also contributed to mental health needs. Recent trends have shown decreases in both opioid epidemic-related metrics (i.e., child welfare cases with parent's substance use as removal reason and overdose deaths). These decreases lend to the incredible efforts WV has made to help adults and families facing these challenges**. DoHS**

does, however, expect a "ripple effect" in mental health needs in the coming years due to increased trauma and substance exposure among children. Multiple indicators have pointed to an increased number of children with higher acuity of mental health need, including higher Child and Adolescent Functional Assessment Scale (CAFAS) scores for children going through the Assessment Pathway. **In the last half of 2024, the proportion of CAFAS scores greater than 90, the score required for Wraparound eligibility,[5] increased compared to the last half of 2023. CAFAS scores of 170 or more have also increased to an all-time high of 16% of applications with a CAFAS assessment completed.**

Increased acuity of need has also impacted placement needs within the child welfare system. Children with additional needs will need kinship or foster parents who are open and willing to help support their needs. Foster families have autonomy to accept or deny placements; they also may have a range of experience levels, which means **an increased number of available home options are needed to properly match the needs, wants, and capability of the family and child being placed. The number of active homes with placements has remained relatively consistent at approximately 1,100 homes at a given point-in-time, with nearly 80% having an active placement since July 2023.**

- **A total of 223 children in Residential Mental Health Treatment Facilities (RMHTFs) or emergency shelter settings were identified as needing community-based placement as of July 31, 2025, indicating a substantial gap between available and needed capacity of foster and kinship homes.**
- On average, **the percentage of licensed families retained over two years increased from the first half of 2023 (45.5%) to the second half of 2024 (49.2%).** This shows homes open for an extended period of time are being retained, but newer homes may be closing more quickly, resulting in a sustained number of total homes (approximately 100 homes opening and closing each quarter).
- The number of children in a hotel placement (at least one day in the month) began increasing in February 2025 and peaked in May 2025 at 91 children. Since May 2025, the number has gradually decreased to 68 children for August 2025, a volume similar to April and March 2025 (both n = 62). **These trends may be due to lower availability of community-based placement capacity for children with high acuity of need; a higher number of children with increased acuity of need may have filled existing options, thus resulting in more children needing residential placement.**

In response to the rising number of children in need of immediate placement, DoHS developed a task force to help prioritize and coordinate placement solutions for children in hotel and shelter settings. These Call-to-Action meetings have allowed DoHS, Child Placing Agencies (CPAs), residential providers, and other key stakeholders to collaboratively identify creative solutions for prioritized children. **These efforts have helped identify more appropriate placements for**

[5] CAFAS score 90 and above is required for eligibility for the CSED Waiver which covers Wraparound services through Medicaid funding.

many children and facilitate discussions for longer-term solutions based on overarching placement needs (e.g., homes for older youth, child care needs for older youth) and in-state residential provider needs (e.g., treatment programs for Autism Spectrum Disorder/Intellectual and Developmental Disability (ASD/IDD), substance use, and sexualized behaviors).

These patterns in increased acuity of need continue to emphasize the importance of expanding options and supports (e.g., foster homes, kinship connection, transitional or independent living programs, and residential homes for older youth and youth with mental health needs) so that once treatment has been completed, the child can return to the community as quickly as possible. The Assessment Pathway offers connection to many of these supports.

Connection to Services

Assessment Pathway referrals increased by 33% in the first half of 2024 (n = 2,006) compared to the first half of 2023 (n = 1,506). The increases were associated with broad-scale outreach efforts completed in late 2023. The pathway averages 228 referrals each month—more than twice the number of admissions to residential facilities. This is a positive finding that demonstrates DoHS's commitment to connecting families to the most inclusive setting that will serve their child's needs.

In addition to increasing connections overall, **DoHS aims to increase the number of family-driven referrals to shift the overall culture and perceptions in WV to allow more children to receive services in their homes and communities while also supporting parents through challenges associated with SED diagnoses.** This strategy could ultimately help prevent potentially avoidable, undesirable outcomes (e.g., child welfare involvement, probation involvement, or RMHTF[6] placement). **In the second half of 2024, 20% of referrals were family-driven. More in-depth analyses around outcomes found that children are less likely to experience out-of-home placement if they were in age groups younger than 13.** Service connections for families and identifying needs earlier when possible are expected to help increase the number of children with positive outcomes.

Service connection to claims-based mental health treatment or therapy HCBS (excluding Wraparound) increased from 59% of children receiving treatment/therapy services within 90 days before referral to 76% receiving the services after referral for approved Wraparound (CSED Waiver)[7] applications. Even children who were not approved had improvements in service engagement after application. Although acknowledging that families navigating the pathway may have a range of needs and acuity, this increase demonstrates that connections to a broad array of services can be made through the Assessment Pathway regardless of determination outcome.

[6] "RMHTF" is often used as a catch-all term for residential stays inclusive of Psychiatric Residential Treatment Facility (PRTF) stays, unless otherwise noted.

[7] Section 3.0 WV Wraparound Services contains more details on payor sources for WV Wraparound, such as the Children with Serious Emotional Disorders (CSED) Waiver.

In CY2024, there were 865 calls to mobile response services, a sustained total number of calls compared to CY2023 (875 calls). Despite the expansion of available state plan services, only 237 children utilized CMCRS in Quarter 4 (Q4) 2024, including 78 children (33%) served through the Medicaid state plan. Analyses showed children going through the Assessment Pathway with a CAFAS score of 140 or more and/or emergency department (ED) utilization were more likely to experience out-of-home placement. **CMCRS services have shown efficacy in keeping children in their homes and communities when it is utilized, but relatively low utilization numbers overall indicate that more children could benefit from these services. Early awareness of crisis services and when a family should use them is critical for effective utilization.** These findings highlight key opportunities for expanded outreach and awareness. Acentra will expand education for families going through the Assessment Pathway regarding the availability and navigation of CMCRS services. **DoHS is also expanding outreach to encourage earlier intervention through connection of both the Assessment Pathway and CMCRS services** via Family Service Centers (expanded to 57 centers in 2024), as well as other key stakeholders such as managed care organizations (MCOs), PCPs, the Hospital Association, and the WV Department of Education (WVDE).

Additional needs identified in the Assessment Pathway process were as follows:

- A high percentage of application closures (**41% of all applications closed**) were largely driven by child welfare referrals before an assessment could be made.
- **Only half of children (51%) approved for CSED Waiver services went on to receive Wraparound services from any payor source**.
- Children who are approved but do not utilize Wraparound services typically did not have Freedom of Choice[8] (FOC) documentation in place.
- Children without FOC documentation in place were most likely to be referred from DoHS, the Bureau for Juvenile Services (BJS), or Probation Services, or the child was age 13 or older.
- Outcomes analyses showed that children who engage with the Assessment Pathway and experience out-of-home placement within 12 months after referral experience the outcome quickly: **55% of children with traditional mental health treatment/therapy service only (after referral) had their out-of-home placement occur within 90 days following application.**
- The **average time to first Wraparound service is 113 days,** meaning these children who have an out-of-home placement, on average, would not have had sufficient time to engage in services before out-of-home placement begins.

[8] The FOC form is required by the Centers for Medicare & Medicaid Services (CMS) and helps ensure families have the opportunity to choose services and providers on a completely voluntary basis.

- The number of children waitlisted for Wraparound services was 150 as of August 30, 2024, lending to longer time frames described above; however, through targeted efforts**, the waitlist has since decreased to 39 children as of August 29, 2025, a 74% decrease. DoHS is optimistic that lower waitlist volumes will contribute to faster timelines to Wraparound services in future reviews.**

Improved referral follow-through and/or simplification of processes within the Assessment Pathway are also needed to reduce the volume of closed applications and expand opportunities for improved connection to services and outcomes to the broader population, including children in Bureau for Social Services (BSS) custody. DoHS has developed a workgroup to collaborate with key stakeholders, including Aetna and Acentra, to identify ways to streamline processes and meet families where they are. This workgroup has already begun addressing needs as of the writing of this report.

DoHS will continue existing efforts to decrease the waitlist for Wraparound services, where considerable progress has already been made to expand capacity. Timeline trends will be monitored more frequently to determine whether waitlist volume decreases impact the average time to services. **DoHS is also leveraging strategies, in partnership with key stakeholders, to help ensure timely completion of the FOC, explore workforce needs and interventions, and monitor the length of Wraparound services to help ensure appropriate use and expanded availability of existing capacity.**

WV Wraparound

The ongoing demand for Wraparound services has continued to rise, with a year-over-year 18% increase in newly opened case totals (2,092 cases in 2024 compared to 1,761 cases in 2023). The number of children accessing Wraparound services at any point in time is now nearly double the number of children in residential treatment for the same point in time. This positive result demonstrates the effectiveness of the continued push to increase access and utilization of high-intensity HCBS, like WV Wraparound services. Detailed outcomes analyses showed the following related to WV Wraparound efficacy in preventing out-of-home placement:

- **Children utilizing WV Wraparound for at least three months were 26% less likely to experience any behavior-related out-of-home placement[9] compared** to those without the service/those who receive the service for less than three months.
- **Children utilizing WV Wraparound for at least three months were 46% less likely to experience residential placement compared to those not utilizing the service.** This effect was also shown for children 13 and older, demonstrating a protective relationship

[9] "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 Youth Services (YS) placement episode, or BJS placement.

with consistent use of Wraparound services and ability to remain in the home and community regardless of age.

Although Wraparound has shown to be effective for children 13 and older, older youth are less likely to engage in intensive services. The Quality Committee is exploring existing peer support service arrays and connections while awaiting final results from the Children's Mental Health Evaluation (CMHE) for more information on family and youth perspectives for facilitators of participation.

Reducing Reliance on Residential Treatment

There was sustained demand for residential treatment services in 2024 (residential census as of December 31, 2024, was 810 children); however, more recent information has shown slight increases in year-over-year residential census, primarily driven by out-of-state (OOS) placements. Preliminary census data as of August 1, 2025, shows 867 children, with 43% OOS (n = 374) compared to a year prior at 849 children in residential settings, with 42% OOS (n = 356). The percentage of children in in-state active residential placement with a length of stay (LOS) greater than six months decreased in 2024 compared to 2023; this shift provides additional evidence of the positive impact of discharge planning efforts. However, children in OOS placement with LOS greater than six months increased in 2024 compared to 2023. Diligent efforts by DoHS and its partners Aetna and Marshall University (MU) to enhance discharge planning have led to increases in the number of children discharged each month; however, simultaneous increases in the number of admissions have resulted in a sustained overall census with seasonal fluctuations.

As part of CQI processes, DoHS reviewed 12-month readmission rates for children discharging from residential placements. **As of the first half of 2024, the readmission rate was 37%**, leading the Quality Committee to conduct a root cause analysis on the relevant timeline considerations and supports needed to reduce the readmission rate. The analysis found that **nearly half (48%) of readmissions are within 90 days of discharge, leading DoHS to identify the first 90 days after discharge as critical to the success of the youth remaining in their community.** A review of services and supports in place found that only 32% of youth who were referred to and approved for CSED before discharge utilized Wraparound following discharge. Based on these results, DoHS has focused efforts on developing enhanced discharge planning, including development and training on a tool for providers to establish more fluid, comprehensive discharge planning; this helps the child and family prepare for and be more confident in returning home and having supports in place to maintain treatment progress upon return to the community.

To assist further with diversion efforts, WV uses the Qualified Independent Assessment (QIA) process to provide clinical recommendations for level of care. Of children with QIA referrals from January through June 2024 with a recommendation of HCBS (n = 288), 44% were noted as moving to or remaining in their community within 45 days after QIA completion. In the second half of 2024, this figure increased to 47% (n = 264), providing evidence of incremental progress toward greater utilization of these recommendations to help children thrive with appropriate supports in their communities.

To decrease reliance on residential placements or out-of-home state placements, DoHS is taking the following actions:

- **Collaborating with partners to understand and address discharge barriers and helping ensure appropriate plans and aftercare services and supports are in place.**
- Working with in-state residential providers to **build capacity to support children with higher acuity** and significant behavioral challenges (e.g., aggressive behavior, ASD/IDD, substance use, sexualized behaviors).
- **Collaborating closely with court representatives**—through the Court Improvement Program—who play a key role in decision-making for children with legal issues or placed in child welfare custody **to expand awareness of services and improve communication around needs and appropriate levels of care**.
- **Increasing utilization of the QIA for children at risk of residential placement** through county- and worker-level quality reports.
- **Incorporating more fluid and focused aftercare plans** for children in residential settings.
- **Collaborating with CPAs to expand and support therapeutic kinship and foster homes willing and able to care for older children and children with mental health needs.**

DoHS continues to make significant progress in designing, developing, and expanding mental and behavioral health services for children and families across the state of WV, including raising awareness of the availability of these services. As previously described, mental health needs of children in WV have increased following the COVID-19 pandemic and the opioid epidemic, resulting in sustained or increased demand for mental health treatment. However, DoHS's continued focus on and expansion of available services and supports is **enabling more children to access Wraparound and other HCBS and offsetting further increases in residential treatment services utilization.** DoHS will continue leveraging existing relationships with schools, judicial districts, PCPs,[10] the Hospital Association, and BSS workers **to expand outreach and education for early connection to critical mental health services.** These efforts are expected to **increase the number of children with positive outcomes over time, as demonstrated through improved functional ability and lower out-of-home placements for children engaged in Wraparound services.**

Additional details about strengths, needs, and next steps for the system and services in place are integrated throughout the report, with accompanying details referenced and included in the supplement to this report.

[10] Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) providers

2.0 Intervention Opportunities

DoHS is focused on providing intervention opportunities for children to support early identification of mental health needs and facilitate connection to services. This approach aims to keep children in their homes and communities and divert them from residential treatment whenever possible and clinically appropriate. Intervention opportunities include screening for mental health needs, the CCRL, Children's Mobile Crisis Response (CMCR), and referral to the Assessment Pathway. The Assessment Pathway is a "no wrong door" approach designed to streamline and facilitate access to assessments and connections to HCBS for children and families.

Screening for possible mental health needs is a critical first step in identifying children who require further evaluation to determine treatment needs and assist with connection to appropriate HCBS. To help ensure broad reach to children across WV who may benefit from behavioral and mental health services, the following entities administer screening practices:

- **PCPs:** Provide screenings for Medicaid and WV Children's Health Insurance Program (WVCHIP)-eligible children through WV's HealthCheck (EPSDT) program within BPH, including youth in YS or Child Protective Services (CPS) custody.
- **BSS – CPS and YS:** Provide screenings, via PCPs and reinforced through HealthCheck, for children who are in DoHS custody for services related to status offenses or juvenile delinquencies (i.e., YS), or for children who are involved in a child abuse and neglect case (i.e., CPS).
- **WV Division of Corrections and Rehabilitation – BJS:** Provide screenings for children who are in juvenile detention and commitment facilities.
- **WV Judiciary and Division of Probation Services:** Provide screenings for children who are on probation.

DoHS submitted a Medicaid State Plan Amendment to establish CCBHCs in WV. CMS approved this amendment effective October 2024. Since then, six CCBHCs have been operationalized across the state. CCBHCs must provide services to anyone seeking help for a mental health or substance use condition regardless of ability to pay. Screening, diagnosis, and risk assessment are among the nine core services these clinics offer, further supporting DoHS's efforts to help ensure children are screened for mental health needs and connected to services.

Children with an identified mental health need (i.e., positive screen) through any of the above screening entities may be referred to the Assessment Pathway for additional assessment and referral to HCBS. Referrals to the Assessment Pathway may also come from calls through the CCRL as well as through CMCR teams.

2.1 Intervention: Mental Health Screening Through Child Welfare, Juvenile Services, and Probation Services

Child Welfare

All children placed in DoHS custody via the child welfare system, including both YS and CPS, must receive a mental health screening within 30 days of placement and be scheduled for a EPSDT well-child visit. All children[11] should have a visit within a year of placement. EPSDT providers are trained to provide referrals to the Assessment Pathway through both electronic referral processes and informational materials connecting families to the CCRL. Quarterly screening rates throughout CYs 2023 and 2024 remained high, ranging between 91% and 96%, consistent with prior periods (see Section S.3.1.1 Child Welfare Screening in the report supplement).

Referrals from BSS workers (CPS and YS) continue to be the top source of referrals to the Assessment Pathway, accounting for 66% of referrals. This provides strong evidence that children are being referred to the Assessment Pathway for further evaluation and connection to services.

Strengthening the BSS workforce has been an ongoing priority for the past several years. Salary increases and retention incentives have been implemented to help fill critical vacancies throughout the state. As of May 2025, BSS worker vacancies were around 8% statewide, with 879 out of 953 authorized positions filled. Filling and retaining positions have shown improvement in lowering caseloads. From January to May 2024, CPS workers had an average caseload of 15.9 compared to 13.2 during the same period in 2025, which is a 17% decrease.

Bureau of Juvenile Services

BJS-involved children are screened at intake and each time they transition between BJS facilities. BJS facility-level screening data indicates the screening process is timely and has been fully adopted as policy. BJS screened 1,062 children in 2024. 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 (see Section S.3.1.2 BJS Screening in the report supplement). The steady and high rate of positive screenings illustrates the importance of seeking earlier intervention for children who are involved with BJS and the potential positive impact that connecting this population with services before entering BJS could have on their outcomes.

Probation Services

Probation officers are responsible for screening youth who are adjudicated as status offenders or as delinquent, as well as pre-adjudicatory children who are in crisis or who do not have a DoHS worker assigned to support early intervention efforts for those children who may have

[11] Some children may not be in child welfare custody long enough to complete a wellness visit (according to an annual scheduled visit).

unmet mental health needs. Screening may also be conducted at other intervals based on the probation officer's discretion. Probation Services screening practices vary by county, with some counties relying primarily on BSS workers to complete screenings. In 2024, Probation Services adjudicated 1,052 children as status offenders or delinquents. Mental health screenings were conducted for 586 children[12] in 2024. The percentage of probation-involved youth with a positive mental health screening throughout CYs 2023 and 2024 ranged between 29% and 36% per quarter (see Section S.3.1.3 Division of Probation Services Screening in the report supplement). Given the influential roles that probation officers have in the lives of the youth and families they support, county-level data is reviewed monthly with chief probation officers to continue encouraging screening rate improvements.

DoHS continues to meet quarterly with its BJS and Probation Services partners to review screening data and focus on quality improvement efforts. Screening is an important safety net for children involved with the child welfare system, BJS, and Probation Services. This group of children engages with multiple entities, including BJS personnel, probation officers, BSS workers, and Aetna care managers, providing multiple opportunities for screening and referral to services. More information on the relationships between BJS and residential placement can be found in Section 6.4 BJS Population at Risk of Residential Placement. BJS and Probation Services screening data is on target for addition to the OQA data store in late 2025, and this integration will enable DoHS to explore the relationships between these entities in greater detail.

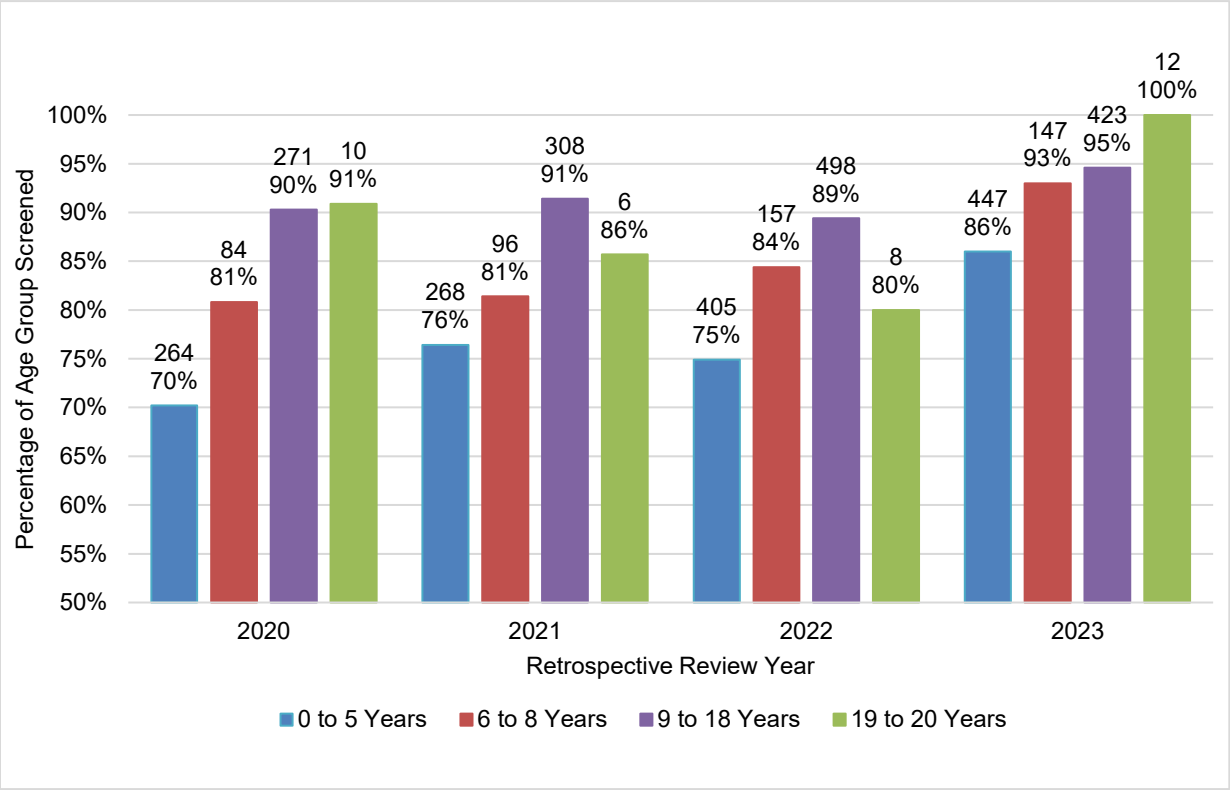
2.2 Intervention: Early and Periodic Screening, Diagnostic, and Treatment Visits

Wellness screenings through HealthCheck are a key focus of DoHS's work to help ensure children are meeting developmental milestones and are receiving important preventative and early intervention services. DoHS continues to review and make available quarterly data on annual EPSDT screenings from claims for eligible children with Medicaid or WVCHIP to facilitate additional discussions and strategic planning with stakeholders. For example, a retrospective analysis of wellness exam records sampled from provider records and administrative claims for Medicaid utilization in 2023 indicated that 90.5% of children in the sample had a mental health screening component included during their visit. During these chart reviews, records are assessed for the presence of specific screenings that have been determined to satisfy the mental health component of the wellness visit. The increased use of standardized, age-appropriate HealthCheck Preventative Health Screening forms is reported to contribute to the rise in mental health screenings. Figure 1 displays mental health screening rates by age group over the previous four years of the retrospective review (2020 – 2023). Screening rates increase along with age, which is most likely related to the typical manifestation of behaviors as the child develops. Consistent increases in screening rates for youth under 9 years old illustrates the opportunity EPSDT well visits provide—hopefully linking youth and families to needed assessments and services before behaviors escalate. The retrospective review also suggested that a referral for mental or behavioral health concerns within 90 days of

[12] Some children screened may not be part of the adjudicated population, as per Probation Services policy.

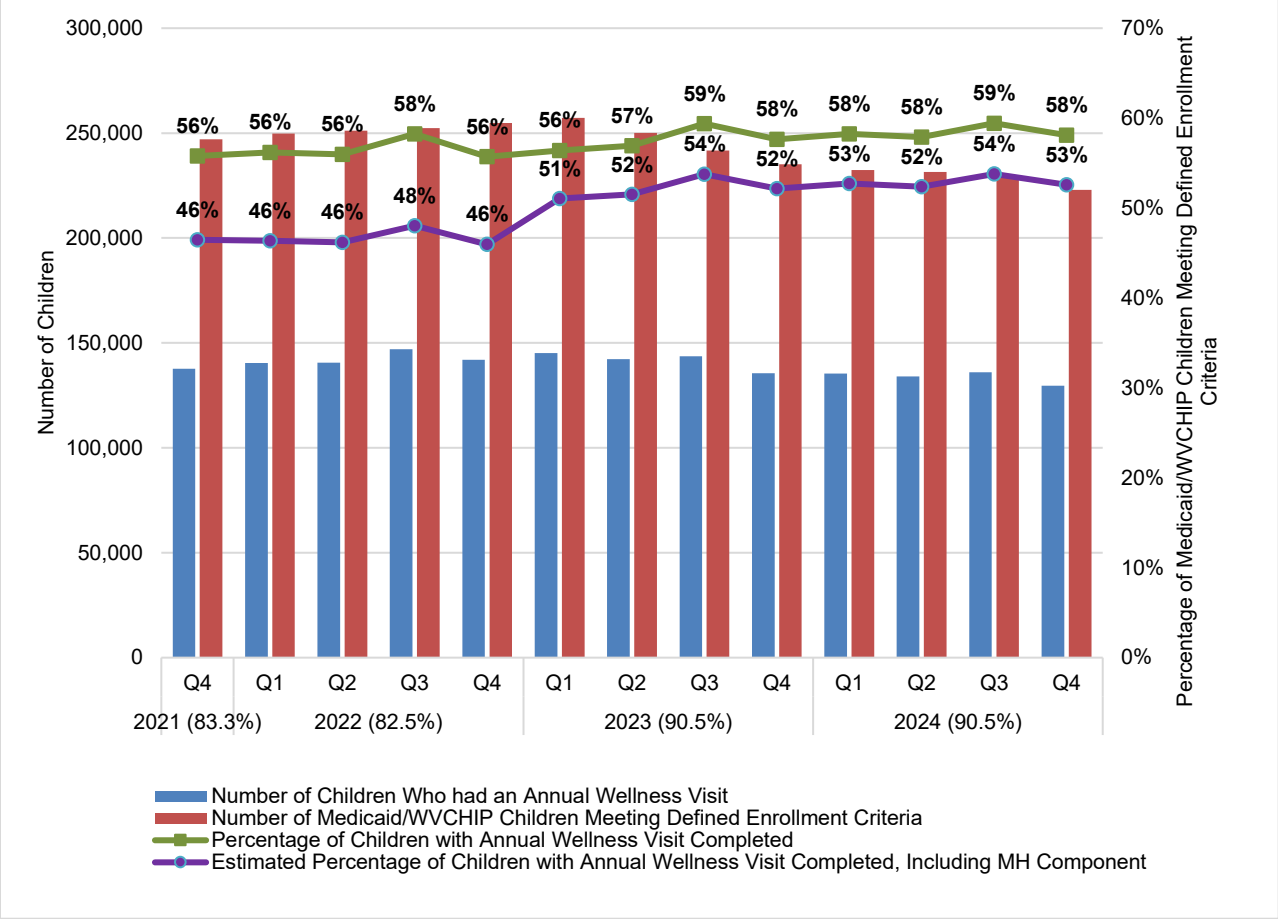
the EPSDT visit was made for a relatively high percentage of children: Of the 1,029 youth included in the review, 38.4% (n = 395) received additional mental health assessment and/or treatment. This positive finding reinforces the benefit of annual EPSDT visits as an early intervention opportunity.

Figure 1: Screening by Age Group From 2023 Retrospective Review



As of December 31, 2024, WV had 129,553 Medicaid members aged 0 to 20 who received an annual HealthCheck (EPSDT) well-child visit in the previous 14 months (Figure 2), representing 58% of the defined Medicaid-eligible population of children (n = 229,918).

Figure 2: Quarterly View of Rolling 14-Month Annual Wellness Screening Rates for Medicaid-Eligible[13] Children Ages 0 to 20



Overall, annual screenings[14] increased from 56% at the end of December 2021 to 58% at the end of December 2024; furthermore, a retrospective review of screenings including a mental health component has shown even greater improvement (83.3% to 90.5%, from CY2021 to CY2023 chart reviews, respectively). HealthCheck specialists review data by region and age to identify providers' potential technical assistance needs. Statewide, HealthCheck conducts outreach to a network of more than 600 providers.

DoHS's annual goal of at least 52% of Medicaid-eligible children receiving an EPSDT screening, including a mental health component, was achieved throughout 2023. Assuming the same rate (in reference to retrospective review) of mental health screenings in 2024, DoHS estimates that the 52% goal was continued to be met. As shown in Figure 2, there has been improvement in the proportion of Medicaid-eligible children screened for mental health needs annually, with 46% screened as of the end of December 2021 compared to 53% at the end of December 2024. Mental health screening rate improvements reflect extensive efforts across DoHS and its MCO

[14] This rate is for all screenings without consideration for the mental health (MH) component.

partners to educate families and providers about the importance of EPSDT visits and addressing access barriers.

2.3 Intervention: Children's Crisis and Referral Line

The CCRL is a centralized access point, established by BBH in 2020, to provide accurate, timely, and accessible information regarding the availability of HCBS and to connect children and families with CMCRS teams and other community-based services, including the Assessment Pathway and WV Wraparound services. Children and families can also connect quickly with someone who can act as a "listening ear" and provide ideas for coping skills, with calls answered, on average, within 13 seconds. Children, families, and those who work with them can call, text, or chat with the CCRL 24 hours a day, seven days a week, at 844-HELP4WV, 844-435-7498, or https://www.help4wv.com/ccrl. Centralized call-line staff at First Choice Services are trained to help individuals quickly connect with behavioral health services and can divert families from inappropriate use of emergency rooms and 911 calls. PCPs can also make referrals through the CCRL via JotForm (electronic secure form referral process) to connect children and families with appropriate services. The CCRL contacts families with referrals made by their PCPs within 24 hours.

Higher rates of incomplete data are expected for the call line, especially demographic information. When a family/person calls in crisis, it might not be prudent to collect all the desired data fields due to the urgent nature of the call or the need to establish rapport quickly. To help ensure accuracy of reporting, BBH has collaborated with the call-line vendor to update the call center's desk guide and data reporting. Further updates are expected by November 2025.

2.3.1 Review Summary

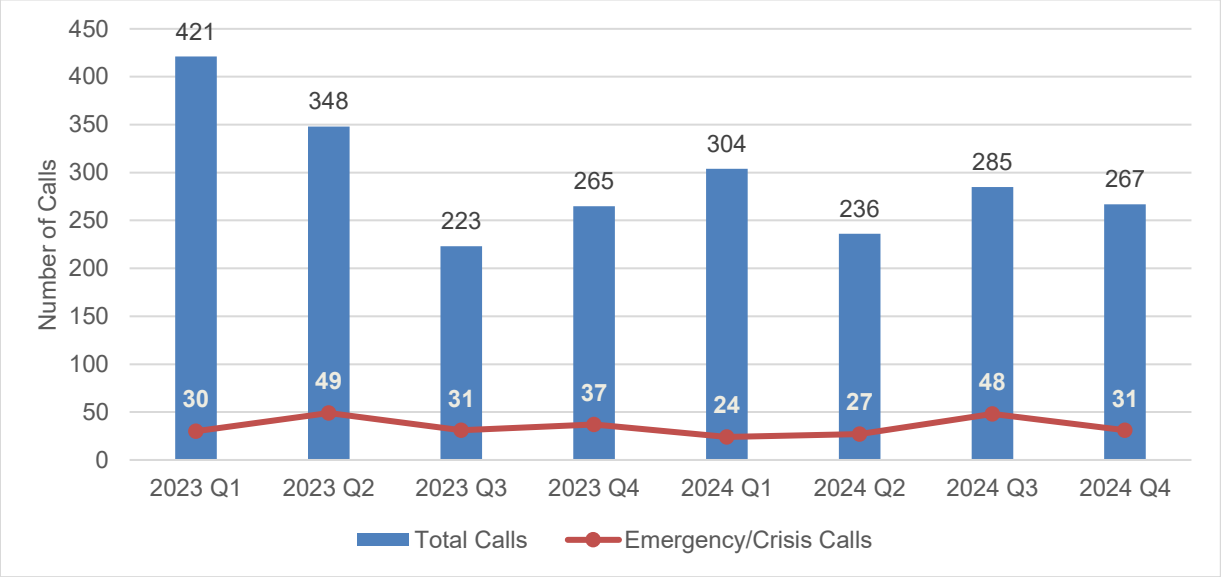
The CCRL received 1,092 calls[15] in CY2024 (averaging 91 calls per month) compared to 1,257 in CY2023 (averaging 105 per month), a slight decrease of 13%. Figure 3 shows the number of calls by quarter and acuity type from Q1 2023 to Q4 2024. In Q1 2023, there were 421 calls; the following quarters showed decreased utilization, with fewer than 305 calls per quarter in 2024.

Calls labeled "emergency/crisis" remained low throughout the period (fewer than 50 calls per quarter). The DoHS Quality Committee has indicated in past reviews that this may be associated with increased use of the line as a referral source. Use of local lines for CMCRS continues to be prevalent, despite marketing efforts for use of the CCRL with warm transfer as needed. This will continue to be monitored; however, both entryways offer connection to the Assessment Pathway, and outreach efforts will be continued to market the line, not only as a resource for families in crisis, but also as a key entry point to mental health services. Increased use of the line for service connection before a potential crisis creates the opportunity to divert

[15] Calls in this context refers to any contact made to the line (call, chat, or text). Calls are unable to be unduplicated at the caller level, as some caller information can be inconsistent or anonymous. Callers who are able to be identified as the same caller within a 30-day period are only counted once every 30 days.

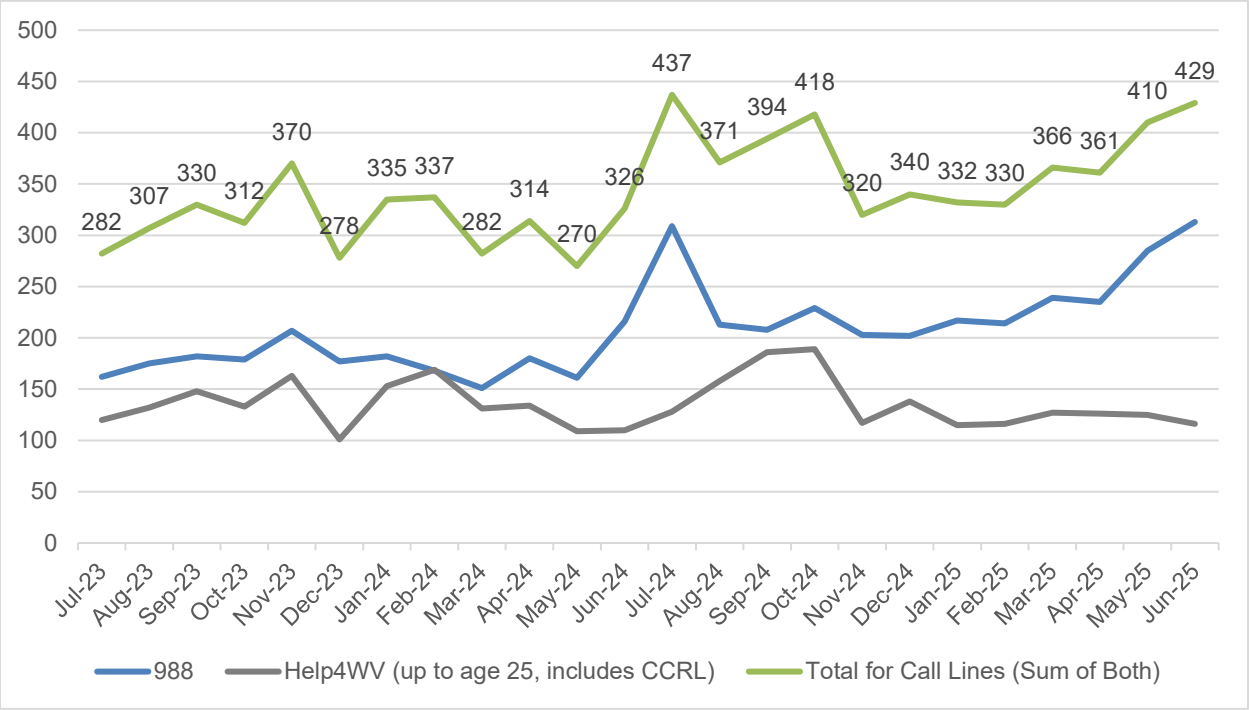
children and families from both crisis situations and out-of-home placements by connecting them to services and supports earlier.

Figure 3: CCRL Calls by Type of Acuity by Quarter, 2023 Q1 to 2024 Q4



Consideration should be given to utilization changes/shifts for the CCRL's sister call line, 988, which was implemented in July 2022. Children, families, and advocates reaching out to either line can be cross-referred to help ensure their specific needs are met most effectively. Due to the urgent nature of calls, 988 is less successful in capturing demographic information, making it difficult to determine how much of 988's call volume is attributed to youth. Monthly 988 calls have increased during Q2 in both 2023 and 2024, diverging from trends in Help4WV calls (umbrella line for CCRL, inclusive of adults in need). Upward trends in call volume correlate with marketing conducted by First Choice Services in summer 2024 for 988 and fall 2024 for CCRL (Figure 4). Given that 988 is a nationwide lifeline, it is often much more visible, with factors such as search engine optimization pointing individuals to this resource in response to a variety of mental health-related keywords. Although search engine optimization is also utilized for the CCRL, the reach is not as great as 988's.

Figure 4: Call-Line Trends for Calls to Help4WV (Umbrella Line for CCRL) vs. 988 for Children and Young Adults up to Age 25 – July 2023 to June 2025



Location of Child in Need – CCRL

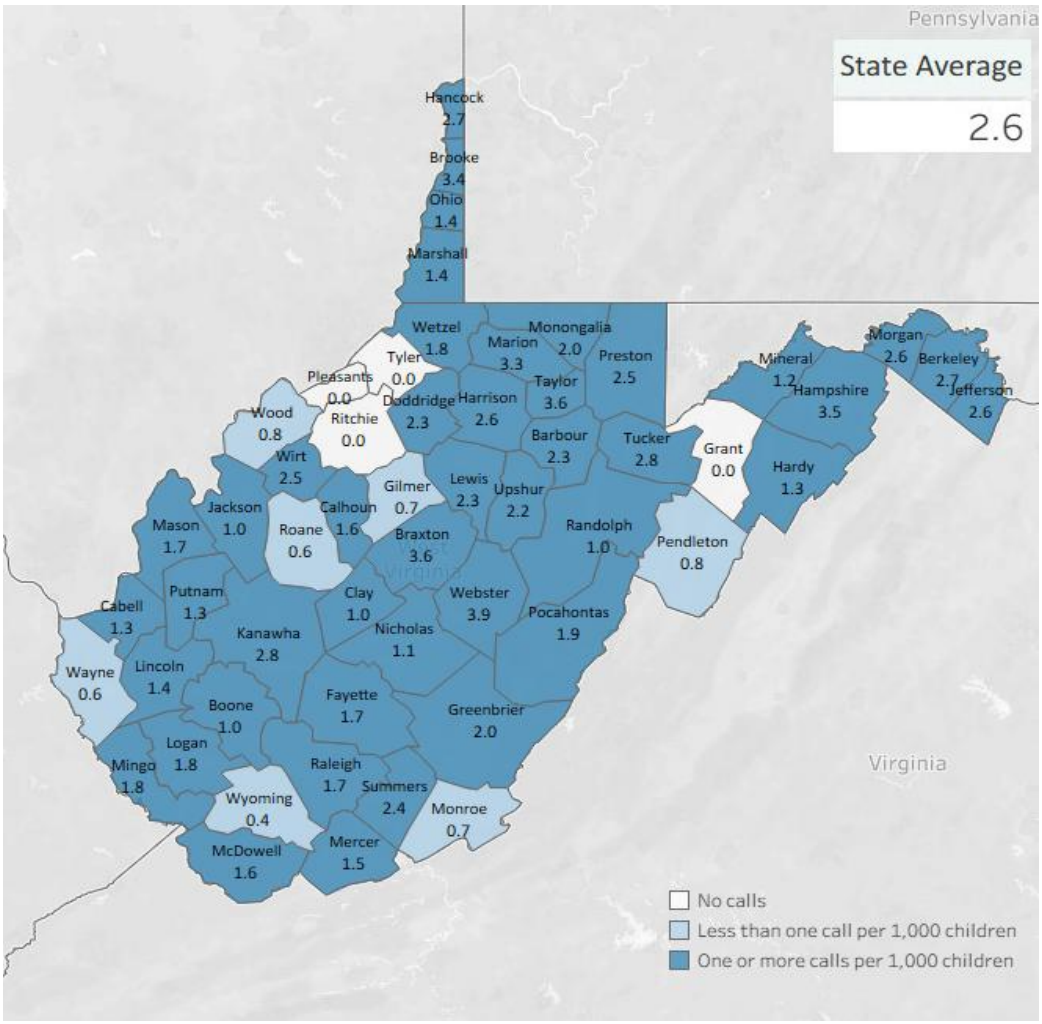
At least one individual from 51 of WV's 55 counties called the CCRL in CY2024. Pleasants County, a rural area, was the only county in the state without a call documented in CY2023 or CY2024. CCRL use in almost every county demonstrates widespread knowledge of the call line. Call information from CY2023 showed only 59% of calls with a WV county listed. Given this finding, increased attention was paid to county-level data completion, which yielded significant improvements in data completion in 2024: 74% of calls with a WV county were listed.[16] Due to the large portion of county data missing for calls in 2023, the county rate per population data could not be accurately compared to 2024 for call rate per county population. In CY2024, the average rate statewide was 2.6 calls per 1,000 children (Figure 5).

DoHS identified Wayne and Wood Counties for prioritized outreach starting in late 2024 due to risk factors for high residential utilization and underutilization of HCBS. CCRL utilization in 2024 in Wayne (0.6) and Wood (0.8) Counties were below the state average. Outreach strategies have placed additional focus on increasing awareness and utilization of HCBS in these counties to reduce reliance on residential services. Events were conducted in Wayne and Wood Counties after being chosen as targeted counties, with venues ranging from social services to community resource meetings. First Choice Services participated in more than 800 outreach

[16] Of calls with a listed county, 2% – 3% were counties OOS and not included with WV county-level information.

events across the state in 2024 and anticipates similar community engagement for 2025. Programmatic leads have met routinely in 2025 to plan outreach strategies and share progress.

Figure 5: CCRL Calls per 1,000 Children Aged 0 – 20 County Population, CY2024



Referral Sources to the CCRL

Referral sources for the CCRL are often unknown; however, most known referral sources include:

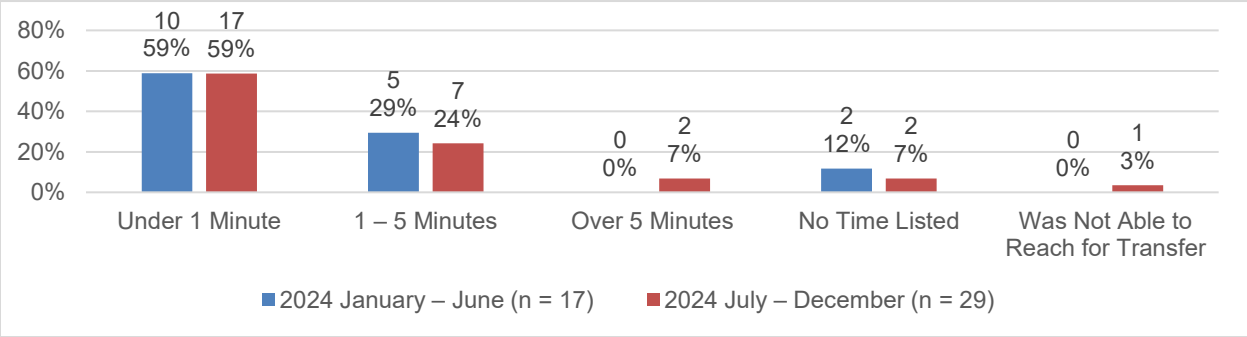
- CCRL website
- Word of mouth from family/friends
- Mental health, medical, or social service professional

Three out of every five calls to the line are made by a loved one, while most of the remaining calls come from professionals or the child themselves (approximately one in five each). Individuals typically contact the CCRL by calling the line; however, 136 callers used the chat or text features in 2024. Understanding the source of a call, use type location, and how individuals learned about the resource can help DoHS and the call-line vendor continue or expand effective

outreach where resources allow. See Section S.3.2 CCRL in the report supplement for specific data regarding caller relation to person in need, call type, and referral source.

Calls reported as "emergency," “crisis,” or “urgent," are documented based on information and family-defined perceptions of a crisis. Families can decide whether mobile response services would be helpful to them. Of callers with a crisis status, 46 received warm transfers to a mobile response unit in CY2024 (Figure 6). More than 80% of transfers occurred within 5 minutes, with three out of five warm transfers occurring in less than 1 minute. Only one transfer in CY2024 was documented as unable to reach mobile response teams, and this was handled through BBH’s standard escalation process. When a CMCRS team cannot be reached, call-line specialists contact regional supervisors or BBH staff directly through a defined escalation process. In addition to these CQI processes, BBH also routinely reviews calls recorded as not being connected to a CMCRS team to help ensure they are escalated at the time and serve as an opportunity to reinforce best practices and protocols with both the CCRL and CMCRS teams.

Figure 6: Timeliness of Warm Transfer Attempt to Mobile Crisis and Stabilization Team of Calls Reported as "Emergency," “Crisis,” or “Urgent" With Transfer Attempt, January to June 2024 vs. July to December 2024



2.4 Intervention: Children’s Mobile Crisis Response and Stabilization

The CCRL can connect children who are experiencing a behavioral health crisis and their families to regional CMCRS services through a warm transfer to the closest regional CMCRS team. Current promotional content emphasizes the connection to crisis services via the CCRL; however, families may also call a CMCRS provider’s crisis line directly. CMCRS services have been available statewide since May 2021. Services were further expanded in January 2024, beyond BBH grant funding and CSED Waiver claims coverage, to include mobile response as a state plan-covered service for all Medicaid-eligible children.

When families use CMCRS services, they determine whether a situation is a crisis from their perspective. The CMCRS team will speak with the child or family member and respond via virtual means or in person in the home, school, or community based on the child’s or family’s preference. The crisis team is expected, on average, to provide on-site support within one hour of the request. After de-escalating the crisis, the CMCRS team completes a crisis plan and links the child or family to appropriate community-based services, including the Assessment Pathway if needed, to help them receive treatment in their home and community and help prevent out-of-

home placement. Children may continue to be enrolled in the service for four to eight weeks after crisis and may utilize additional CMCRS services as needed.

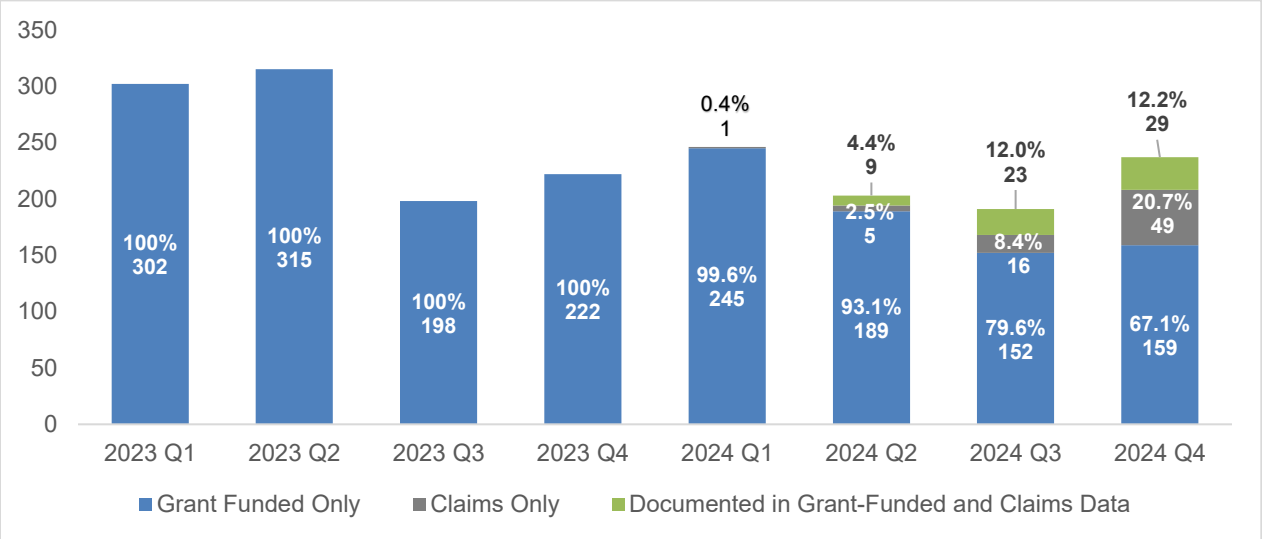
2.4.1 Review Summary

CMCRS utilization trends from grant and Medicaid funding were combined to help understand broader use of CMCRS services across WV. Due to issues with incomplete reporting in the Epi Info system (which collects BBH grant-funded CMCRS data) and the switch to state plan-covered services in early 2024 for Medicaid-funded services, data in this section is considered preliminary.

Figure 7 shows CMCRS utilization from Q1 2023 to Q4 2024 and the proportion of children enrolled by payor source. More than 300 children received CMCRS services via grant funds in both Q1 and Q2 2023. Enrollment decreased to 198 children documented in Q3 2023. Data in this quarter and beyond are considered preliminary and incomplete because some grant-funded providers had difficulty adjusting to the Epi Info System V2, released in Q3 2023, potentially accounting for the decrease in calls. More frequent data reviews, including provider-level reporting, occurred in the last half of 2024 and continued into 2025 to understand potential areas of improvement and leverage feedback opportunities to enhance data completion.

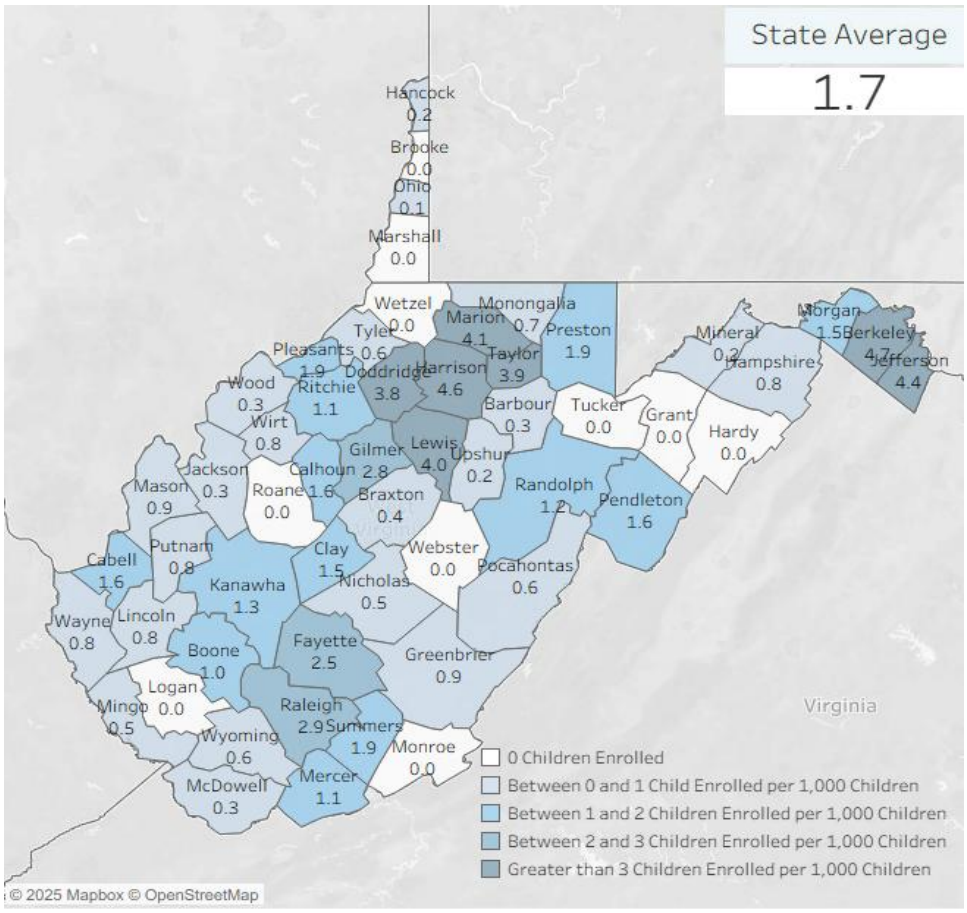
Although the number of children receiving newly implemented state plan services through Medicaid increased over 2024, as new providers were onboarded, the overall number of children utilizing CMCRS has decreased. Only 237 children utilized CMCRS in Q4 2024, including 78 children (33%) served through the Medicaid state plan. The Quality Committee acknowledged the underutilization of this service and plans to expand awareness by collaborating with key stakeholders—such as MCOs, PCPs, the Hospital Association, and the WVDE—to share information about the services and when/how they can be used. Calls to CMCRS will be monitored monthly at the provider level to better understand the drivers for the decrease in overall calls, including addressing any issues related to data completion. County-level data will be shared with providers for additional input and strategic planning.

Figure 7: CMCRS Quarterly Enrollment Totals and Service Utilization, Q1 2023 – Q4 2024



County-level utilization of CMCRS continues to be an important consideration for outreach and capacity building. With the implementation of state plan services, the number of agencies providing mobile response services has expanded from six grant-funded agencies to 12 total agencies providing mobile response across the state. Statewide, approximately two in every 1,000 children in WV received CMCRS in 2024 (Figure 8). County utilization rates varied broadly, identifying needs to raise awareness and potential areas where increased coverage may be helpful. The counties of focus for DoHS, Wood (0.3) and Wayne (0.8), served fewer than one child per 1,000 child population. Increasing utilization of mobile response, resulting in increased stabilization and linkage to other services, could help to decrease out-of-home placements in these counties.

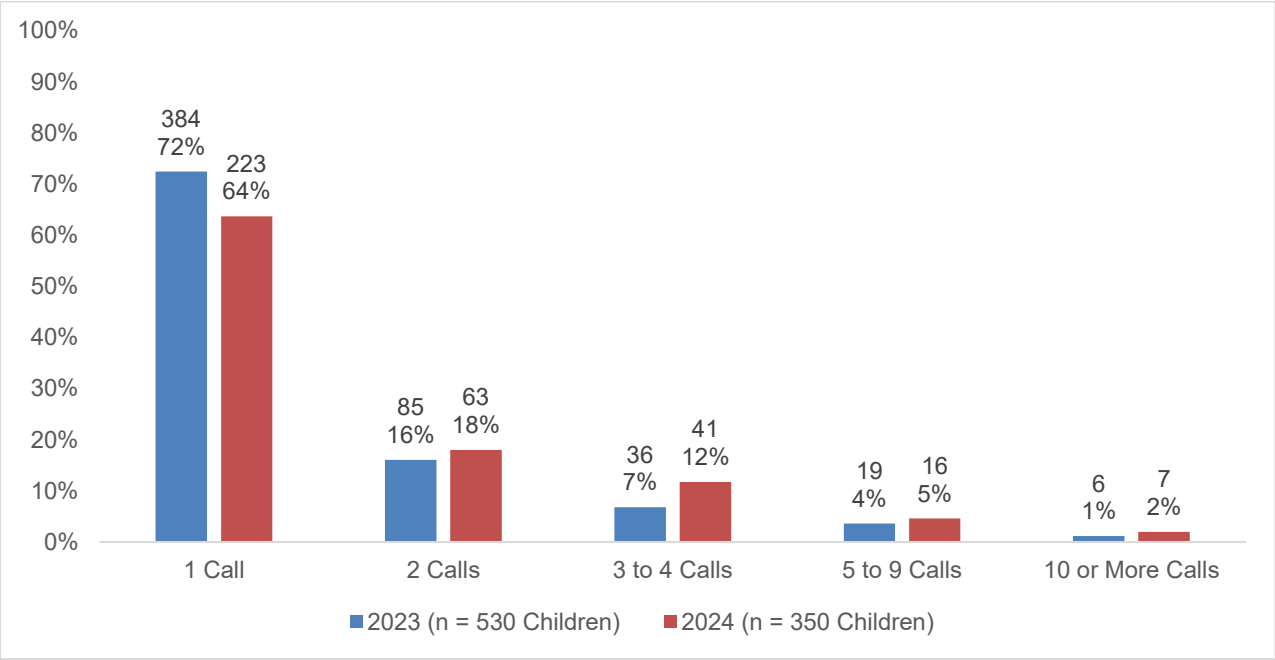
Figure 8: Enrollment Rate in CMCRS per 1000 Child Population by County, CY2024



CMCRS services provide a key opportunity for individuals needing connection to preventative and supportive services, such as Wraparound services. While CMCRS services are designed to provide short-term support, the connections and planning developed during these services are meant to provide the family with longer-term stability when possible. Repeat call data was reviewed to understand call frequency per child. Note: Data completion for children enrolled through grant funding was low, with 39% and 51% of children missing call information in 2023 and 2024, respectively. Figure 9 shows the frequency of repeat call utilization for children with known call information.

There were 875 total calls in CY2023 (1.7 calls per child) compared to 865 calls in CY2024 (2.5 calls per child). The percentage of children with only one CMCRS call dropped from 72% in CY2023 to 64% in CY2024. For the remaining children, additional needs were met through multiple interactions. The reason for the increase in children with more than one call is unclear at this time. DoHS plans to analyze CMCRS referral practices to the Assessment Pathway, with a provider-level analysis and feedback planned for fall 2025. This analysis can be used to help ensure proper referrals to longer-term HCBS are in place to avoid inappropriate use of CMCRS services or the family only using services during a crisis.

Figure 9: Number of CMCRS Crisis Calls Reported per Child Served, CY2023 – CY2024*



***Note:** Excludes provider-initiated follow-ups and children with missing call data (n = 342 and n = 361 youth in 2023 and 2024, respectively).

2.5 Intervention: Referrals to the Assessment Pathway

WV continues to improve access to and quality of mental health services through the implementation of the Assessment Pathway. The Assessment Pathway emphasizes HCBS for children with SED or youth up to age 21 with serious mental illness (SMI).

Because children can access the behavioral health service system via multiple avenues, DoHS has implemented a “no wrong door” approach to the Assessment Pathway, which is designed to:

- Streamline behavioral and mental health referrals and service provision for children and families regardless of the child’s current setting (e.g., biological, foster, adoptive, or kinship home; residential or BJS facility)

- Provide children and families with accurately, timely, and accessible information regarding the availability of HCBS
- Connect children and families to WV Wraparound and other HCBS
- Aid families with the CSED Waiver application process
- Objectively determine the intensity of services that will best fit the child's needs via the QIA process, enabling children with lower acuity to be diverted to the community when their needs can be met in that setting

Instead of requiring families to navigate these behavioral health services themselves, the Assessment Pathway streamlines access points for assessment of children's mental or behavioral health service needs and provides appropriate linkages to services while the assessment process is being completed. The Assessment Pathway also connects families to services when children are transitioning back to their home or community setting after an out-of-home or residential placement.

Children who enter the Assessment Pathway receive interim HCBS to meet interim needs while an assessment is taking place, and families also receive information regarding connection to crisis services. Children are referred to HCBS that are appropriate for their needs, including WV Wraparound services for those who are eligible. PBS and ACT are also part of the HCBS service array available to children. Details on utilization of these services are available in Sections S.3.3 Behavioral Support Services and S.3.4 Assertive Community Treatment (ACT) in the report supplement. Children completing the QIA process will receive further assessment of their treatment needs, including whether a residential treatment or other more integrated setting is clinically appropriate to meet current needs, given the imminent risk. The QIA process is further outlined in Section 6.2 QIA.

2.5.1 Comprehensive WV Wraparound Referrals

The Assessment Pathway offers multiple entry points for families, providers, and advocates to refer children and families to key HCBS, including WV Wraparound. WV Wraparound[17] is an intensive HCBS, often considered a hospital diversion-level service. The Wraparound team primarily identifies needs and connects children and families to resources and services, essentially helping ensure they are "wrapped" in supports needed to improve their outcomes.

Seasonal fluctuations, typically associated with the school calendar, have been observed across several indicators in trend data. As shown in Table 1, Assessment Pathway referrals are typically higher in the first half of the CY. The second half of the CY includes part of summer break and the winter holiday season—when referral activity is often lower. Referrals have been compared with the prior year's same six-month period to help establish a clearer understanding of any changes in referral practices. The largest change in referral volume was seen in the first

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

half of 2024, with a 33% increase in the number of referrals compared to the first half of 2023. Referrals during the second half of 2024 decreased by only 3%, showing very little change in the number of sustained referrals compared to the second half of 2023. At 1,370 referrals from July to December 2024, the pathway averages 228 referrals each month, more than twice the number of admissions to residential facilities as referenced in Section 7.0 RMHTF Services.

Outreach material for WV Wraparound, including information about the CCRL, was distributed to a wide range of audiences in December 2023, which increased referrals in early 2024 by 33% demonstrating the effectiveness of the outreach strategy. The Quality Committee continues to identify strategies to help ensure outreach remains sustainable with available resources. In 2025, the Quality Committee focused on conducting outreach to schools, judges, and focus counties (Wood and Wayne), as well as utilizing vendor resources and outreach to help ensure awareness of the CCRL entryway and the availability of service/support connections for families.

Table 1: Comprehensive Assessment Pathway (WV Wraparound Referrals): Six-Month Period Comparison

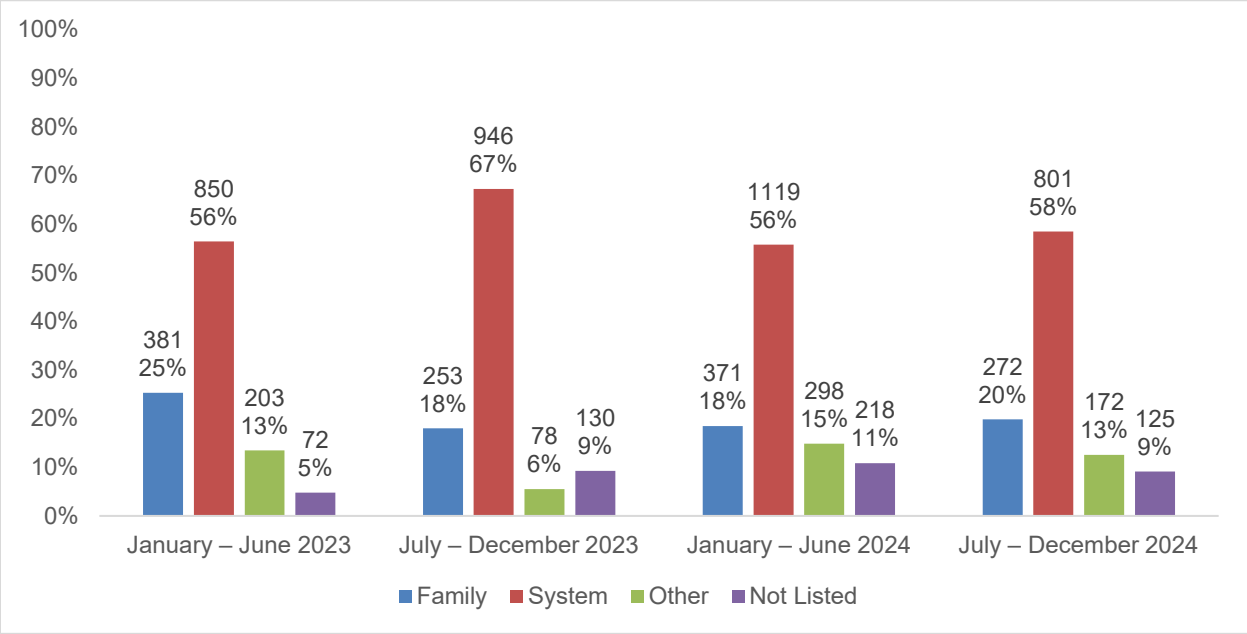
January – June 2023	January – June 2024	Percentage Change – First Half of 2023 Compared to 2024	July – December 2023	July – December 2024	Percentage Change, Second Half of 2023 Compared to 2024
1,506	2,006	33%	1,407	1,370	-3%

Referrals continue to be made in all 55 counties, offering evidence that awareness and referral practices have continued statewide. The Quality Committee has concluded that it is difficult to evaluate county-level referral rates without considering other factors and influences (e.g., need for services, fluctuation in volume that may seem drastic in counties with small populations, awareness, and service availability). Based on a similar recommendation from the Quality Committee in fall 2023, DoHS shifted to a more sophisticated county-level analysis that incorporates Assessment Pathway referrals along with other key indicators, such as RMHTF utilization, to identify high-risk counties for further analysis, action, and outreach. This analysis assisted DoHS's choice of Wood and Wayne Counties for focus based on identified need related to potential underutilization of HCBS and overutilization of RMHTF.

All referrals to the Assessment Pathway offer an important opportunity for a child and family to get connected to key services and supports based on the family's needs. However, family-driven referrals to the pathway are critical to empowering families and helping prevent adverse outcomes, such as the need for a system-level intervention. Additional supports are in place for

family-based referrals via the Assessment Pathway Support Team[18] to give families a consistent person to help them navigate the application and determination process for WV Wraparound and connect them to services to meet more immediate needs. Family-based referrals can originate from the CCRL, MCOs, CMCRS, families, primary care physicians, mental health professionals, school personnel, or regional care coordinators. Family-driven referrals as a percentage of overall referrals have fluctuated over the six-month periods of review: Referrals decreased from 25% to 18% between the two halves of 2023 but have gradually increased, up to 20% in the last half of 2024 (Figure 10).

Figure 10: Aggregate Assessment Pathway Referrals by Six-Month Period, CY2023 – CY2024



DoHS strives to increase family-driven referrals, with the ultimate goal of having these referrals exceed systems-based referrals. The intent of this goal is to shift the overall culture and perceptions in WV to allow more children to receive services in their homes and communities while also supporting parents through challenges associated with SED diagnoses, which could, in turn, help prevent potentially avoidable/undesirable outcomes (e.g., child welfare involvement, probation involvement, or RMHTF placement). Family-driven referral volume is a key indicator that DoHS monitors monthly to understand referral practice fluctuations/impacts of targeted efforts (such as the large-scale outreach initiative in December 2023) and ongoing efforts to help families identify needs and become connected to services in a timely manner.

DoHS took steps to increase connection to resources and supports through the expansion of Family Support Centers (FSCs); as of 2025, there are 57 statewide FSCs. FSCs provide another opportunity for children and families to be connected to the Assessment Pathway or other resources. FSC-offered programs and services are designed to build protective factors,

[18] The Assessment Pathway Support Team includes BBH-contracted regional care coordinators to assist family-based referrals in service connection.

such as parental knowledge, resilience, social connections, and emotional competence while providing concrete support during times of need. FSCs also provide services to families based on the four Temporary Assistance for Needy Families (TANF) purposes. FSC services are not restricted to at-risk families; they are offered to any family in a community who would benefit from the services and programs available.

Additional detail on referral sources and county-level Assessment Pathway referral trends can be found in Section S.3.5 Referrals to the Assessment Pathway in the report supplement. This information is utilized as part of DoHS's internal quality review processes to inform county-level improvement activities and outreach.

2.5.2 Assessment Pathway Timeliness and Eligibility

DoHS remains focused on understanding the overall timeline for children and families to access services, as well as the experiences of families and any barriers they may encounter as part of the process. Details on the overall timeline to services are captured in Section 4.3 Timeline to HCBS Following Referral to the Assessment Pathway. Within the overall timeline to services, DoHS continues to monitor the timeline from receipt of the CSED Waiver application to eligibility determination for children who complete the eligibility determination process (Figure 11). As part of data quality improvement efforts, CSED Waiver application data collection and reporting were transitioned to Acentra's Atrezzo system in November 2024. This transition included resolving a significant number of pending applications, some of which had been outstanding for long periods of time. As a result, a refresh of the eligibility determination data shows average timelines skewing higher compared to data for the same periods captured in prior DoHS Quality and Outcomes reports. Nonetheless, median timelines remained within the required contract timelines (45 days) throughout CYs 2023 and 2024. The timeline to eligibility determination depends on the family's responsiveness and their availability to participate in the assessment process, including completing required program documents. Additionally, the Quality Committee noted an important caveat: These timelines may significantly vary, such as when there is a closure early in the process versus the completion of full eligibility determination.

Figure 11: Timeline From CSED Waiver Application to Eligibility Determination by Quarter, CY2023 to CY2024

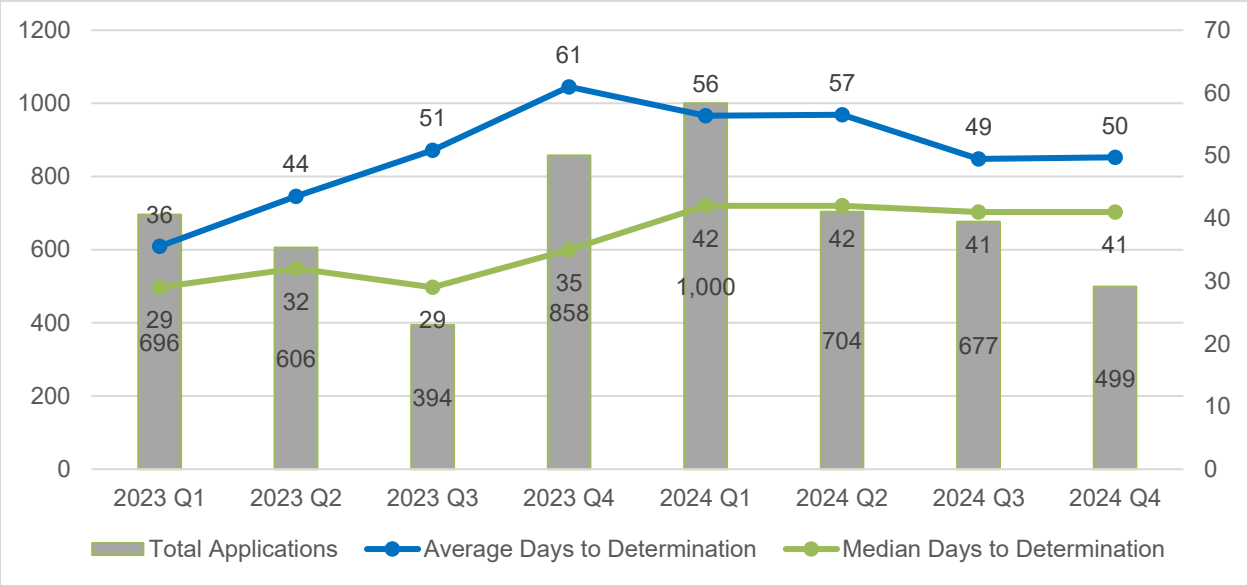


Table 2 below compares application status for the six-month periods for CYs 2023 and 2024. The total number of CSED applications processed has remained fairly consistent, excluding the first half of 2024, which followed focused outreach regarding Wraparound services in late 2023. Given the known positive outcomes associated with CSED Waiver services, as shown in Section 4.0 System Engagement and Outcomes, DoHS remains concerned about the relatively high percentage of applications closed prior to completion.

Closed applications decreased in the second half of 2024 to 33%, following higher closures in the second half of 2023 (49%) and during the first half of 2024 (44%). Higher rates of closures may in part be associated with the cleanup of CSED Waiver pending application data. DoHS completed a detailed analysis of closed applications to investigate how far into the application process children got before their application was closed. Results of this detailed analysis can be found in Section 4.3 Timeline to HCBS Following Referral to the Assessment Pathway. DoHS recognizes that children whose applications are closed have a reduced opportunity to connect easily to high-intensity HCBS, so DoHS remains focused on identifying steps to reduce the number of closures and better support families with completing the process while recognizing family preferences and needs.

Collecting closure reasons and identifying the closure requestor were added to Acentra's CSED Waiver application data collection in Atrezzo effective November 2024. Analysis of this data, which is planned for the second half of 2025, will provide additional insight into the factors impacting application closures.

Approval rates have increased slightly over the last 18 months, with 42% – 47% of applications being approved. Denials increased to their highest level (15%) in the second half of 2024, which may be due to an increased number of applications during this period. Children denied eligibility for services are offered other available mental health service options.

Table 2: CSED Waiver Application[19] Status Across Six-Month Periods, CY2023 to CY2024

Status	January – June 2023		July – December 2023		January – June 2024		July – December 2024	
	n	%	n	%	n	%	n	%
Approved	855	65.1%	542	42.1%	755	43.4%	600	47.3%
Closed	391	29.8%	630	49.0%	762	43.8%	422	33.3%
Denied	64	4.9%	98	7.6%	200	11.5%	190	15.0%
Pending*	3	0.2%	16	1.2%	24	1.4%	57	4.5%
Total	**1,313**	**100.0%**	**1,286**	**100.0%**	**1,741**	**100.0%**	**1,269**	**100.0%**

***Note**: Multiple pending cases were still being resolved at the time this data was pulled. Cases showing as pending for 2023 and 2024 have since been resolved. According to the report by Acentra, some cases can remain open for an extended period at the request of families.

CAFAS/Preschool and Early Childhood Functional Assessment Scale (PECFAS) scores for children navigating the CSED Waiver eligibility process are shown in Table 3. For children with scores reported, the percentage of those with scores below 90 decreased throughout 2024. Scores greater than 90 increased, specifically scores of 170 and higher (to an all-time high of 16.3%), which potentially indicates increasing acuity levels of children in need of services. Referral to the Assessment Pathway continues to be an opportunity to provide families with information on available resources and connect children with other services even if they do not qualify for or choose to specifically take advantage of CSED Waiver services.

Table 3: CAFAS/PECFAS Scores for CSED Waiver Applicants,[20] CY2023 to CY2024

CAFAS/PECFAS Score Range	January – June 2023		July – December 2023		January – June 2024		July – December 2024	
	n	%	n	%	n	%	n	%
0 – 80	92	8.2%	82	9.9%	79	6.3%	39	4.1%
90 – 120	429	38.0%	325	39.2%	531	42.2%	375	39.5%
130 – 160	453	40.2%	309	37.2%	450	35.7%	381	40.1%
170+	154	13.7%	114	13.7%	199	15.8%	155	16.3%
No Score Reported	185	--	456	--	482	--	319	--
Total	**1,313**	**100%**	**1,286**	**100%**	**1,741**	**100%**	**1,269**	**100%**

[19] This figure is only inclusive of applications to the CSED Waiver, some families referred to the comprehensive Assessment Pathway do not go on to apply to CSED Waiver.

[20] This figure only includes applications to the CSED Waiver; some families referred to the comprehensive Assessment Pathway do not go on to apply to CSED Waiver. Percentages shown in the table exclude individuals with no score reported.

2.6 Key Themes and Next Steps – Intervention Opportunities

The CCRL continues to be an important entry point for the Assessment Pathway, as well as a medium to access crisis services, especially for family-based referrals. First Choice Services, the CCRL provider, monitors call loads and weekly/seasonal trends to help ensure adequate coverage to meet family and child needs, including use of the CCRL's sister line, 988, which has increased in volume over the past few years. First Choice Services can train its staff to help with appropriate connections and referrals regardless of which line is used. The centralized call-line staff help individuals quickly connect with behavioral health services and can divert inappropriate use of emergency rooms and 911 calls. Call-line data will continue to be reviewed routinely to identify additional outreach opportunities for families across the state, provide technical assistance to call-line staff and the teams they refer to (as needed), and improve call and referral quality, including review of calls unable to be transferred in a timely manner.

First Choice Services and BBH will continue conducting outreach to target counties—as well as more general statewide outreach—to help increase the number of families aware of the CCRL and, ultimately, increase the proportion of family-based Assessment Pathway referrals (thus helping to prevent systems involvement where possible).

Statewide CMCRS coverage creates an opportunity to offer crisis relief and plans for stability to support families and children in need, helping prevent unnecessary placements for mental health treatment. Most children enrolled in CMCRS can be stabilized during one call, with follow-up and referrals to longer-term services provided. Appropriate referral practices will be analyzed and reinforced through provider-level review. Awareness of CMCRS services is critical for increased utilization and improving outcomes. The Quality Committee noted the importance of helping families and stakeholders understand that a "crisis" is defined by the family and that reassurance may be needed when a child seems to need CMCRS.

DoHS is implementing and exploring additional opportunities to spread awareness of the CCRL, which includes connection to CMCRS. Outreach in 2025 has included educating school counselors and schools with Expanded School Mental Health (ESMH) programs on the CCRL. Next steps include disseminating informational materials to the boards of education in all 55 counties, as well as reaching out to other key access points, such as EDs, the WV Hospital Association, and PCPs. Vendors and providers also conduct local and regional outreach to build awareness (e.g., at school open house events). CQI processes will continue to be leveraged to drive targeted outreach.

Overall referrals to the Assessment Pathway remain steady, with all counties continuing to make referrals to support children and families to be assessed and connected to services when needed. Improvements in the rate of children receiving mental health screenings during wellness visits expand opportunities for early connection, including increasing family-driven referrals. This continues to be a primary focus to help ensure early intervention, prior to systems involvement, to connect children and families to HCBS and support diversion efforts. The expansion of FSCs—totaling 57 statewide as of 2025—has created another opportunity for children and families to be connected to the Assessment Pathway or other resources. FSCs are designed to connect families to a range of supports and services across the state. BJS and

Probation Services continue to partner with DoHS to screen their systems-involved youth and refer to the Assessment Pathway when appropriate. DoHS remains focused on helping children complete the determination process, including identifying steps to reduce the number of closures and better support families completing the process while simultaneously recognizing the overarching importance of family choice. Next steps include identifying and addressing steps in the process that can be streamlined to decrease burden on individuals making referrals.

3.0 WV Wraparound Services

WV offers Wraparound to children with SED or SMI through the Assessment Pathway as described in Section 2.5 Intervention: Referrals to the Assessment Pathway. WV Wraparound provides supports to "wrap" around the child and family to help them be successful in the home and community and avoid out-of-home placement. Common services include family therapy and in-home support. WV Wraparound is funded through three sources. To maintain consistency, trust, and rapport, children and families may choose to keep the same Wraparound Facilitator when transitioning between funding sources.

- **CSED Waiver Services:** DoHS implemented the CSED Waiver effective March 1, 2020, as the primary means to help ensure Wraparound services are available for children with SED. CSED Waiver services are funded through a federal match, significantly expanding funding resources and sustainability of Wraparound services. The five-year waiver renewal, approved in early 2023, extended waiver services through January 2028. The CSED Waiver provides additional services[21] to Medicaid state plan coverage for members aged 3 to 20 who meet eligibility criteria. CSED Waiver Wraparound service use is encouraged for children who meet eligibility criteria to best utilize WV's available resources, including federal matching funds. WV is the only state in the nation to include the 217-Medicaid eligibility group in the CSED Waiver, which helps remove financial barriers to access HCBS if the applicant meets medical eligibility for the waiver. This expansion allows children who would not typically be eligible for Medicaid services to receive the necessary support to help them remain successful in their home and community.
- **BSS' Safe at Home (SAH) WV Program and BBH CMHW:** Wraparound services are also offered through the BSS SAH WV program and the BBH CMHW to provide Wraparound services while children are undergoing the CSED Waiver eligibility determination process and to meet the needs of children who may not qualify for CSED Waiver services.

Regardless of the funding source, WV Wraparound can help connect children and families to an array of HCBS that enable children who may otherwise require institutionalization to remain in their homes and communities. WV Wraparound services are available statewide, and children have been served in all of WV's 55 counties.

[21] The CSED Waiver offers the following institutional level of care services: Wraparound Facilitation, In-Home Family Support, Family Therapy, In- and Out-of-Home Respite, Independent Living/Skills Building, Job Development, Individual Supportive Employment, Assistive Equipment, Community Transition, Peer Parent Support, Non-Medical Transportation, and Specialized Therapy. Prior to February 2024, Mobile Response services were also offered as part of the CSED Waiver service array. These services were added to DoHS's state plan in February 2024 and were therefore removed from the CSED Waiver.

The agencies funding Wraparound services strive to:

- Help children and families thrive in their homes, schools, and communities
- Implement a seamless system of care that includes statewide Wraparound services available through a “no wrong door” approach
- Provide consistently trained Wraparound Facilitators and high-fidelity Wraparound services consistent with the National Wraparound Initiative (NWI) model
- Reduce the number of children removed from their homes due to SED or SMI
- Improve quality of life as evidenced in school, living situations, interpersonal relationships, and employment stability

DoHS continues efforts to improve the quality and fidelity of WV Wraparound services. Highlights include the following:

- Per the 2024 MU Wraparound Fidelity Report recommendation, DoHS hired a statewide Wraparound coordinator in September 2024. This coordinator was tasked with helping align Wraparound funding sources, monitoring, and reporting on progress toward fidelity, and identifying needs and next steps to improve service delivery with Wraparound providers, DoHS Wraparound program leadership, and external Wraparound subject matter experts.
- DoHS updated Wraparound programmatic and policy documents across the applicable bureaus in 2024 to incorporate key elements from the Document Assessment Review Tool (DART). This was an effort to help ensure these documents provide guidance that leads to the provision of high-fidelity Wraparound. The DART is the tool used by MU to complete reviews that lead to the recommendations captured in the fidelity report and is recognized as a standard fidelity tool by the NWI.
- MU completes fidelity reviews annually to provide input to the extent to which Wraparound services are being implemented to fidelity.
    - MU established a Fidelity Team in 2025 to provide continuous, targeted feedback to Wraparound providers. A Transformational Collaborative Outcomes Management and Fidelity Expert is assigned to each agency to support reaching high fidelity.
- A Wraparound Fidelity and Child and Adolescent Needs and Strengths (CANS) Performance Improvement Project (PIP) team meets regularly to discuss progress on the implementation of prioritized recommendations from the annual fidelity report and also to review DoHS-produced key indicator trends to advance quality improvement efforts for Wraparound services.
- Wraparound Facilitators and supervisors are required to participate in training on the Wraparound process, including leading the child and family team. These trainings are

offered to Wraparound providers on a recurring basis through DoHS's contract with the University of Connecticut.

Given the sustained demand for WV Wraparound services, DoHS and its partners have taken steps to continue to manage available capacity and expand service providers as follows:

- CSED Waiver services were further expanded through the addition of CCBHCs, which were established in WV effective October 2024. All CCBHC providers in WV must provide CSED Waiver services.
- The number of CSED Waiver service providers expanded in all 55 counties between March 2024 and December 2024 (see Section S.4 WV Wraparound Services in the report supplement for more details).
- Effective October 2024, CSED Waiver Wraparound services transitioned to a per member, per month payment rate structure. Two service levels, high and moderate, were implemented to provide comprehensive support and coordination to address the complex needs of each member more effectively.
- Provider- and record-level reporting in the CANS automated system on CANS timeliness and length of service for children enrolled in Wraparound were operationalized in August 2025 to streamline data access, support data quality checks, and facilitate improved case management.

DoHS maintains ongoing efforts and outreach to raise awareness of the Assessment Pathway and connection to WV Wraparound services. Enhanced information is now included on the WV Children Thrive Collaborative website. Postcards highlighting WV Wraparound and the CCRL, including a QR code linking to the Kids Thrive Collaborative website for how-to information, were mailed to all school administrators in August 2025 for distribution to families. Additionally, an information sheet (i.e., bench card) was developed for court system representatives to increase awareness of Wraparound services and to guide the courts on how they can best support linking families to these resources. DoHS intends to present this information sheet to legal system stakeholders in fall 2025 lunch-and-learn sessions.

DoHS representatives recently delivered formal presentations related to the Assessment Pathway, WV Wraparound, and DoHS CQI practices to inform these processes and services at the following conferences:

- EveryChild NOW Conference, February 2025
- WV School Counselor Association Conference, March 2025
- All In Foster Care Summit, May 2025
- UConn Conference: Building a World Where Young People Thrive, July 2025

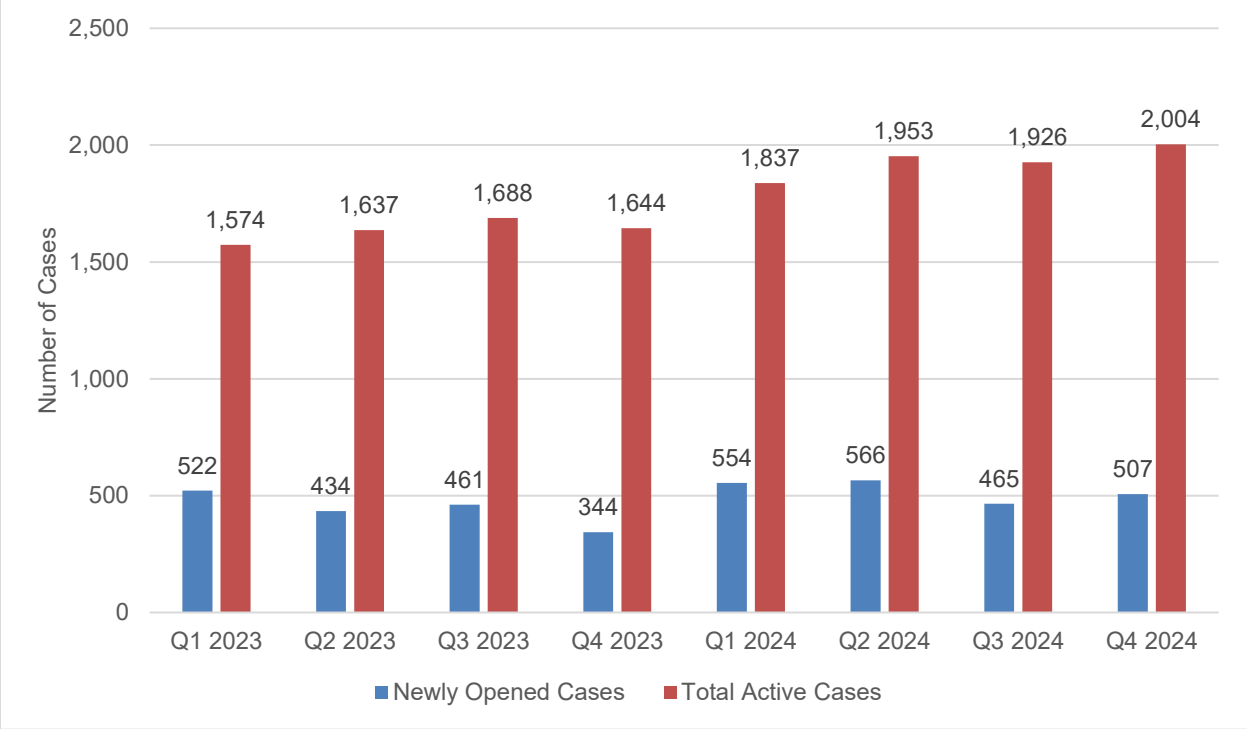
Connections have been made with educators, counselors, and social workers, all of whom have regular opportunities to engage with children and families and share information on resources and connection to services.

3.1 Review Summary

Aggregate WV Wraparound

Statewide utilization of WV Wraparound services has continued to expand with active cases, increasing 27% from 1,574 children in Q1 2023 to 2,004 children in Q4 2024. The ongoing demand for Wraparound services maintains a steady, slight increase across most quarters, with a year-over-year 18% increase in newly opened case totals (2,092 cases in 2024 compared to 1,761 cases in 2023) (Figure 12).

Figure 12: Statewide Aggregate Wraparound Active and Newly Opened Cases by Quarter, Q1 2023 – Q4 2024 (Data as of July 31, 2025)

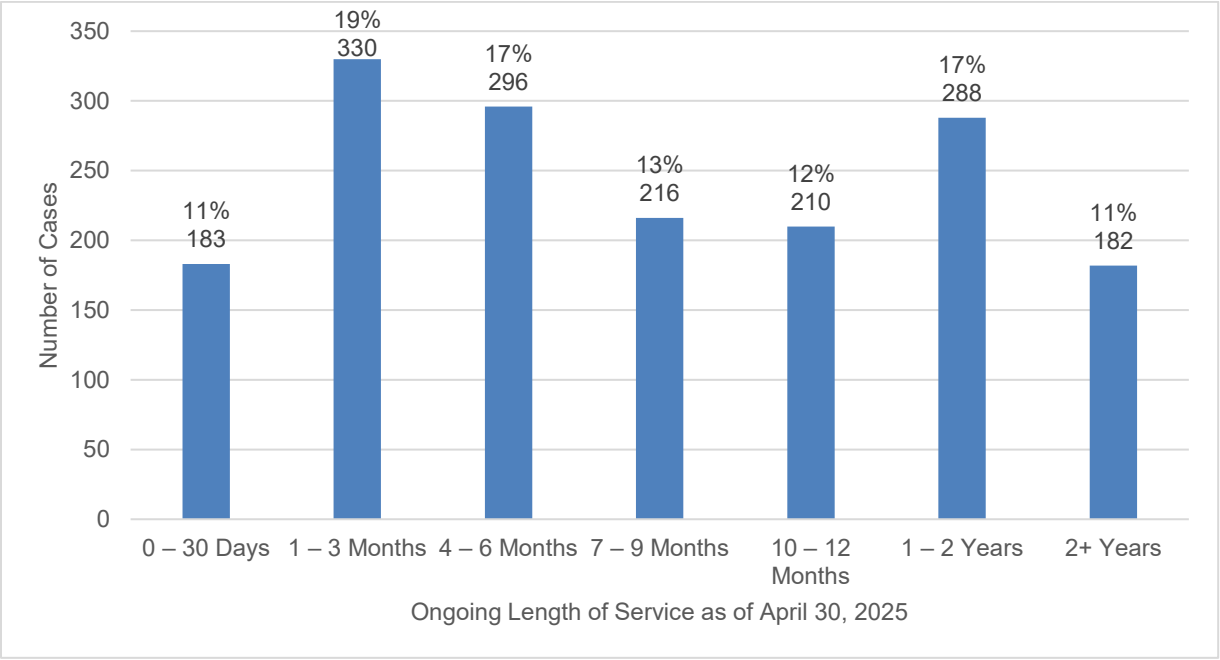


Given the sustained demand for Wraparound services and the potential for staffing capacity challenges with growing demand, Wraparound program leaders have begun reviewing length-of-service data for children in Wraparound services. Although services are always individualized to child and family needs, typical Wraparound length of service is expected to be, on average, no longer than 18 months.[22] Wraparound training cites services are expected to generally average between nine and 12 months. Results of the Wraparound length of service analyses for active cases in the CANS automated system showed that 11% of cases (n = 182) have been active for over two years, with an additional 17% (n = 288) active one to two years (Figure 13). In total, as many as 28% of cases may potentially be using Wraparound services beyond what is expected.

[22] According to national data per the University of Connecticut National Training Institutes for Social Work.

The new provider-level reports made available in the CANS automated system will help DoHS and providers identify cases that may warrant further review to determine whether a child is ready to transition to less intensive services, subsequently freeing up capacity for additional children to access services. This initiative was recently identified by Wraparound program leadership as an opportunity to increase additional Wraparound capacity to serve other children in need, when appropriate. As part of this effort, Wraparound program teams are collaborating closely with providers to help ensure cases in the CANS automated system are closed when a child has completed services. This continued focus on improving data accuracy will support capacity and caseload management efforts, enabling more children to receive these essential services.

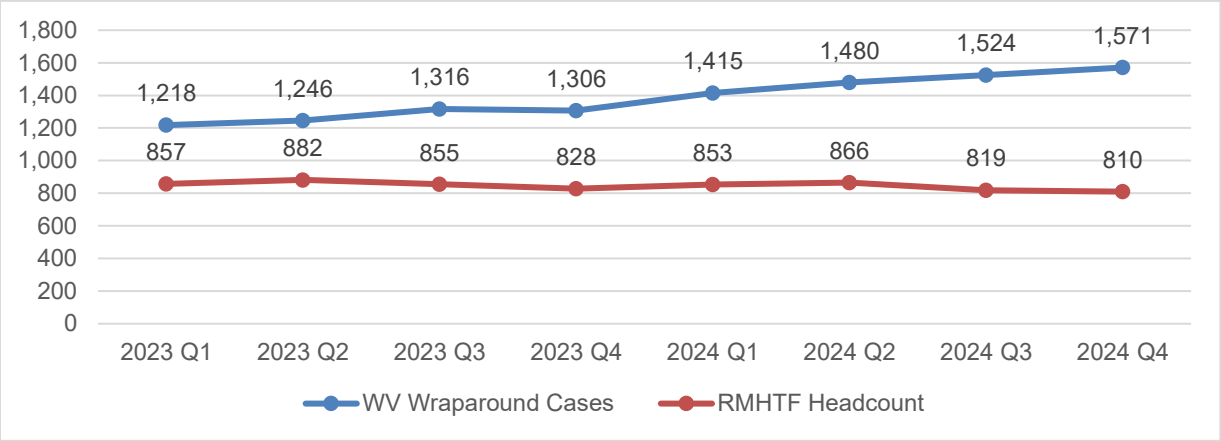
Figure 13: Wraparound Length of Service for Active Cases as of April 30, 2025



MU is also continuing to support Wraparound provider agencies with caseload management through a Wraparound Facilitator caseload and capacity tracking tool. This tool considers provider-specific details, including Wraparound Facilitator full-time equivalency (FTE) status, as well as the intensity of the child's needs by incorporating child-level CANS results. Information from this tool is used in individual discussions with providers to support facilitator capacity management and fidelity efforts.

As indicated in Figure 14, the number of children accessing Wraparound services at any point in time is now nearly double the number of children in residential treatment for the same point in time. This is a positive result of continued efforts to increase access and utilization of high-intensity services such as WV Wraparound.

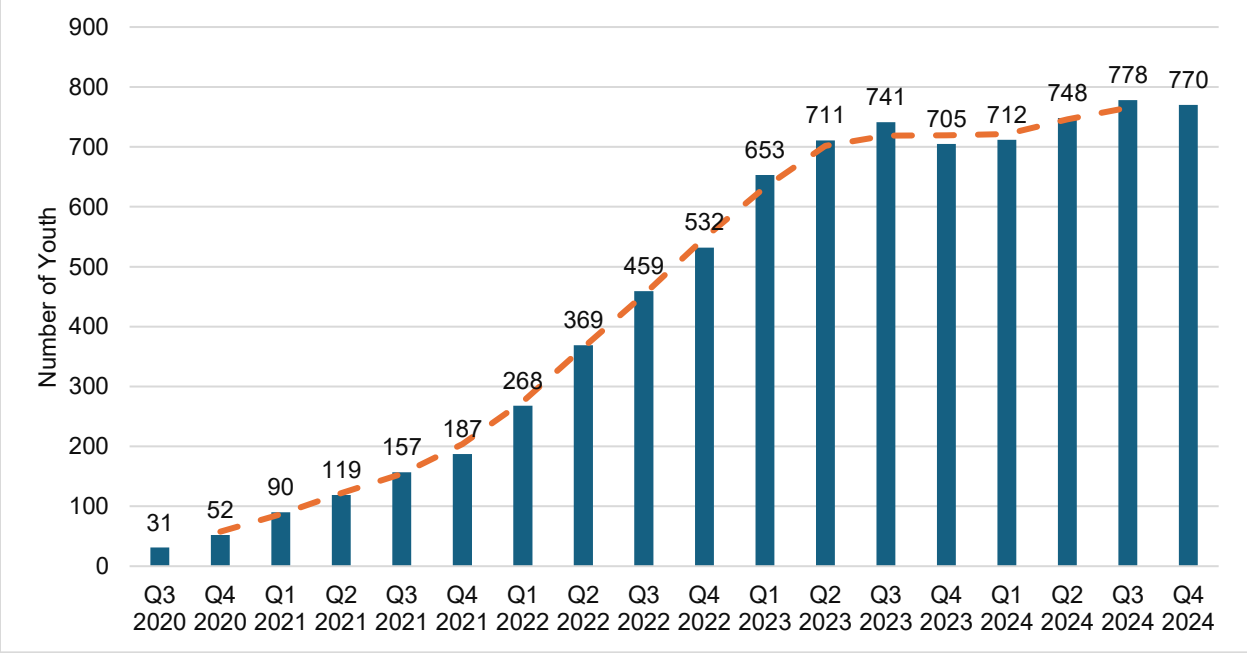
Figure 14:[23] Wraparound End-of-Quarter Point-in-Time Active Cases Compared to End-of-Quarter Residential Census, Q1 2023 to Q2 2024



CSED Waiver Service Utilization

The number of children accessing CSED Waiver services has continued to increase since the CSED Waiver's implementation in March 2020, with some leveling since Q3 2023 (Figure 15). While the growth rate has moderated as expected for five years following the implementation of the waiver, more children continue to be supported in the community with these critical services.

Figure 15: Unique Youth CSED Waiver Service Utilization (Excluding Independent Evaluations), Waiver Inception Through Q2 2025)



[23] Data pulled from People's Access to Help (PATH) as of April 15, 2025, from EDS as of March, 31, 2025, and CANS as of July 31, 2025.

Aetna manages prior authorizations, service utilization, care coordination, and the provider network for CSED services. Aetna conducts reviews of all enrolled members to help ensure the members' plan of care addresses all identified goals and needs. Periodic reviews of members' claim history are conducted to help ensure all services outlined in their care plan are being delivered as well as to provide an opportunity to address any barriers, including capacity issues impacting services. These existing processes will be further enhanced and incorporated into DoHS's overall quality sampling review processes in 2026 to continue gaining more insight into each child's and family's experience with the service system.

Other utilization monitoring efforts include ongoing program trainings, learning sessions, and monthly policy and billing spotlight meetings with providers, which were initiated in early 2023. Meetings with individual providers to review utilization and billing trends were also initiated in 2023. During follow-up meetings with individual providers, any changes in utilization and billing trends are reviewed and discussed.

Additional details on CSED Waiver services utilization by service type are captured in Section S.4 WV Wraparound Services in the report supplement. Consistent with prior periods, the services with highest utilization include Wraparound Facilitation, Family Therapy, and Family Support. Only about 10% of children and families access respite services. Based on feedback from the CMHE, families desire more respite services; however, DoHS acknowledges the challenges of providing respite services[24] based on provider feedback and is coordinating with providers successfully offering this service to identify strategies that can be expanded across the network.

CSED Waiver service utilization is also reviewed at the county level. Results of county-level service utilization comparing the first and second halves of 2024 can be found in Section S.4 WV Wraparound Services in the report supplement.

Improved Outcomes (Functional Abilities) for Children Accessing Wraparound

Improvements in functional ability were noted in the most recent Wraparound Fidelity Report published in July 2025 by MU.[25] The DART is the tool used by MU to complete reviews and is a recognized fidelity tool by the NWI. An additional component of the evaluation for Wraparound services is the use of the Wraparound Fidelity Index Short Form (WFI-EZ) tool, which is used to gain perspectives of caregivers, children, and Wraparound Facilitators on services provided. Of families completing the WFI-EZ survey, 97% (n = 178) reported high satisfaction with Wraparound services. Fidelity categories were assessed on a scale indicating whether Wraparound services were meeting high fidelity for a given benchmark indicator. Categories to assess the program's progress to achieve high fidelity, in order from greatest to least, are as follows: (1) high fidelity, (2) adequate, (3) borderline, or (4) inadequate. As shown in Table 4, overall fidelity improved—a very positive finding demonstrating efficacy of focused efforts in

[24] For clarity, to avoid service duplication, children in foster care are not eligible for CSED respite services. These services are provided via CPAs, which provide services and supports for foster families.

[25] The report can be accessed at the following link: https://kidsthrive.wv.gov/Documents/2025 Wraparound Fidelity Report - Final 7.14.25.pdf

improving Wraparound services in WV. All subcategories had score improvements noted since the fidelity review published in 2023. The area with the most significant need for improvement identified was natural community support, which received a borderline score. High fidelity was demonstrated in the outcomes-based indicator, supporting marked improvement in the lives of children and families using Wraparound.

Table 4: Fidelity Benchmark Indicators, 2023 Fidelity Review vs. 2025 Fidelity Review

	Overall Fidelity	Effective Teamwork	Natural Community Support	Needs Based	Outcomes Based	Strength Family-Driven
2023 Report	Adequate	Adequate	Borderline	Borderline	High Fidelity	Adequate
	71	65	62	73	75	81
2025 Report	Adequate	Adequate	Borderline	Adequate	High Fidelity	Adequate
	74	67	63	78	79	84
Reference: Score Needed for High Fidelity	75+	70+	70+	80+	75+	85+

Table 5 shows specific areas where functional improvement occurred; the rate of children with a positive outcome improved in every outcome subcategory from 2023 to 2025, except for slight decreases in the percentage of children with no arrests or probation interactions. Outcomes were reviewed for cases with at least six months of Wraparound services. As previously described, through collaboration with the National Wraparound Implementation Center (NWIC), providers, and MU, DoHS is taking steps to sustain positive outcomes and address ongoing needs to achieve high-fidelity service provision.

Table 5: Fidelity Review Outcomes Results – Comparison of 2025 to 2023

Indicator	Improvement?	2025	2023
Stable living situation	↑	85% (n = 97)	72% (n = 116)
No ER or hospitalization	↑	85% (n = 97)	71% (n = 114)
Reduced mental health symptoms*	↑	76% (n = 88)	46% (n = 68)
Improved interpersonal functioning*	↑	70% (n = 72)	54% (n = 69)
Improved school attendance	↑	85% (n = 88)	45% (n = 63)
Improved School functioning*	↑	62% (n = 65)	47% (n = 62)
No arrests or probation violations	↓	72% (n = 51)	80% (n = 77)

*Indicates a combination of “partially met” and “fully met” categories

3.2 Key Themes and Next Steps – WV Wraparound

Demand for WV Wraparound services has sustained, with the overall number of children accessing Wraparound continuing to increase. A year-over-year increase in newly opened Wraparound cases totaling 18% was observed, with 2,092 new cases in 2024 compared to 1,761 new cases in 2023. Given this demand, capacity expansion and management efforts continue.

Although services are always individualized to child and family needs, as many as 28% of cases may potentially be using Wraparound services longer than expected per evidence-based practice. Wraparound program teams are working closely with providers using new provider-level reports in the CANS automated system to support capacity and caseload management efforts, allowing the opportunity for more children to receive these essential services and helping ensure that children receive Wraparound for a clinically appropriate amount of time.

DoHS continues to be highly focused on the child and family journey through the Assessment Pathway and subsequent connection to Wraparound services, with the goals of understanding any barriers and facilitating increased connection to these critical services in partnership with Acentra Aetna, and Wraparound providers. Details on key findings and next steps are included in Section 4.0 System Engagement and Outcomes.

Outreach to raise and maintain awareness of Wraparound services will be recurring, with specific focus on school and court system representatives.

4.0 System Engagement and Outcomes

Children with SED and their families may have a range of needs and circumstances that impact their ability to engage in the services and supports that could be most helpful to them. The Quality Committee has often acknowledged both the importance of family voice and choice in the service engagement process and gaining buy-in with families and stakeholders in order to maintain rapport and build trust. Rapport and trust were identified as key facilitators for families interviewed through the CMHE.

In CY2024, DoHS further evolved its CQI strategy to better understand key interactions and outcomes by focusing analyses on key populations, systems engagement at various intervention points, and related outcomes. Through review processes, DoHS has been able to assess whether systemic needs are being met by determining whether the system is reaching the “right children” with the “right services” at the “right time” and with the “right amount” of intervention. DoHS conducted a series of in-depth analyses throughout 2024 and 2025 to investigate these questions.

4.1 Exploring the Child-Level Journey

In August 2024, the Quality Committee reviewed information for subpopulations of children with SED in CY2023, including children who meet at-risk criteria, children who have accessed crisis services, children who use WV Wraparound, and children who were approved through the Assessment Pathway. The Quality Committee reviewed the percentage of children within these and other subpopulations with certain interaction points (e.g., ED utilization, wellness visits, HCBS utilization) as well as residential placements to understand intervention points and outcomes.

The Quality Committee observed key differences between service utilization and subpopulations, such as lower rates of residential admission for children utilizing Wraparound services for at least three months compared to other children of similar acuity of need. This analysis also showed only 46% of children approved for CSED Waiver services went on to utilize Wraparound services from any payor source. The Quality Committee considered the possibility that families may not understand and/or may not want the intensity of CSED services. To investigate factors related to service utilization and outcomes, the group agreed to assess and better understand factors influencing families whose children qualify for CSED services but do not go on to access those services.

By way of follow-up, a chart review was conducted for children approved (meeting eligibility criteria) for CSED Waiver services but not accessing Wraparound. A total of 30 charts, 15 systems-based referrals, and 15 family-based referrals (as previously defined in Section 2.5.1 Comprehensive WV Wraparound Referrals) were selected at random to determine the root cause for lack of engagement in services.

Key findings and themes from the chart review included:

- FOC[26] documentation, which is the final piece of documentation required to select a provider and start CSED Waiver services, was not completed for 80% of children's referrals sampled (n = 24).
    - Most referrals without FOC documentation in place were systems-based referrals (71%, n = 17) and/or for children age 13 or older (63%, n = 15).
    - Only 29% (n = 7) of children without an FOC directly declined services.
    - Information on FOC findings was shared with Aetna to help meet family's needs and further expand creativity in contacting attempts and leveraging mental health provider relationships to help families connect to services more quickly, thereby, avoiding barriers.
- Some children were placed in residential settings before they could engage in Wraparound services, emphasizing the importance of identifying needs and making connections earlier.
    - Wraparound services were not initiated following discharge from residential treatment for children who were in residential placement (n = 8) at the time of or following determination despite being approved for WV Wraparound.
    - As reported in the July 2024 edition of this report, the readmission rate from residential for children discharging in the last half of 2022[27] was 43%. Additional information on the in-depth readmission and post-discharge service utilization analysis for children discharging in 2023 from residential treatment can be found in Section 7.0 RMHTF Services. Following the review, a workgroup was established in January 2025 to address aftercare needs systematically.

In May and August 2025, additional elements were added to the OQA data store, helping streamline analyses and enabling more timely/broad outcomes and timeline to services analyses for key populations. To expand on previous analyses, focus was placed on analyzing children in the Assessment Pathway to allow opportunities to equate acuity of need and identify a key starting point for children in need of services.

4.2 Connection to HCBS Following Referral to the Assessment Pathway

The Assessment Pathway is designed to provide a straightforward and supportive avenue for families to determine the intensity of their child's needs and connect them with appropriate services to best support the child and family. DoHS reviewed a cohort of children who had

[26] The FOC form is required by CMS and helps ensure families have the opportunity to choose services and providers on a completely voluntary basis.

[27] Children discharged from an RMHTF in July to December 2022 (n = 390)—excluding youth aged 17 years and up at discharge—to determine if they were readmitted within 12 months following discharge.

referrals to the Assessment Pathway in January to June 2024 to analyze their journey through the pathway and timeline to services. Children in BJS or RMHTF custody at the time of determination, or children on hold[28] at any point between determination and start of first service, were excluded from this analysis to remove factors related to time frame to discharge that could vary significantly based on the child's needs.

The information below summarizes key findings associated with 1,449 children with a CSED Waiver application via the Assessment Pathway submitted between January and June 2024:

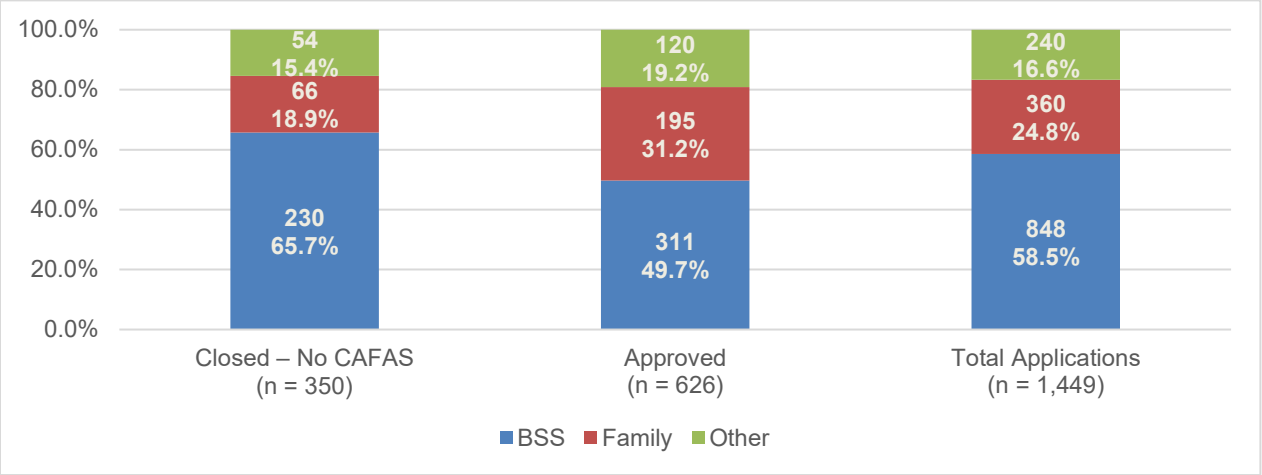
- A total of 41% of applications were closed (n = 597).
    - Nearly three out of five of the closures (59%, n = 350) did not have a CAFAS completed before being closed, meaning initial assessment was not completed, thus reducing the opportunity for service connection.
    - Applications originating from the child welfare system (within BSS) were more likely to be closed compared to referrals from other sources. Applications from the child welfare system represented 59% of total applications but 66% of closed applications (Figure 16).
- A total of 43% of applications were approved (n = 626).
    - Of approved applications, 51% went on to receive Wraparound services.
- A total of 12% of applications were denied due to not meeting eligibility criteria, with the remaining 4% considered pending for final determination.[29]

Review of processes in the Assessment Pathway and related referral systems identified complexities (e.g., multiple forms and connection points for child welfare workers, multiple people needing to engage for children with BSS) that likely contributed to the high rate of closure for applications with child welfare as the referral source. DoHS is taking steps to collaborate with vendors and child welfare workers, where possible, to identify ways to streamline processes, help meet needs, and identify and eliminate redundancies. To date, this has included materials and education for workers to use with families to help them understand what to expect in the Assessment Pathway process and what their role will be.

[28] "On hold" refers to the inability to participate in services due to various reasons such as parent request or in RMHTF or BJS custody. When a case is put on hold, case assignment to a provider is not pursued until the child is available to begin services.

[29] As part of data quality improvement efforts, CSED Waiver application data collection converted to Acentra's Atrezzo system in November 2024. This transition included resolving pending applications. Some cases can remain open for an extended period at the request of families. Pending cases for the January – July 2024 time period were resolved following completion of this analysis. Pending case status will continue to be monitored and resolved as part of data quality and completion efforts.

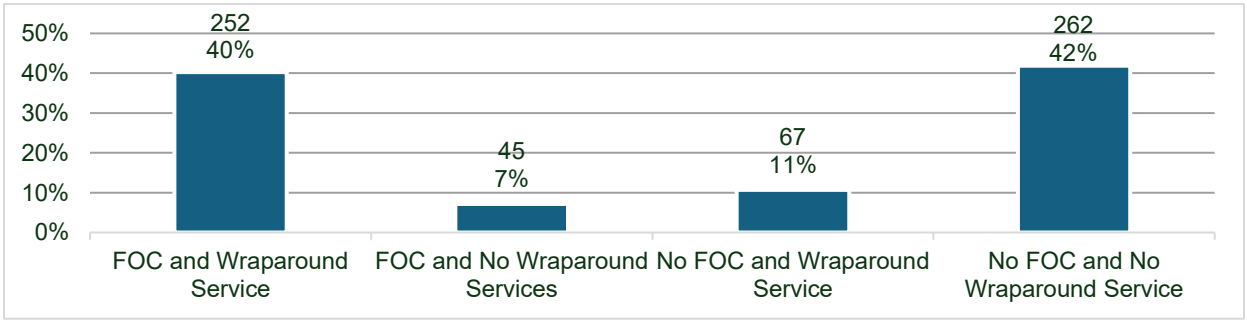
Figure 16: Percentage of Applications (Closed – No CAFAS, Approved, and Total Applications) by Referral Type



***Note:** "Other" Includes court system or referrals marked as "other."

The Quality Committee also focused on the finding that only 51% of children approved for CSED Waiver services went on to receive Wraparound services. Approval for CSED Waiver services indicates a child meets the criteria for hospital-equivalent services, so regular HCBS for mental health may be insufficient to divert from RMHTF placement. Based on results from the sample review (as previously described), the group further explored whether FOC submission was still an obstacle to accessing Wraparound services. As shown in Figure 17, 42% of approved applicants had no FOC completed and no Wraparound services received, yet they made it through the full determination process to receive the approval, including a CAFAS assessment and independent evaluation. The Quality Committee discussed current practices for FOC completion and worked with Aetna to update practices to include additional assistance to families in completing the FOC form, which has since been implemented. Wraparound service engagement and FOC completion will continue to be monitored to help ensure the process does not create obstacles for families accessing services.

Figure 17: Relationship Between FOC[30] and Wraparound Service Utilization

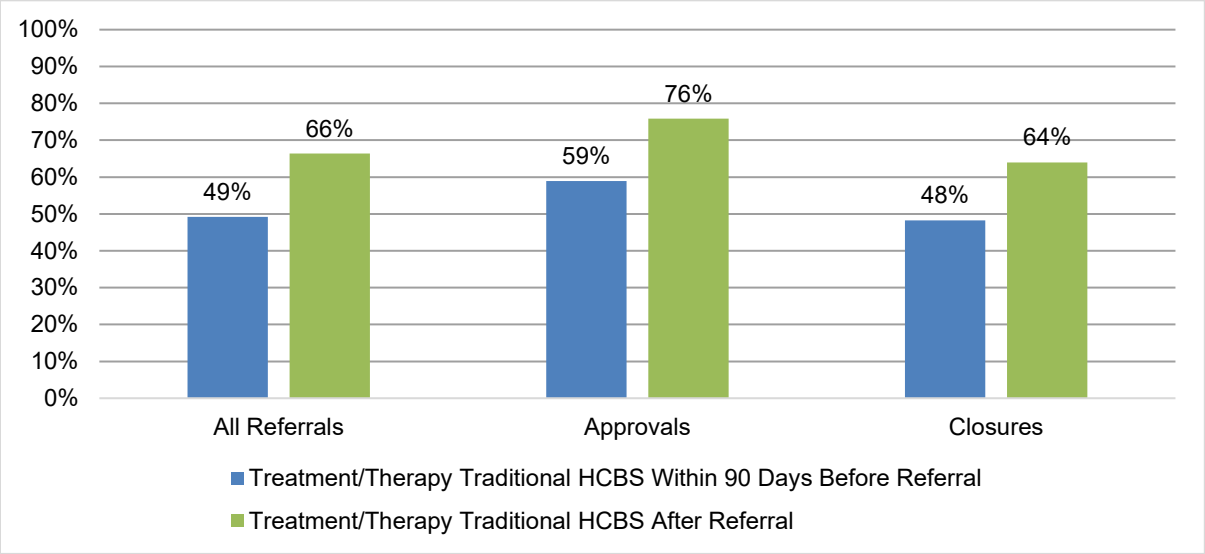


[30] Children receiving Wraparound from non-federal funding sources can have services without the FOC being in place, explaining how some children had services without an FOC (11%).

Increased Connection to Treatment/Therapy HCBS Following Referral to the Assessment Pathway

The Quality Committee also reviewed indicators related to general connection to mental health services (beyond Wraparound) for children referred to the Assessment Pathway. As shown in Figure 18, service connection to claims-based mental health treatment or therapy HCBS (excluding Wraparound) increased from 59% of children receiving treatment/therapy services within 90 days before referral to 76% of children receiving the services after referral for approved applications and from 48% to 64% for closed applications. Treatment/therapy HCBS includes but is not limited to services such as counseling, therapy, medication management, and case management. While acknowledging families navigating the pathway may have a range of needs and acuity, this increase demonstrates that service connections are made through the Assessment Pathway—beyond Wraparound services and regardless of determination outcome. This is consistent with past reporting, demonstrating the efficacy of connections made for families.

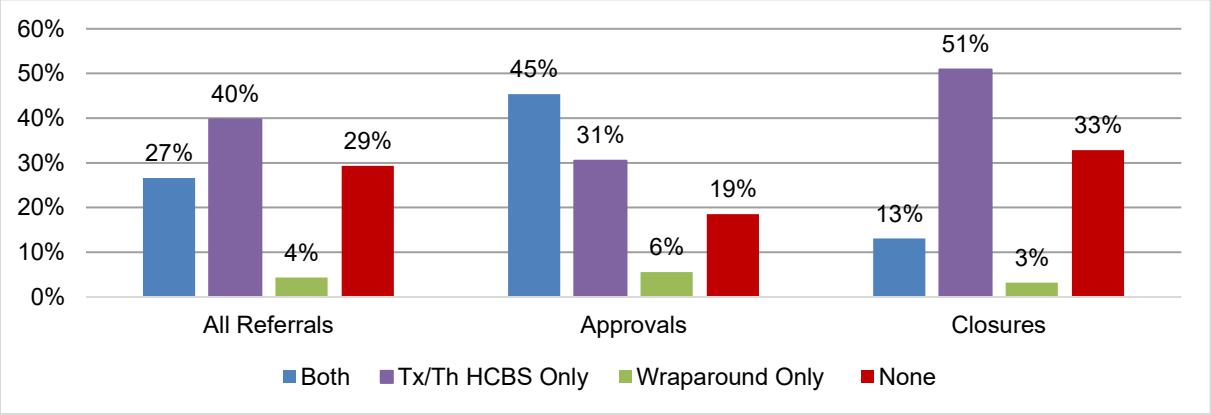
Figure 18: Children Receiving Treatment/Therapy Traditional HCBS Before and After Referral



Service utilization for all referrals was assessed to understand if all children were utilizing a mental health treatment service after referral, including both treatment/therapy and Wraparound services. Assessment and evaluation services were not considered treatment services. As shown in Figure 19, of all children referred to the Assessment Pathway, 71% went on to utilize a traditional treatment/therapy or Wraparound HCBS, including 67% of children with closed applications. Children approved for CSED Waiver services were more likely to utilize a traditional treatment/therapy or Wraparound HCBS, with 19% not having any mental health treatment or therapy service in claims data or WV Wraparound services documented compared to 33% of closures. Of the children approved for services, 51% utilized Wraparound and 45% used both traditional treatment/therapy and Wraparound. A third of children approved only utilized traditional treatment/therapy.

This information shows most children used services after approval; however, the service intensity, given the documented level of acuity, for these children with traditional treatment/therapy services may be insufficient to meet their needs. DoHS is using the CMHE to better understand why children with high acuity of need do not go on to engage in Wraparound or other high-intensity services to meet their needs. This information will be used in strategic planning to help meet families where they are. The CMHE is ongoing, with updated results expected in late 2025.

Figure 19: Services[31] After Referral by Determination Status



4.3 Timeline to HCBS Following Referral to the Assessment Pathway

For families who need mental health services, especially those with a high acuity of need, timing is critical. DoHS reviewed the steps in the process to assess overall timelines, as well as the time associated with each step to assess timeliness of connection to Wraparound services.

The average time from referral to Wraparound service (regardless of determination status) was:

- 113 days (3.8 months) overall
- 96 days (3.2 months) for children with interim[32] Wraparound services
- 128 days (4.3 months) for children without Wraparound interim services

These overall timelines were broken down into individual steps to examine the linear process. Children able to be served through interim Wraparound services were excluded, yielding longer time frames displayed stepwise than in total, as the information is skewed toward children who may have had some of the longest time to services. However, a benefit to this approach is the ability to understand in greater detail each step for children with some of the longest waits to Wraparound and where obstacles may lie. It should also be noted that not all children had data

[31] Tx/Th HCBS is abbreviated to represent traditional treatment and therapy home and community-based services.

[32] Interim Wraparound services are provided by BBH grant-funded or SAH providers to allow Wraparound services to begin before final CSED determination is made.

recorded at each touchpoint, so the stepwise timeline cannot be added together to create the total time frame.

With a total average timeline of over four months (as previously mentioned), the process for children who did not utilize interim Wraparound services included the following steps and timeline, on average, to receive Wraparound services through CSED Waiver:

- 7 days from referral to CAFAS assessment
- 48 days (1.6 months) from CAFAS assessment to CSED Waiver determination[33]
- 52 days (1.7 months) from CSED Waiver determination to FOC signed
- 36 days (1.2 months) from FOC signed to first Wraparound service

This review process revealed that, on average, children are experiencing long wait times before starting Wraparound services. The Quality Committee discussed several reasons timelines may be delayed with themes centering around the following topics.

Timely Family Engagement or Response

Meeting families where they are to help with navigating process steps, completing paperwork, and scheduling independent evaluations could help timelines. Acentra noted that parents may frequently delay independent evaluations, causing lengthier time frames to determination. Some families do not respond to contacts from the MCO for the FOC process or require significant outreach to contact them after determination. To address this, DoHS developed a plan to help ensure Acentra and Aetna could better leverage resources, existing family contacts, and local providers to contact the family and help them complete the FOC in a timely manner, enabling more expedient linkages to a Wraparound provider. As previously noted, DoHS is also working to address the administrative burden on child welfare workers with the Assessment Pathway process to reinforce timely response and connection.

Wraparound Facilitator Capacity and Waitlists for Services

Family-based referrals to interim Wraparound must be covered by BBH grant funding. A limited number of providers have grants for the service, and—to help ensure continuity of services for the child and family—facilitators are permitted to “follow” the child when they transition to CSED Waiver-covered services. In the past, this often resulted in children going on a waitlist for interim Wraparound services and often remaining on the waitlist until they were determined eligible for CSED Waiver-covered services, which has a broader provider network through Medicaid funding. Significant work has been conducted to resolve this obstacle, including decreasing the number of children on the waitlist in Q2 2025 by collaborating with providers to re-evaluate their services and expand their capacity. Capacity expansion included using memorandums of understanding with non-grant-funded Wraparound providers to expand available resources.

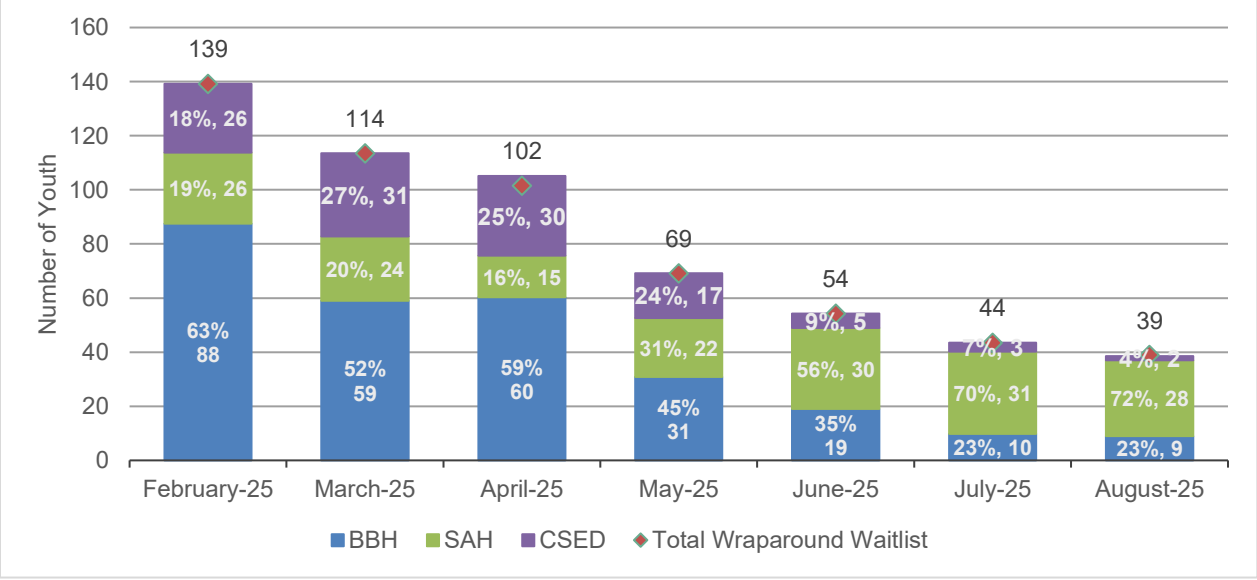
[33] Methodology differs here from other CSED-specific reporting that looks at only the CSED process. This analysis examines the more comprehensive Assessment Pathway for children who go on to receive Wraparound services.

Systems-based interim Wraparound (SAH payor) has historically had a smaller waitlist than other payor sources. This is being maintained in volume as of August 2025 but has not yielded the decreases other payor sources have seen; this is likely due to the large influx of children entering SAH services monthly, most of whom do not go on a waitlist (91% of estimated monthly need as of March 2025). SAH was also one of the first WV Wraparound services in the state, with the broadest provider network, before CSED was implemented. Some Wraparound providers have expressed that they are still adjusting to using the CSED Waiver as a payor source, as they have historically been more likely to enroll children with SAH as the payor source. DoHS provides technical assistance and education to providers to best utilize available resources, including the federal match available through the CSED Waiver.

The waitlist for children starting CSED Waiver services has also been reduced by expanding allowances for telehealth services, when appropriate, for children in counties where capacity was an issue. DoHS, in partnership with Aetna, continues work to expand the number of providers offering WV Wraparound services, with eight new providers added in CY2024. BSS now requires all SAH providers to also provide CSED-funded services.

DoHS monitors waitlist metrics weekly. Figure 20 shows the point-in-time waitlist at the end of each month, reflecting progress between February 2025 and August 2025 from the described interventions. The waitlist decreased by 72% during this period. Notably, referrals to the Assessment Pathway have not shown significant decreases, indicating the decrease in waitlist numbers is not due to lower referral volume and that efforts to reduce the waitlist have been successful.

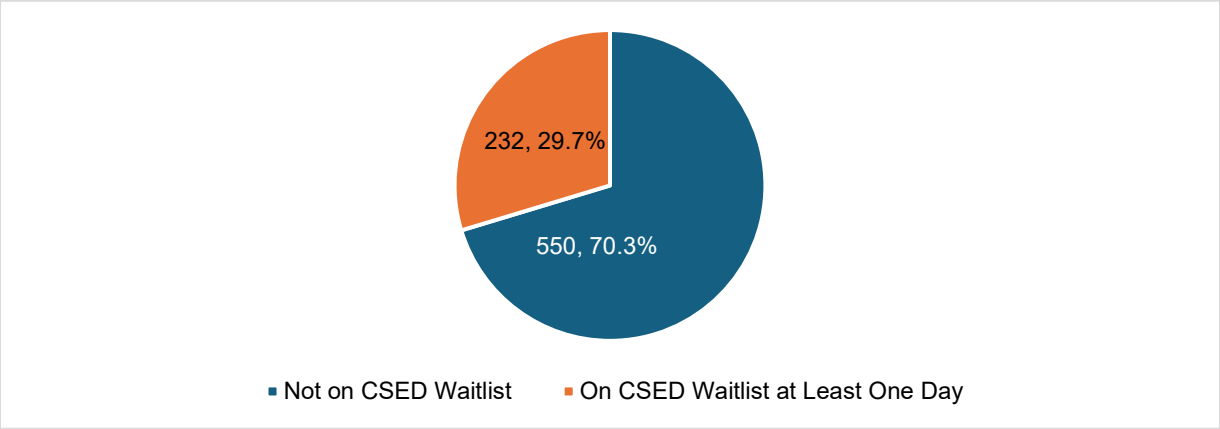
Figure 20: Average Weekly Waitlist for WV Wraparound Services by Funding Source[34]



[34] Since data is not de-duplicated, a weekly average was used rather than the sum for each month. Each category is averaged individually; therefore, totals may not be the sum of the three payor sources.

Further analysis of children with an FOC in place—i.e., ready to start CSED Waiver Wraparound services—showed that 70.3% (n = 550) of children did not have to be placed on a waitlist prior to starting services in CY2024 (Figure 21). For children who did go on a waitlist, the average time on the waitlist was 66 days, with a median of 48 days. DoHS reviews county-level waitlist data weekly to identify areas of capacity need, which influences the direction and intensity of outreach in certain regions of the state for provider onboarding and/or existing provider expansion.

Figure 21: Children With an FOC in Place in 2024, Percentage Placed on a Waitlist at Least One Day for CSED Services (n = 782)



Children may access other services while waiting for higher intensity services such as Wraparound. To assess the timeline to access other services in comparison to Wraparound, DoHS analyzed the timeline to treatment/therapy services. Table 6 shows the median time to treatment/therapy was 83 days for children new to this service. While some services funded through grants or other sources may not be captured here, and mobile crisis services could meet some interim needs if utilized, the Quality Committee acknowledged that service timelines were likely too long to meet needs. Next steps include leveraging existing systems (e.g., CCBHCs and local resources) to help ensure more timely connection to services and working to decrease the waitlist to encourage utilization of Wraparound services for those eligible.

Table 6: Time to New* Claims-Based Mental Health Treatment/Therapy HCBS (Excluding Wraparound)

	All Referrals	Closed Applications	Approved Applications
Median	83	59	90
Average	106	92	114

***Note:** Children with services in the 90 days before referral or with Wraparound have been excluded from this metric.

4.4 Outcomes Following Referral to the Assessment Pathway

DoHS explored outcomes, including predictive and protective factors associated with those outcomes, to identify additional opportunities for prevention and intervention. DoHS reviewed information for a cohort of children who had a closed or approved application to the Assessment

Pathway/CSED between January 2023 and June 2024 and who had a CAFAS score greater than or equal to 90 (n = 2,448). Children with BJS or RMHTF placement at the time of referral were excluded from the review, and some analyses also excluded youth with an existing child welfare placement at time of referral to allow more opportunity to understand situations for children not actively living in these out-of-home settings (e.g., children who may be subject to "time-to-service" delays due to a need to discharge, equity in chance to have a new out-of-home placement, etc.). Including only children with CAFAS 90+ in this review helped ensure equity in acuity of need and risk for out-of-home placement, as observed in past analyses, across all children in the cohort.

The following subpopulations[35] were also considered to help understand service engagement and acuity-related outcomes:

- Closed application and no services (n = 67)
- Approved application (i.e., determined eligible) and no services (n = 112)
- Approved application and utilized only assessment/evaluation-related[36] mental health HCBS without treatment/therapy or Wraparound (n = 62)
- Approved application and utilized at least mental health HCBS treatment/therapy[37] but not Wraparound (n = 583)
- Approved application and utilized Wraparound[38] at least three months (n = 799)

Demographic information and acuity level of need were reviewed to assess differences in the subpopulations. The subpopulation of children utilizing Wraparound for at least three months had the smallest ratio of older children at 44% age 13 or older. All other subpopulations had more children 13 years old or older represented, with 55% or more total children in this age category. Differences were also seen in acuity among subpopulations by reviewing the percentage of children with a CAFAS score between 90 and 130 versus a CAFAS score of 140+. Subpopulations with treatment/therapy or Wraparound for three months or more—the highest levels of service intensity considered—had similar proportions of children with a CAFAS score of 140 or more at 45% each compared to 39% of children in a subgroup with no services or only assessment/evaluation services. Due to these similarities, subpopulations with treatment/therapy or Wraparound for three months or more were considered at a similar risk for

[35] These subpopulations are not inclusive of all children in the total cohort but were chosen to focus on outcomes for children with specific engagement criteria, allowing results to be interpreted more clearly.

[36] Assessment/evaluation-related Mental Health HCBS: Examples include diagnostic/screening processes, psychological/psychiatric diagnostic evaluations, behavioral assessments, and neurobehavioral status exams.

[37] Treatment/Therapy HCBS: Examples include psychotherapy with patient, office/outpatient, family psychotherapy, group psychotherapy, adaptive behavior treatment, and family adaptive behavioral treatment.

[38] Wraparound: Includes BBH Wraparound, SAH Wraparound, and all CSED Waiver Services (Wrap, In-Home Supports, Family Therapy, etc.).

residential placement based on acuity and were used to compare outcomes based on service utilization.

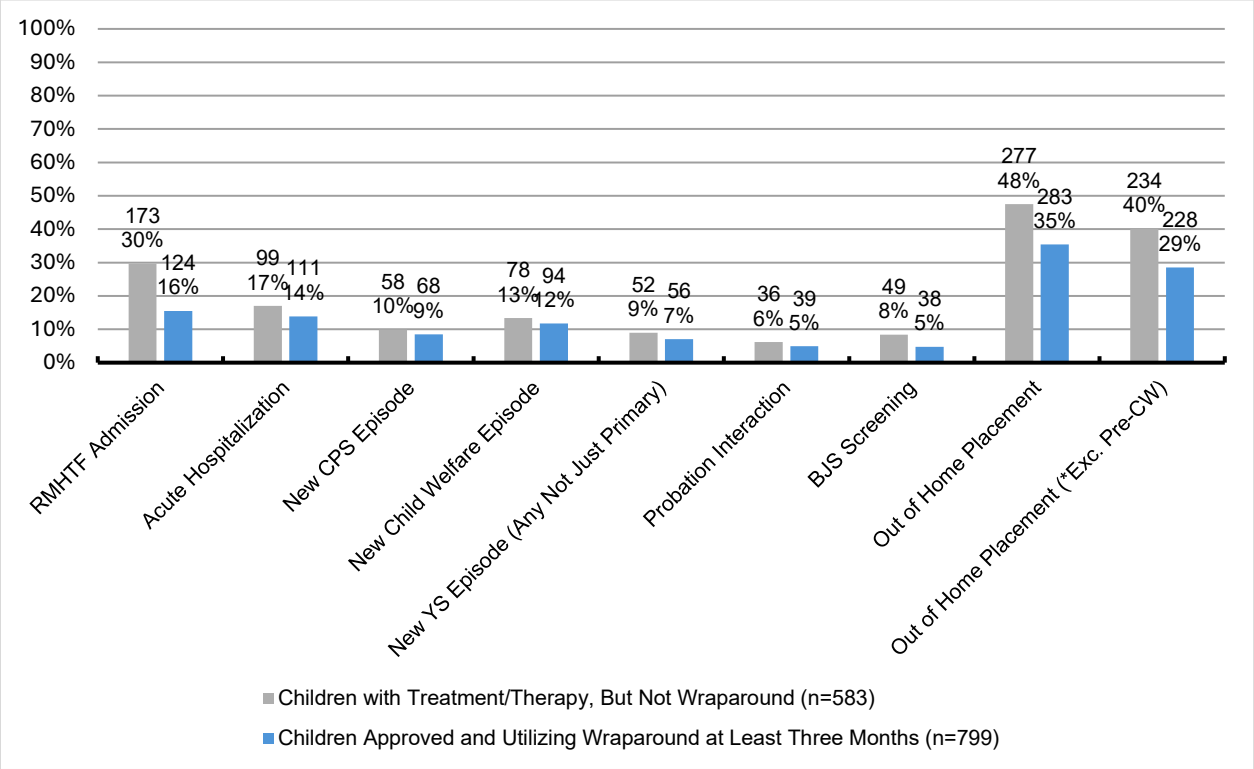
Several outcomes were assessed for (a) children approved and utilizing treatment/therapy but not Wraparound and (b) children approved and utilizing Wraparound for at least three months (Figure 22). Out-of-home placements[39] were the outcomes with the greatest differences across the two groups of service intervention.

Fewer children utilizing Wraparound for three months or longer had a new out-of-home placement, which was demonstrated regardless of whether they were in a child welfare placement at the time of application based on the following:

- Children with Wraparound for at least three months were less likely to have a residential admission within 12 months after referral to the Assessment Pathway (16%) when compared to children utilizing traditional treatment/therapy services (30%).
- Children with demonstrated high acuity of need and utilizing Wraparound for at least three months were more likely to remain in a community setting (48%) than their peers who used traditional mental health treatment or therapy (35%) within 12 months after application

[39] 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.

Figure 22: Outcomes Within 12 Months of Application – Subpopulation Comparison



***Note:** The "Out-of-home placement (exc. Pre-CW)" indicator excludes children who were in child welfare (CW) custody at the time of application.

Predictive and Protective Factors for Out-of-Home Placements, Including Residential Placements

DoHS used multiple logistic regression models[40] to assess predictive and protective factors for residential and out-of-home placement to address a child's needs for the full cohort of children.[41] Children with an existing child welfare placement at the time of referral were excluded from this analysis to maintain a more preventative focus with the populations considered. Children less than 5 years old were also excluded due to ineligibility for most non-CPS-related out-of-home placements. Several variables were referenced to identify whether they were predictive or protective in nature, including age groups compared to:

[40] Each model used a threshold of p-value < 0.05 to determine statistical significance.

[41] Children with an application to the Assessment Pathway between January 2023 and June 2024, including only children with a CAFAS score of 90 or more and a determination of "closed" or "approved."

- 15- to 16-year-olds[42]
- Biological sex
- CAFAS score of 140 or more compared to scores between 90 and 130
- Service utilization, including:
    - No documented mental health HCBS
    - Evaluation/assessment mental health HCBS only
    - Received at least treatment/therapy services but not Wraparound
    - Wraparound services for at least three months[43]
    - ED utilization
    - CMCRS usage

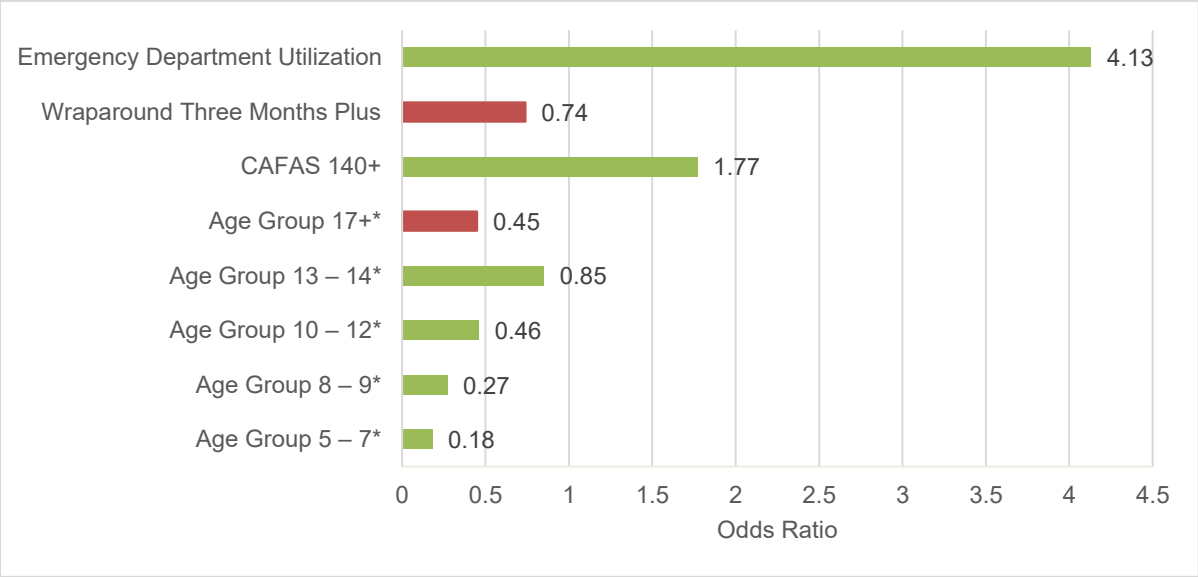
Predictive and Protective Factors for Out-of-Home Placement

The first model was developed to identify predictive and protective factors for out-of-home placement to address a child's mental health needs within 12 months after a referral to the Assessment Pathway, including the following: RMHTF admission, acute hospitalization, new YS placement episode, or BJS placement. Figure 23 shows the odds ratios for indicators determined to have a statistically significant impact on the odds of out-of-home placement. The protective factors, representative of characteristics associated with a child being less likely to experience out-of-home placement, included children in age groups younger than 13 and children who utilized Wraparound services for at least three months. Not utilizing Wraparound for at least three months, a high acuity of need (CAFAS 140+), and ED utilization were statistically significant predictive factors.

[42] Children aged 15 and 16 were used as the comparison group because they are the age group with the greatest number of children in residential settings. However, the analysis was also run using 13- to 14-year-olds as the comparison group, which yielded similar results.

[43] Three months of service utilization was selected as a minimum threshold, as it is associated with the approximate time frame for the first phase of Wraparound to be completed.

Figure 23: Odds Ratio for Statistically Significant Predictive (Red) or Protective (Green) Factors for Out-of-Home Placement



***Note:** Each age group was compared to 15- to 16-year-olds for the odds comparison.

Results included:

- Children utilizing WV Wraparound for at least three months were 26% less likely to experience out-of-home placement compared to those without the service/those who receive the service for less than three months.
- Children in younger age groups were less likely to experience out-of-home placement, meaning the younger the child, the less likely they were to experience out-of-home placement compared to 15- to 16-year-olds (e.g., children 8 – 9 years old were 73% less likely to experience out-of-home placement).
    - The exception to younger age groups being less likely to be placed out-of-home was 13- to 14-year-olds, whose odds of out-of-home placement were not significantly different from 15- to 16-year-olds.
    - Children 17 years or older were less likely to be placed out of home within 12 months of referral; however, this may be due to ineligibility for some programs for children 18 or older, as well as the willingness of the child to voluntarily participate once they were no longer a minor.
- ED utilization was the greatest predictor of out-of-home placement: youth with this service were 313% more likely to be placed out of home than youth without this service.
- Children with a CAFAS score of 140+ were 77% more likely to have out-of-home placement than those with a CAFAS score between 90 and 130.

- Children not utilizing Wraparound services for three months or more were 35% more likely to have an out-of-home placement than children with at least three months of Wraparound services.

For children experiencing out-of-home placement, this outcome occurs quickly—regardless of service category—with 42% of children who received Wraparound for three months or more and 55% of children who received traditional mental health treatment/therapy service only having the initial out-of-home placement occur within three months following application (Figure 24). The median time to placement that occurred within 12 months of referral was 82 days (slightly less than three months) for children with traditional mental health treatment/therapy service only and 114 days (approximately 3.5 months) for children with Wraparound at least three months (Table 7). Given the average time to first Wraparound service is 113 days, these children, on average, would not have had time to engage in services before out-of-home placement.

Figure 24: Children With Out-of-Home Placement Within 12 Months of Application – Timeline to Outcome

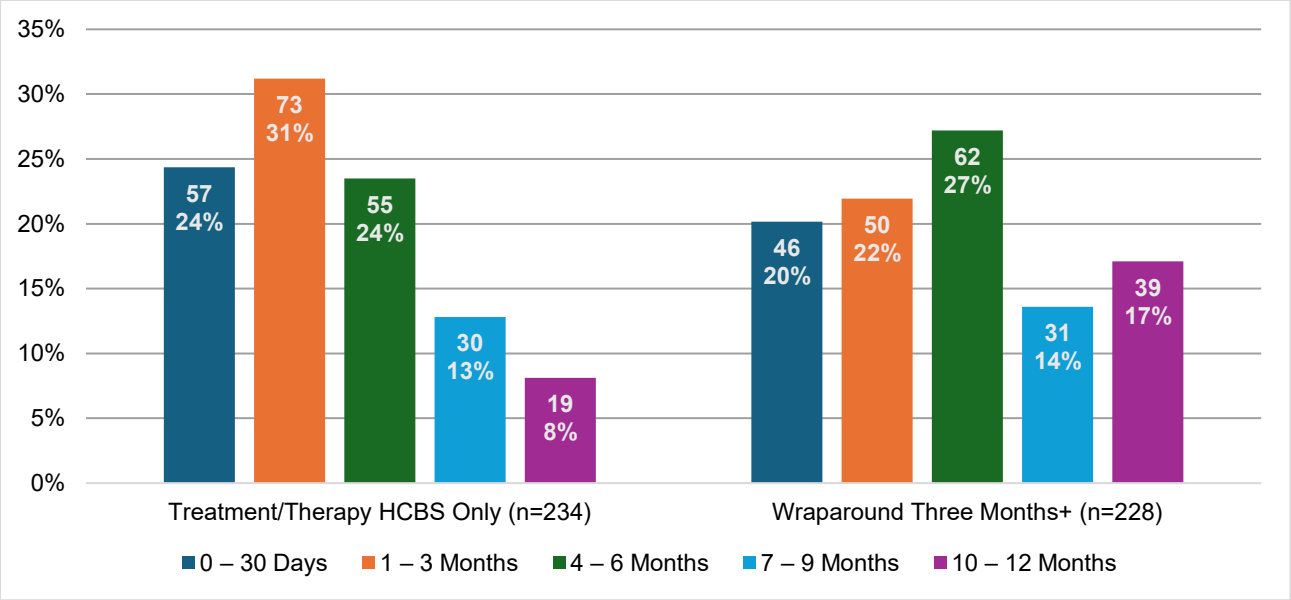


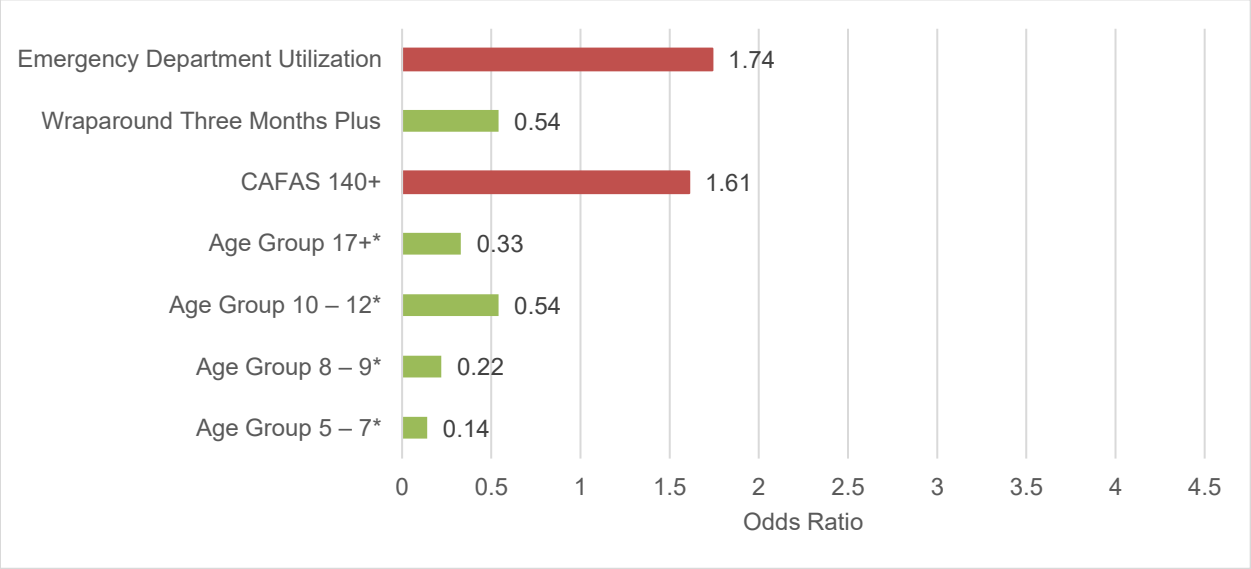
Table 7: Summary Statistics for Children Experiencing Out-of-Home Placement by Service Utilization Type

Population	Number of Out-of-Home Placements	Percentage of Population Placed Out of Home	Mean Time (Number of Days) to Out-of-Home Placement	Median Time (Number of Days) to Out-of-Home Placement
Treatment/Therapy HCBS Only	234	40%	106.5	82
Wraparound Three Months+	228	29%	134.1	113.5

Predictive and Protective Factors for Residential Placement

A second logistic regression model was developed to identify predictive and protective factors specifically for residential placement within 12 months after a referral to the Assessment Pathway. Figure 25 shows the odds ratios for indicators found to be statistically significant. The protective factors included children in age groups younger than 13 and children who utilized Wraparound services at least three months—similar to the protective factors for out-of-home placements. Predictive factors also showed similar results as the model for out-of-home placement outcomes, though there were some differences in magnitude; predictive factors included not utilizing Wraparound at least three months, a high acuity of need (CAFAS scores of 140+), and ED utilization.

Figure 25: Odds Ratio for Statistically Significant Predictive (Red) or Protective Factors (Green) for Residential Placement



***Note:** Each age group was compared to 15- to 16-year-olds for the odds comparison.

Results included:

- Children utilizing WV Wraparound at least three months were 46% less likely to experience residential placement compared to those without the service. This demonstrated a stronger relationship of Wraparound preventing residential placement compared to the broader category of out-of-home placements.
- Children in younger age groups were less likely to experience residential placement, (e.g., children 8 – 9 years old were 78% less likely to experience residential placement compared to 15- to 16-year-olds).
    - The exceptions to this were 13- to 14-year-olds, who were not significantly different from 15- to 16-year-olds.
    - Children 17 years or older were less likely to be placed in residential settings, but this may be due to ineligibility for some programs for children 18 or older, as well

as willingness of the child to voluntarily participate once they were no longer a minor.

- Children with ED utilization had the highest likelihood of residential placement and were 74% more likely than children who did not utilize the ED.
    - Although this was a key predictive factor, it was not as strong an indicator for residential placements because it was for the broader category of out-of-home placements. This difference was largely driven by inpatient hospitalizations for out-of-home placements, indicating some more acute needs of children driving out-of-home placements and the relationship with ED utilization.
- Children with CAFAS scores of 140+ were 61% more likely to be admitted to residential placement than those with a CAFAS score between 90 and 130.
- Children not utilizing a Wraparound service for three months or more were 85% more likely to have a residential placement within 12 months of referral compared to those who utilize Wraparound for at least three months. The relationship between a lack of consistent, high-intensity service utilization (Wraparound) and being placed out of the home was stronger for predicting residential placement than the broader category of out-of-home placements.

As evidenced in the preceding summary, engaging younger children with mental health needs and their caregivers in services earlier provides a key opportunity to promote strong mental health coping skills at an earlier age, which could, in turn, help children manage changes more effectively as they progress into adolescence. DoHS is leveraging existing relationships with schools participating in ESMH programs to help ensure these schools are aware of both high-intensity services and how to connect to them. Similar outreach is also being conducted within judicial districts with primary care (EPSDT) providers and with providers via the WV Hospital Association to offer training and education for earlier intervention. Postcards with WV Wraparound and CMCRS service information have been mailed to all 55 county school boards for dissemination to families. In addition to expanded outreach efforts, BSS is moving to a new Child Welfare Model in fall 2025. This move will help shift the model by increasing its ability to place safety measures in the home—ideally outside of an open CPS case—and help support families without court involvement and overly invasive protocol, when appropriate and safe to do so. High-intensity mental health services will be crucial to keeping families with these needs together and helping prevent intensive systems involvement.

Older youth are more likely to have lower engagement in intensive services. The Quality Committee is exploring existing peer support service arrays and connections while awaiting final results from the CMHE and more information on family and youth perspectives for facilitators of participation.

The timeline to out-of-home placement was explored for this second model as well. Children who had only traditional treatment/therapy services experienced residential placement at nearly twice the rate of children with three months or more of Wraparound utilization. Of those who were admitted, 41% of residential placements occurred within three months of application

(Figure 26), with a median timeline of 107 days (about 3.5 months) (Table 8). In contrast, for children with Wraparound for three months or more and a residential placement, the median time to placement was 165 days (approximately 5.5 months), with a more evenly distributed timeline to placement. This difference may suggest that children who were quickly placed following referral may not have had adequate opportunity to start Wraparound services, given the timeline to services was an average of 113 days (about 3.5 months).

Figure 26: Children With Residential Placement Within 12 Months of Application – Timeline to Outcome

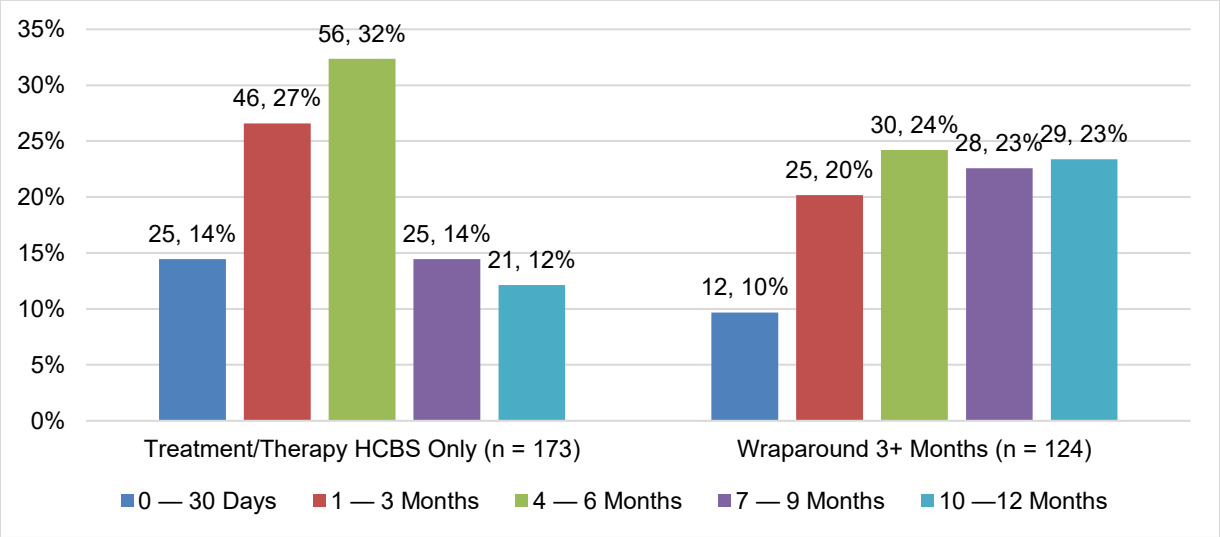


Table 8: Summary Statistics for Children Experiencing Residential Placement by Service Utilization Type

Population	Number of Children Admitting	Percentage of Population Admitting	Mean Time (Number of Days) to RMHTF Admission	Median Time (Number of Days) to RMHTF Admission
Treatment/Therapy HCBS only	173	30%	130.2	107
Wraparound Three Months+	124	16%	168.8	165

DoHS is prioritizing decreasing these timelines, as they are understood to be integral to a child's positive outcomes. Efforts to decrease the waitlist and address immediate needs have been successful in a short time and are ongoing. The decrease in children going onto a waitlist for Wraparound services should also help reduce timelines to services, allowing high-intensity services to start more quickly, with the overarching goal of providing necessary supports to help prevent out-of-home placement. In addition to reducing waitlist numbers, timely completion of the FOC is also being addressed through creative contacts and leveraging other Medicaid billable services to help providers connect to families early and assist families with timely submission of the FOC.

DoHS has also implemented routine reviews of Wraparound length of service for children actively enrolled in WV Wraparound services. This information will continue to help program administrators identify providers who may have children on their caseloads for durations longer than expected or appropriate with Wraparound standards, which will create opportunities to address transition needs for children ready to graduate from Wraparound services and expand capacity for other children in need of high-intensity services.

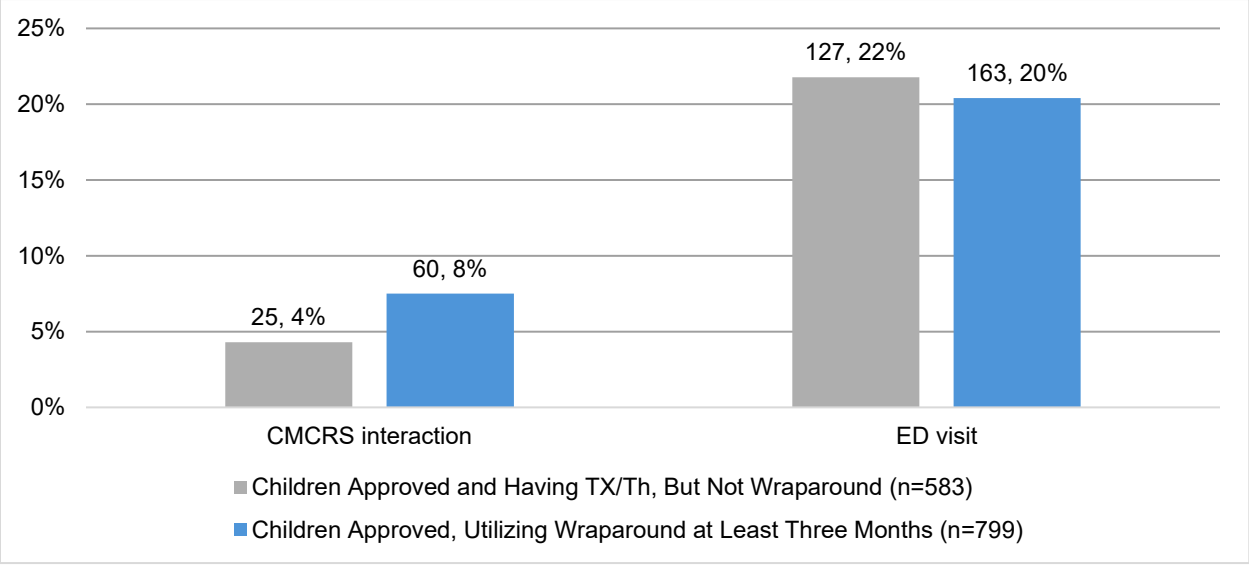
Predictive and Protective Factors for Children 13 and Older

A third model was reviewed to understand whether predictive and protective factors were similar for children 13 and older. The analysis showed similar results to previous models. Specifically, children aged 13+ utilizing WV Wraparound for at least three months were 38% less likely to experience residential placement compared to those without the service. This demonstrates a protective relationship with consistent use of Wraparound services and the ability to remain in the home and community regardless of age.

Crisis Service Utilization for All Referrals to the Assessment Pathway

CMCRS is a critical service shared with every child and family who goes through the Assessment Pathway. However, as shown in Figure 27, CMCRS appears to be underutilized, with only 8% of children using Wraparound for three months or more and 4% of children using treatment/therapy (not Wraparound) also having a CMCRS service. This can be compared to about one in five children from each of these subpopulations using the ED for mental health needs, a much higher rate of utilization.

Figure 27: CMCRS and ED Utilization by Subpopulation Type

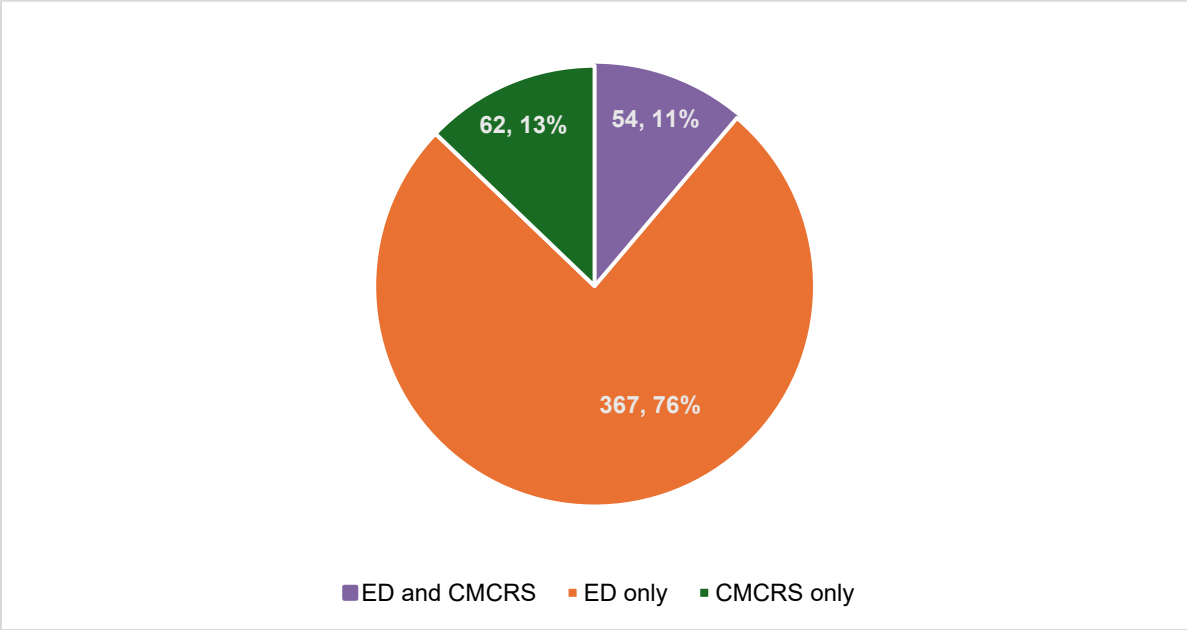


Factors Associated With CMCRS Utilization

A deeper assessment of children utilizing Wraparound for three months or more showed that children who used CMCRS were 65% less likely to be admitted to RMHTFs than those not using CMCRS. This was the only model that showed CMCRS utilization as a statistically

significant protective factor. The Quality Committee discussed the topic and considered that low utilization may be preventing CMCRS from being a statistically significant protective factor for other groups. Approximately half of the children who received Wraparound for three months or more, who used CMCRS after application, used it before starting Wraparound. Figure 28 shows crisis utilization by type for children in the larger cohort, with most children who experienced a mental health crisis utilizing the ED only (76%) and 24% in total using CMCRS (either CMCRS only or in combination with the ED) within 12 months of referral.

Figure 28: Intervention Type for Children With "Crisis" After Application Date (n = 483 Youth With ED or Mobile Response Interaction Within 12 Months After Application)



The ED continues to be identified as a key intervention point to help ensure connection to appropriate crisis services and longer-term HCBS for mental health. As noted, this information will be discussed with the WV Hospital Association to identify needs and opportunities DoHS can leverage to assist providers with awareness and connection for their clients. As illustrated through the review of timeline to out-of-home placement, early awareness of crisis services—well before a crisis plan is developed with the Wraparound team—is key. Acentra (the vendor responsible for managing applications) will help educate families going through the pathway regarding CMCRS availability by helping families navigate when it would feel "right" to use mobile response—specifically, that a crisis is defined by the family and can vary significantly in severity based on their needs. CMCRS teams are specially trained in mental health de-escalation and stabilization and may have additional training in this field than the typical ED.

4.5 Key Themes and Next Steps – System Engagement and Outcomes

While several analyses and reviews were completed in 2024 and 2025 to better understand existing mental health systems and outcomes, several key themes emerged to help DoHS with CQI efforts. The information below summarizes these themes and outlines next steps as identified through quality review processes.

- Regardless of a child's age, utilizing WV Wraparound services at least three months was associated with a child being less likely to experience out-of-home placement.
- Regardless of service utilization or specific outcome type, children aged less than 13 years old were less likely to experience out-of-home placement.
    - DoHS will continue leveraging existing relationships with schools, judicial districts, primary care (EPSDT) providers, the Hospital Association, and BSS workers to expand outreach and education on efficacy for early connection to critical mental health services.
    - Older youth have lower engagement in intensive services. The Quality Committee is exploring existing peer support service arrays and connections while awaiting final results from the CMHE for more information on family and youth perspectives for facilitators of participation.
- Children with a CAFAS score of 140+ and/or ED utilization were more likely to experience out-of-home placement.
    - Data related to ED and CMCRS utilization suggests CMCRS may be underutilized.
    - The ED continues to be identified as a key intervention point to help ensure connection to appropriate crisis services and longer-term HCBS for mental health. DoHS will work with the WV Hospital Association to identify any needs and opportunities DoHS can take to assist providers with awareness and connection for their clients.
    - As illustrated through the review of timeline to out-of-home placement, early awareness of crisis services is key—well before a crisis plan is developed with the Wraparound team. Acentra will expand education for families going through the pathway regarding the availability and navigation of CMCRS services.
- Time to services is critical for diversion efforts and may impact the ability to prevent out-of-home placement for some children.
    - On average, children who experienced out-of-home placement as an outcome did not have an adequate opportunity to engage in high-intensity Wraparound services, further emphasizing the importance of a streamlined path to services as well as early intervention.
    - Considering the progress demonstrated, DoHS will continue existing efforts to decrease the waitlist for Wraparound services, help ensure timely completion of the FOC, explore workforce needs and interventions, and monitor length of Wraparound service to help ensure appropriate use and expanded capacity.
- Improved referral follow-through and/or simplification of processes within the Assessment Pathway are needed to lessen the volume of closed applications,

expanding opportunities for improved connection to services and successful outcomes to the broader population, including children in BSS custody.

- Positive outcomes emphasize the importance of children in BSS custody being connected to Wraparound through the Assessment Pathway despite current challenges in follow-up processes for BSS workers.
- DoHS has developed a workgroup to collaborate with all parties involved to identify ways to streamline processes and, as of the writing of this report, has already begun addressing identified needs.

DoHS will continue to review key indicators for timeliness and outcomes following Assessment Pathway involvement to drive important decision-making. This will help influence the ability for children and families to have the proper supports in place to remain or return to the most integrated setting.

5.0 Community-Based Placement Capacity

Community-based placement capacity is a key component for transitioning children back to the community as well as maintaining them in the community following an out-of-home placement, especially for those in the child welfare system. In March 2024, DoHS launched a recruitment campaign to address the foster parent shortage and released an additional update in May 2024 highlighting the need for certified foster families.[44] The update noted that about 250 children at that time were in need of a foster home.[45]

Community-based settings must be equipped to provide a supportive and stable environment for children with SED, recognizing that the needs of each child—and the capacities of families and community settings—can differ significantly. As will be described further in Section 7.0 RMHTF Services, having an appropriate community-based setting to receive treatment and/or to discharge to has been identified as a primary barrier for many children. To begin addressing some of the needs associated with this barrier, DoHS is focused on strengthening the existing tiered foster care model and community-based supports/services available to youth and families. BSS has expanded supports and training available to kinship families in May 2025 to help families stay together. Additionally, all foster parents are trained in caring for children in the tiered therapeutic foster care model, and additional training/support are provided based on the needs of the children in the home. A rate increase took effect in October 2023 for CPAs and socially necessary service providers. Increases to these providers' rates were intended to assist with foster family recruitment, provide additional supports necessary to maintain youth within a stable foster family placement, and, when appropriate, facilitate reunification with biological families. The tiered foster care model allows a child to remain in placement even if their needs fluctuate. By increasing supports to the child and family if needs increase, there is an opportunity to proactively divert the child from a placement disruption, including RMHTF placement, when it remains clinically appropriate to keep the child with their family.

5.1 Review Summary

DoHS strives to provide every child in WV with the opportunity to grow and thrive in their community when it is safe and clinically appropriate for them to do so. Unfortunately, finding a home in a community-based placement can be a significant barrier for children who are in residential care, for children who are older, and/or for children in the child welfare system with SED diagnoses and who are unable to return to their biological family. For these children to be able to remain in the community and have success utilizing HCBS options, it is critical that they can build and foster relationships with loving and committed families. Given the needs of this population, DoHS, in collaboration with CPAs, is identifying ways to increase supports to foster

[44] West Virginia Department of Human Services. May 1, 2024. "West Virginia Department of Human Services Celebrates National Foster Care Month." *West Virginia Department of Human Services.* Accessed September 25, 2025. https://dhhr.wv.gov/News/2024/Pages/West-Virginia-Department-of-Human-Services-Celebrates-National-Foster-Care-Month.aspx

[45] "In need" includes children in emergency shelters or RMHTFs with a documented need for a foster home—regardless of other factors that have been prioritized in other areas of this report.

parents and kinship parents. DoHS and its partners also continue to provide supports to biological families to increase the likelihood of reunification success, as well as to youth of transitional age who want to pursue independent living options. As HCBS are expanded and gain acceptance in communities, DoHS anticipates that the level of support available will help change the culture around the need for RMHTF placement and help families become more empowered—whether they are foster, kinship, or biological—to stay together.

5.2 Foster Care and Kinship Homes

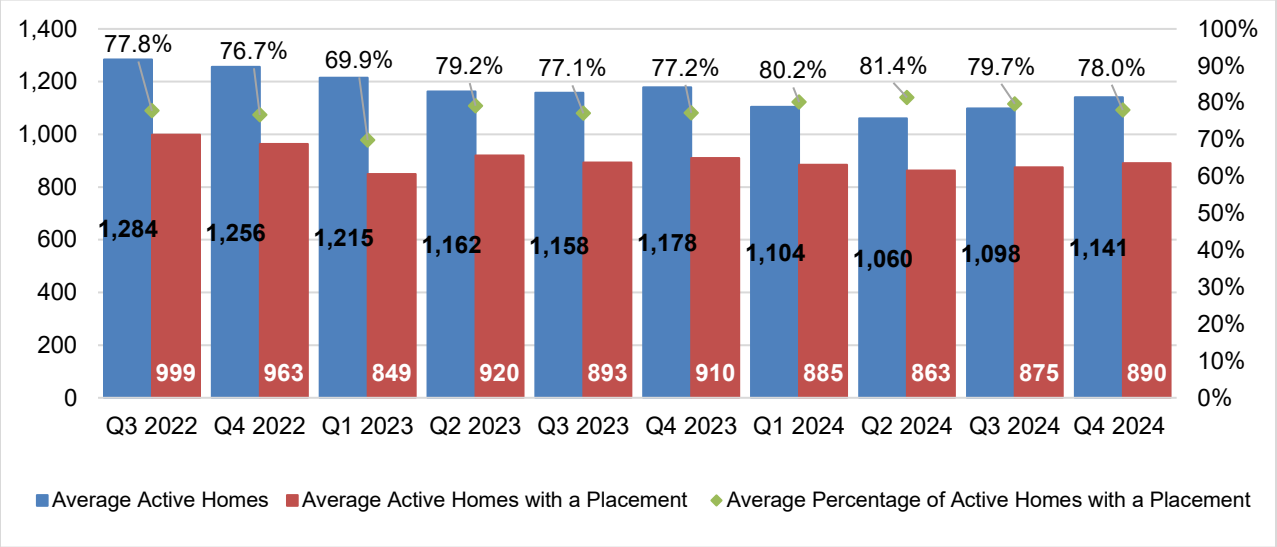
Foster placements in WV—including children in certified foster homes or certified kinship placements—are coordinated through CPAs and BSS. As noted, DoHS is focused on strengthening the existing tiered foster care model, which enables youth to remain in a single foster placement without requiring a move as their needs increase or decrease. In this model, if a child's needs change, then the supports provided to the child and family are also modified to align with those new needs. DoHS continues to meet at least quarterly with CPAs to help ensure open communication and feedback on successes and barriers related to the recruitment and retention processes, including regular data reviews on key performance indicators. The primary focus of discussion continues to be on recruiting new foster families and retaining experienced foster families, including families who have experience with children with significant mental health needs. CPAs continue to express that additional support will be required for these families to feel cared for and to be successful (such as need for after-school programs and care). The October 2023 rate increase was applied to funds directly received by CPAs and was intended to help address this need, although current data has not reflected a meaningful change in home openings or retention since that rate increase.

5.2.1 Foster Care Homes

CPAs are responsible for recruiting and retaining certified foster families using the statewide tiered foster care model. Figure 29 shows the average number of active homes by quarter has decreased over time. In CY2024, there was a slight increase in active homes[46] along with decreases in homes with a placement. The number of active homes has remained relatively consistent at approximately 1,100 homes, with nearly 80% having an active placement since July 2023. Rate fluctuations for homes with active placements further emphasize the critical need for certified foster homes, especially given the range of factors to consider regarding matching a child with a family that is willing and able to meet their needs.

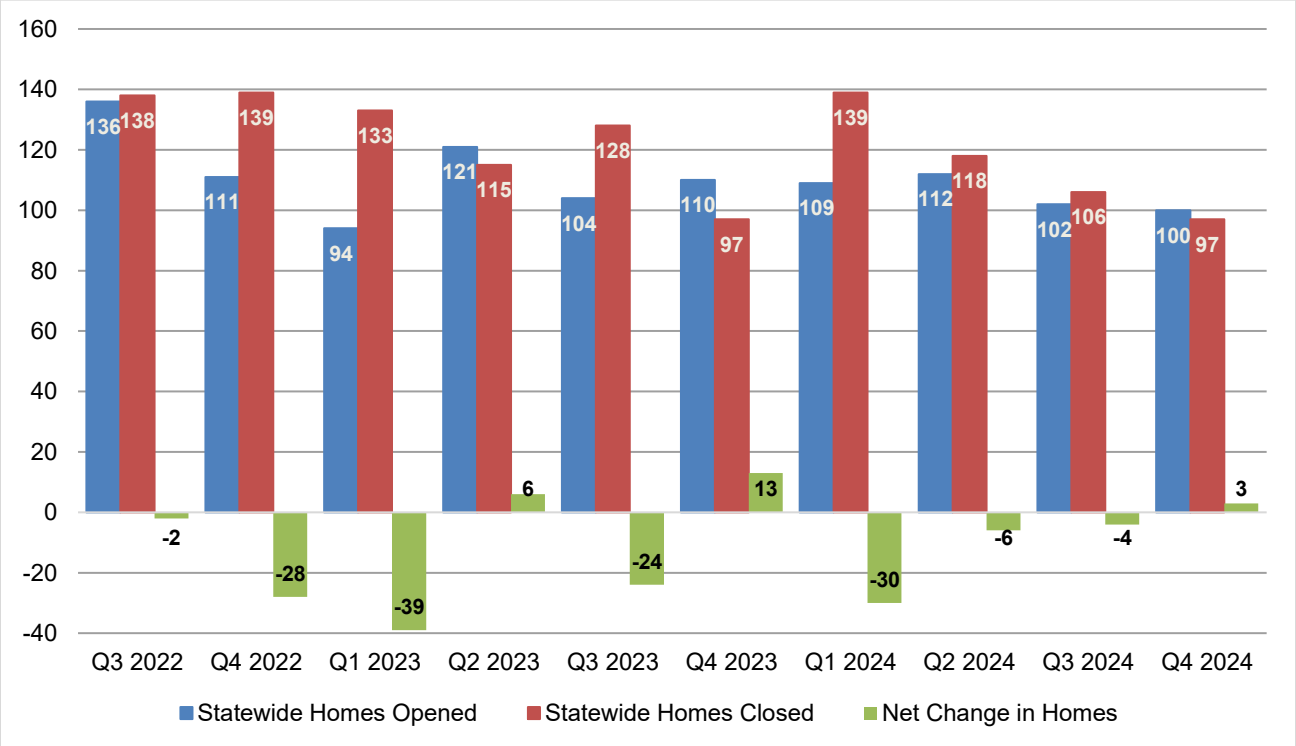
[46] A "certified" home includes all homes licensed for foster care, while an "active" home excludes those not capable of currently accepting a placement

Figure 29: Average Monthly Foster Care Home Capacity by Quarter (CY), Q3 2022 to Q4 2024



As shown in Figure 30, the ratio of homes closed to opened improved over the course of 2024. While the beginning of the year saw a large net decrease of 30 homes, there was very little net change in the following three quarters. Approximately 100 homes opened and closed in each quarter, indicating more consistent turnover of foster families. The beginning of the year is typically associated with net loss of homes due to a high volume of adoptions around the winter holidays.

Figure 30: Foster Care Homes Opened/Closed by Quarter (CY), July 2022 to December 2024



In previous years, DoHS collaborated with MU to survey foster parents to better understand their experience. The results have been used to help ensure foster and adoptive families have more opportunities for improved communications and mental health system navigation. In 2024, the Legislature passed House Bill 4975,[47] requiring a web-based communication system be established to better facilitate communication between families and those involved in the youth's case. This came to fruition in September 2025 with the rollout of the Communication and Operations Mobile Engagement Tool (COMET), which is expected to be statewide by the end of 2025. DoHS will report quarterly on its utilization. DoHS has continued to share resources with families via press releases and social media updates. Although no surveys are currently scheduled, DoHS is considering opportunities to gather insight from foster families to help ensure they are receiving the support needed for successful placement.

System enhancements to MDT processes in past years, as well as close work with the court systems to provide ongoing collaboration and training, are anticipated to continue positively impacting placement stability and foster care family recruitment and retention. Child Stat meetings, a child welfare-focused CQI initiative, have been reviewing information through qualitative reviews such as time to first contact, quantity and quality of visits with children and adult caregivers, and case plan completion. Districts are then assigned action steps to address any needs. BSS has noted improvements through these processes, which are expected to enhance available information for decision-making among the MDT and others and, ultimately, outcomes for the child.

Indicators for foster home closure reasons, where families can have multiple reasons for closure, from July 2024 to June 2025 showed the following:

- Approximately one-third of reported voluntary closure reasons were related to adoption and legal guardianships (41%, n = 143).
- More than a quarter of voluntary closures were due to a change in family circumstances, such as medical reasons, lost jobs, and divorces (28%, n = 100).
- More than a third of homes (34%) with an involuntary closure reason were due to families failing to respond to agency referrals or completing required training.

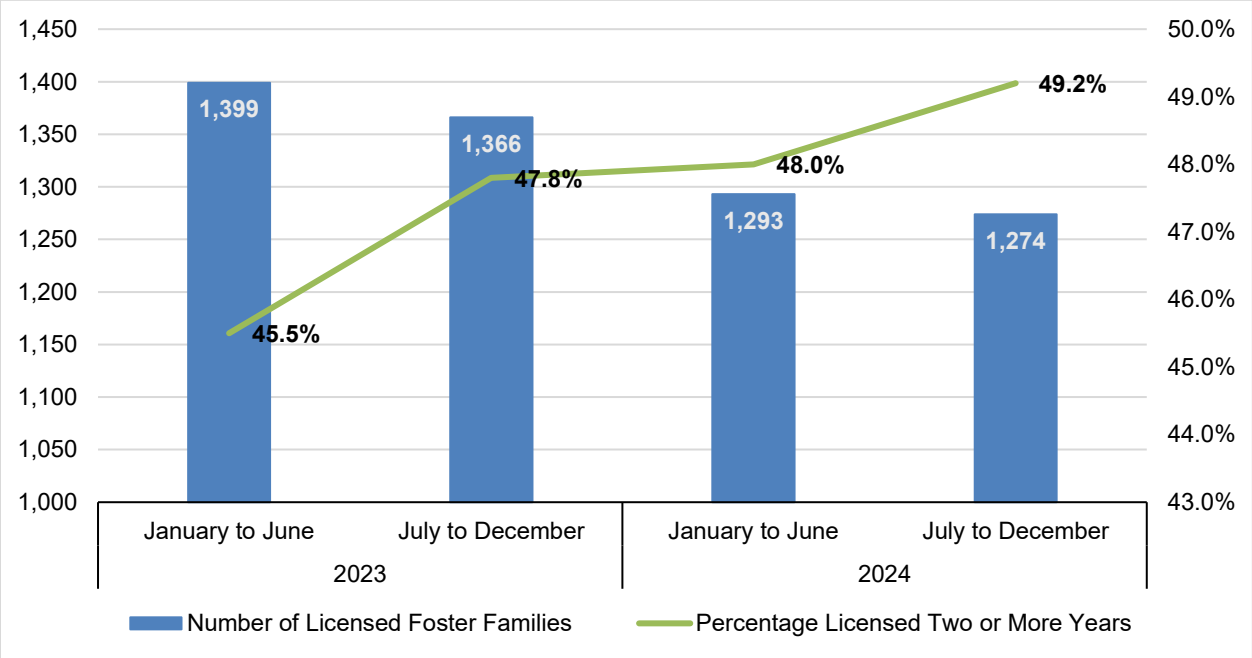
Closure reasons are reviewed with individual CPAs at least quarterly. A new reporting tool—implemented for fiscal year 2026—adjusted some indicators to collect more specific, actionable data.

DoHS and CPAs also review retention data at least quarterly. Figure 31 shows the number of licensed foster families compared to the percentage who have been licensed for at least two years. Note that the number of licensed families is higher than the number of active families, as some will become temporarily inactive for various reasons, such as taking a break from

[47] Christopher Marshall. September 8, 2025. "Interim Report: Joint Committee on Children and Families." *Wrap Up, West Virginia Legislature.* Accessed September 26, 2025. https://blog.wvlegislature.gov/headline/2025/09/08/interim-report-joint-committee-on-children-and-families-3/

fostering or managing health or short-term family needs (e.g., surgery or pregnancy). On average, the percentage of licensed families retained over two years increased from the first half of 2023 (45.5%) to the second half of 2024 (49.2%). There was a nearly 9% (n = 125) decrease of licensed foster homes over the two-year period; however, only 10 of those homes were licensed for at least two years, demonstrating that attrition is largely among foster parents with fewer years of involvement. Retention is understood to be largely influenced by nurturing strong relationships between CPAs and foster families. A retention rate of nearly 50% is considered a strength of WV's system. DoHS will continue to work with CPAs to better understand opportunities to improve retention and ultimately increase the availability of experienced foster homes.

Figure 31: Number of Licensed Foster Families and Percentage Retained for Two or More Years



During past reviews, the Quality Committee requested that county-level information be assessed for regional needs along with the ability to plan more strategically. Given the autonomy afforded to each foster family, it is not possible to predict the exact number of homes available for children of various characteristics at any one time; however, it was agreed that a ratio of the average number of certified homes compared to therapeutic foster care placements within a given county could provide an approximate regional view of levels of need for a given area. A higher ratio indicates a greater need for additional foster homes, given that, in day-to-day circumstances, an open and active home does not necessarily indicate a placement would be accepted. Therefore, it is ideal to expand the pool of available homes to increase the likelihood of an appropriate match. Additional details on county-level findings can be found in Section S.6 Community-Based Placement Capacity in the report supplement.

The statewide average ratio of certified homes to placements in Q3 2024 (July to September) was 1.3, meaning, on average, there was one home for every one child placed. Wayne and Wood Counties, both with a high rate of RMHTF utilization, had ratios of 1.3 and 0.7,

respectively. About 25% of counties had higher ratios, indicating higher relative need for foster home recruitment in these areas. For counties with smaller populations though, neighboring counties may be relied on for adequate placement capacity, especially if safety related to proximity is a concern. However, it is ideal for counties to have more families available than needed to support the range of children in care to accommodate foster family autonomy.

In relation to these needs, and as noted in the previously mentioned press release, DoHS partnered with Mission WV and Aetna to implement a statewide foster care campaign that focused on expanding recruitment for families who are willing to accept teenagers and children with more intense needs. Some themes of the campaign were:

- Emphasizing reunification and supportive co-parenting
- Promoting choices and support available to foster families
- Providing positive messaging
- Utilizing foster parent's own experiences to recruit additional families

This campaign launched in March 2024 and garnered nearly 800 inquiries by the end of the same year. In its April 1, 2025, Impact Report, Mission WV reported that 73% (n = 472) of inquiries were still engaging and gathering information. Because becoming a foster parent takes much thought and consideration, it may take more time to fully realize campaign impacts; however, more immediate solutions are being explored to meet acute needs.

As older youth make up a large volume of children in care, county-level ratios were also analyzed in respect to capacity for youth 13 and older. The statewide average ratio was 0.5, indicating there could be adequate capacity for older youth at a state level, if the available foster homes are compatible with the child and their needs. During this quarter, 16 counties had no teen placements, which lowers this average. Approximately 25% of foster families have indicated a willingness to accept teenagers, with 18% having a teen placement.

Several counties have more limitations on available homes, with a range of 0.7 to 2.0 placements per home. This essentially means, setting autonomy aside for review/analytical simplicity only, the number of certified homes available in these counties would require one to two youth aged 13 and older to be placed in each home. Both Wayne and Wood Counties indicated higher need for capacity, with ratios of 1.2 and 0.7, respectively. The wide variation in willingness of foster home families to accept a given placement, combined with the challenges of multiple placements in one home, highlights the need to focus on increasing the number of foster homes willing to accept teenagers.

5.2.2 Kinship Homes

The placement of children in kinship homes is a strength of WV's system of care. WV has historically led the nation in kinship placements. On average, from July to September 2024, 52%

of in-state placements were in kinship homes.[48] Although this is a decrease from previous reporting periods, DoHS has also noticed a shift in the overall number of youth in child welfare custody, which has declined by more than 1,000 between 2021 to 2024. According to child welfare data, the removal of children due to a caregiver's substance use disorder (SUD) has declined since 2018.[49] While this is a promising finding, it is important to consider the generational impacts of the crisis, as well as impacts on mental health related to the COVID-19 pandemic and subsequent social isolation. Youth exposed to substances/trauma or impacted by separation from their caregiver may be exhibiting signs and symptoms of behavioral health (mental health and substance use) disorders, which could lead to child welfare involvement (through YS) as adolescents and young adults. Trends in data throughout this report demonstrate increased acuity of need in WV. While the overall number of children in the child welfare system has decreased over the past few years, the percentage of children placed in foster or kinship care has also decreased, with in-state residential census being maintained and OOS residential census increasing, an indicator of increased need. Some of these youth may be reunited with caregivers or residing in kinship care; the challenges for others may be too intense for a community setting, resulting in residential placement being most appropriate. More information on placement type changes over time can be found in Section S.6 Community-Based Placement Capacity in the report supplement.

The Quality Committee noted some counties have higher rates of kinship placement than others. Furthermore, Wood County was flagged among multiple risk/need data indicators, including being noted as in high need of foster homes (especially for youth aged 13 and older), a low proportion of kinship placements compared to other counties, and one of the greatest rates of residential placement in WV. These findings are shared with CPAs and workers in these noted areas to address and troubleshoot barriers to establishing and retaining homes and placements in these communities.

5.3 Characteristics of Children in Need of Foster or Kinship Care

To better understand additional foster and kinship capacity needs, DoHS completed an analysis[50] of 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

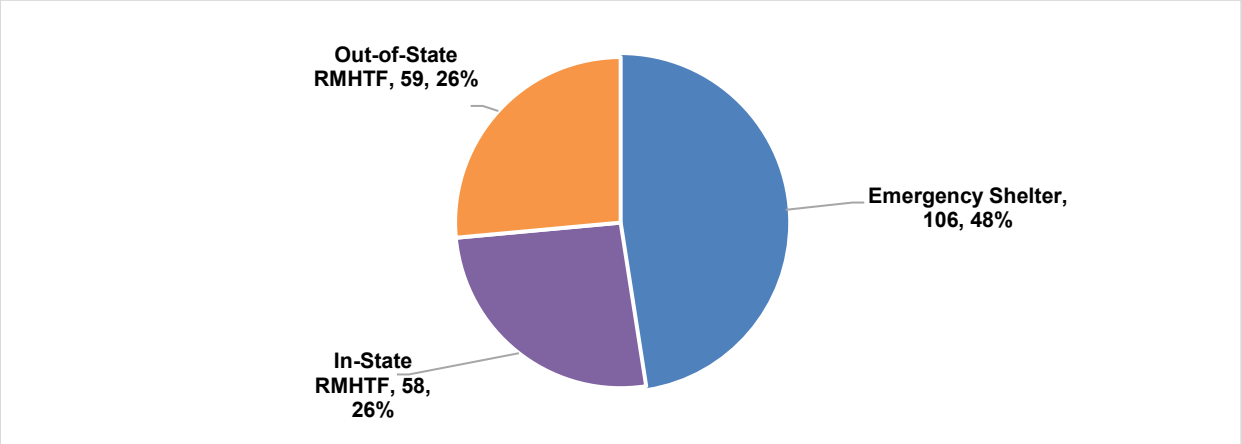
[48] This includes both certified and non-certified kinship homes.

[49] West Virginia Department of Human Services. April 23, 2025. "40 Percent Decline in Overdose Deaths in WV Linked to Fewer Kids Entering Foster Care Due to Parental SUD." *West Virginia Department of Human Services.* Accessed September 25, 2025. https://dhhr.wv.gov/News/2025/Pages/40-Percent-Decline-in-Overdose-Deaths-in-WV-Linked-to-Fewer-Kids-Entering-Foster-Care-Due-to-Parental-SUD.aspx

[50] Data was sourced from Aetna's Quickbase System for discharge planning to understand details not directly captured in PATH. 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. Children in hotels were not included in this analysis because of the typically short-term nature of these stays, and hotel stays are not captured in Aetna's Quickbase system.

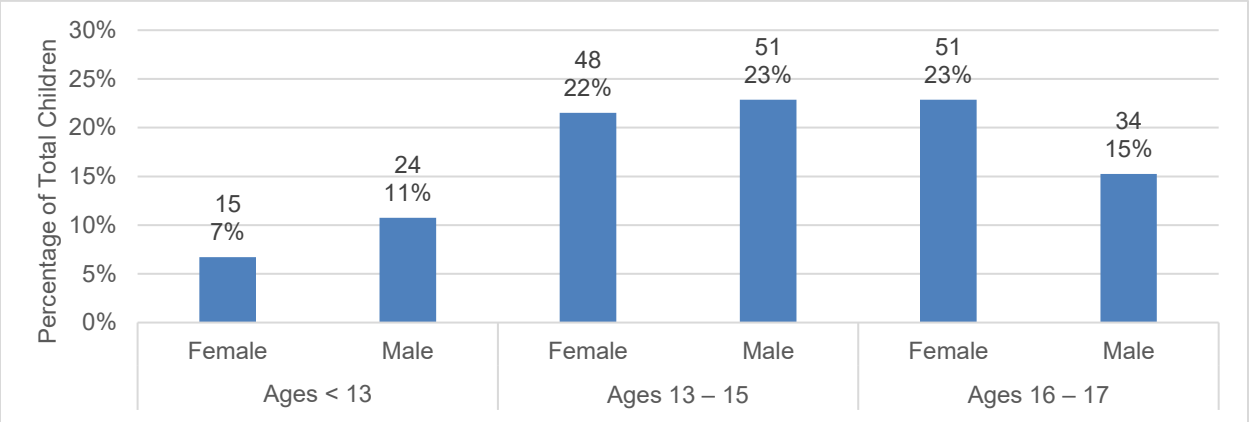
RMHTF whose discharge barrier data included “behavior being unchanged or escalating”, “awaiting transitional living”, and/or “court ordered” were excluded. Additionally, youth in emergency shelters with a barrier of “awaiting transitional living” were also excluded. Children with these barriers were excluded because these barriers may indicate the child is not ready for more immediate discharge. After applying all criteria, 223 children were identified as needing community-based placement, indicating a substantial need for additional foster and kinship homes. The current placement setting for these children is shown in Figure 32, with 52% (n = 117) residing in an RMHTF and the remainder (n = 106, 48%) being in shelter settings. Children in need of a community-based placement were nearly evenly split between in-state and OOS placements, with 59 children in OOS RMHTF compared to 58 children in in-state RMHTF settings.

Figure 32: Placement Setting for Children in Need of Community-Based Placement as of July 31, 2025 (n = 223)



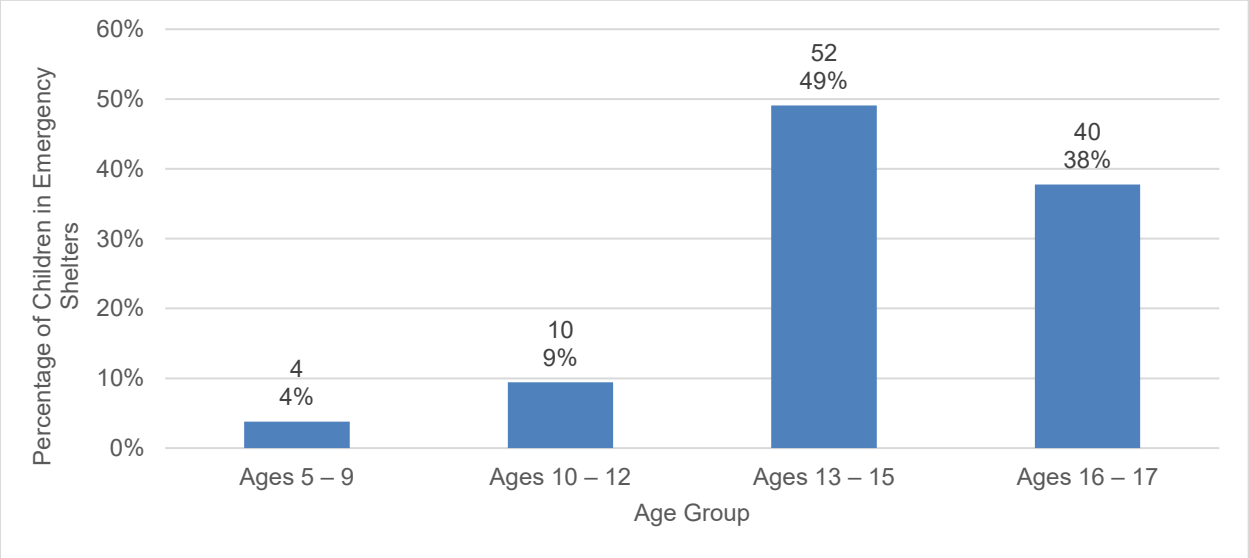
Age and sex distribution were also examined to provide additional insight into family recruitment (Figure 33). Youth under 13 years old represented 18% (n = 39) of the overall group, with males being more represented in this age range. Of those 13 and over, 46% are male (n = 85), representing a cumulative 38% of those in need. There were 99 females represented age 13 and over, 54% of children in need age 13 and over (44% of those in need).

Figure 33: Age and Sex Distribution for Children in Need of Community-Based Placement as of July 31, 2025 (n = 223)



For youth in shelter settings, as depicted in Figure 34, only 14 children were <13 years old (13%), representing a lower proportion than the total population in need shown in Figure 33 above (18% <13 years old, n = 39). The most common age of children in shelters who need a home was 13 – 15 years old (49%, n = 52). The needs of youth in emergency shelters can vary greatly when compared to those in RMHTFs. Not all youth in an emergency shelter need mental health treatment and those who do may be able to be served in a community-based setting with appropriate support. It is important when recruiting foster families that they are made aware of supports that can be put in place to strengthen their willingness to accept a child with greater needs. More information on trends in shelter placements can be found in Section 6.1 Hotel and Shelter Placements.

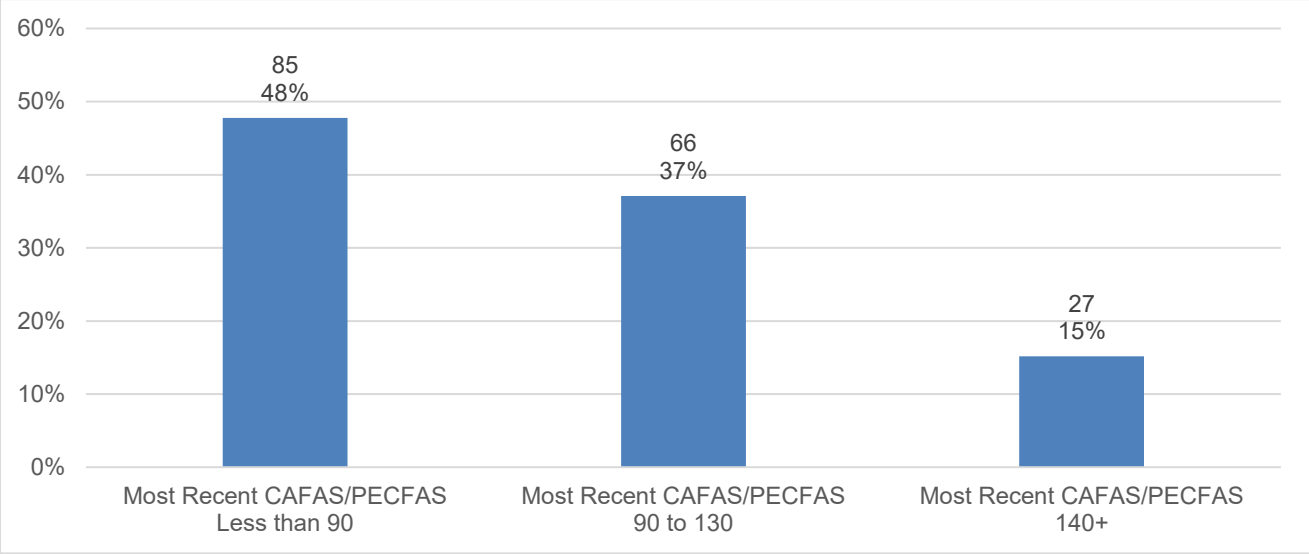
Figure 34: Age Distribution for Children in Need of Community-Based Placement Residing in an Emergency Shelter as of July 31, 2025 (n = 106)



In addition to age and sex, DoHS explored the acuity of mental health needs by reviewing CAFAS/PECFAS scores for children in this cohort. As previously described, a CAFAS score

below 90 would typically indicate a child with lower acuity of need, while children with a CAFAS score of 140 or more would typically be among the highest acuity of need. Nearly half of children in need of a community-based placement (48%) had a most recent[51] CAFAS score below 90, indicating a likely lower acuity of need (Figure 35). Only about one in seven children, or 15%, who are in need of a home had a CAFAS score ranging 140+.

Figure 35: Most Recent CAFAS/PECFAS for Children in Need of Community-Based Placement by Age Group as of July 31, 2025 (n = 178*)

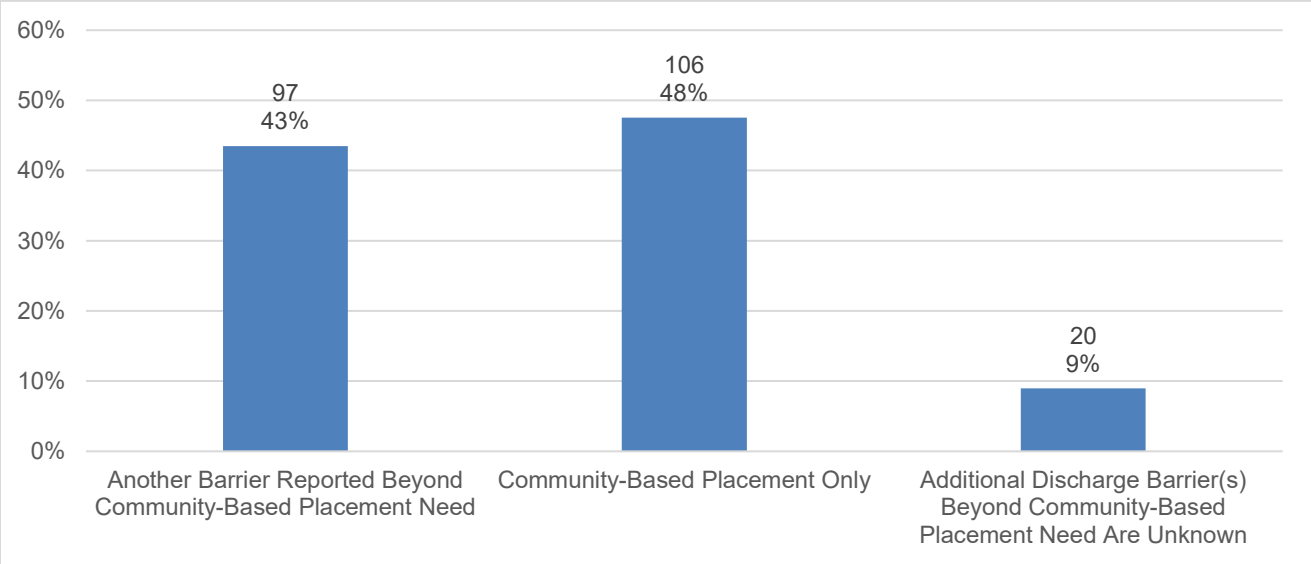


***Note:** In total, 45 youth with no CAFAS score listed were excluded.

As shown in Figure 36, almost half of children who need a community-based placement (43%, n = 97) were reported as having at least one additional discharge barrier or no other reported barrier to discharge (48%, n = 106). Approximately one in 10 children (9%, n = 20) lacked complete discharge barrier data, so the full extent of their discharge barriers beyond the documented need of community-based placement was unknown.

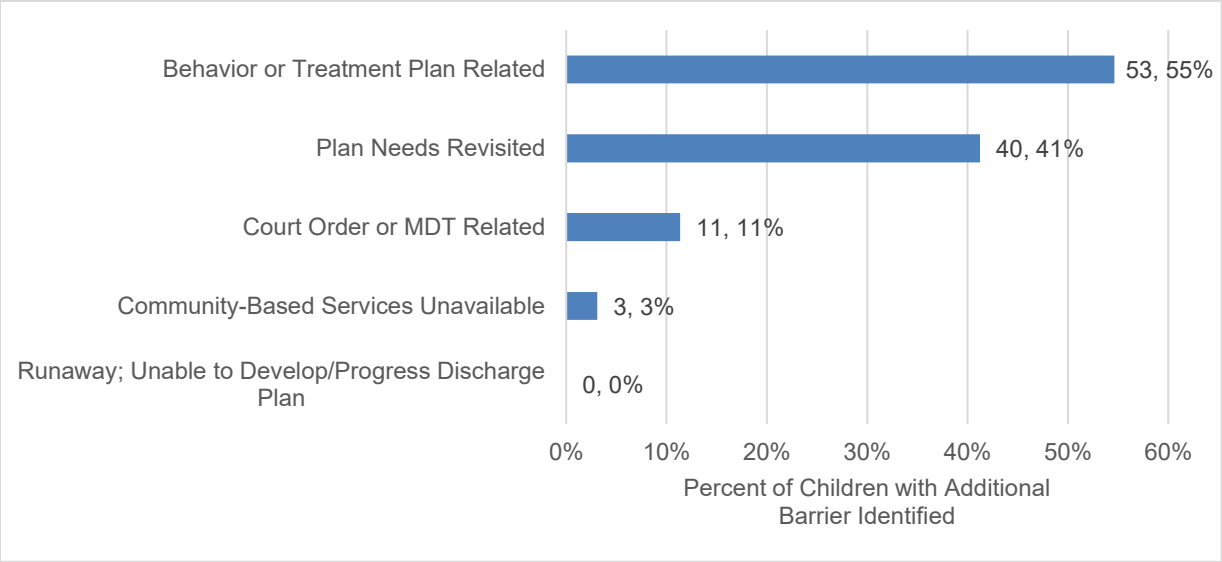
[51] CAFAS scores are reported through utilization management, which are sourced from RMHTF and shelter providers. Results may vary from those completed by the CSED Waiver process via Acentra and also from CAFAS scores at admission to these facilities.

Figure 36: Discharge Barriers for Children in Need of Community-Based Placement as of July 31, 2025 (n = 223)



Discharge barriers for the 97 youth with additional needs documented are displayed in Figure 37. The barrier most represented was behavior or treatment plan related (55%), highlighting the need for families equipped to accept placement for children with mental health needs. Community-based supports are in place to help maintain these families. Furthermore, there may be additional considerations for children with a barrier related to "not meeting treatment goals," especially if the child has been in placement for an extended amount of time. The child may not be meeting treatment goals due to impacts of the placement environment/congregate (non-family-based) setting, or goals may be unrealistic or unnecessary for the child's situation. Depending on the case, ongoing behaviors may resolve if the child was moved to the community as behaviors can often arise in the congregate care environment. Nearly half of children with an additional discharge barrier beyond community-based placement listed the need to update the discharge plan (n = 40, 41%). This additional barrier for some children may be associated with their placement need. Having a high-quality, timely discharge plan to meet the current needs of the child is extremely important to a child's success in and after treatment, even when child welfare and/or family situations can be fluid. Aetna plans to revisit this need with its Case and Utilization Management teams to emphasize the importance of having accurate, valid plans in place and to enhance protocol for following up with providers when reported plans are deemed inadequate. Case managers are also trained and will continue to be coached in strategies to help children and families overcome or navigate barriers to discharge. When a discharge plan is developed and reviewed, the following questions should always be considered: How can the child's needs be met? What supports/services could help them thrive with a family and reassure that family they can confidently accept the placement?

Figure 37: Additional Discharge Barriers for Children in Need of Community-Based Placement as of July 31, 2025 (n = 97)



Given the additional common barriers listed for this subgroup, such as the plan needs revisited (often due to the family circumstances preventing reunification), more frequent discharge plan updates may be needed for the child, understanding the situation may be more fluid in nature. If inpatient treatment is not needed, RMHTF settings should not be used as placements for children while family circumstances are managed; therefore, it is important that the child has a kinship or foster home as an alternative while family circumstances and needs are being managed.

Information on the characteristics of children in shelter and RMHTF placements in need of a community-based placement will continue to be shared with CPAs and other stakeholders to help inform recruitment strategies and supports needed for children ready to discharge to the community. Updates for these indicators will be provided routinely to help ensure recruitment strategies remain aligned with the characteristics of children in need.

5.4 Placement Stability

Children involved with the child welfare system are the largest subgroup referred to the Assessment Pathway, which indicates the high level of need for this group in addition to recognized trauma history and the relationship with behavioral health needs.[52] Given children in child welfare custody have already been removed from their home of origin due to abuse or neglect by parents or caregivers, and/or their own legal or behavioral issues, DoHS monitors the placement stability of children in custody. Understanding indicators related to placement disruption helps program leaders identify potential supports needed to help prevent further

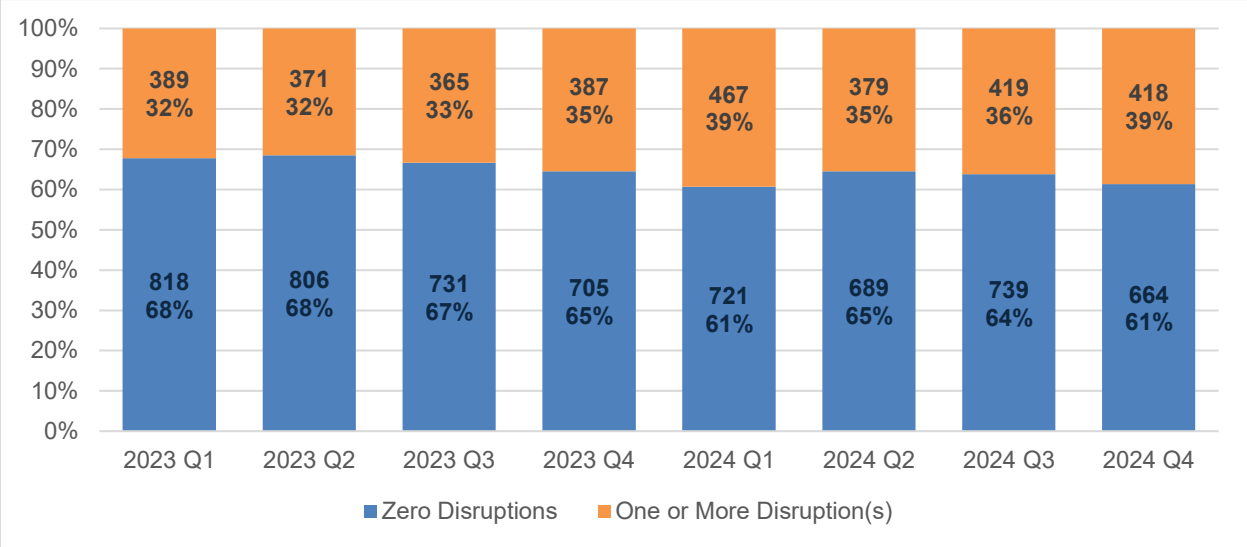
[52] Bessel van der Kolk. 2014. *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. New York City: Viking.

disruption in the child's life or future children's lives, including helping children live in the most integrated setting.

Placement stability was assessed by quarter of entry to help understand the volume of children experiencing a placement disruption,[53] timelines to disruption, and potential changes over time as interventions are implemented. DoHS started formally monitoring this indicator in May 2025; therefore, more time will be needed to evaluate the impact of targeted changes. Reporting should be considered baseline to understand disruptions.

From Q1 2023 to Q4 2024, approximately one in three children in child welfare custody had a placement disruption within 12 months of entry into their child welfare episode[54] (Figure 38). The percentage of children experiencing disruption started to increase in Q4 2023 and has risen as high as 39% in Q1 and Q4 2024. Q3 and Q4 2024 disruption data, based on placement data through August 2025, is considered preliminary because a full year has not passed since tracking entry began for children entering during those periods.

Figure 38: Children With One or More Placement Disruption(s) Within 12 months by Quarter Entering Care, Q1 2023 – Q4 2024



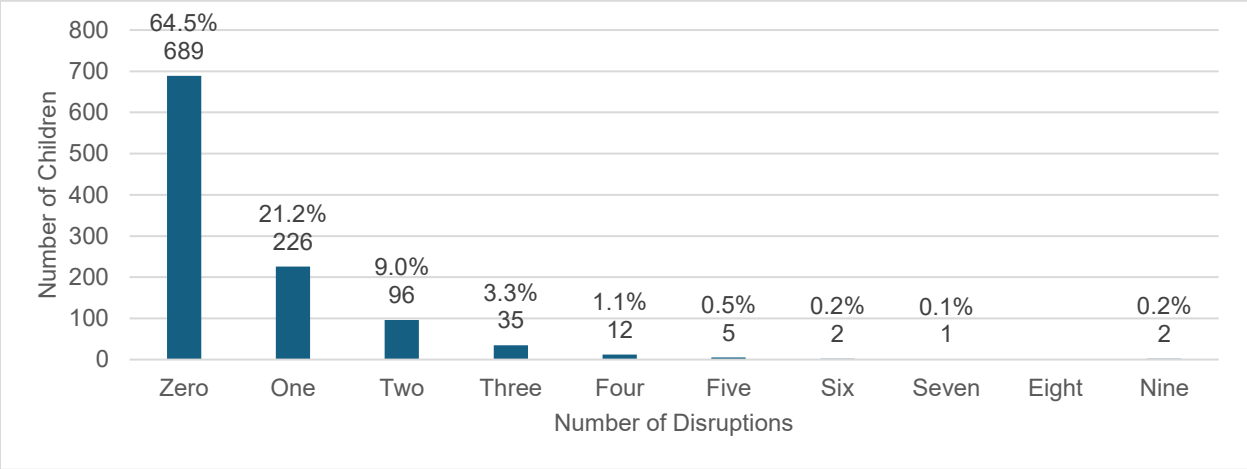
Children may have a range of reasons for disruption from a placement, and some disruptions may be unavoidable. This could include situations such as a kinship or foster parent's illness that results in the child being unable to stay in that home for a significant period of time. These situations are not easily extracted from available data. The number of disruptions a child has

[53] To complete this analysis, DoHS developed a hierarchy to define placement disruption, as not all placement changes are considered a disruption. For example, going from residential treatment to a foster home is not considered a disruption, but going from a foster home to residential treatment would be. Children going from one foster or kinship home to a new foster or kinship home, etc. would be considered disruptions as well. Consecutive, back-to-back episodes or placements with the same provider or family were merged into one to help ensure accuracy of child-level tracking.

[54] The start of the child welfare episode is the date they were first removed from their home of origin.

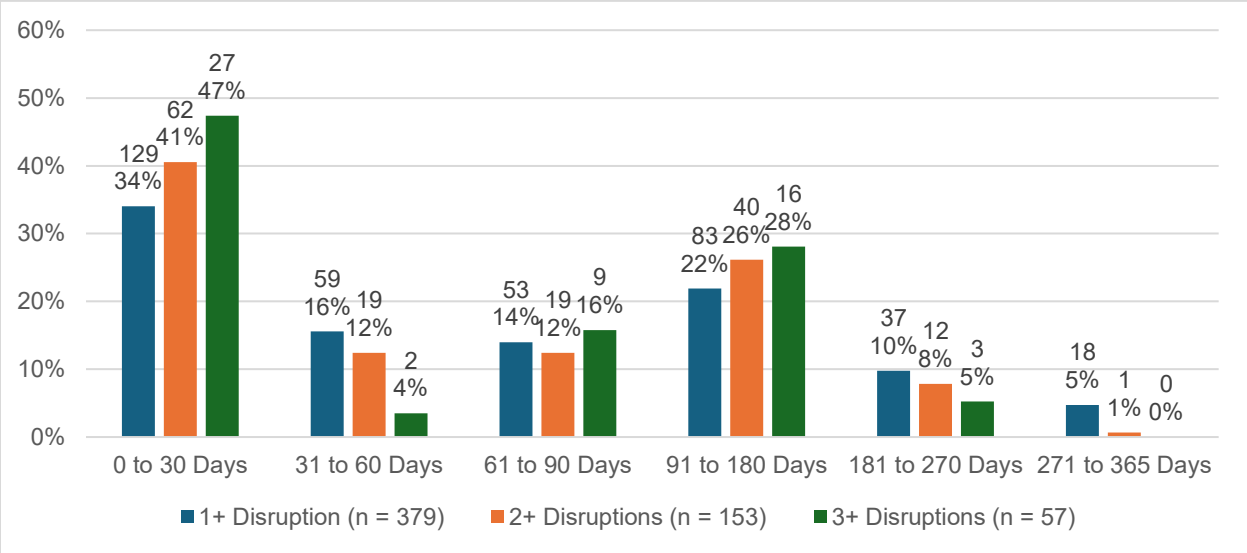
may indicate the amount of support a child needs to maintain stable placement in the future. Figure 39 shows the number and percentage of disruptions for each child entering child welfare custody in Q2 of 2024. Most children (65%) experienced no disruptions within 12 months of entering care. Children with one or more disruption represented 35% (n = 379) of children entering in Q2 2024. Most children with a disruption experienced only one disruption (21%, n = 226), 9% (n = 96) of children had two disruptions, and the remaining 5% (n = 57) had three or more.

Figure 39: Number of Placement Disruptions Within 12 Months of Entry for Children Entering Care in Q2 2024 (n = 1,068)



While there were few children with multiple disruptions, the number of disruptions was correlated with a shorter time to first disruption. This may indicate varying levels of needs for children coming into care and demonstrates the need for implementing supports quickly. As shown in Figure 40, one in three children with at least one disruption were removed from initial placement within 30 days compared to nearly 50% within 30 days of children with three or more disruptions within 12 months of entering care. Despite reviewing 12 months of placements for children entering care in Q2 2024, most children with a disruption (85%) experienced such within six months of initial placement. The median time to initial disruption for children with one or more disruption was 61 days (average of 85 days), while the median time for children with three or more disruptions was 53 days (average of 65 days). These findings demonstrate a critical timeline to identify and provide supports to children in care and their caregivers, ideally within the first 30 days of entry.

Figure 40: Time to First Disruption* for Children With Placement Disruptions Within 12 Months of Entering Care (Entries in Q2 2024)

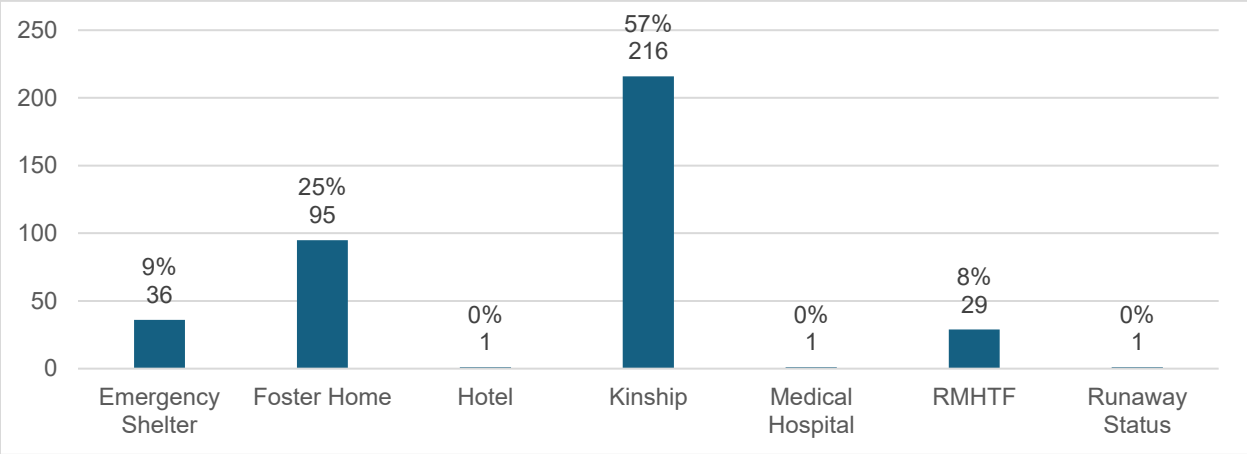


***Note:** Disruption groups are not mutually exclusive.

Figure 41 shows the placement type[55] in which the child experienced their first disruption, with the majority (57%, n = 216) of children disrupting from kinship placement. This information, combined with timelines previously described, underlines the importance of quickly placing supports (ideally within 30 days of placement) for kinship caregivers and children. In response to this information, BSS is implementing greater supports for kinship caregivers. As demonstrated in other report sections, identifying mental health needs early and making swift connections to services is a critical element to helping prevent disruption and out-of-home placement (including residential placement). BSS is working to streamline processes and help CPS and YS workers make referrals and establish connections to services for all children in need in a timely manner.

[55] Hotel data was unavailable in PATH before August 2024. Therefore, disruption data for this period may not specifically depict disruption to or from hotel for all occurrences, as these placements may have been grouped with emergency shelters in older documentation.

Figure 41: Placement Type at Time of Disruption (Where the Child Was Disrupted From) – Youth With at Least One Disruption Within 12 Months of Entering Care (Entries in Q2 2024; n = 379)



5.5 Transitional Living for Vulnerable Youth (TLVY)

DoHS continues to expand community-based services to meet the specific needs of children in care, including the addition of community-based TLVY homes specifically designed to support youth aged 16 to 21. Eligibility for TLVY was expanded to 16-year-olds based on provider feedback as of CY2025.[56] In these homes, youth can gain skills to support independent living and access necessary mental and behavioral health treatment from community-based mental health providers. These homes became operational in September 2023, with an initial capacity to support up to 22 youth. Given increased demand for these homes, DoHS has collaborated with providers to expand capacity over the past two years. Providers have operationalized multiple homes since late 2023, with 49 homes as of the end of 2024. As of September 2025, WV has a total capacity for 59 TLVY placements.

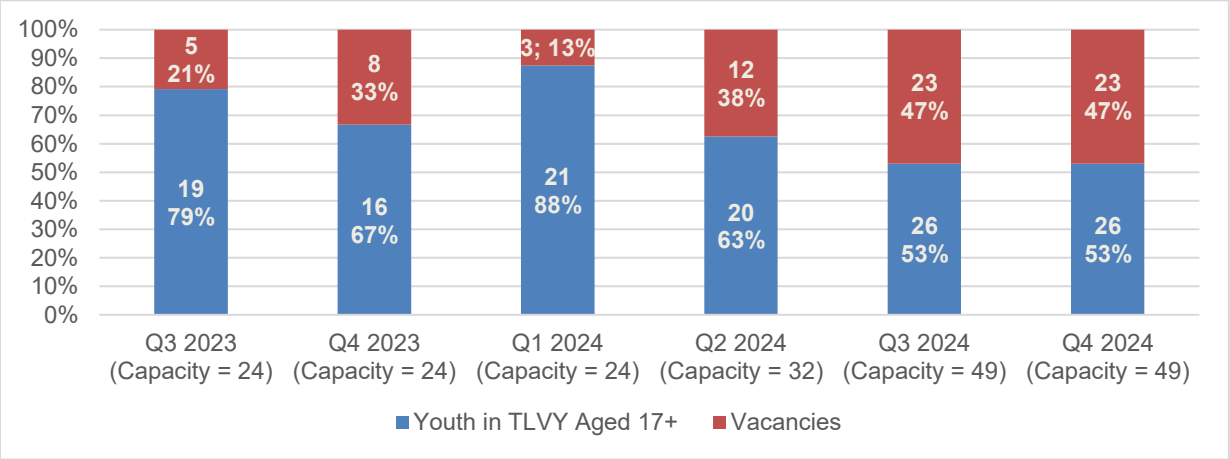
Demand for community-based placements for youth ages 18 to 20 remains high, with this group making up 11.9% of the prioritized discharge population[57] when compared to just 2.5% of the general RMHTF population. Utilization of TLVY capacity is captured in Figure 42. Approximately 53% of available capacity is being utilized as of Q4 2024, leaving capacity available to serve up to 23 additional youth. Providers have indicated, however, that staffing challenges have limited their ability to serve all youth for which they have licensure. DoHS is working with providers to identify solutions and address barriers. Per the in-state prioritized discharge planning data for the period between July and December 2024, there were 80 youth ages 17 and up. Available TLVY capacity, not limited by staffing, could potentially be utilized to support these youth transitioning to the community by leveraging available resources. Expanding eligibility to age 16

[56] Visuals in this report reference data for 2023 and 2024—when eligibility was for age 17 to 21; future reporting will expand to include 16-year-olds.

[57] As detailed in Section 7.2 Prioritized Discharge Planning, the prioritized discharge population is defined as youth in in-state RMHTF and PRTF placement from July to December 2024 with recent CAFAS/PECFAS scores less than 140 who have an anticipated discharge date in the next 60 days.

may also broaden options for youth and help increase opportunities to leverage available capacity. Aetna noted in the Quality Committee review that it would have case managers continue to look for opportunities to help ensure awareness of TLVY service options and help connect youth appropriate for TLVY services.

Figure 42: Youth Aged 17+ in TLVY Placement as a Percentage of TLVY Capacity by Quarter Since TLVY Inception in Q3 2023 to Q4 2024



Note: In 2025, eligibility for TLVY expanded to ages 16 – 21; future reporting will reflect this change.

5.6 Key Themes and Next Steps – Community-Based Placement Capacity

WV needs to recruit foster homes statewide, although some areas have higher need than others, such as counties in the southern part of the state. Wayne County, a prioritized county for intervention, was among those with higher relative need. Kinship placements appear to be providing some balance in counties with less capacity, allowing youth to foster relationships with people who already have a meaningful role in their lives.

Special consideration should be given for community-based settings for youth aged 13 and over, as children in this age range compose a large percentage of children in need of placement. Foster families may hesitate to take on teenagers as placements due to the stigma around the age group and concerns around related behaviors. Children in this age group often have a history and/or level of need that makes it difficult to place them in the community. Wayne and Wood Counties (both prioritized for outreach) have high rates of RMHTF utilization and are in the higher relative need category for foster home capacity for youth aged 13 and over. Statewide, only 25% of foster families are willing to take youth 13 and over, and this rate is not adequate to meet the volume and diversity of needs for children currently in care. TLVY is an available option for those 16 and older and should be leveraged as a resource to provide placement and permanency for youth ready to move toward independent living.

DoHS is taking steps to strengthen community-based placement availability despite identified challenges. Changes in the reasons youth are entering care, such as residual effects of the opioid crisis and the COVID-19 pandemic, might be shifting the settings and skill sets of caregivers best suited to meet youths' needs.

Meetings with and feedback from CPAs and other stakeholders have been a strength of CQI efforts and will continue in the coming year. WV foster home capacity has decreased over time, with the number of active homes stabilizing in the last several quarters due to relatively equal numbers of homes entering and exiting every quarter. Although data is preliminary, adoption or establishment of legal guardianship is the most common reason homes close. Recruiting and retaining foster home families has remained an ongoing challenge noted by CPAs, especially for homes willing to accept older children and/or children with SED. However, with the emphasis on CQI helping retention efforts over the past year, there have been increases in foster homes staying licensed and willing to accept placements for two years or longer. CPAs will continue retention efforts, along with strategic planning and marketing for recruitment of foster parents interested in accepting an older child or children with mental health needs into their home. DoHS will continue to develop strategies in collaboration with CPAs, focusing on county-level findings and identifying characteristics of children in need of a certified foster home. Results will be shared with CPAs to focus on recruitment efforts.

DoHS is also collaborating with CPAs to explore process enhancements for identifying foster placement needs and prioritizing youth identified as being “difficult to place.” One strategy for this has been to explore implementation of an electronic referral system for foster placement needs. DoHS is awaiting feedback from a child welfare system evaluation from the Change & Innovation Agency, which will influence the direction of a new referral system. The system is expected to provide more timely data, including report and dashboard visualization to CPAs and BSS staff. This will enable continued awareness of foster home recruitment needs and children who have continued need for placement, regardless of timespan, from the initial referral (in cases where immediate placement cannot be found). These strategies provide an opportunity for growth and improvement, which will be monitored in future reports to identify the impacts of these initiatives.

Approximately one in three children in child welfare custody experiences disruption from their initial placement, with most disruptions being from kinship or foster placement. The median time to initial disruption for children with one or more disruption was 61 days, demonstrating the critical timeline to identify and provide supports to children in care and their caregivers, ideally within 30 days of entry. Expanded support (through mental health services or child welfare-related supports) will factor in critical timelines to help ensure each child’s needs are identified in order to help improve overall placement stability.

The data consistently shows a pattern of older youth (18 to 20) being overrepresented among the prioritized discharge planning population compared to the general RMHTF population. The pattern of need for youth age 13 and over continues to emphasize the importance of expanding options—such as foster homes, kinship connection, transitional or independent living programs, and non-treatment-based group homes for older youth—so that once their treatment has been completed, they can return to the community as quickly as possible. With TLVY having 48% of capacity available, there is opportunity to explore additional strategies for maximizing existing resources and capacity.

6.0 Imminent Risk of Residential Placement

DoHS remains mindful of children at imminent risk of out-of-home placement, including residential treatment. To support early identification and diversion efforts, DoHS has implemented several processes, listed below, and actively monitors key indicators to recognize those at imminent risk. Children in child welfare or BJS custody who may be considered at imminent risk of residential placement include:

- Children in hotel or shelter placements, especially those with prolonged stays
- Children eligible for a QIA
    - Disrupting/at risk of disrupting from living situation
    - Court-involved due to behavior
    - The child is a danger to themselves or others
    - Court ordered to a residential facility.
- Children who have been referred to OOS placement or who are at risk of OOS placement due to the above-mentioned reasons (eligible for QIA)
- Children in BJS placements

CQI processes are still developing around these groups and being refined when needed to improve outcomes and diversion opportunities.

6.1 Hotel and Shelter Placements

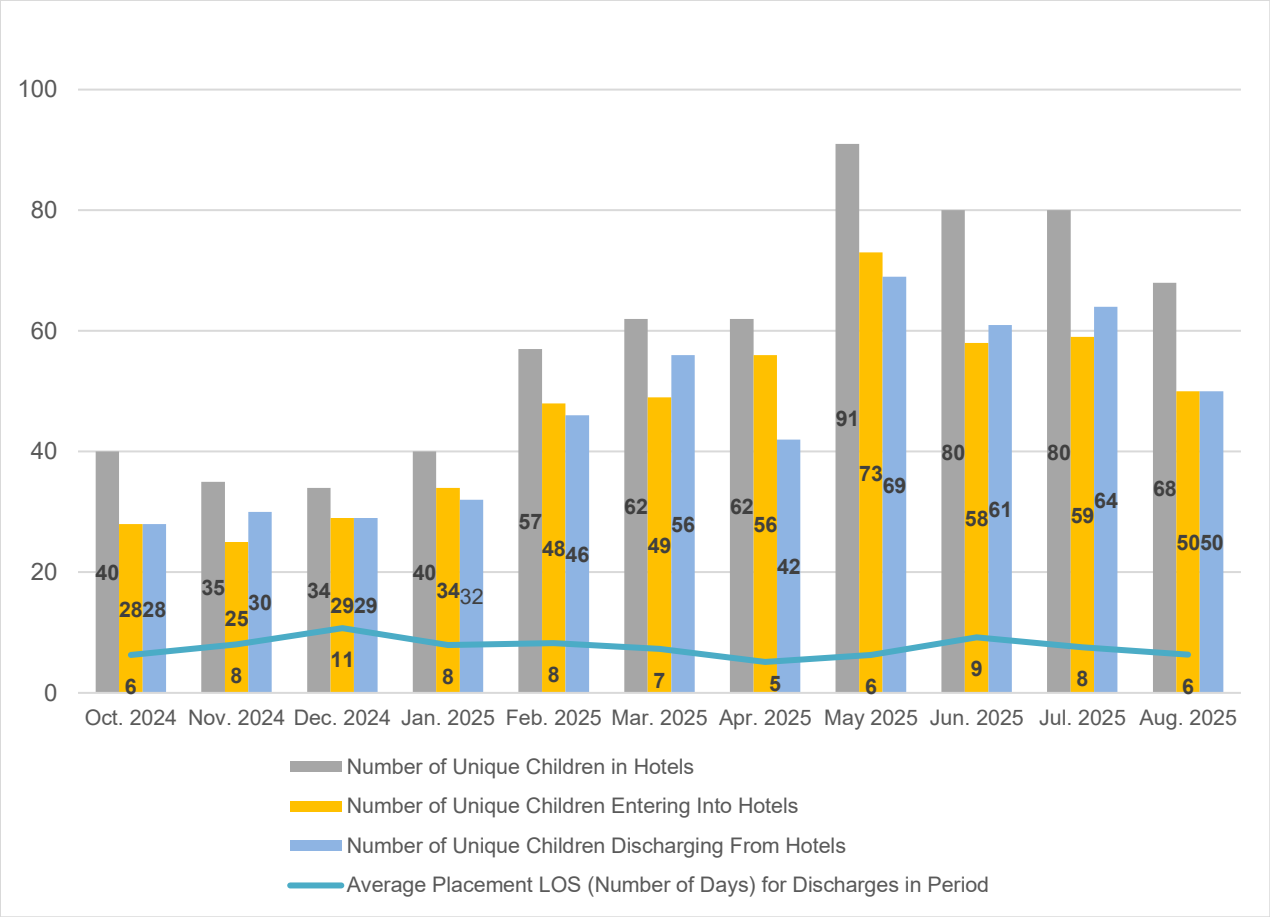
Children who do not have a community-based placement identified are typically placed in emergency shelters. When shelter placement is not an option, a child may be placed in a hotel setting until a more appropriate placement can be found. These settings are meant to be temporary and used in limited cases where no other option is available. As described in Section 5.0 Community-Based Placement Capacity, despite efforts to increase available foster homes, more homes are needed to meet existing needs. This is further evidenced by recent hotel and shelter placement data, which has shown increased utilization starting in late 2024. While 2025 data is outside the primary time frame for this report, data from this period has been included for important context and for a timely update to understand and address ongoing needs.

Hotel Stays

Figure 43 shows that the number of children in a hotel placement (at least one day in the month) began increasing in February 2025 and peaked in May 2025, with 91 children placed in a hotel in May 2025. Since May 2025, the number of children in such a placement has gradually decreased to 68 for August 2025, a volume similar to April and March 2025 (both n = 62). In response to the rising number of children requiring a hotel placement, in early 2025, DoHS developed a task force to address needs by prioritizing and coordinating placement solutions for children in hotel and shelter settings. These Call-to-Action meetings have allowed DoHS, CPAs, residential providers, and other key stakeholders to collaboratively identify creative solutions for

prioritized children. These efforts helped identify more appropriate placements for many children as well as facilitate discussions for longer-term solutions based on overarching placement needs (e.g., homes for older youth, child care needs for older youth) and in-state residential provider needs (e.g., treatment programs for ASD, sexualized behaviors, female children). Focus on creative solutions to find placement have also helped maintain lower LOS, despite increased volume of children in hotel settings, driving demand for community-based placement.

Figure 43: Unique Children in Hotel Placements* at Least One Day and Average LOS, October 2024 – August 2025



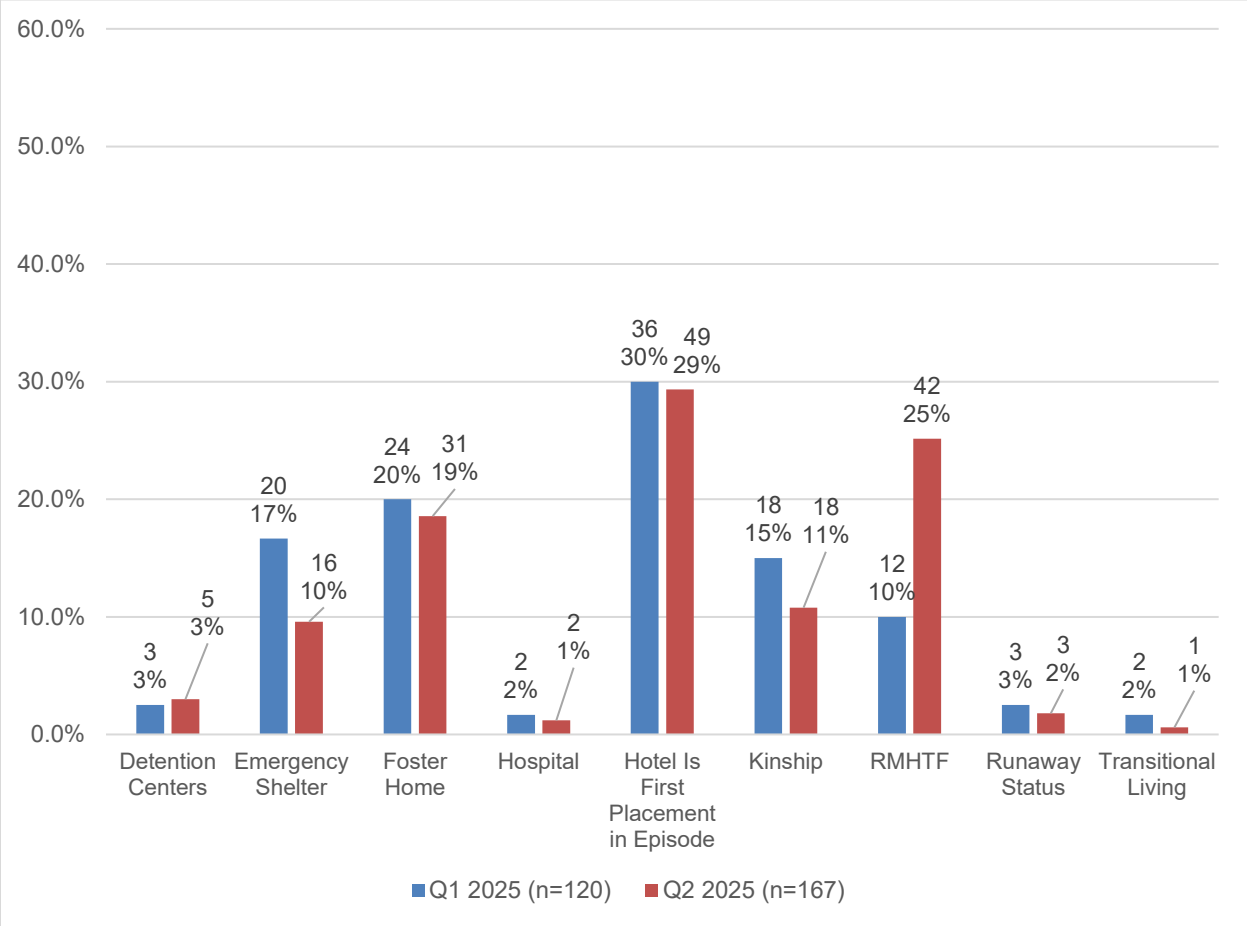
***Note:** Concurrent placements for hotel stays have been linked together due to the nature of these placements to produce a better understanding of time in placement.

The average LOS in a hotel has remained between five and nine days since October 2024. From April to June 2025 (Q2), 30% of children with a hotel placement were placed for a week or longer (n = 48 of 162). The average time in Q2 was eight days, with a median of four days.

To understand drivers, outcomes, and resource needs, DoHS explored placement settings before and after hotel stays (Figures 44 and 45). When considering what placement occurred directly before the hotel placement, initial placement in a hotel in the child welfare episode was the most common in both quarters (30% for Q1 2025 and 29% for Q2 2025). There have been major shifts in other categories since hotel volume has increased, including increases in the rate

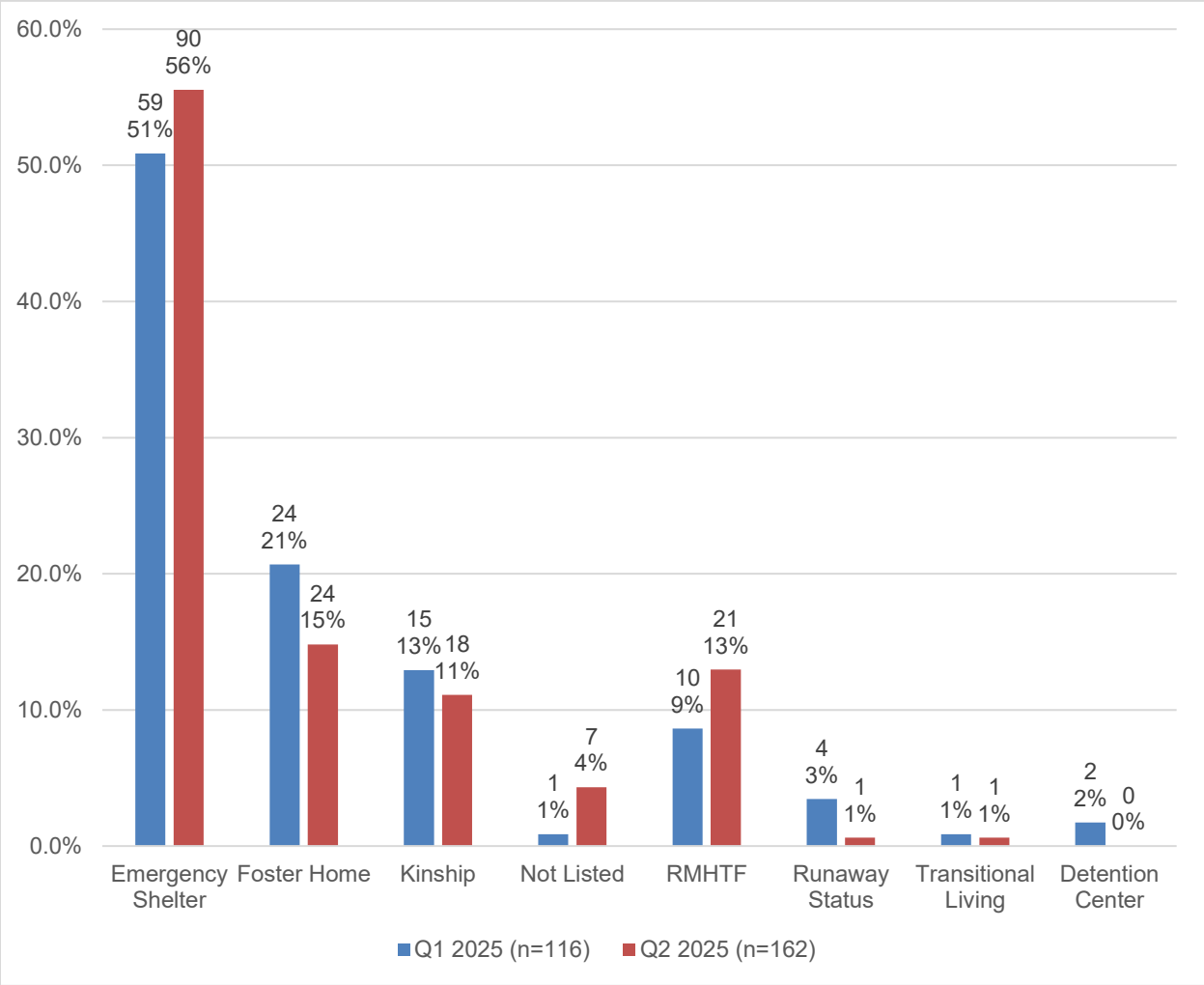
of RMHTF being the placement before hotel; RMHTF placements were only 10% in Q1 2025, but increased to 25% in Q2 2025. The increases in children moving from an RMHTF to a hotel may indicate a disruption from placement due to the facility's inability to meet the child's needs or the child being discharged after completing treatment without a home to go to. Without a chart review, exit reasons are unclear as to the exact reason for discharge. More information will be reviewed internally to investigate specific drivers, but initial results point to needs related to treatment models as well as discharge planning placement efforts (e.g., helping ensure discharge is not abrupt and a placement plan is in place as treatment concludes).

Figure 44: Summary of Hotel Stays – Q1 2025 Compared to Q2 2025, Placement Type Before Initial Hotel Placement



The most common placement after a hotel stay was a shelter (56% in Q2 2025, up from 51% in Q1 2025, Figure 45). Increases have been identified with RMHTF as the next placement (9% in Q1 to 13% in Q2), while foster home as the next placement has trended downward (21% in Q1 to 15% in Q2). This may be a result of capacity limitations of foster homes willing to accept older youth and/or youth with higher acuity of mental health needs. Children in hotels may also need a higher intensity of service, which could include residential placement. QIA referrals and recommendations are expedited for a quicker turnaround time for children in hotels to help with appropriate decision-making.

Figure 45: Summary of Hotel Stays (Discharged) – Q1 2025 Compared to Q2 2025, Placement Type After Initial Hotel Placement



Shelter Placements

Figure 46 shows gradual increases of the number of children in a shelter placement (at least one day in the month) from October 2024 to April 2025, which has remained stable at around 200 children served per month since then. This indicator demonstrates an increased demand for placements that can accommodate a variety of needs, some of which may not be met with existing in-state capacity. As previously described, foster parents have the autonomy to decide which placements are likely the best fit for their family, which means existing capacity can be limited by foster families' willingness to accept youth based on characteristics such as their age or acuity of need. The average LOS has fluctuated, ranging from 35 to 62 days since October 2024. From April to June 2025 (Q2), 54% of children with a shelter placement were placed for a month or longer (n = 147 of 272). The average time to discharge for Q2 discharges was 58 days, with a median of 40 days. Despite a higher number of children in shelters, LOS has remained relatively stable, due to work being done with the Call-to-Action task force to help identify placement solutions whenever possible.

Figure 46: Unique Children in Shelter Placements at Least One Day and Average LOS, October 2024 – August 2025

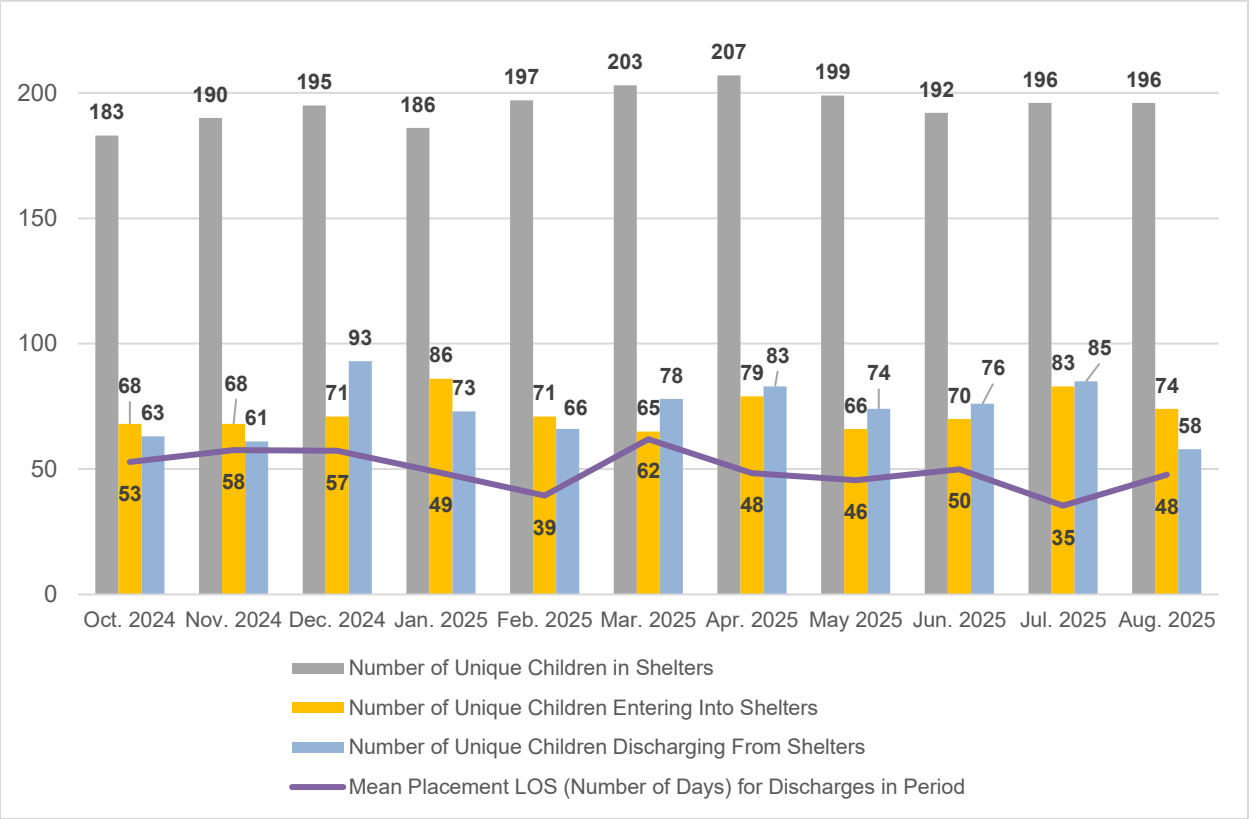
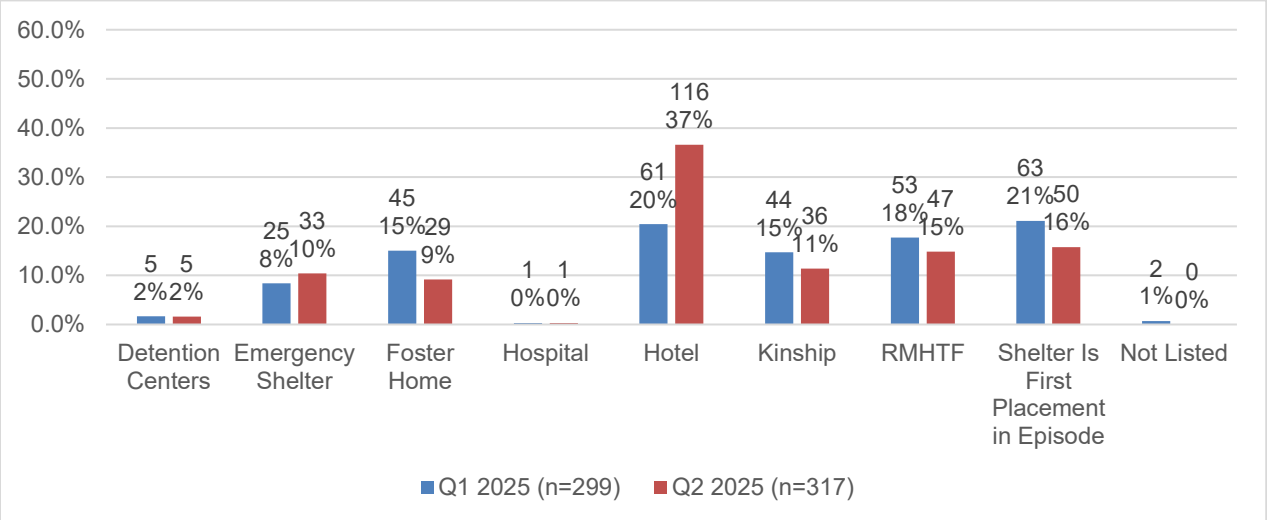


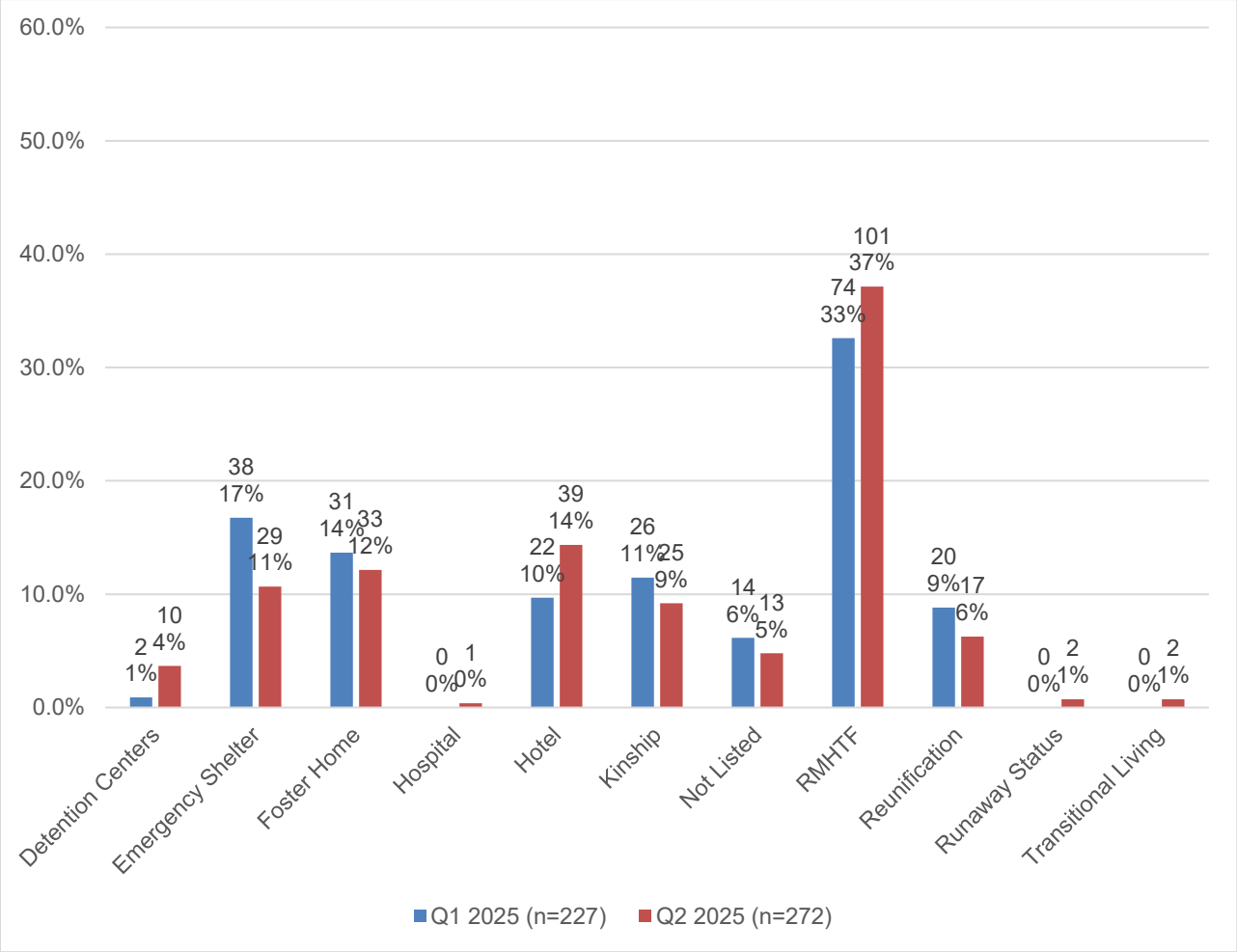
Figure 47 shows placement setting before shelter placement for youth in shelters in Q1 and Q2 2025. Given previously described increases in hotel stays, the increase in children coming from hotels and going into shelters—up from 20% in Q1 2025 to 37% in Q2 2025—may be expected. Most other placement types showed a slight decrease from Q1 to Q2.

Figure 47: Summary of Children With Shelter Placements – Q1 2025 Compared to Q2 2025, Placement Type Before Shelter Placement



Placement in an RMHTF setting after a shelter stay has increased from 33% in Q1 to 37% in Q2 2025 (Figure 48). Children being discharged to kinship care, foster care, or reunification trended down in comparison. Again, this may be due to both lower availability of community-based placement capacity for children with high acuity of need, as well as increased acuity of need, which may also result in more children needing residential placement.

Figure 48: Summary of Shelter[58] (Discharged) – Q1 2025 Compared to Q2 2025, Placement Type After Shelter Placement



DoHS plans to conduct an analysis during the coming months of children in residential placement to identify interactions and characteristics of children entering these settings to help more clearly identify and address needs, including placement needs based on the child's acuity. Leveraging data-informed strategies, DoHS will subsequently continue to work with CPAs, residential providers, and stakeholders to identify and address needs via creative solutions.

[58] Some children may have multiple shelter placements (some concurrently). For this analysis, these stays were not combined.

6.2 Qualified Independent Assessment

Any child involved with child welfare who is at high risk of residential placement should always be referred for a QIA as part of the Assessment Pathway process. Children referred for QIA receive further assessment to more objectively evaluate their level of acuity and assess the most appropriate and integrated setting to meet the child's needs. "High risk" is defined as meeting at least one of the following categories:

- Judicial involvement or court order indicates the child may need residential care, requests exploration of residential placement options, and/or requests that a referral be made to residential treatment facilities.
- The child is uncooperative with the court's requests.
- The child has disrupted other arranged placements, 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 assessed as unsafe, and no alternative family settings are available.
- The child has no stable family home or other living arrangement available.
- The child requests placement in an RMHTF.
- The child has been adjudicated as a status offender or delinquent.
- The child has been previously adopted, and the adoption is at risk of disruption.
- The child is a danger to themselves or others.

Acentra, the contracted vendor, completes the QIA process and resulting recommendations reports. A BSS caseworker submits the CSED Waiver application at the same time as the QIA referral, if an application has not already been submitted, to ensure full assessment for services. A CAFAS/PECFAS and CANS assessment are utilized in the QIA process. Once these assessments, collateral contact interviews, and clinical reviews are completed, Acentra recommends the intensity of services that would meet the child's needs using the CANS Decision Support Model. The QIA identifies the child's needs and recommends the appropriate level of intervention and most integrated service setting to meet those needs.

6.2.2 Review Summary

On average in CY 2024, over 100 children were referred for a QIA each month. Table 9 reports the number of referrals in 2023 and 2024. The increase in referrals from 879 in 2023 to 1,304 in 2024 was largely due to BSS' work to train child welfare workers on appropriate referral practices as well as the focus on county-level data reviews to influence targeted intervention and technical assistance to help county districts identify when a referral is necessary. A process was developed to expedite referrals, which have immediate imminent risk of residential placement. Given the time sensitive nature of expedited referrals, the target timeline for completion of the QIA is 14 days compared to 30 days for regular referrals. Criteria for

expedited referrals include youth with court orders to residential placement and youth in DoHS custody who were placed in an ED, acute hospital unit, or hotel setting. In 2023, 32% of referrals met criteria for expedited assessment. In the following year, this number increased to 39% (Table 9), which may be due to increased utilization of the process for children with imminent risk. DoHS continues to collaborate with the vendor to optimize the QIA process to complete all referrals as quickly as possible.

Table 9: QIA Referrals by Year, 2023 and 2024

	2023	2024
Total Referrals	879	1,304
Percentage Expedited	32%	39%

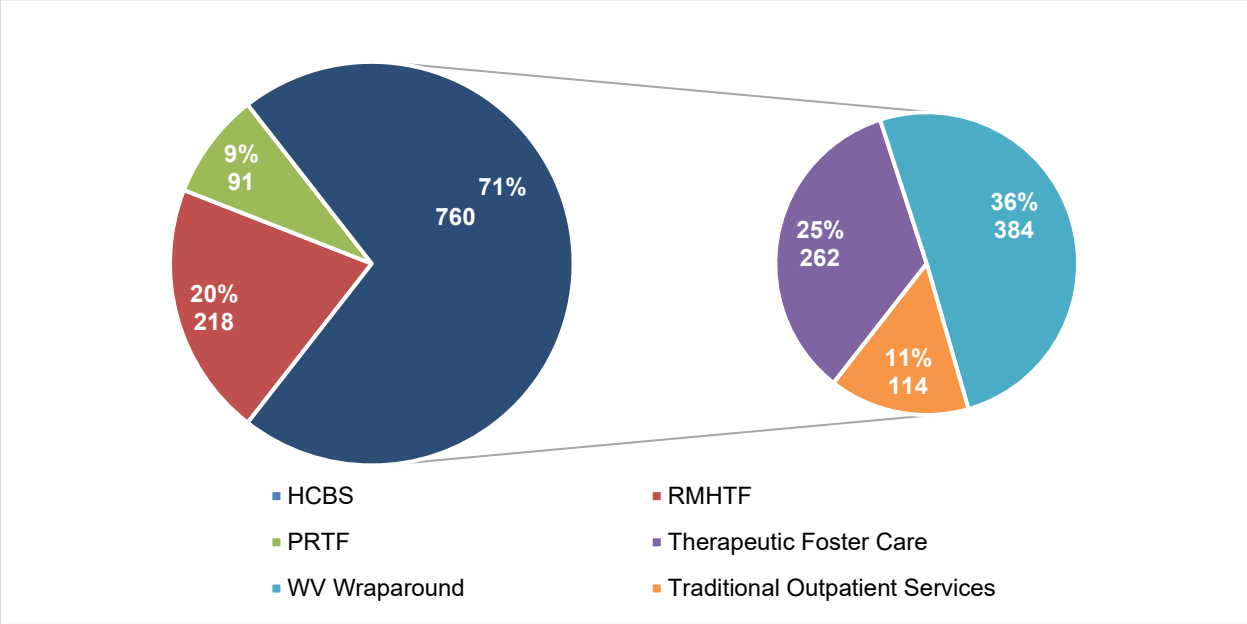
DoHS has worked diligently with Acentra to monitor timeliness and address barriers to meeting expected timelines for referrals. Some components of these efforts have included Acentra hiring additional assessors, implementing an escalation process to help ensure timely contacts and BSS worker responses to requests for information, and increasing both the frequency and quality of data review. As the QIA process has expanded, the percentage of referrals documented and completed within 30 days or less has improved. Completed referrals originating from July to December 2024[59] (n = 494) were communicated back to DoHS, on average, 26 days following referral. DoHS continues to work closely with Acentra to reinforce and enhance processes to encourage punctual, quality assessment reports for clinically focused decision-making. It is essential for recommendations to be provided in a timely and accurate manner to help ensure this process is done in a way that allows for diversion opportunities. Expedited referrals continue to be a challenge, though. Strategies to make lines of communication easier for all parties are needed to meaningfully impact the ability to complete these time-sensitive referrals within 14 days. DoHS is working closely with Acentra and BSS workers to address these barriers.

DoHS collaborates with MU and the Praed Foundation to automate the Decision Support Model predicated on the CANS assessment tool. The model consists of five levels of intervention. Level 1 is the lowest level of intervention or need and consists of treatment and services offered through traditional foster or kinship care, while Level 5 is the highest level of intervention, which reflects PRTF-provided treatment. The Decision Support Model assists with making intensity of intervention recommendations based on treatment need and complexity. If a QIA recommendation differs from the Decision Support Model, the assessor must justify their recommendation. For children with a completed QIA referral in 2024 (n = 1,069 total referrals), 71% (n = 760) received a recommendation to obtain treatment via HCBS (Figure 49). This finding shows that nearly three in four children at imminent risk for RMHTF who were reviewed

[59] Significant efforts to shorten timelines were put in place in early 2024; therefore, only the last half of 2024 was included because data from this period more accurately conveys current expectations for timelines to recommendation.

through the QIA process were recommended to have services provided in the home and community—a key opportunity for diversion based on objective and clinical decision-making.

Figure 49: QIA Recommendations by Setting, January to December 2024 (n = 1069)



QIA recommendations can be used to aid decision-making and reframe cultural norms to help prevent inappropriate use of residential treatment facilities. Access to timely QIA information to make informed decisions will offer a continued opportunity to shift cultural norms/practices with placements. Case managers/coordinators through MU and Aetna have opportunities through discharge planning and other case management work to participate in MDTs and advocate and bring QIA recommendations forward in addition to caseworkers and other team members. Prompt QIA information will also help establish standards of assessment and objective determination for treatment needs before making referrals to an RMHTF. The QIA process has also been a focus of BSS's outreach and education with the judicial community to assist with understanding the benefits of this process while also building rapport as implementation moves forward and the process improves. Enhanced processes and protocols are being expanded to help ensure the quality and validity of QIA recommendations.

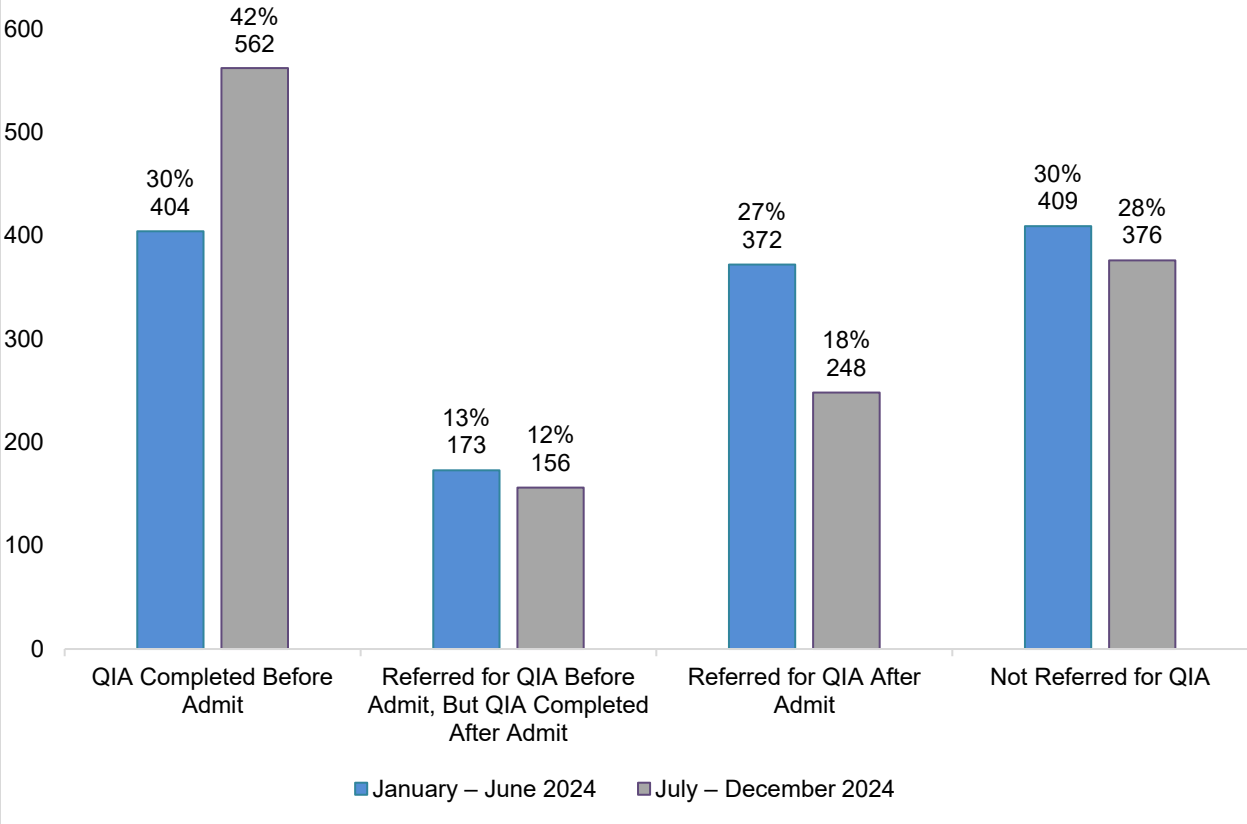
6.2.3 QIA Completion Prior to RMHTF Admission and Related Outcomes

As part of the implementation of the QIA process, DoHS aims to have a QIA completed for every child who is admitted to an RMHTF. Given the volume of children in residential facilities and the recurring demand for QIAs for children at imminent risk of residential placement, it would not be possible to complete all referrals at the same time and in a timely manner. Therefore, DoHS has prioritized referrals for children who are at imminent risk of residential placement. This strategy is expected to offer opportunities for diversion from inappropriate placement and allow youth who are newly admitted to a residential placement to have a recommendation in place, ideally, prior to admission. As previously noted, safety net procedures have been developed with Aetna to identify children without QIAs entering RMHTFs and to

follow up with providers to submit a referral. Enhanced availability of QIA status information with Aetna began in May 2024 and will expand to weekly updates in October 2025. It is expected that, over time, as children are discharged and new children are admitted utilizing the QIA referral process, all children in residential facilities will have had a QIA.

Figure 50 shows children in RMHTF placement at any point in 2024 along with information regarding QIA referral status by semi-annual period. The number of youth with a completed QIA prior to admission showed marked improvement, with an increase from 30% during the prior six months to 42% in July to December 2024. There was little change in the percentage of children with no QIA referral at any point, with both January to June 2024 and July to December 2024 representing 30% and 28% of youth, respectively. A worker- and county-level report was implemented in June 2025 to help identify children at imminent risk and identify focused opportunities for education on timely referral practices through quality review processes.

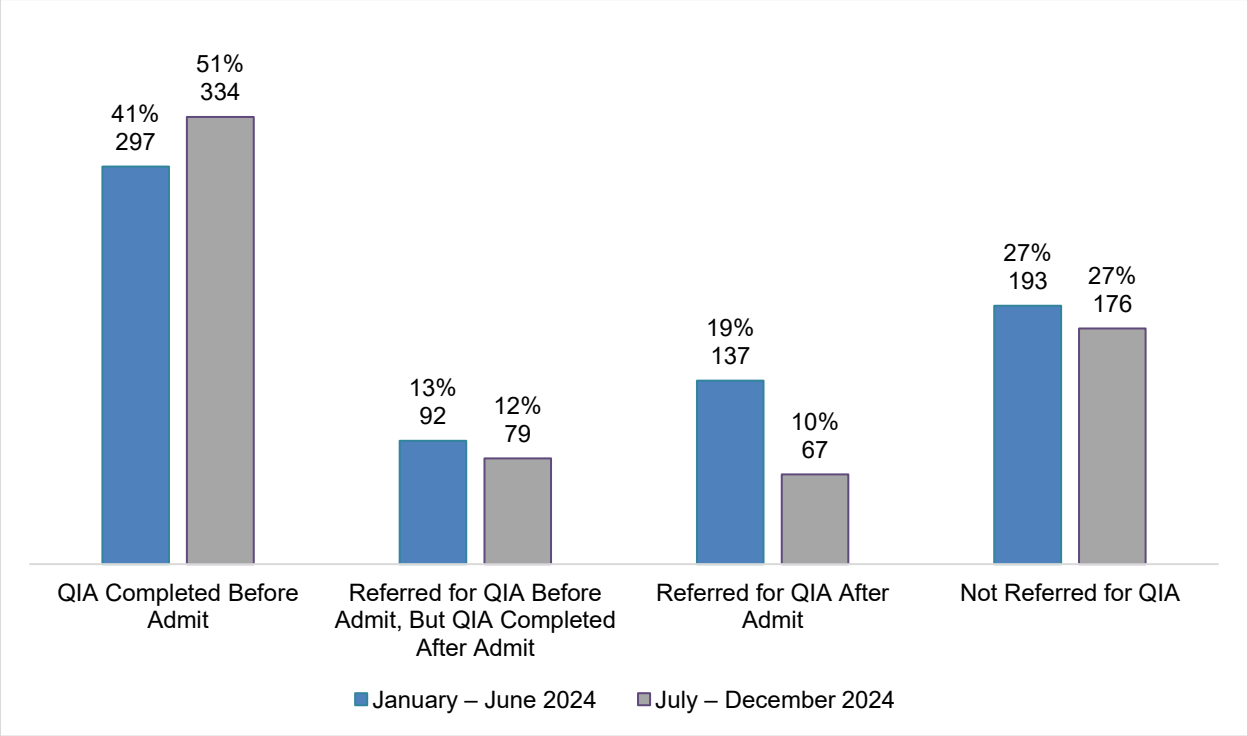
Figure 50: Children in Active RMHTF Placement Compared to Time Frame of QIA Referrals, January – June 2024 (n = 1,358) vs. July – December 2024 (n = 1,342)



DoHS also reviews monthly QIA status for new admissions to RMHTFs to measure the implementation progress of the QIA process. This is demonstrated in Figure 51 at the state level by semi-annual period. From the first half to the last half of 2024, QIA completion prior to RMHTF admission increased from 41% to 51%. This is an encouraging finding likely associated with the focused efforts for timely referral and recommendation, which is expected to increase insight into child clinical needs and to offer opportunities for diversion from inappropriate placement. Slightly more than a quarter (27%) of youth admitted to an RMHTF in the CY had

not been referred for a QIA. DoHS continues to work on strategies to help ensure every child has a clinical recommendation in place that can be used to help ensure appropriate placement. As previously mentioned, DoHS will continue using CQI review processes to influence decision-making, accountability, and follow up to help ensure the QIA process is followed and completed in advance of placement to a less integrated setting.

Figure 51: RMHTF Admissions* by QIA Status, January – June 2024 (n = 719) vs. July – December 2024 (n = 656)

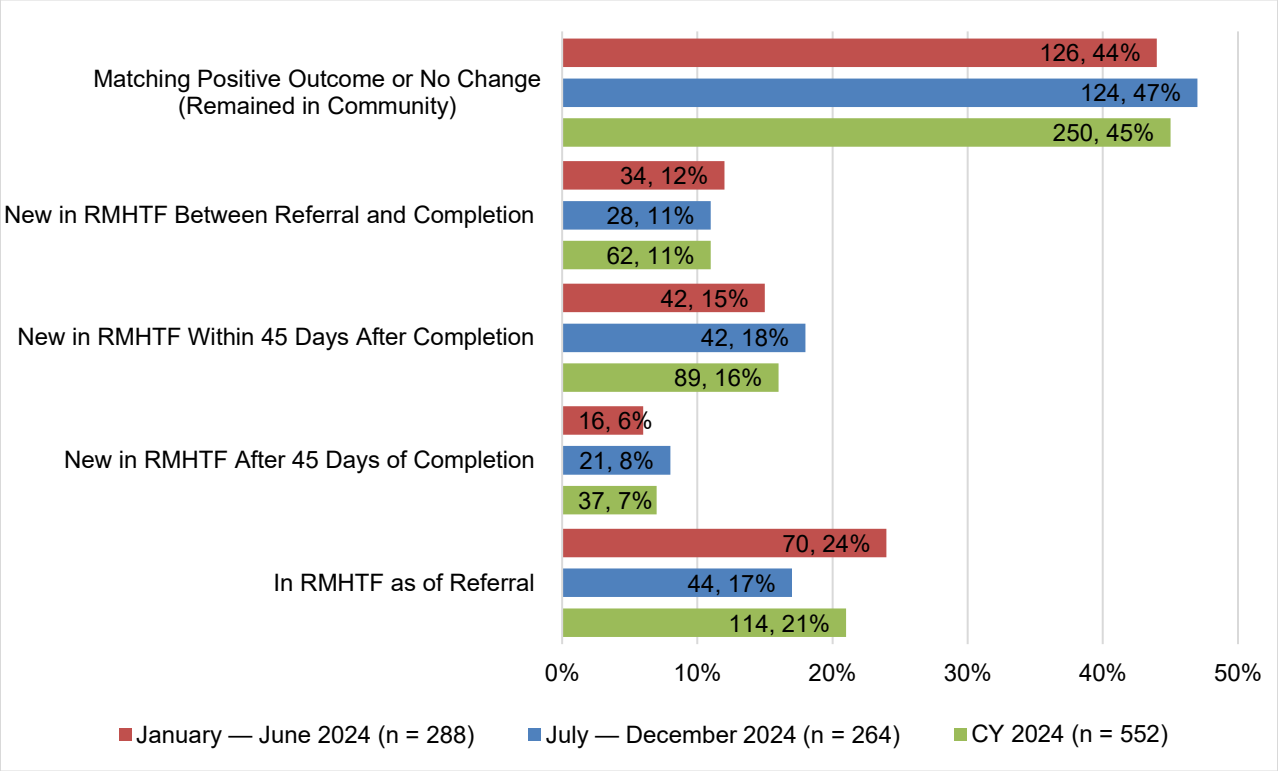


***Note:** If individual children had multiple stays per month, the most recent stay was utilized for the analysis.

As noted throughout this section, QIA recommendations are intended to offer opportunities to divert children from inappropriate settings based on their clinical needs. Of children with QIA referrals between January and June 2024 with a recommendation of HCBS (n = 288), 44% were noted as moving to or remaining in their community within 45 days after QIA completion (Figure 52). In the second half of 2024, this increased to 47% (n = 264), which shows incremental progress toward greater utilization of these recommendations to help children thrive with appropriate supports in their communities. Conversely, in CY2024, 16% (n = 89) were placed in an RMHTF within 45 days of completion; this may be considered a missed opportunity for diversion, given the applicable clinical recommendation. Driving factors for recommendations not being followed are not yet concretely understood. Some drivers may be related to timing (children already court ordered to residential placements around the time of QIA referral or already in an RMHTF placement at the time of recommendation). Other considerations for outcomes related to QIA recommendations included 11% of children being placed while waiting for the QIA to be completed. Some improvements were also seen with the percentage of children already placed in RMHTF at the time of referrals decreasing (24%, n = 70, January –

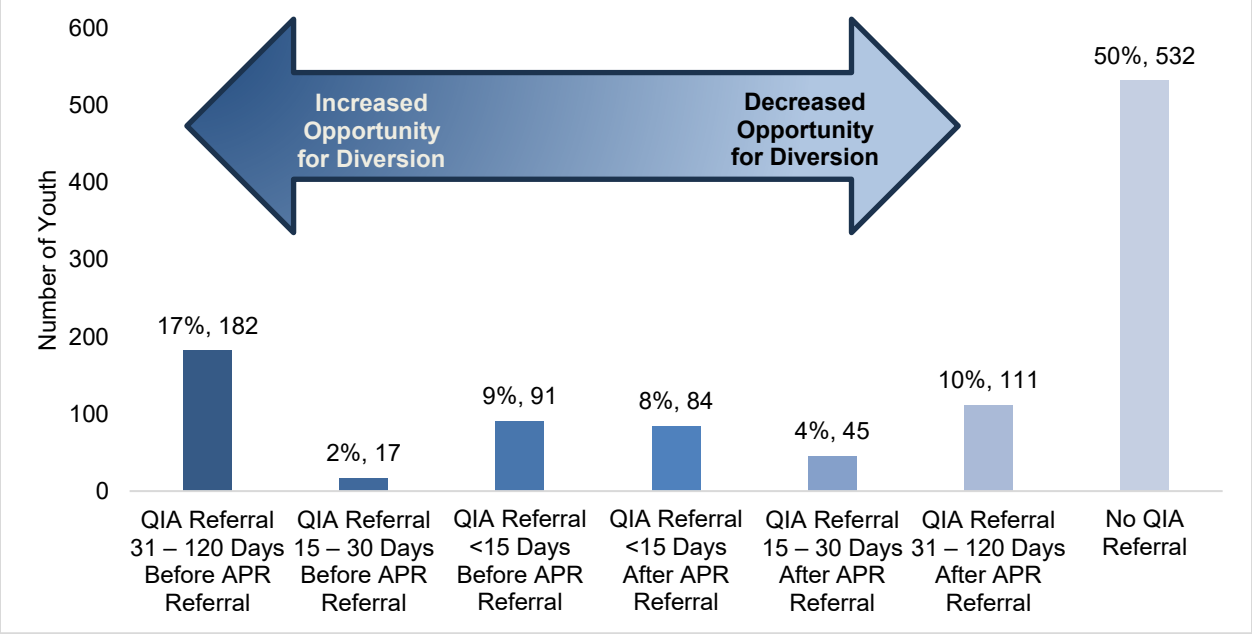
June 2024; 17%, n = 44, July – December 2024), highlighting the continued importance of and focus on timely referral practices, including early identification of imminent risk.

Figure 52: Outcomes for Children With a QIA Recommendation for HCBS, CY2024



An Automated Placement Referral (APR) feature was implemented in the PATH system to allow a child's information to be sent to all in-state providers at the time of a residential placement request. Providers can respond by asking for more information or by accepting or declining the referral. BSS leadership recommended monitoring in-state RMHTF referrals made via the APR process compared to QIA referrals instead of only looking at RMHTF placements to enable a more real-time response to identifying imminent referral needs. Figure 53 compares referral data from the QIA and in-state APRs from July to December 2024. As shown by the arrow, the bars to the right indicate inadequate time for QIA recommendation feedback and decreased opportunities for diversion, whereas the bars to the left indicate increased opportunities for diversion, given consideration for the time needed to obtain a recommendation from the QIA process. The results found that 50% (n = 532) of in-state RMHTF referrals had not received a QIA referral, 22% completed a referral to the QIA process after the RMHTF referrals had already been submitted, and 9% were completed in less than 15 days prior to completing an RMHTF referral. These results reinforce the opportunities previously described that identifying and referring a child early provides a greater opportunity to improve outcomes. Some QIA referrals, encouragingly, were submitted well in advance of the RMHTF referral, with 17% of referrals for RMHTF having had a QIA referral made more than 30 days in advance of submitting the RMHTF referral, with the remaining 2% having a QIA submitted within 15 to 30 days of an APR referral. DoHS will use the previously described CQI efforts (e.g., CQI processes, worker training) to address timely referral needs.

Figure 53: Timeliness of QIA Referral Compared to In-State RMHTF Referral Processes (APR) (n = 1,062), July to December 2024



6.3 Out-of-State Risk

DoHS established an OOS risk referral protocol in late 2022 to enable close monitoring of youth being admitted to OOS facilities. The protocol requires multiple levels of BSS leadership to review the referral, helping ensure all other options have been explored and that the youth is admitted to the most integrated placement given their unique needs. An automated tracker for children at risk of OOS placement went live in fall 2024. As shown in Figure 54, nearly one in three children referred to this process were able to be diverted from an OOS facility to more integrated placement,[60] based on referrals made in the formal tracking system January through June 2025 (differing period due to data availability).

[60] In-state facilities, community-based placement, and juvenile incarceration facilities are considered more integrated than OOS facilities due to proximity to a youth's community of origin.

Figure 54: Outcome of Closed OOS Risk Referrals[61] (n = 342), January to June 2025

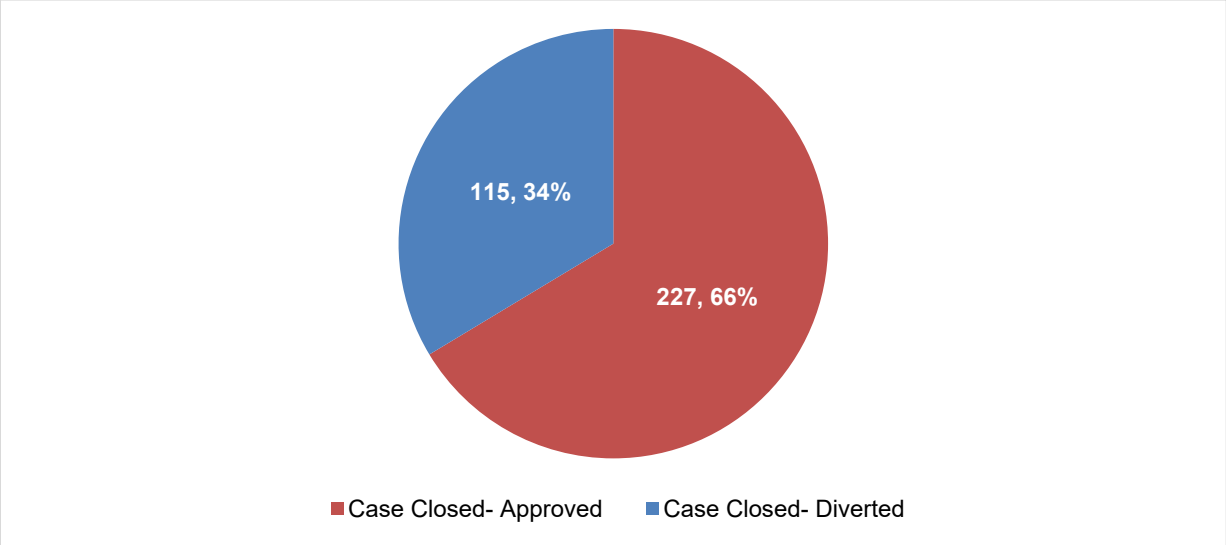


Table 10 displays referrals by sex as well as the referral outcome. Males made up the majority of all referrals as well as approvals (56% and 62%, respectively). Females represented slightly more diversions than males at 51%.

Table 10: Sex of Youth Referred for OOS Placement, January to June 2025

Referral Status	Male	Female
Case closed, approved (n = 227)	140 (62%)	87 (38%)
Case closed, diverted (n = 115)	56 (49%)	59 (51%)
Total cases closed (n = 342)	196 (57%)	146 (43%)
All referrals[62] (n = 575)	322 (56%)	253 (44%)

Youth ages 13 and older were referred at the highest volume (82% of all referrals; Table 11). It is expected that referrals for those 18 and older would be smaller due to limited BSS interaction with youth over the age of 17, as they are no longer minors. Referral volume for youth in the 5 – 9 age category is unexpected and will be monitored closely moving forward to help diversion efforts and help ensure all children, especially given their young age, have had an adequate opportunity to utilize HCBS to meet their mental health needs when clinically appropriate. Nearly 20% of diversions were for youth 10 – 12 years old. DoHS acknowledges the critical intervention point that occurs during adolescence, as evidenced across multiple analyses, and is striving to create approaches to reach this group as early as possible.

[61] Data is reflective of referrals, not unique youth. Youth may have had more than one referral during the period.

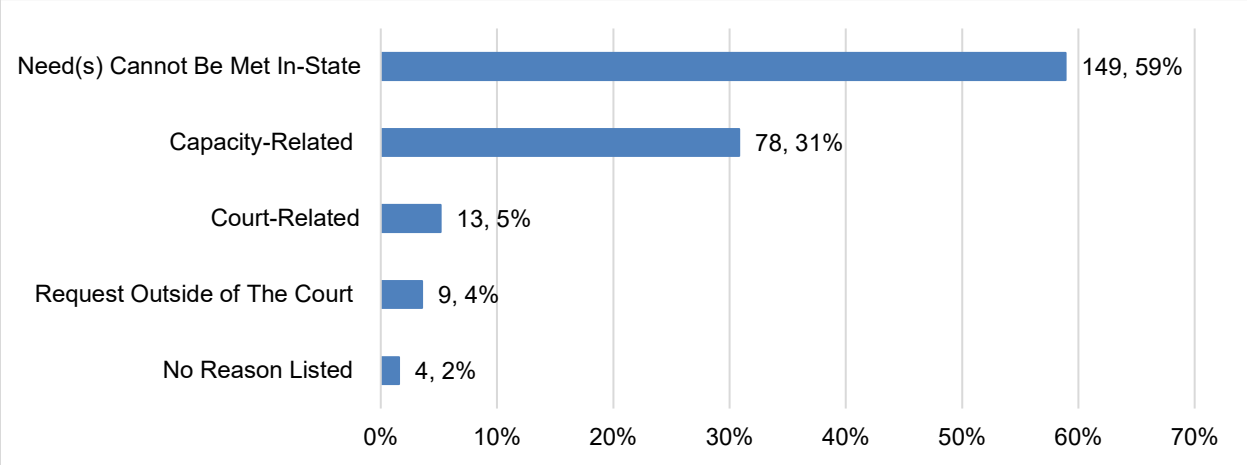
[62] "All referrals" is inclusive of cased that have been approved, diverted, and are pending.

Table 11: Age at Time of OOS Placement Referral, January to June 2025

Referral Status	Ages 5 – 9	Ages 10 – 12	Ages 13 – 17	Ages 18+
Case closed, approved (n = 227)	11 (5%)	28 (12%)	186 (82%)	7 (3%)
Case closed, diverted (n = 115)	3 (3%)	20 (17%)	89 (77%)	3 (3%)
Total cases closed (n = 342)	14 (4%)	48 (14%)	275 (80%)	10 (3%)
All referrals (n = 575)	28 (5%)	78 (14%)	458 (80%)	10 (2%)

Considering approval reasons from January to April 2025 to allow for data lag, the majority of youth (59%) had one or more needs that could not be met in state (Figure 55). Examples of these needs include aggression, fire-setting, self-harm, ASD/IDD, SUD, sexualized behaviors, trauma, medical-related needs, or step-down care. More information on these specialized needs groups can be found in Section S.7.2 OOS Risk in the report supplement. Many of these behaviors require specialized treatment that is not currently available with in-state providers or is only available at a limited capacity. In-state capacity is often based on a number of admission criteria, such as age, sex, specific need, and IQ. DoHS is using this information to identify systemic gaps with in-state specialized care and to gain insight into what types of specialized services are needed to serve WV youth closer to home.

Figure 55: Approval Reasons for OOS Placement, January to April 2025 (n = 253)



Note: Youth may have multiple reasons for approval; therefore, the categories in Figure 55 are not mutually exclusive.

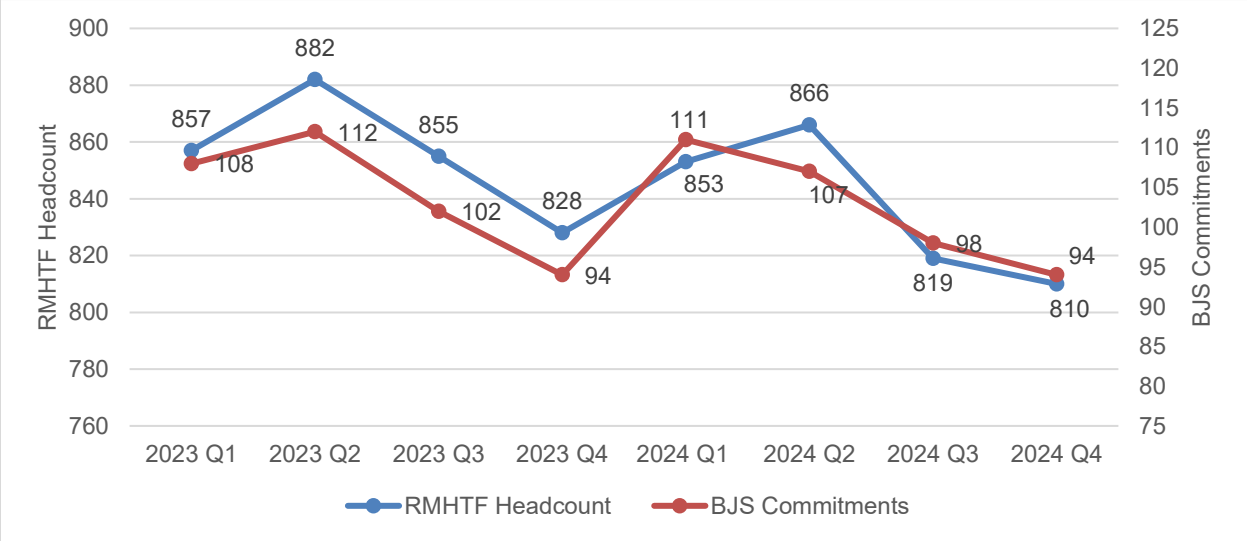
6.4 BJS Population at Risk of Residential Placement

As noted in Section 2.1 Intervention: Mental Health Screening Through Child Welfare, Juvenile Services, and Probation Services, the percentage of BJS-involved youth with a positive mental health screening is consistently between 76% and 80%. Based on the prevalence of high rates

of positive mental health screenings for BJS-involved children, DoHS recognizes that these children are likely at imminent risk of entering residential treatment. DoHS and BJS meet quarterly to review indicators associated with children in the BJS population, including mental health screening data. Based on these reviews and the known risk for these children, DoHS and BJS are interested in better understanding the relationships between children involved in BJS and children utilizing residential treatment, including whether the same children may be involved in both systems throughout the child's journey.

When a child has been adjudicated for delinquent acts through the court system, they may be committed to BJS. As a first step to understanding any correlations, quarterly point-in-time census data of children committed to BJS was overlayed with quarterly point-in-time RMHTF census data over CYs 2023 and 2024 (Figure 56). Both BJS commitments (red line) and RMHTF census data (blue line) follow a similar trend, hitting a high point in Q2 2023, with RMHTF census at 882 and BJS commitments at 112, in line with the increased demand for residential treatment observed during the first half of 2023, and ultimately decreasing by the end of Q4 2025 to 810 youth in RMHTF and 94 youth committed to BJS custody. As a next step, DoHS plans to conduct a broad, outcomes-based analysis of the child-level journey, including a further exploration of the relationships between children interacting with both BJS and RMHTF, outcomes for children exiting the BJS system, placement following transition out of BJS, and services utilized post-transition. Integration of BJS child-level data into the OQA data store is in development and is expected by year-end 2025, which will facilitate this analysis in the future.

Figure 56: End-of-Quarter BJS-Committed Children vs. RMHTF* Population, CY2023 and CY2024

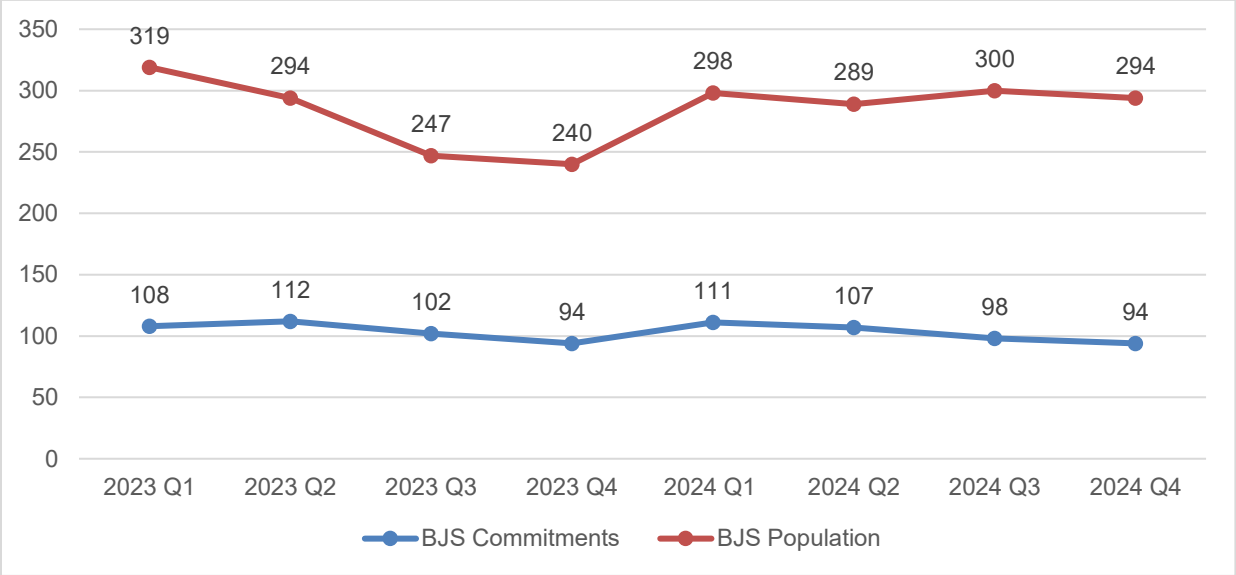


***Note:** Residential data pulled from PATH as of April 15, 2025, and from EDS as of March 31, 2025.

The high rate of positive screenings among the BJS population indicates that these children may be considered at high risk for residential placement if their mental health needs are not met. DoHS trended end-of-quarter BJS commitments against the overall BJS population to investigate the magnitude of the number of children who may be at risk (Figure 57). The full BJS population over this time period is between 240 and 319, while BJS commitments for the same period range between 94 and 112 children. Using Q4 2024 as an example, there are 200

youth[63] in BJS placement who were not committed to BJS custody and, therefore, may be discharged in the near term. As many as 80% (160) of these youth may screen positive for mental health needs. This represents a significant number of children considered at imminent risk who may be discharging from BJS each quarter and highlights the importance of helping ensure mental health services are in place prior to transitioning out of BJS in order to support their success in the community and reduce potential recidivism. This also highlights the importance of appropriate assessment to help ensure the child is served in the most integrated setting following transition out of BJS. DoHS and BJS will continue partnering to help ensure parents, guardians, and advocates are aware of the options available to these children based on their assessed needs as well as those youth who are committed to BJS and will be discharged following fulfillment of their court-ordered time in BJS custody.

Figure 57: End-of-Quarter BJS Commitments vs. End-of-Quarter BJS Population, CY2023 and CY2024



6.5 Key Themes and Next Steps – Imminent Risk

To support early identification and diversion efforts, DoHS has implemented several administrative and CQI processes to monitor and meet needs for children at imminent risk of out-of-home placement, including residential treatment. Data from these processes will continue to be monitored to support diversion efforts and enhance future practices.

Hotel and shelter placements have increased in 2025 but have since stabilized. Higher volumes and trend increases point to more reliance on residential placements and hotel placements, highlighting the importance of understanding placement needs and changes in acuity for children in child welfare custody.

[63] Calculated by subtracting the BJS commitments (n = 94) in Q4 2024 from the total BJS population (n = 294).

The QIA process is a key component of helping ensure children are assessed for appropriate treatment intervention and placed in the most integrated setting to meet their needs. This process has and will continue to assist in diverting children from unnecessary residential placement. Social service managers, Acentra, and Aetna have been active in this process since implementation through data review and discussion. To help ensure quality and validity of QIA recommendations, more robust processes and protocols are being developed. Ongoing monitoring of timeliness for QIA completion is essential to help ensure information can be beneficial in time-sensitive situations.

To increase utilization and trust in the QIA process statewide, expanded outreach and education around the importance of the QIA process will be continued with focused efforts in prioritized counties (Wayne and Wood). This includes ongoing review and feedback to social service managers at a county level, engagement with the court community, and persistent integration into MDT decision-making.

The OOS risk referral process helps prevent youth from being sent to OOS facilities without due diligence to identify more appropriate placement. Approximately a third of youth have successfully been diverted to a more integrated placement. Data collected through the tracker informs DoHS of youth needs, which can be used to help inform decision-making for developing in-state capacity.

DoHS has identified a high prevalence of mental health needs among children involved in BJS, with up to 80% screening positive. Recognizing these youth are at imminent risk for residential treatment, DoHS plans to examine outcomes for children exiting BJS—including subsequent placement, service use, and timelines. Emphasis is being placed on helping ensure timely access to mental health services and appropriate assessments to support transitions to the most integrated settings, reduce recidivism, and promote community success. DoHS and BJS will continue collaborating to inform families and advocates about available supports based on assessed needs.

The OQA is planning to conduct an analysis in early 2026 to better understand the characteristics and interaction points of children prior to RMHTF admission. This analysis will help further identify intervention points and diversion opportunities for children at imminent risk of RMHTF placement.

7.0 Residential Mental Health Treatment Facility Services

The overarching goal to improve outcomes for children with SED is to reduce the state's reliance on RMHTFs, ensure children remain in the most appropriate and integrated settings, and to increase availability of HCBS. DoHS continues to make progress in this area. As noted in Section 3.0 WV Wraparound Services, the number of children accessing Wraparound services at any point in time is now nearly double the number of children in residential treatment for the same point in time, a positive result of the continued efforts to increase awareness, access, and utilization of HCBS.

Following an increase in census in the first half of 2023, demand for residential treatment services plateaued and was then followed by a decrease in the second half of 2024, primarily driven by reduced in-state placements, although a small reduction in OOS placements was observed as well. While demand is expected to continue as part of the continuum of services clinically appropriate to meet the needs of children with higher levels of acuity, primary focus areas for DoHS and its partners, Aetna, MU, and residential providers, are as follows:

- Helping ensure all children entering residential treatment have a QIA completed to support clinically appropriate placements (Section 6.2 QIA contains more details).
- Prioritizing discharge planning efforts.
- Understanding the profiles and needs of children entering both in-state and OOS residential treatment and using this information to develop in-state capacity to support youth with high acuity of need so that they can transition from OOS placements and be served closer to their homes and communities.
- Understanding the predictive and protective factors that influence out-of-home placements, including placement in residential treatment (Section 4.0 System Engagement and Outcomes contains more details).
- Helping ensure adequate discharge and transition planning are in place, including services to allow children to be successful in the community once discharged (Section 8.0 Post-Discharge Intervention and Aftercare contains more details).
- Building and optimizing community-based placement capacity, services, and supports (Section 5.0 Community-Based Placement Capacity and Section 3.0 WV Wraparound Services contain more details).

7.1 Residential Services

The following figures depict information regarding children in child welfare custody who are placed in residential settings and those parentally placed in PRTFs.

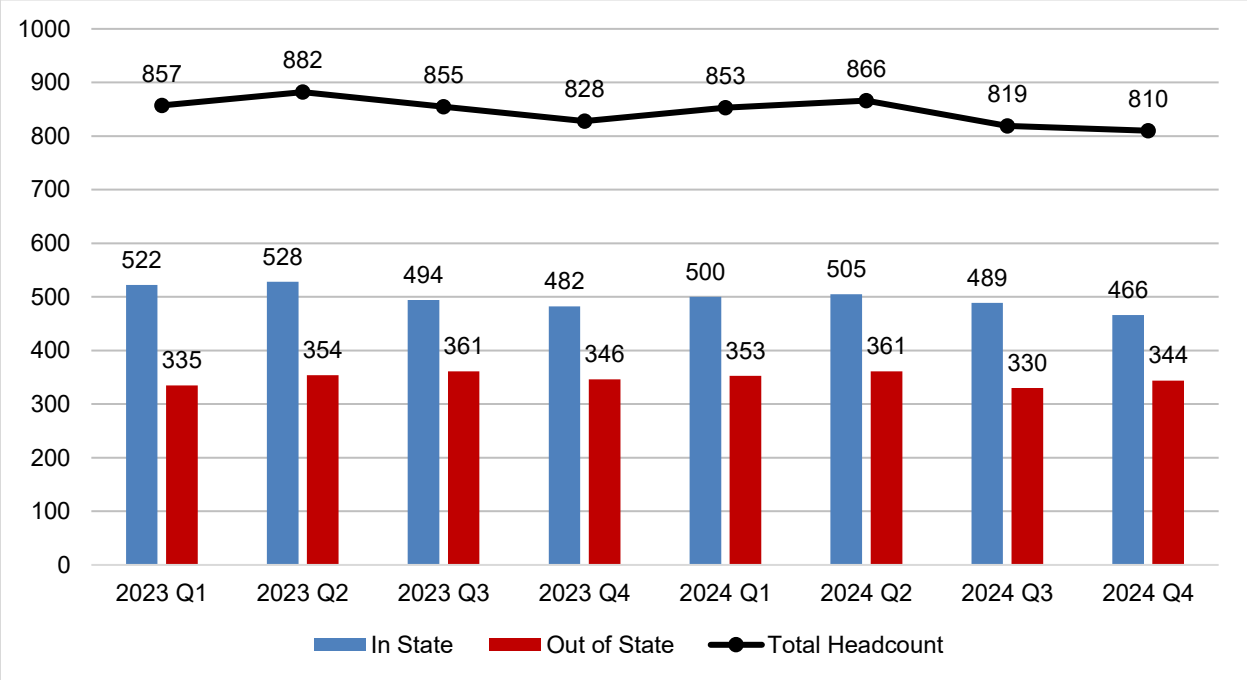
Point-in-Time Census

Figure 58 illustrates the monthly point-in-time census at the end of each quarter for CYs 2023 and 2024. As noted in the July 2024 Quality and Outcomes report, the census increased in the first half of 2023, aligning with the increase in mental health needs observed in mental health-

related ED visits and the increased demand for mental health treatment nationally. The census remained stable with expected seasonal fluctuation throughout 2023 and the first half of 2024. However, the census decreased in the second half of 2024, primarily due to reduced in-state placements, although decreased OOS placements were also observed. While there were minor fluctuations across quarters, the approximate percentage of in-state versus OOS placements remain at 60% and 40%, respectively. The year-end 2024 census was at 810 children. Given demand and mental health needs rising nationally, the efforts of DoHS and its partners appear to be successfully stabilizing the census, which might have otherwise increased.

DoHS leadership monitors the census on a weekly basis. Although outside of the period of review for this report, increased demand for residential treatment was observed in early 2025. The availability of data and indicators related to residential treatment have expanded through continued development of the OQA data store, allowing for deeper analysis to understand these trends and the factors influencing them.

Figure 58: Monthly RMHTF Point-in-Time End-of-Quarter Census, Q1 2023 to Q4 2024



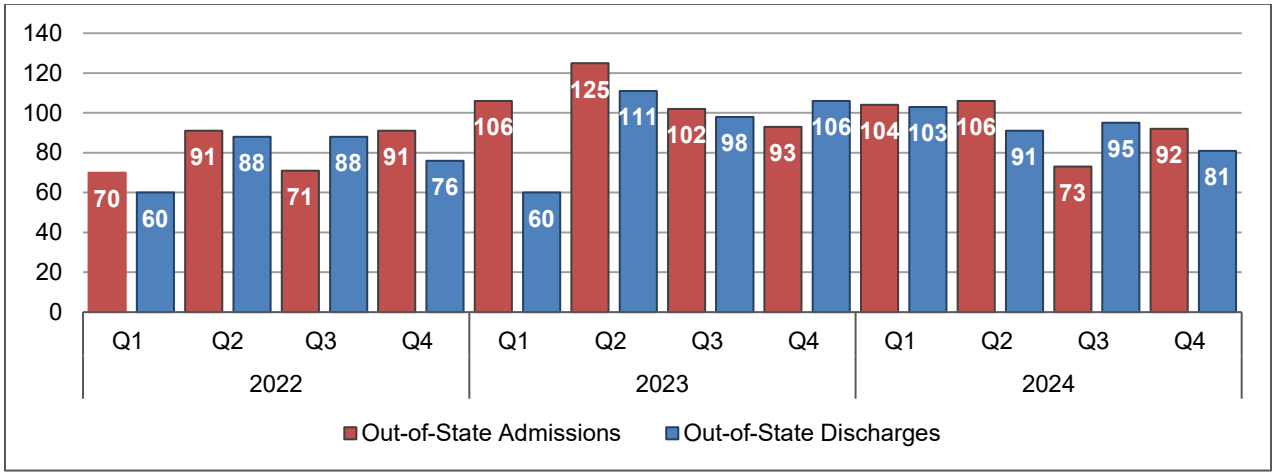
Note: In some months, the sum of in-state and OOS census may be slightly less than the total headcount due to a small number of placements with incomplete data related to in-state status. Data was pulled from PATH as of April 15, 2025, and from EDS as of March 31, 2025.

Admission and Discharge Trends

To understand trends, seasonality, and factors influencing census year-over-year figures in greater detail, DoHS closely monitors in-state and OOS admissions and discharges. OOS and in-state admissions versus discharges by quarter for CYs 2022 through 2024 are captured in Figures 59 and 60. The first half of 2023 showed a marked increase in demand for residential treatment, particularly demand for OOS placement. OOS admissions (red bars) exceeded discharges (blue bars) as observed in Q1 2022 to Q1 2023 (Figure 59). In Q2 2023, MU began

overseeing discharge planning efforts for children in OOS placements. Following MU's involvement, the level of OOS discharges increased, reaching levels in excess of 100 per month in Q2 2023 and beyond when compared to 60 in Q1 2023. However, the increased demand for OOS placements, which began in early 2023 and continued into 2024, has largely offset the increase in discharges, resulting in OOS census remaining stable.

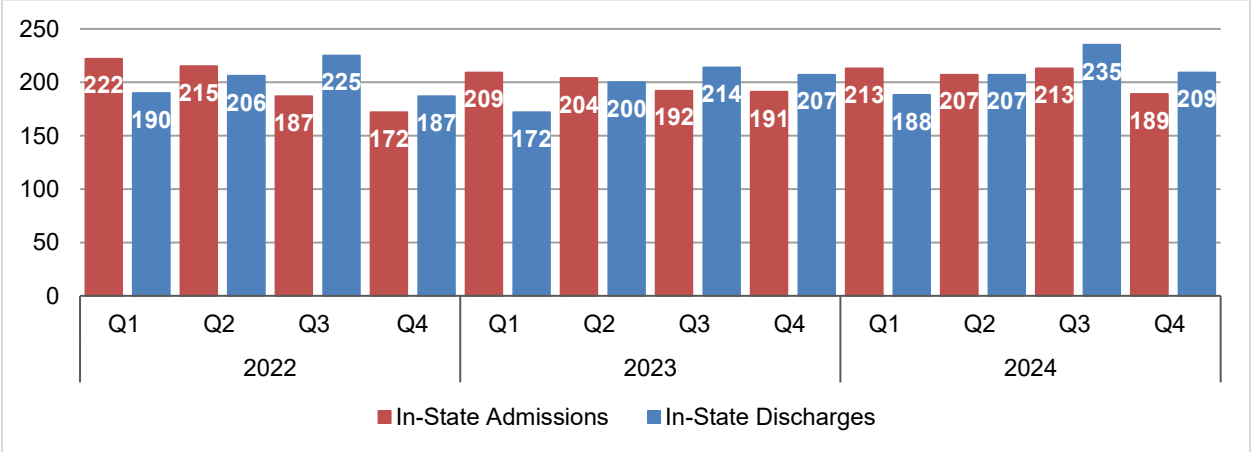
Figure 59: OOS Admissions vs. Discharges by Quarter, January 2022 to December 2024



Note: Data pulled from PATH as of August 15, 2025, and from EDS as of July 31, 2025.

Historically, an increase in in-state admissions is observed in the first half of each year, with more discharges occurring in the second half. This pattern, likely the result of seasonality associated with school schedules and holidays, was observed in the second half of 2024, resulting in an overall census decrease (Figure 60). Discharges were higher in magnitude in the second half of 2024 compared to prior years, a positive result of the continued enhancement of in-state prioritized discharge planning efforts. Specifically, discharges in the second half of 2024 reached a high of 444 compared to the second half of 2022 (n = 412) and the second half of 2023 (n = 421).

Figure 60: In-State Admissions vs. Discharges by Quarter, January 2022 to December 2024

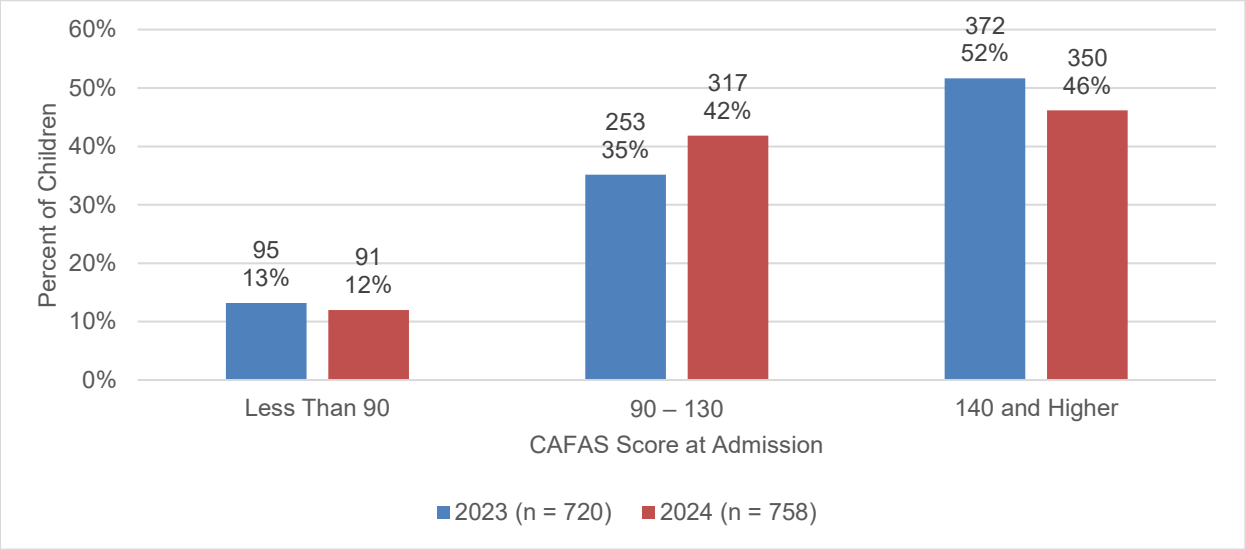


Note: Data pulled from PATH as of August 15, 2025, and from EDS as of July 31, 2025.

CAFAS/PECFAS Score Analysis and Trends

Figure 61 shows the distribution of CAFAS/PECFAS scores for children admitted to RMHTF placement in CYs 2023 and 2024 with a CAFAS/PECFAS completed within 45 days of admission (before or after admission). This figure includes data for 720 admissions in 2023 and 758 admissions in 2024; 442 and 435 admissions in 2023 and 2024, respectively, with no CAFAS/PECFAS scores were excluded.[64] In 2023, 13% of youth (n = 95) entered placement with a CAFAS/PECFAS score less than 90 compared to 12% (n = 91) in 2024. While slight, this reduction in the percentage of placements with a score less than 90 is positive movement because of the comprehensive efforts by DoHS and its partners to help ensure children are appropriately placed. The percentage of scores between 90 and 130 increased from 35% in 2023 to 42% in 2024, while the percentage of scores 140+ decreased from 52% to 46%.

Figure 61: CAFAS/PECFAS Score Distribution for Children Admitted to RMHTF, CY2023 and CY2024



County-Level Utilization

For the purposes of making quality improvements, understanding county-level changes, and identifying where to focus efforts, DoHS continues to track residential placement rates by child's county of origin. DoHS program teams recognize that this data cannot be reviewed in isolation and must be considered in the context of other data and influencing factors. A comparison of statewide residential treatment utilization between CYs 2023 and 2024 can be found in Section S.8 RMHTF Services in the report supplement. The results showed a small decrease (-1.1%) in utilization from 2023 to 2024, reflecting a stable census across the two periods. The overall

[64] Children in OOS residential placement and short-term, acute PRTF, as well as children who discharged within 45 days following admission, were excluded from the analysis if there was no CAFAS/PECFAS administered within 45 days of admission. The CAFAS/PECFAS assessment is not expected for children in short-term PRTF due to the short-term nature of this treatment. CAFAS/PECFAS scores for children in OOS placement are currently unavailable for reporting but can be expected in future reports.

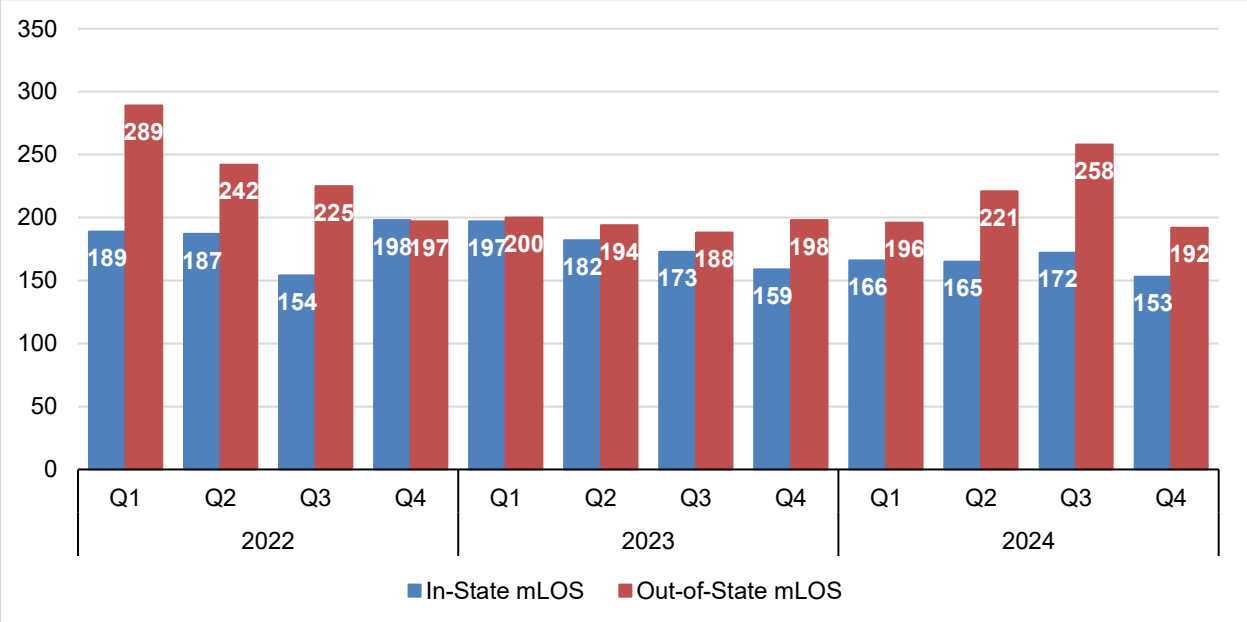
state rate for residential placement was 4.3 per 1,000 WV children in 2024. In late 2024, program teams selected Wood and Wayne Counties for focused efforts to reduce residential treatment utilization. Wood County showed a residential utilization rate of 4.5 in 2024 per 1,000 youth population, and Wayne County showed a rate of 6.4 per 1,000 youth population. 2024 county-level data is considered as a baseline to understand efficacy of outreach strategies for prioritized counties.

Length of Stay

DoHS continues to monitor LOS to understand any trends and influencing factors. Figure 62 captures median LOS trends by quarter for in-state and OOS placements for CYs 2022 through 2024. Median LOS is represented to capture trends more accurately because children with long LOS can skew the mean. This LOS analysis is based on children discharged during the relevant period of review (i.e., completed stays).

In-state LOS has remained relatively stable (approximately 160 – 180 days during most quarters). OOS LOS shows some variability, ranging from a low of 192 days in Q4 2024 to a high of 289 days in Q1 2022. Children in OOS placement often have higher levels of acuity than children served in state, which may require a longer LOS before the child is ready to be discharged to the community.

Figure 62: RMHTF In-State and OOS Median LOS (mLOS) by Quarter, 2022 – 2024

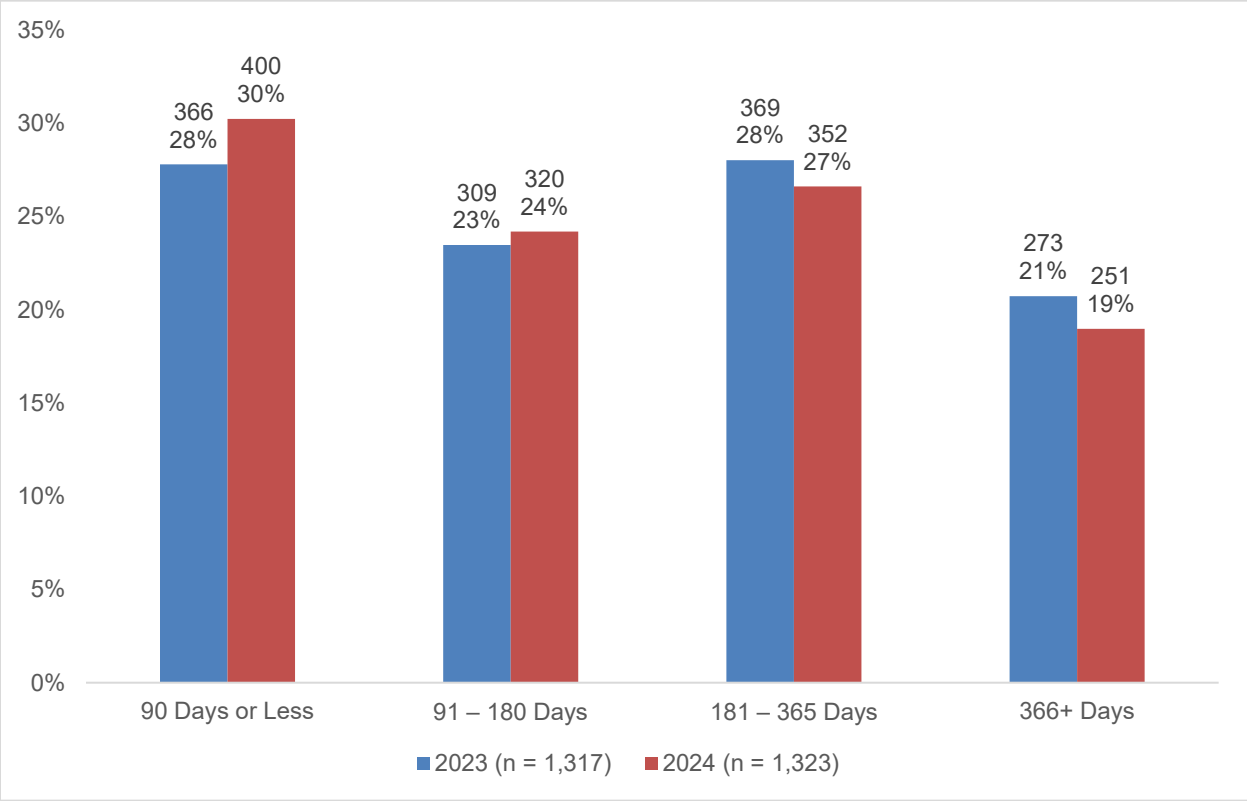


As part of prioritized discharge planning efforts, DoHS tracks and monitors anticipated discharge dates and any changes in these dates, which ultimately impact overall LOS. One component of the strategy identified to meet the sustained demand for residential treatment is to decrease LOS for children in placement, thereby freeing up capacity for additional children who may need treatment. To better understand how LOS is impacted by children who remain in residential treatment over long periods, as well as how prioritized discharge planning efforts in

2023 and 2024 may be influencing LOS, DoHS completed an LOS analysis that includes active placements (i.e., ongoing stays) as well as those who were discharged, comparing 2023 and 2024. Figure 63 below shows in-state median LOS distribution for children discharged during the period and those in active placement. Figure 64 shows the same indicator for OOS placements. For those children still in active placement as of the last day of each CY (i.e., December 31), this date was used to calculate their LOS.

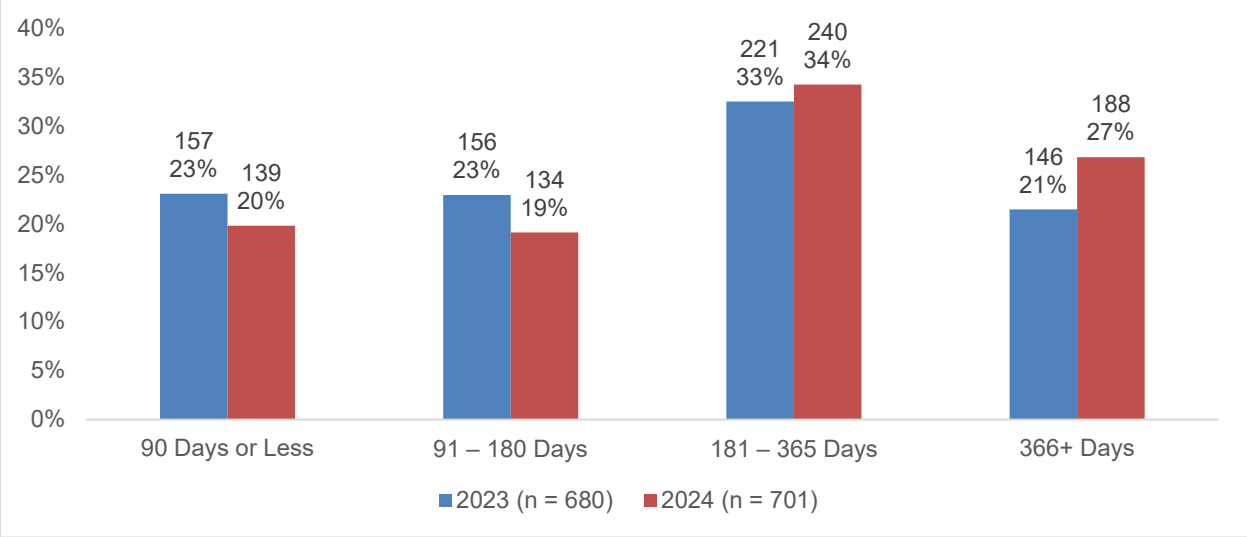
In-state median LOS, including active placements for 2024, is 159 days, an 8% decrease from 173 days in 2023. LOS greater than six months have trended down for in-state placements. These findings are positive results stemming from the coordinated discharge planning efforts.

Figure 63: In-State Median LOS Distribution Inclusive of Discharged and Active Placements, CY2023 (n = 1317) vs. CY2024 (n = 1323)



The median LOS for OOS placements, including active placements was 221 days for 2024, an increase of 27 days (14%) compared to the median of 194 days for 2023. LOS greater than six months trended up for OOS placements. This may be evidence of increasing acuity levels of children in OOS placement, as well as limitations on in-state residential capacity and eligibility requirements. DoHS is collaborating with residential providers to identify barriers to accepting in-state placements for children in clinical need of residential services, including providing step-down services from OOS facilities when clinically appropriate. As noted previously, BSS is working with in-state providers to adjust their facilities and treatment programs to serve higher acuity individuals.

Figure 64: OOS Median LOS Distribution Inclusive of Active Placements, CY2023 (n = 680) vs. CY2024 (n = 701)



DoHS will continue to monitor LOS trends, as reduced LOS are a key part of the overall strategy for helping ensure capacity is available to meet the sustained demand for residential treatment across WV. DoHS will also continue its efforts to better understand discharge barriers and other factors influencing LOS. This is part of a coordinated effort to simultaneously help ensure available capacity to meet the demand for residential treatment services and that services are clinically appropriate.

7.2 Prioritized Discharge Planning

DoHS continues to collaborate actively with Aetna and MU to prioritize discharge planning for children currently placed in residential settings. The goal is to help ensure all involved stakeholders focus on addressing any discharge barriers for these children as well as helping ensure services are in place following discharge, so they can successfully remain in their homes and communities. Discharge plans continue to be in place for 95% of children, which meets the expected threshold.[65]

Through the recurring review of prioritized discharge planning indicators, the group observed that anticipated discharge dates were routinely being extended, resulting in longer stays than initially anticipated. Further investigation revealed that discharge barriers were not always being captured accurately and completely. As a result, over the past year, there has been a significant push to help ensure all discharge barriers are being identified and documented for each child. Consequently, some shifts in the top discharge barriers have been observed (i.e., behavioral challenges have been identified as the primary barrier, and fewer youth are documented as having no barriers to discharge).

[65] Some allowance is made for lag time associated with time needed to develop discharge plans and submit them through Aetna's authorization process.

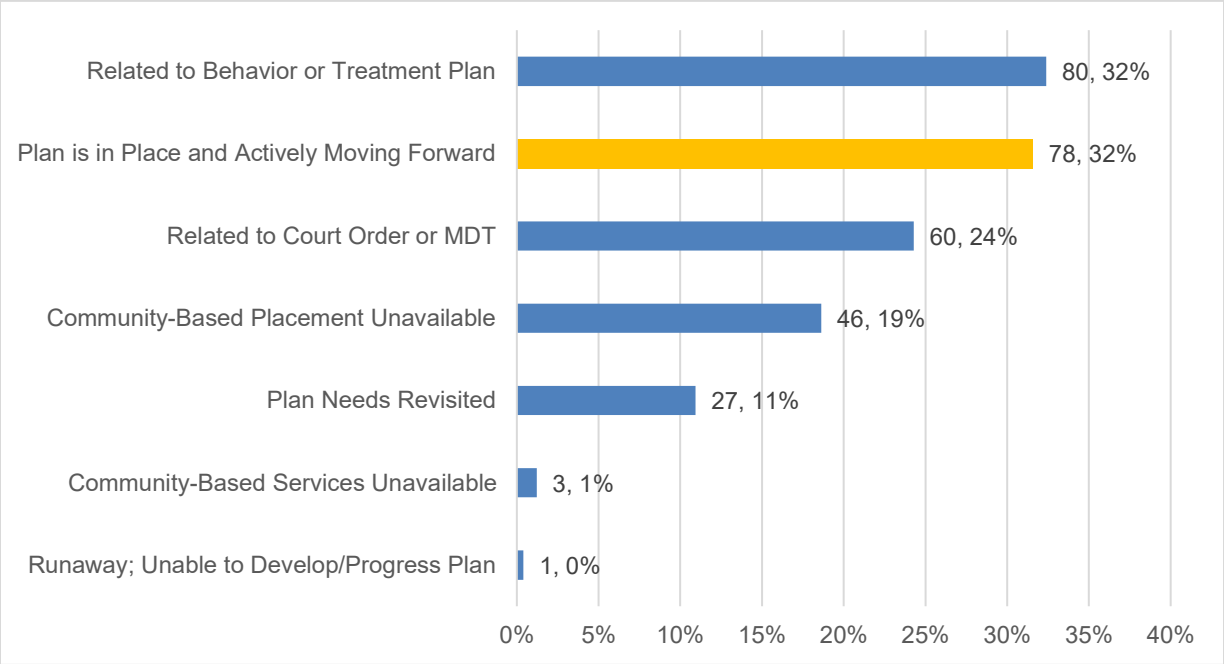
In-State Prioritized Discharge Planning

Throughout the second half of 2024, DoHS and its partners prioritized discharge planning efforts for children in in-state residential placement with a CAFAS/PECFAS score less than 140 who also had an anticipated discharge date in the next 60 days. The information that follows is for youth meeting these criteria for the period between July and December 2024 (n = 260).[66] As of February 28, 2025, 55% (n = 143) of prioritized children had been discharged to the community or to transitional living.

Primary grouped discharge barriers[67] for the in-state prioritized discharge planning population are shown in Figure 65.[68] Data for 32% of these children (n = 78) indicate there are no barriers; the discharge plan is in place and actively moving forward. The top documented barriers to discharge for the prioritized discharge planning population were as follows:

- Related to behavior or treatment plan (32%, n = 80)
- Related to court order or MDT (24%, n = 60)
- Community-based placement unavailable (19%, n = 46)

Figure 65: Grouped Discharge Barriers for the Prioritized Discharge Planning Population, July – December 2024 (n = 247)



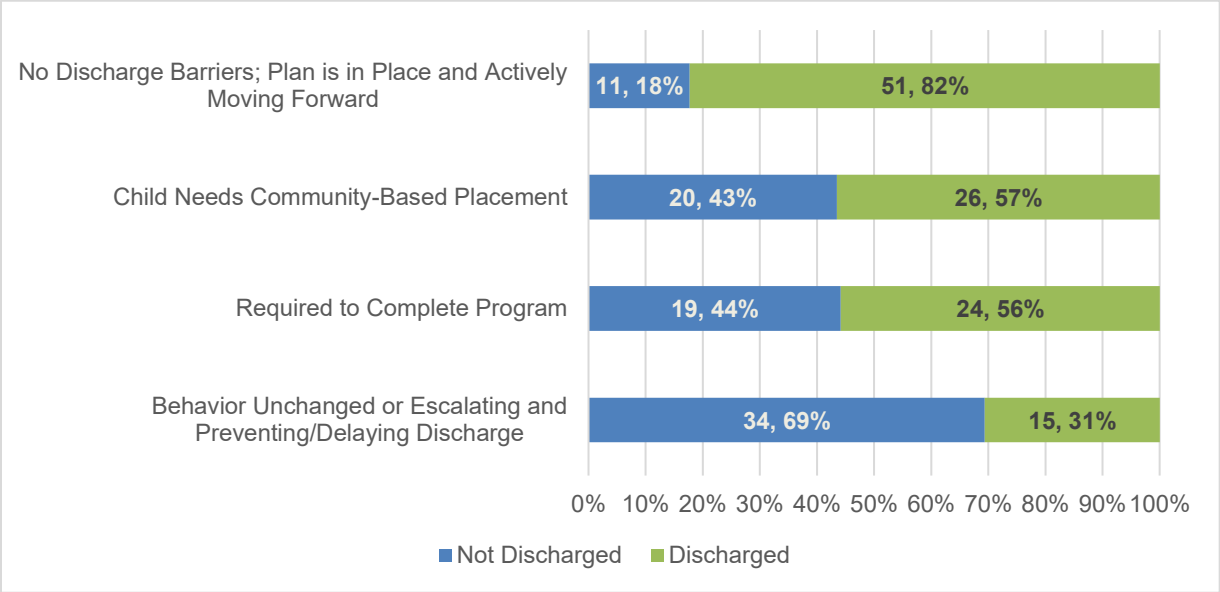
[66] The July – December 2024 time period was selected rather than the full CY, as the revised criteria for in-state prioritized discharge planning was initiated in June 2024.

[67] Similar discharge barriers are grouped together for ease of review.

[68] Only 247 children have a discharge barrier status reported; 13 children (5%) had missing data and were excluded from the figure. A total of 50 children (20%) have multiple discharge barriers listed.

DoHS also evaluated outcomes (i.e., discharged versus not discharged) by individual discharge barriers for the in-state prioritized discharge planning population (Figure 66). As expected, children with no discharge barriers were more likely to be discharged (82%) compared to those in need of community-based placement (57%) and those required to complete the program before discharge (56%). Among the most commonly listed discharge barriers, the rate of discharge was lowest for children with behavior-related challenges impacting their ability to return to the community (31%).

Figure 66: Top Discharge Barriers by Discharge Status for the Prioritized Discharge Planning Population, July – December 2024 (n = 247)



DoHS, Aetna, and MU representatives continue to meet biweekly to review and collaborate on the cases of children prioritized for discharge. Through this process, it became apparent that the list of children being reviewed was too large to manage successfully. To refine the list and account for barriers that the group may have the most opportunity to successfully influence, the group decided to shift the prioritized discharge planning population in May 2025 to those children in in-state residential placement who do not have a home to go to and focus on community-based capacity-building efforts. Efforts to address community-based placement capacity are further detailed in Section 5.0 Community-Based Placement Capacity. This shift in the prioritized discharge planning population resulted in a lower number of cases for review biweekly and, therefore, allowed more time to focus on each case. Given how recent this change was and ongoing discussions to make this process more effective, resultant data and information will be shared in future reporting.

DoHS recognizes that the court system, including judges, are key partners in helping ensure children and families get connected to services to best meet their needs. DoHS continues to work closely with court system representatives through the Court Improvement Program. Recently, an informational flyer was developed to help address awareness and education including: the misperception that youth must be child welfare-involved to receive services, to encourage reliance on MDT recommendations, and if a court order is deemed necessary to

encourage that it simply order WV Wraparound so DoHS can assist with the appropriate connections. To further support this effort and help ensure judges and attorneys have clinical information to assist them in decision-making, in summer 2025, DoHS and Aetna focused on helping ensure children in residential placement for more than six months whose only barrier is related to a court order have a QIA completed. DoHS, in partnership with Acentra, is focusing on quality improvements to QIA reporting to capture key information necessary for informing court recommendations more effectively.

Behavior-related barriers are expected, especially given the challenges and acuity level of children whose level of care is best met through residential treatment. Typical behavioral challenges for children in placement may include physically and/or verbally aggressive behavior, SUD, and sexualized behavior. As noted in Section 6.3 Out-of-State Risk, requests for OOS placement are often associated with these behaviors. Similar behaviors are also noted in the OOS placements update from MU below. BSS continues to work with in-state residential providers to build capacity to support children experiencing these challenges, as described in Section 6.3 Out-of-State Risk. As a result of these efforts, in June 2024, one provider converted their facilities to serve males with high-acuity treatment needs, with capacity to support 52 youth. Additionally, in March 2025, another provider converted a facility to serve males with high-acuity treatment needs, with capacity to support 12 youth. BSS continues discussions with all existing providers interested in pivoting their services to serve high-acuity youth. As of the writing of this report, there are no plans for additional in-state providers to expand into this level of care. New Hope, an OOS agency that will be adding a facility in WV, is in the final stages of completing licensing of a new six-bed facility to serve high-acuity males with mental health and ASD diagnoses (expected in fall 2025). DoHS will be monitoring the impact on OOS placements based on these in-state facility changes to support youth with severe behavioral challenges.

Summary indicators for children prioritized for discharge and the associated outcomes are reviewed and discussed with BSS, Aetna, and MU monthly. Thorough analysis into information about children with no barriers who remain in placement indicates some continued underreporting of discharge barriers. By asking more questions for children who are continuing in care, barriers surface and can then be documented; this process is essential to supporting efforts by the group to address these barriers. The timeline to anticipated discharge is being reviewed at the provider level to explore why some facilities may have longer LOS than others and to discuss whether LOS are appropriate compared to clinical need. While acknowledging the circumstances and influences for each child are complex and evolving, having these critical conversations is expected to raise awareness and inform future discharge planning efforts.

OOS Placements Update

DoHS strives to bring children back to WV to help build connections and networks of support in their local communities, including engaging with their schools and families, to improve the possibility of reunification. To support this goal, effective April 2023, BSS contracted with MU's WV Intensive Clinical Care Coordination Team (WVICCC) to support clinical assessments (i.e., QIA) and discharge planning for all children in OOS RMHTFs and PRTFs. The WVICCC team reviews each case, makes recommendations, and helps develop and implement the discharge plan. When a residential treatment option is the most appropriate level of care, the team

determines whether an alternative in-state residential treatment provider within proximity to the child's community is available and in the child's best interest. The team collaborates with the OOS provider, BSS worker, Aetna, and community partners.

Per MU's 2024 annual report, between January and December 2024, 677 children were in an OOS placement;[69] 59% (n = 382) had an open YS case, while 31% (n = 201) had an open CPS case. Youth may have multiple factors that make them high risk; high-risk criteria for these youth were as follows:

- 44% (n = 285) demonstrated severe aggressive behavior
- 27% (n = 178) self-harming behavior
- 16% (n = 104) sexualized behaviors or offenses
- 13% (n = 86) severe substance use
- 10% (n = 62) ASD

Generally, children are being placed OOS due to the lack of in-state providers willing to accept these children due to their risk factors. More information on children approved for or diverted from OOS placement can be found in Section 6.3 Out-of-State Risk. For the January to December 2024 period, 378 children in OOS placement returned to WV.

Based on the continued high demand for OOS residential placements, MU shared the following observations that are hindering the discharge planning process:

- Lack of adequate communication and notice that a child will be discharged, impacting the ability to effectively plan for the discharge
- Failure to involve all relevant stakeholders in treatment team meetings
- Lack of supportive services following discharge to support child and family success after returning home
- Lack of in-state residential facilities willing to serve female children with high acuity

DoHS and MU are collaborating on how to best resolve these challenges with the discharge planning process. As a next step to further inform discharge planning and intervention efforts, MU is completing chart reviews for children with multiple OOS placements to investigate themes. Results of this investigation will be used to inform future discharge planning efforts.

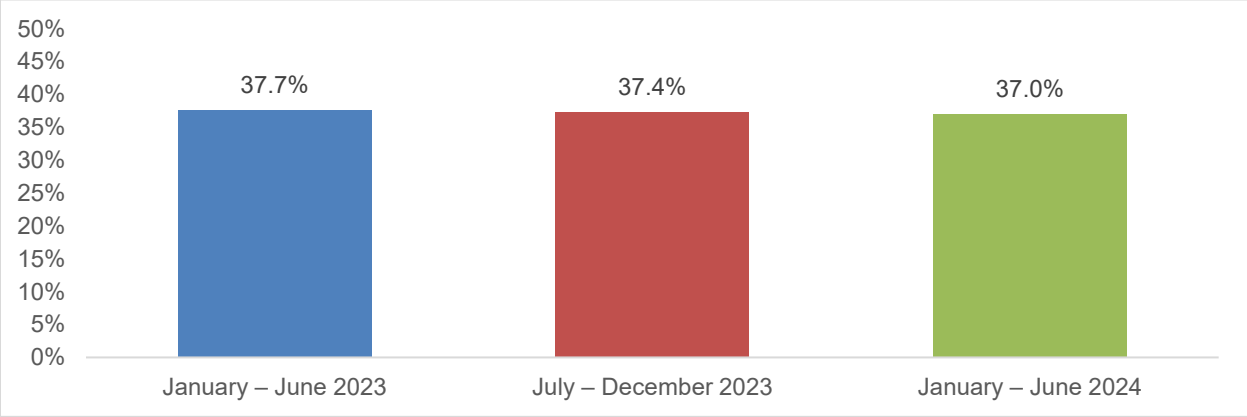
7.3 Residential Readmission

Some children may not be successful in the home and community and, therefore, may experience multiple placements in RMHTFs (i.e., readmissions) during their life cycle of care and support. DoHS routinely monitors readmission rates as a key indicator of whether children's

[69] Data sourced from MU OOS Care Coordination tracking system.

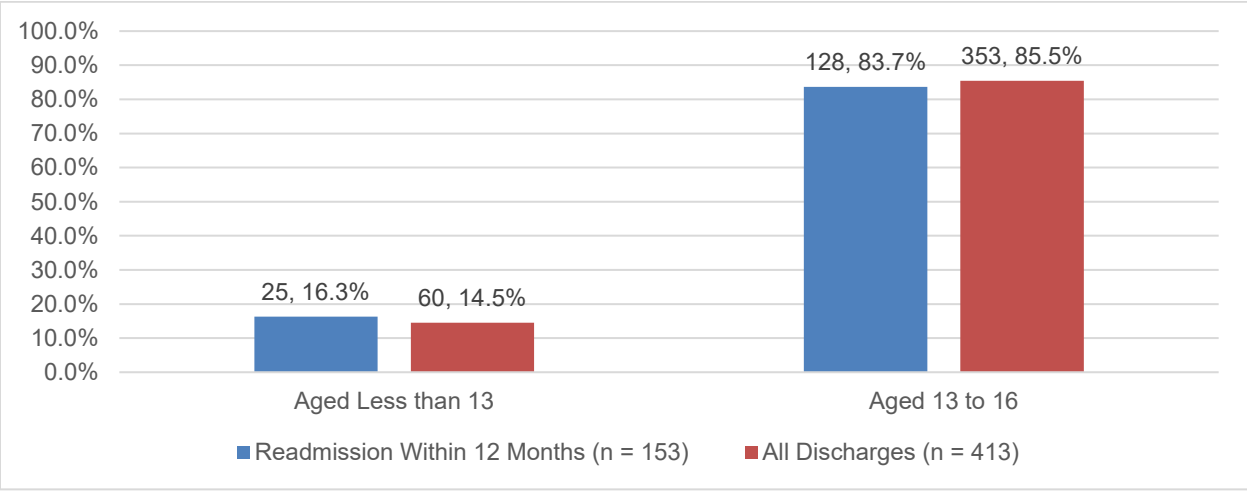
needs are being met in their homes and communities following discharge from residential treatment. Readmission rates for each six-month period from 2023 through the first half of 2024 are shown in Figure 67 below. This analysis is based on children who discharge within each six-month period and readmit within 12 months of their discharge date. Youth ages 17 and older were excluded from the analysis because children's residential treatment facilities do not typically admit youth ages 18 and over. Readmission rates have remained consistent over the last 18 months (between 37% and 38%), a level that DoHS recognizes as too high and is committed to reducing.

Figure 67: Residential Readmission Rates by Six-Month Period, January – June 2023 Through January – June 2024



To understand readmission trends in greater detail, DoHS analyzed readmissions by age (Figure 68). Of the 413 total discharges between January and June 2024, 60 (14.5%) were younger than 13. The rate of children in this age group who readmitted was similar (16.3%, n = 25), indicating that age was not a major factor influencing readmission rates for children who were discharged in the first half of 2024.

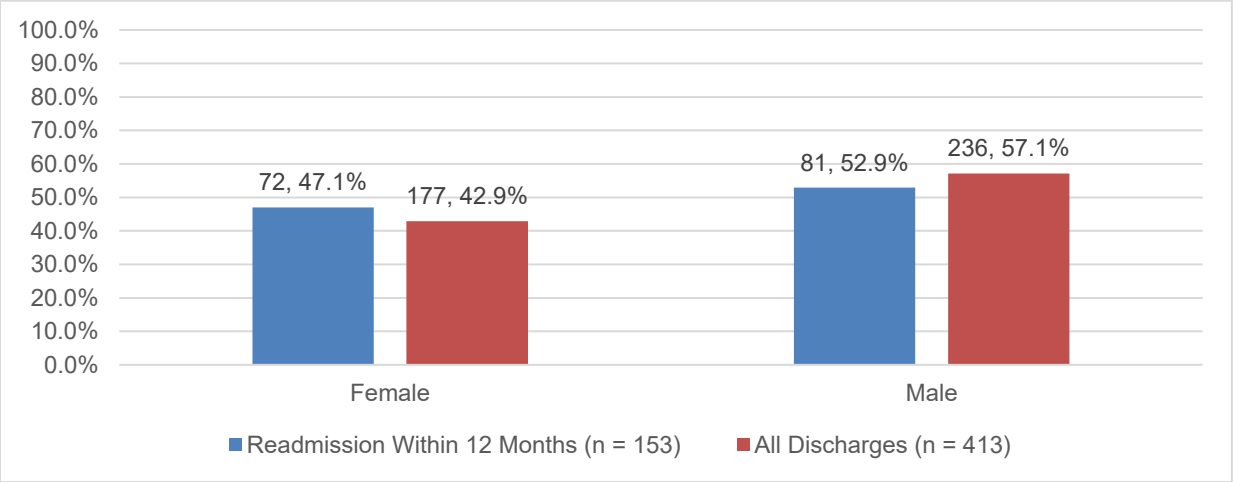
Figure 68: Readmission by Age Group for Discharges, January to June 2024



Note: Children aged <10 were included with the 10 – 12 age group due to a very low n for children <10.

DoHS also evaluated the sex of children readmitting (Figure 69) and found that, although females compose 43% of the overall population of children discharging, they make up a higher percentage (47%) of children readmitting. Females have a higher readmission rate at 41% (i.e., 72 readmissions of 177 discharges) compared to males at 34% (i.e., 81 of 236). The higher readmission rate among females suggests a need for a tailored discharge planning approach for this group and further highlights the importance of having services in place prior to discharge.

Figure 69: Readmission by Sex for Discharges, January to June 2024

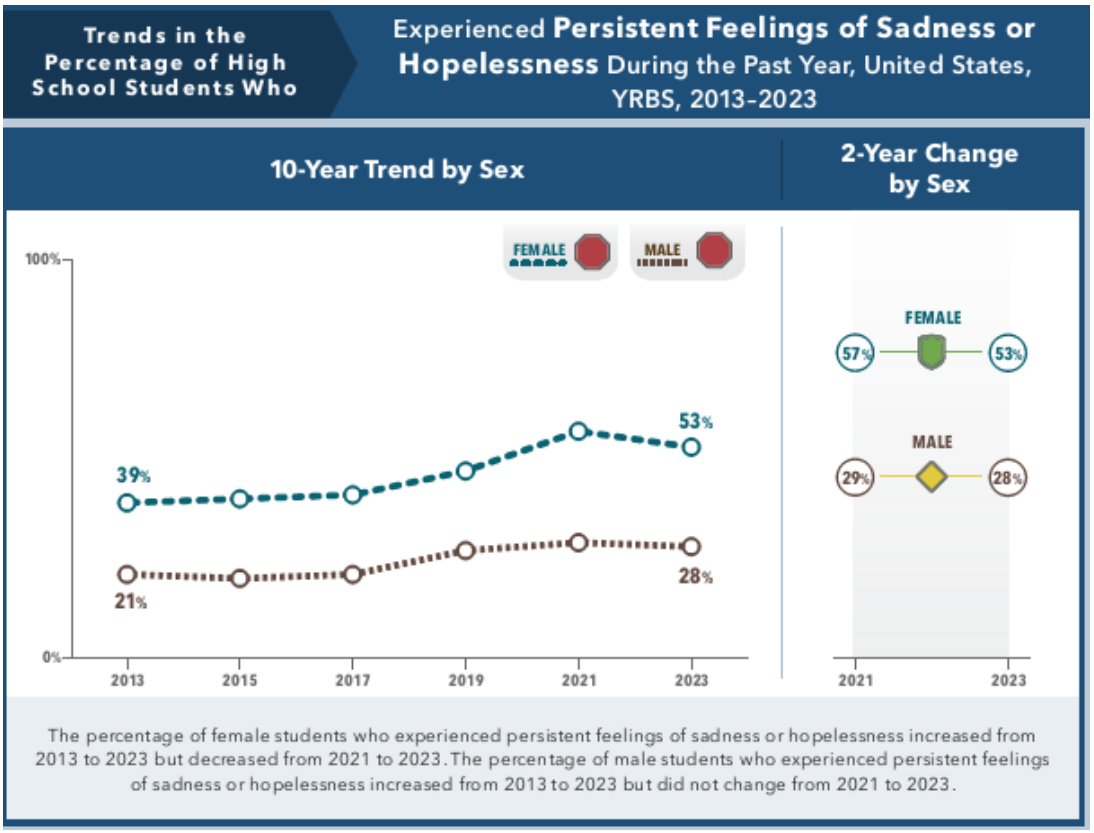


The YRBS [70] indicates trends for mental health indicators have been increasing since 2011, likely associated with the opioid epidemic, which resulted in rising numbers of overdoses and child welfare cases. Recent trends have shown decreases in both metrics,[71] highlighting the extensive efforts WV has taken to help adults and families facing these challenges. DoHS does, however, expect residual effects in future mental health needs due to increased trauma and substance exposure. For the indicators such as contemplating suicide and persistent feelings of sadness or hopelessness, most of the increase since 2019 (i.e., pre-pandemic) documented in the YRBS is driven by females (Figure 70). These trends demonstrate a change in mental health-related factors for female children following the pandemic, emphasizing the importance of helping ensure services and supports are in place immediately following discharge to meet their unique needs. As noted previously, MU cited the lack of in-state residential treatment providers who can serve females with higher acuity. Currently, only one in-state PRTF is available to serve females with high acuity as well as one agency that operates three facilities that serve females in a Level 3 group residential setting. BSS has emphasized the need for building out programming for high-acuity females with all potential providers interested in joining the WV service array or existing providers looking to pivot with their current services.

[70] Centers for Disease Control and Prevention. August 6, 2024. "YRBS Data Summary & Trends Report." *Centers for Disease Control and Prevention.* Accessed September 25, 2025. https://www.cdc.gov/yrbs/dstr/

[71] West Virginia Department of Human Services. April 23, 2025. "40 Percent Decline in Overdose Deaths in WV Linked to Fewer Kids Entering Foster Care Due to Parental SUD." https://dhhr.wv.gov/News/2025/Pages/40-Percent-Decline-in-Overdose-Deaths-in-WV-Linked-to-Fewer-Kids-Entering-Foster-Care-Due-to-Parental-SUD.aspx

Figure 70: Trends in Percentage of High School Students Who Experienced Feelings of Sadness or Hopelessness, 2013 to 2023



Helping ensure services and supports are in place upon discharge from residential treatment is critical, especially given the consistently high level of readmissions. As a starting point to evaluate whether services are in place for children following discharge from residential treatment, DoHS completed an analysis of services following discharge and the associated timeline to receipt of those services. Results of this analysis and associated next steps from the October 2024 DoHS Quality Committee review are captured in Section 8.0 Post-Discharge Intervention and Aftercare.

7.4 Key Themes and Next Steps – RMHTF

Sustained demand for residential treatment services continues, but diligent planning efforts by DoHS and its partners Aetna and MU have helped stabilize the RMHTF census. DoHS and its partners will continue to meet monthly to review discharge planning indicators and discuss ways to improve the discharge planning process. DoHS, Aetna, and MU recently identified that (a) communication challenges among those involved in the discharge planning process and (b) helping ensure all of the right people are involved in treatment team meetings and aligned with the discharge and transition plan are barriers to discharge planning efforts. The three entities are collaborating to address these issues.

The percentage of children in in-state active residential placement with an LOS greater than six months decreased in 2024 compared to 2023, serving as additional evidence of the positive

impact of discharge planning efforts. However, children in OOS placement with an LOS greater than six months increased in 2024 compared to 2023. DoHS and MU are taking steps to analyze this shift. Part of DoHS's overall strategy to meet the sustained demand for residential treatment is to decrease LOS for children in placement, thereby freeing up capacity for additional children who may need treatment.

DoHS is collaborating with providers and other stakeholders to address in-state capacity and treatment program needs, including building capacity to support children with higher acuity and significant behavioral challenges (e.g., aggressive behavior, substance use, sexualized behaviors). As a result of these efforts, in June 2024, one provider converted their facilities to serve males with high-acuity treatment needs, with capacity to support 52 youth. Additionally, in March 2025, another provider converted a facility to serve males with high-acuity treatment needs, with a capacity to support 12 youth. A new provider is expected to be onboarded in fall 2025 to include a six-bed facility for males with mental health and ASD diagnoses. DoHS will be monitoring the impact on OOS placements based on these in-state facility changes to support youth with severe behavioral challenges.

DoHS acknowledges that the court system, including judges, plays a vital role in helping ensure children and families are connected to the services they need. Through the Court Improvement Program, the DoHS continues to collaborate closely with court representatives. Recently, an informational flyer was developed to raise awareness about the availability of WV Wraparound services and to guide the courts on how they can best support linking families to these resources. This flyer will be presented at a lunch-and-learn session for legal system stakeholders in fall 2025.

Among the 758 children admitted to residential treatment in CY2024 with a CAFAS/PECFAS administered within 45 days of admission, 12% had a CAFAS/PECFAS score below 90. This proportion decreased slightly from 13% in CY2023 and is evidence of the comprehensive efforts to help ensure children are appropriately placed and complete the QIA process before admission. DoHS continues monitoring and process improvements to help ensure QIAs are completed before admission.

As noted in Section 4.0 System Engagement and Outcomes, DoHS is in the early stages of evaluating predictive and protective factors impacting out-of-home placement, including residential treatment specifically. Next steps include more detailed analyses of the profiles and needs of children entering both in-state and OOS residential treatment. That information will be used to continue to develop in-state capacity to support high acuity youth and to inform potential gaps in HCBS that would assist with preventing out-of-home placements.

On average, 37% – 38% of children are readmitted to residential treatment following discharge. Given high rates of readmission and the importance of helping ensure services are in place to support successful transition to the community, DoHS completed an analysis of services following discharge from residential treatment. Findings and next steps will be further detailed in Section 8.0 Post-Discharge Intervention and Aftercare.

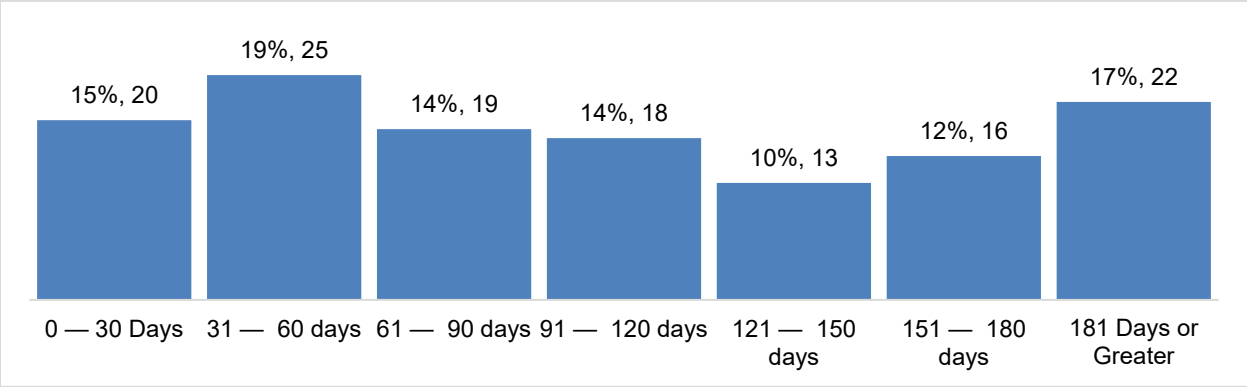
8.0 Post-Discharge Intervention and Aftercare

In fall 2024, DoHS conducted analyses to investigate the factors influencing readmission to RMHTF. The Quality Committee decided that the next step to understanding why readmission occurs was to examine the services in place upon discharge. Data suggest that timely connection to Wraparound services upon discharge decreases a youth's likelihood of readmission. The 2023 and 2024 CMHE reports found that some youth felt returning to a less structured environment, such as their family home, contributed to them returning to past negative behaviors and habits. Caregivers who were interviewed expressed a desire to be included in conversations around treatment and discharge planning because of their insight into their youth experience as well as wanting reassurance that the youth was prepared to return to the home. Youth and caregivers agreed that continuity of care or lack thereof influenced their success after discharge. DoHS explored the types of services a child is connected to, time to connection, and time to readmission (where applicable) to further understand current practices and identify opportunities to decrease readmission to residential facilities.

8.1 Aftercare Services and Impact on Readmission to RMHTF

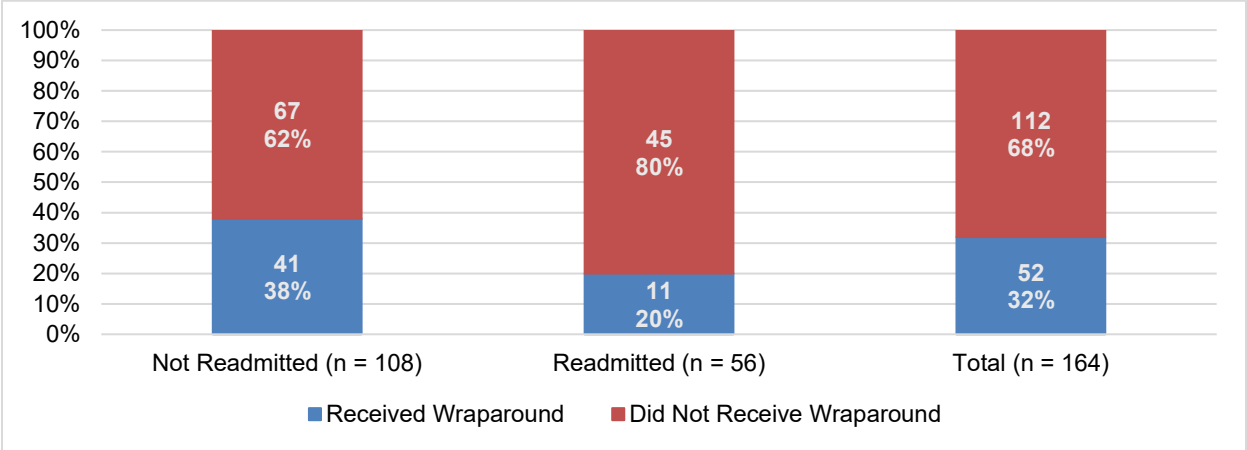
In October 2024, the Quality Committee reviewed analyses on readmission rates for a group of children under the age of 17 who were admitted and discharged from RMHTF at any point in 2023, with potential readmission through March 31, 2024. A total of 439 youth were discharged during the period with 133 readmissions—a readmission rate of 30%. All youth represented would have had at least 90 days between discharge and possible readmission, which is found to be a critical time in the post-discharge time frame. One limitation of this analysis is not all youth had the same amount of time to allow for readmission (beyond 90 days). For example, a youth discharged in March 2023 had approximately one year to readmit, while a youth discharged in December 2023 only had three months. Readmission analyses conducted more recently, including those presented in Section 7.3 Residential Readmission, have addressed this limitation by using a dynamic cutoff date for each child, based on the child's discharge date, to help ensure that all youth had the same amount of time for possible readmission (12 months). As shown in Figure 71, 48% of readmissions were within 90 days of discharge, so DoHS has identified the first 90 days after discharge as critical to the success of the youth remaining in their community. The average time to readmission was 108 days, and the median was 93 days.

Figure 71: Distribution of Time to Readmission for Youth Admitted and Discharged From RMHTF in 2023 With Readmissions Through March 31, 2024 (n = 133)[72]



Beginning the WV Wraparound application process while a child is still in placement provides time for the services to be put in place upon discharge. As shown in Figure 72, approximately one-third (32%, n = 52) utilized WV Wraparound after returning to the community. Of children in the cohort reviewed with an approved application prior to discharge, those who went on to utilize Wraparound were less likely to readmit (11 readmissions of 52 users; readmission rate of 21%) than those who did not use Wraparound (40% readmission rate). Although fewer readmissions among Wraparound users is positive evidence supporting the effectiveness of Wraparound, the utilization rate of only 32% is low.

Figure 72: Wraparound Utilization by Readmission Status – Youth Approved for CSED Before Initial RMHTF Discharge (n = 164)

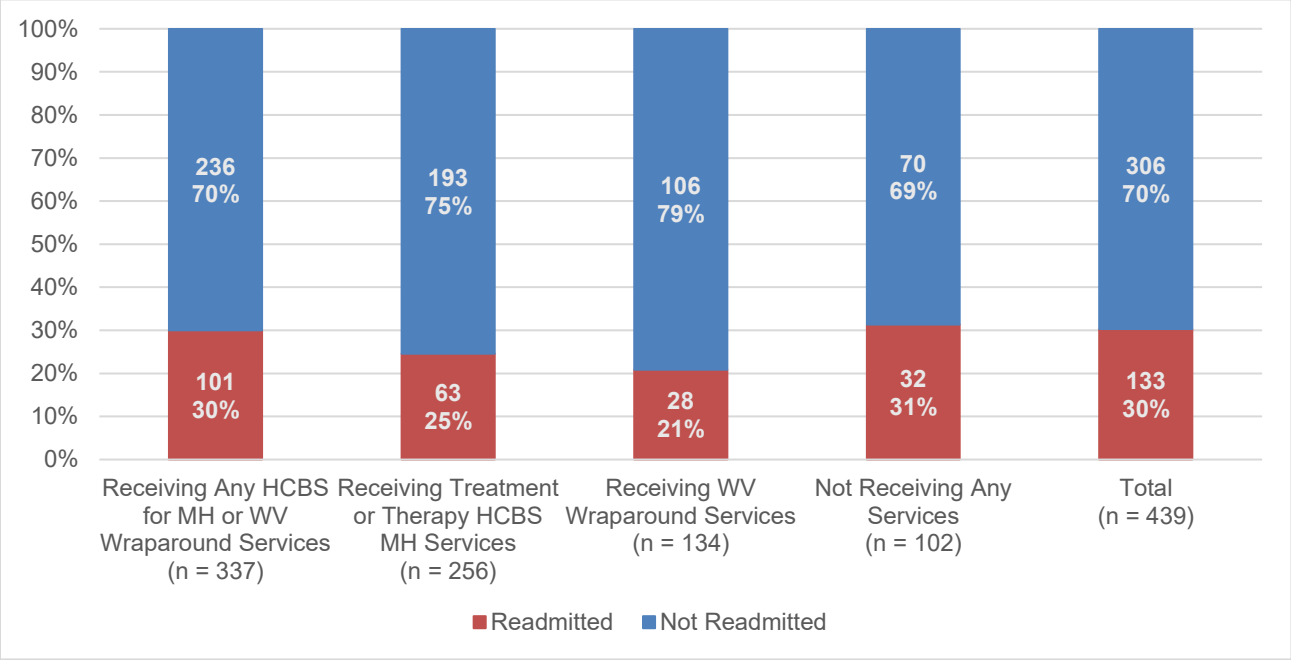


This analysis also reviewed subgroups based on service utilization type to further understand what services have the greatest impact on preventing readmission (Figure 73). Overall, no difference was observed between the broader “any HCBS or WV Wraparound services” (30%

[72] The readmission analysis in Section 7.3 Residential Readmission was conducted after this analysis. That section’s analysis uses slightly different inclusion criteria, impacting sample size and accounting for the difference between the two analyses.

readmitted) and “not receiving any services” (31%) groups. Excluding youth who only received assessment and evaluation services, positive results were observed for those who received either treatment and therapy or WV Wraparound; readmission rates for these groups were 25% and 21%, respectively. Children utilizing WV Wraparound had the lowest rate of readmission, reaffirming the efficacy of this service when utilized in a timely manner. Detailed analyses showed that a large percentage of children were not referred to the Assessment Pathway during discharge planning.

Figure 73: RMHTF Readmission by Service Utilization[73]



8.2 Key Themes and Next Steps – Post-Discharge Intervention and Aftercare

Based on the findings from these analyses, the Quality Committee agreed that helping ensure quality and consistent transition after discharge, referred to as “aftercare,” was a critical component in preventing readmission to RMHTF. An Aftercare Workgroup was established with the goal of identifying strengths and weaknesses of current discharge planning by providers and developing and implementing an aftercare protocol. The workgroup first met in early 2025, established action items, and has continued to meet throughout the year as required to further this work.

It is understood that successful discharge planning begins at the time of admission. Effective discharge planning should involve the youth, their family, and identified HCBS providers to outline a clear continuity of care agreed upon prior to returning home. As identified in the

[73] “Total” is the sum of “receiving any HCBS for MH or WV Wraparound services” and “not receiving any services.” Categories are not mutually exclusive. MH is the abbreviation for mental health.

analyses above, connecting children and families to services quickly upon discharge, including the right level of intensity to meet their needs, is critical. The Aftercare Workgroup has developed a standardized discharge plan, including a crisis plan. The document will be piloted in fall 2025, with feedback from providers incorporated in the full implementation planned for early 2026. Providers will receive training and technical assistance as part of the rollout. The standardized discharge plan is intended to be a living document that follows the youth through their treatment journey. As changes occur, the document should be updated to help ensure that discharge planning reflects their current state. Key features of the document are:

- Caregiver engagement
- Clear documentation of barriers, needs, and service connections
- Contact information for those involved in the youth's journey
- Highlighted goals, both achieved and aspirational
- Youth- and family-specific crisis planning

The Aftercare Workgroup also plans to engage with other key stakeholders outside of residential providers, including education transition specialists with the WVDE. Concerns related to education are frequently a factor in discharge planning. Matters such as acceptance of credits or continuation of a technical program are areas that can influence a child's post-discharge journey. It is important that youth can maintain their academic progress and/or career goals upon return to their community.

In addition, DoHS will continue to review provider-level readmission data. These analyses allow for better understanding and discussion around impacts on acuity and discharge planning practices, expanding conversations with providers who may be serving those with less successful readmissions outcomes. Conversely, lessons can also be learned from providers who have lower readmission rates, potentially identifying best practices for widespread adoption.

9.0 Conclusion: Priorities and Next Steps

DoHS continues to make significant progress in designing, developing, and expanding mental and behavioral health services for children and families across WV, including raising awareness of the availability of these services. As previously described, the mental health needs of children in WV increased following the pandemic and opioid epidemic, resulting in sustained and increased demand for mental health treatment. DoHS's continued focus on and expansion of available services and supports is enabling more children to access Wraparound and other HCBS and offsetting further increases in RMHTF services utilization.

DoHS has identified the following overall themes as WV seeks to continue to understand systemic needs and improve and expand services to meet mental health needs:

- Youth receiving WV Wraparound have positive outcomes, including keeping children in their homes and communities and improving functional abilities.
- Multiple metrics point to increased need and increased acuity, including high demand for services, supports, and specialized placements, thus straining existing resources.
- A key protective factor for preventing out-of-home placement is early identification, allowing children and families to be connected to services and supports before potential system involvement and, ideally, before they are in crisis. Early intervention may also help younger children develop coping skills that will support them throughout adolescence.
- Timely connection to services within 30 – 90 days of first interaction is critical to help prevent residential placement or readmission.
- Placement capacity to meet needs is limited, especially for teenagers and children with mental health needs. A rising number of children have been placed OOS for treatment needs that could not be met in state. Meanwhile, the number of foster homes has plateaued, with only a quarter willing to accept youth 13+, despite increased hotel and shelter volume. Together, these results highlight the need for placements for children with a range of needs both in in-state facilities and in the community.
- For children placed in residential settings, having an effective discharge plan that engages the family and helps ensure aftercare services are in place upon discharge are critical to help prevent readmission.

DoHS will also continue to prioritize the connection to timely, intensive services for eligible children by expanding outreach strategies, identifying specific characteristics and intervention points for children at highest risk, decreasing obstacles in assessment processes, implementing effective discharge planning, and identifying solutions for existing placement needs. DoHS is committed to continuing to transform children's mental health programs toward increased use of evidence-based practices and high-quality care that facilitates positive outcomes, improved quality of life, safety, and permanency for children and families.

Note: Additional details on topics covered in this report are available in the supplement.