

AGREEMENT BETWEEN THE STATE OF WEST VIRGINIA AND THE UNITED STATES DEPARTMENT OF JUSTICE: Report By Subject Matter Expert

April 2022

Integrating Systems • Improving Outcomes



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Introduction

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

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

How This Report Differs from Prior SME Reports

The first four SME reports (December 2019, June 2020, December 2020, and August 2021) focused on consultation and technical assistance to DHHR and recommendations to support West Virginia in meeting its obligations under the Agreement through designing its plan, readying for implementation, and commencing with the initial implementation of Agreement requirements. Beginning with this fifth report, April 2022, the SME reports will now include formal ratings of compliance which will be phased in over a two-year period. Table 1 below describes the compliance rating schedule culminating in the compliance review of all Agreement provisions by the Fall of 2023.

TABLE 1. SCHEDULE FOR PHASING-IN OF COMPLIANCE REVIEWS

Agreement Categories	Spring 2022	Fall 2022	Spring 2023	Fall 2023
Assessment	X	X	X	X
Wraparound	X	X	X	X
Assertive Community Treatment (ACT)	X	X	X	X
Quality Assurance & Performance Improvement System (QAPI)		X	X	X
Screening		X	X	X
Target Population		X	X	X

Children’s Mobile Crisis Response (CMCR)		X	X	X
Residential Reductions			X	X
Behavioral Support Services			X	X
Therapeutic Foster Care			X	X
Outreach & Education				X
Workforce				X
All Other Provisions				X

Table 2 below defines the four compliance rating categories used. Additional details regarding the criteria used for each compliance rating, and the process, are detailed in Appendix D.

TABLE 2. COMPLIANCE RATING CATEGORIES

Category	Criteria
Substantial Compliance	Has undertaken and completed the requirements of the paragraph; no further activity needed OR Has undertaken and completed the requirements of the paragraph--met with updates continuing to occur.
Partial Compliance	Compliance has been achieved on some of the components of the assessed paragraph or section of the agreement, but significant work remains; Has developed deliverables that indicate the state is actively addressing the requirements of the paragraph; Has provided data that indicates the State is actively addressing the requirements of the paragraph; Has implemented activity and has yet to validate effectiveness; Has implemented activity but has not developed procedures to assess the effectiveness of the service or has not taken adequate measures to ensure its sustainability after the agreement terminates; AND/OR Has begun activities but not completed implementation activities.
Non-Compliance	Non-compliance indicates that most or all of the components of the assessed paragraph or section of the agreement have not been met; Has made little or no progress to meet the targets set forth in the Agreement, Implementation Plan or other plans; Has done no work to meet the date as set forth in the paragraph of the Agreement; OR Has not provided data or access to staff so that the Subject Matter Expert may properly assess compliance.
Not Rated	Not Rated indicates a paragraph or section of the agreement where the parties have agreed that the Subject Matter Expert shall not rate the State’s compliance during the assessment period.

Given this change in approach, this fifth report is organized into two different sections:

- Section one provides the SME’s compliance ratings for the topic areas selected for compliance review in this report: Assertive Community Treatment, Assessment, and Wraparound.
- Section two of the report describes the State’s progress on the remaining provisions of the Agreement since the August 2021 report, and recommendations for the coming six months of work and beyond.

Information reflected in this fifth SME report is derived from calls with State leadership and team leads, including calls with topical workgroup leads, and a thorough review of documents, data, spreadsheets, policies, memoranda, and other information provided by the State (detailed in Appendices A and B.)

Section One: SME Compliance Ratings and Recommendations for Assertive Community Treatment, Assessment and Wraparound

Compliance Rating Introduction

The SME relies on written information submitted by DHHR, and data from the Quality Assurance and Performance Improvement (QAPI) System provided by the State to arrive at its assessment of compliance. Written documentation of compliance will focus on external facing documents shared with stakeholders/public, and internal facing documents provided to the SME by the State such as contracts, policies and procedures, training manuals, and written answers by the State to formal questions submitted by the SME.

Deriving compliance from written document has limitations as even the best-intentioned policies neither succeed nor fail on their own merits; rather, progress is dependent upon the processes of implementation and related oversight and monitoring. Noting this limitation, the SME's compliance ratings will include an assessment as to whether the State's planned approach will likely result in compliance with the Agreement. The SME will rely on data from the QAPI, including findings from its surveys of families, youth, and providers, and implementation of the State's continuous quality improvement (CQI) plan in which the State implements changes to policies, procedures, practices, and regulations based on trends in QAPI data, including stakeholder feedback. In addition, as DHHR engages stakeholders, families, youth, and providers in forums, workgroups, and other collaborative processes, the SME will incorporate learnings from those efforts.

It is important to recognize that attaining and sustaining compliance with the Agreement provisions is not a static activity; it will require ongoing collection, monitoring and oversight of data, and subsequent changes to policy and practice based on that validated data and related analyses. The SME emphasizes the design and implementation of the State's QAPI System, which would include a CQI plan in which the State regularly adjusts its policies, practices, and activities based on data. Ongoing oversight and reporting on the Implementation Plan will demonstrate that the State has the capacity to constructively manage policy changes to continuously improve the availability, accessibility, and quality of services for children, as it navigates the realities of changing State and Federal legislative, regulatory, and fiscal landscapes.

All criteria are applied specific to the report period reviewed. For example, a rating of partial compliance in one report period would not necessarily continue to be rated as partially compliant if there is no continued evidence of progress. A rating of substantial compliance in one report period would not continue to be rated as substantially compliant if achievements were not maintained and substantiated through policy, operating procedures, oversight and monitoring, and data collection and analysis, as applicable.

In this initial compliance rating, the SME included draft documents as evidence of compliance in determining compliance ratings. For future reports and related ratings, including maintenance of a rating of partial compliance or to move a rating of partial compliance to full compliance, the State will need to provide finalized or codified documentation. Example of such documentation include, but are not limited to provider and policy manuals; standard operating procedures; training curricula and evaluation; provider or public bulletins, or other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring tools and reports; audit or quality sampling plans and reports; outreach and education materials; plans or reports related to family and

youth engagement; oversight and monitoring plans; CQI or performance improvement plans; and data indicators and related analyses.

Finalized and codified means the document must be in its final form and available to the respective agencies, bureaus, divisions, and/or the public via DHHR's website or a contractor's website, or through established internal processes and systems (i.e., BSS and FACTS system, as an example). In including draft documentation, the SME acknowledges DHHR's effort to comply with the Agreement. To maintain this progress, DHHR will need to provide data or other documentation that clearly demonstrates these written documents are actualized by its divisions, agencies, or bureaus and their respective staff, in collaboration with children, youth, and families.

ASSERTIVE COMMUNITY TREATMENT

AGREEMENT REQUIREMENT 10

ACT is a treatment model in which a multidisciplinary team assumes accountability for a small, defined caseload of individuals and provides the majority of direct services to those individuals in the individual’s community environment and that operates with high fidelity to an assessment tool, such as Dartmouth Assertive Community Treatment Scale.

Compliance Rating	Partial Compliance
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Explanation: The service definition included in *Chapter 503, Licensed Behavioral Health Centers Provider Manual*, is consistent with this Agreement definition. The manual includes requirements for fidelity (p. 45); however, it does not include a specific fidelity assessment tool (i.e., the Dartmouth Assertive Community Treatment Scale or the Tool for Measurement of Act (TMACT)). *KEPRO Assertive Community Treatment Behavioral Health Retrospective Review Tool* is used for retrospective review but is not an assessment tool.

The State will need to provide documentation of its fidelity assessment tool mentioned in Appendix 503E (“[r]ecertification review is conducted one year following the certification by BMS or their designee to ensure compliance with requirements. This review will consist of a site visit to score the ACT team on adherence to the fidelity scale, organizational and policy requirements”) and fidelity scores to demonstrate that ACT providers are operating with high fidelity. The State will need to document the process to establish initial and ongoing fidelity, including the credentials of the individual(s) assessing fidelity and the process for the fidelity determination.

AGREEMENT REQUIREMENT 24

Ensure **timely, statewide access** to in-home and community-based services **sufficient to meet the needs** for every child in the target population, including Wraparound facilitation, behavioral support services, children’s mobile crisis response, therapeutic foster family care, and **assertive community treatment**.

Compliance Rating	Partial Compliance
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Explanation: ACT is not yet available statewide. See Agreement Requirement 39.

Regarding statewide access, as part of its implementation plan, the State noted it had reviewed the availability of ACT statewide and found that the northern and eastern panhandle regions did not have an ACT team within 100 miles. The state has since secured a provider in the northern panhandle. It supplied grant funds to Mountaineer Behavioral Health in August 2021 and anticipates that services will begin no later than August 2022.

The State has identified an organization (Mountaineer) for the eastern panhandle, which is the one region remaining without an ACT provider. However, the provider has been unable to fully staff ACT to begin operations. The State provided a document, *ECOVID Program Report Excerpts*

about Assertive Community Treatment (ACT) Start-up in the Eastern Panhandle (EPH), which details the meetings, communications, and other steps taken to recruit providers but notes “Mountaineer Behavioral Health has been conducting significant workforce activities to staff multiple expansion efforts to meet the tremendous need in the region. Mountaineer is posting on Indeed, ADP, and LinkedIn, as well as a variety of other social media, with limited results. Mountaineer also hosted a two-day job fair (2/15/22 and 2/16/22), which resulted in generating staff for direct care positions but was not so effective for attracting therapists, medical providers, or nursing workforce... Mountaineer will again be revisiting any additional options for recruitment strategies specific to the hiring of sufficient staff to keep a team staffed with the combination of skills, professional training, and interest in providing the difficult work demanded of an ACT Team 24/7/365.” DHHR has used many approaches to support the provider including grant dollars, technical assistance on hiring strategies, and oversight meetings to monitor that the provider is engaged in consistent, ongoing recruitment efforts. The SME recommends that DHHR continue these oversight meetings to ensure this remains a priority for the provider, and to brainstorm different strategies that could be used for recruitment and retention. Recognizing that hiring is a particular challenge in this region of the State, and that there are limited providers that serve this area, DHHR should engage with this provider regarding any specific barriers to hiring and retaining staffing compared to other providers that serve this area to share successful strategies and to monitor that any provider-specific practices such as wages, onboarding, or retention of its personnel are not hindering hiring.

Regarding timely access, the State provided data on ACT utilization and average length of episode by service year for individuals 18-20. The State will need to offer documentation and/or data to demonstrate that young adults are timely served, including response time to referral standards/requirements, required timeframes for appointment/service engagement, and data showing measurement of those response times; and, where needed, any performance improvement activity to improve timeliness as indicated by the data. If performance improvement is required of a vendor, DHHR will also need to demonstrate its oversight activities with the vendor to ensure that DHHR standards are met, and quality improvement processes are applied, if needed.

Regarding the requirement that services are sufficient to meet need, the State will need to develop an approach to monitoring capacity to ensure sufficiency. The SME’s August 2021 report suggests ways this can be conducted. Like DHHR’s efforts to monitor Wraparound (discussed in Section Two of this report), similar processes are needed for ACT.

More generally, the State will need to submit documentation regarding how the Bureau of Medical Services (BMS) is authorizing ACT services overall in light of the medical necessity requirements in *Chapter 503*, which limits eligibility for ACT to individuals with “three or more hospitalizations in a psychiatric inpatient unit or psychiatric hospital in the past 12 months; five or more hospitalizations in a psychiatric inpatient unit, psychiatric hospital, or Community Psychiatric Supportive Treatment Program in the past 24 months; or 180 days total length of stay in a psychiatric inpatient unit or psychiatric hospital within the past 12 months... [or] other specific target populations who exhibit medical necessity for the service (e.g., persons who are homeless

and who have a severe and persistent mental illness, members with a mental illness who have frequent contact with law enforcement or the criminal justice system, or members with co-occurring mental illness and chemical addiction who require consistent monitoring.”

The *KEPRO Assertive Community Treatment Behavioral Health Retrospective Review Tool* includes rating information related to weekly review of a member’s status, documentation of needs, and follow-up planning, but that documentation pertains only to those who have already been enrolled with ACT, not those who may be waiting for authorization from BMS.

The *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document)* includes two measures related to ACT (“number/proportion of youth over age 18 offered the choice of ACT or Wraparound” and “number/proportion of youth over age 18 who chose ACT versus Wraparound”) with KEPRO as the responsible party but no guidance included—that is, no timeframe for review or guidance to ensure that youth are being offered the choice timely.

To fully comply with this requirement, the State will need to provide additional documentation for the SME to review such as Standard Operating Procedures; BHO Contracts; provider contracts; service descriptions; medical necessity criteria; provider communications, including bulletins and other transmittals; provider and policy manuals; billing and reporting requirements and manuals; staffing qualifications; and conveyed in meetings with providers and stakeholders.

Training must also reflect these requirements, including information on how providers should offer youth and families a choice between ACT and Wraparound. This and related information should be present in initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

AGREEMENT REQUIREMENT 24.1

Aforementioned services will be provided in a manner that **enable the child to remain with or return to the family (or foster/kin/independent living where applicable)** whenever possible [and DHHR shall ensure **statewide access** to these programs to prevent crisis and promote stability in the family home (or foster/kinship home, where applicable)]. See related Agreement Number 39.

Compliance Rating	Partial Compliance
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Explanation: *Chapter 503* includes, as part of ACT’s purpose, “[t]o reduce psychiatric hospitalization for members with serious and persistent mental illnesses; to provide an established clinical relationship with the member and his or her natural **support system to promote continuity of care; to improve successful integration into the larger community through non-traditional approaches to broadening a member’s social support base; to ensure that the member’s basic needs for sustaining community living are addressed**, promoting acquisition of independent levels of adult living skills whenever possible.” Service elements include “[s]ustained effort to

engage the member in treatment, medication education and prompting, and **skill development activities to facilitate more integrated and successful community living**; comprehensive and appropriate assessment of medical, environmental and social needs; maintenance of on-going involvement with the member during stays in environments such as inpatient care, convalescent care facilities, community care hospitals, or rehabilitation centers to assist in transition back to a community placement; assistance with securing necessities (e.g., food, income, safe and stable housing, medical and dental care, other social, educational, vocational, and recreational services); facilitation of maintenance of living arrangements during periods of institutional care; and **collaboration with family/personal support network.**” [Emphasis added]

The *KEPRO Assertive Community Treatment Behavioral Health Retrospective Review Tool* includes Question 15 “Does the documentation indicate efforts to link the member to natural supports/activities/services in the community including providing support to those primary support networks?” Although the State provided information on retrospective reviews, we did not receive scores for existing providers to verify the number of providers who received a 3 (“100% of the documentation meets this standard”), 2 (“99% to 75% of the documentation meets this standard”), 1 (“74% to 50% of the documentation meets this standard”), or 0 (“under 50% of the documentation meets this standard”) in measures related to service to prevent crisis and promote stability.

The SME notes that KEPRO conducts these retrospective reviews, but the SME did not receive any documentation regarding how the State uses these reviews and fidelity assessment scores to ensure that services are provided in the most integrated setting and what steps, if any, it takes when retrospective reviews or fidelity monitoring surfaces compliance issues. The State will need to provide SOPs and other documentation for how it uses retrospective reviews and fidelity scoring to ensure ACT providers are fulfilling the purpose described in *Chapter 503*.

The State did provide a draft paragraph that it anticipates adding to *Chapter 531, Psychiatric Residential Treatment Facility Services* in July 2022 that will require such facilities to review residents’ records to see if they meet the clinical criteria for the ACT program and inform residents, families, and other involved entities about the availability of ACT. If a resident meets the clinical criteria for ACT, the facility “is required to reach out [to] the ACT team that is located in the resident’s home address.” When information is finalized regarding the choice and process for a youth’s selection between ACT and Wraparound, this *Chapter 531* content will need to be revised to reflect that change.

Such a change will assist the State in meeting the Agreement requirement to return children/youth to their family or independent living, prevent crises, and promote stability. Apart from the planned change to *Chapter 531* mentioned above, changes to *Chapter 503* may be necessary to alert ACT providers to the planned revisions in *Chapter 531*.

More broadly, ACT has been identified as a service that **enables a youth to remain with or return to their family (or foster/kin/independent living where applicable)**. Therefore, the State must ensure that every effort is made to provide services in a manner that supports the youth to be

successful in the community. Full compliance in this area should be evidenced by individualized care plans, coordination with other services and supports, identification of transition-aged youth specific services and resources, responsiveness to after-hours calls from the youth or family or linkages with CMCR (as appropriate), and training materials that expound upon the developmental needs of youth and young adults ages 18-20 across life domains, appropriate to the cognitive, social-emotional, and physical abilities, as well as their experiences and preferences.

AGREEMENT REQUIREMENT 25

Aforementioned services are intended to advance the state’s compliance with ADA and will be provided **in the most integrated setting** appropriate to meet the needs of the target population.

Compliance Rating	Partial Compliance
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Explanation: Chapter 503 provides clear language regarding the expected standard for services provided outside of an office setting, which is a proxy for integrated setting as it lists among the Fidelity Indicators the requirement that “a minimum of 75% of service must be delivered outside of program offices.” However, the SME did not receive any documentation regarding how the State determines that service locations are the “most integrated setting” to meet the needs of young adults 18-20. The State will need to provide SOP and other documentation regarding how this requirement is monitored and measured, and any CQI processes used to correct performance.

The *KEPRO Assertive Community Treatment Behavioral Health Retrospective Review Tool* includes one question that may be read to implicitly include the requirement that services are delivered in the most integrated setting (“Question 14: Are the activities appropriate and individualized to the assessed need and functional level of the member?”), but no further detail is included.

The SME notes that KEPRO conducts these retrospective reviews, but it did not receive any documentation regarding how the State uses these reviews and fidelity assessment scores to ensure that services are provided in the most integrated setting and what steps, if any, it takes when retrospective reviews or fidelity monitoring surfaces compliance issues. To fully comply with this requirement, the State will need to provide retrospective review scores for ACT providers, SOP, and/or other documentation regarding how it monitors and oversees the retrospective review process, as well as any CQI or corrective processes it uses to correct deficiencies.

Training must also reflect the expectation that the majority of services delivered are provided in the most integrated setting appropriate to meet the needs of the target population. Such training should include initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

AGREEMENT REQUIREMENT 26

Aforementioned services will be **delivered at times and locations mutually agreed upon by the provider and the child and family** (or foster or kinship care family where applicable) to assist in practicing skill development in the context of daily living.

Compliance Rating

Partial Compliance

Explanation: *Chapter 503* provides language regarding the expected standard for services provided outside of an office and includes language on skills development (“[t]o ensure that the member’s basic needs for sustaining community living are addressed, promoting acquisition of independent levels of adult living skills whenever possible”) and ACT service elements on page 45 (“... skill development activities to facilitate more integrated and successful community living” and “Facilitation and improvement of daily living/community living skills.”)

Neither the manual nor any other documentation received details how the State determines that the young adults and their identified family receive skill development for daily living at times and locations mutually agreed upon. To meet this requirement, the State will need to provide SOPs and/or other documentation regarding how it monitors and measures this requirement, as well as any CQI plans or corrective processes it uses to correct deficiencies.

Training must also reflect the expectation that services are provided in a mutually agreeable manner. Such training should include initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

AGREEMENT REQUIREMENTS 27

The child in the target population, or his or her guardian for a child under 18, maintains the right to refuse offered services.

Compliance Rating

Partial Compliance

Chapter 503 (p.48) notes the right of a member to refuse ACT services. In addition, the State’s [Your Guide to Medicaid 2020](#) notes that “You have the right to choose and/or make decisions about health care for you and your children.”

The State will need to provide SOPs and other documentation regarding how it monitors and measures this requirement, as well as any CQI plans or corrective processes it uses to correct deficiencies. It should also collect and provide data regarding the number, demographics, and geographic locations of youth and families declining to participate in ACT to actively monitor any barriers to service accessibility and availability.

Training must also reflect the expectation that youth and families have the right to refuse services. Such training should include initial and continuing education; coaching; curricula, including seat-

time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals. The State must document its training on the subject of consent to participate in treatment and services to avoid the appearance of coercion. The training should include best practices for engaging youth and families across different communities and cultures, recognizing the historical and structural racism and bias in health care systems that may lead youth and families to feel reluctant or coerced to participate, as well as the stigma attached to receipt of behavioral health services across many cultures and communities.

The State will need to provide documentation of how it obtains consent for participation and treatment when English is not the primary language of the youth or family.

AGREEMENT REQUIREMENT 28

Ensure timely provision of mental health services to address any immediate or urgent need for services.

Compliance Rating

Partial Compliance

Chapter 503 requires “24-hour crisis response for ACT members” and “[t]ransportation or facilitation of transportation to necessary community and Medicaid services as specified on the treatment plan” and includes as a fidelity indicator “[t]he program provides 24-hour services for crisis intervention.” In addition, Appendix 503E, Application for Assertive Community Treatment Team, requires the “[c]apacity to rapidly increase service intensity for an individual when his or her status require.”

In conversations with the State, the SME learned that retrospective reviews of ACT service occur on an 18-month cycle and the State will send a reviewer out upon complaint. However, no information was provided regarding the number of complaints, review processes, or resolution related to urgent need or other aspects of ACT.

The SME did receive data in *ACT Utilization and Average Length of Episode (ALoS) by Service Year for Individuals 18-20*, but that data includes service units, which are billed on a per diem basis (H0040 is billed once per day, on a 24-hour basis). There is not a modifier to differentiate the service components within the H0040 code.

The ACT service requires a daily log documenting the discussion of each individual enrolled and start and stop times. A weekly summary is required that identifies the individual’s assessed needs, number and type of ACT activities, and follow-up plans. In addition, a 90-day review of comprehensive plan and/or documentation of team meetings. These logs and 90-day reviews are included in *KEPRO Assertive Community Treatment Behavioral Health Retrospective Review Tool*.

While the data mentioned shows general utilization, additional documentation is still needed regarding how the State monitors the provision of *crisis service* under ACT as part of certification, re-certification, fidelity monitoring, and retrospective review, as well as any CQI or corrective

processes it uses to correct deficiencies. (Certification occurs after the initial application and is in effect for one year. Thereafter, recertification occurs every two years.)

AGREEMENT REQUIREMENT 28.1

Aforementioned mental health services will **be provided in consultation with the child and family** (or foster or kinship parent, where applicable)

Compliance Rating	Partial Compliance
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See Agreement Number 26. *Chapter 503* states, "The team must develop an initial service plan for the ACT member within seven days of admission into the program. The initial plan must authorize the services to be provided to the member until the comprehensive plan for the member is complete. The ACT Team, **including the member**, must amend or develop a comprehensive service plan for the member within 30 days. The plan must describe goals and specific objectives **the member hopes to achieve** with the assistance of ACT. The comprehensive plan must identify the services to be provided under ACT and must be **approved by the member**, as signified by his or her signature, date and start/stop time." [Emphasis added.]

The SME acknowledges that the State has established the member is expected to participate on the ACT team, outline their goals, and approve the plan. However, the State has not provided information on how the ACT teams are expected to engage the youth and their family in developing a team and the goals they want to achieve. The State should provide protocols and training for how this information is provided to ACT teams and a process for reviewing the quality of the engagement. This can be achieved through interviews with individuals who have received services, as well as through satisfaction surveys.

The State also speaks to the role of the "member" but not the role of the family, which is critical to this Agreement and particularly relevant for youth who have identified family providing significant caretaking or other support. The State should provide evidence of training and quality assurance activities regarding meaningful engagement of youth and family members, with a focus on the nuanced role of family members who are part of a team with a youth ages 18-20.

AGREEMENT REQUIREMENT 28.2

Aforementioned mental health services will include in-home and community-based services and **linkage to other service providers.**

Compliance Rating	Partial Compliance
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Chapter 503 includes the following as ACT service components: "counseling, problem solving, and personal support; psychiatric services and medication management; assistance in obtaining necessary primary care services; facilitation and improvement of daily living/community living skills; behavior management as necessary and appropriate; 24-hour crisis response for ACT

members; and transportation or facilitation of transportation to necessary community and Medicaid services as specified on the treatment plan.”

In addition, the *KEPRO Assertive Community Treatment Behavioral Health Retrospective Review Tool* includes questions on service delivery overall (Question 10: “Does the documentation of the weekly summary include: a review of the number, type, and duration of the ACT activities, the identified needs, and the follow up plan?” and Question 14: “Are the activities appropriate and individualized to the assessed need and functional level of the member?”)

Although the State provided information on retrospective reviews, the SME did not receive fidelity scores for existing providers to verify the number of providers who received a 3 (“100% of the documentation meets this standard”), 2 (“99% to 75% of the documentation meets this standard”), 1 (“74% to 50% of the documentation meets this standard”), or 0 “under 50% of the documentation meets this standard”) related to service delivery.

The SME notes that KEPRO conducts these retrospective reviews but did not receive any documentation regarding how the State uses these reviews and how it is using fidelity assessment scores to ensure that in-home and community-based services and linkages are being provided and what measures, if any, it takes when retrospective reviews or fidelity monitoring surfaces compliance issues. The State will need to provide SOPs and other documentation regarding how it monitors and measures how ACT is linking to in-home and community-based services, as well as any CQI plans or corrective processes it uses to correct deficiencies.

Training must also reflect the expectation that ACT is appropriately and timely linking to in-home and community-based services. Such training should include initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

The State’s planned updated to *Chapter 531* includes language on linkage to HCBS: “The facility is responsible to educate residents, families/guardians, and other involved entities on the available services in their community including but not limited to CSED Waiver (Children’s Serious Emotional Disorder Waiver, Safe at Home, Mobile Crisis Response, Intensive Outpatient, and other Outpatient Services” but does not provide further detail on how the State intends to monitor and oversee the requirement. The SME has not received any information regarding updates to *Chapter 503*, which was last updated in 2018. The current language is adult-centric and does not mention, for example, access to EPSDT services for young adults 18-20 or the transition to ACT from the CSED Waiver and its related services including Wraparound.

AGREEMENT REQUIREMENT 39

Ensure ACT is **available statewide**.

Compliance Rating	Partial Compliance
<p>As part of its implementation plan, the State noted it had reviewed the availability of ACT statewide and found that the northern and eastern panhandle regions did not have an ACT team within 100 miles. The State has since secured a provider in the northern panhandle. It supplied grant funds to Mountaineer Behavioral Health in Aug. 2021 and anticipates that services will begin no later than Aug. 2022.</p> <p>The State has a provider in the eastern region, but the provider has been unable to fully staff ACT to implement. The State provided a document <i>ECOVID Program Report Excerpts about Assertive Community Treatment (ACT) Start-up in the Eastern Panhandle (EPH)</i> which details the meetings, communications, and other steps taken to begin service delivery in the eastern region with no date determined at this time.</p> <p>If the state achieves this timeline and Mountaineer Behavioral Health has trained its staff and is operational, the SME expects this rating to be revised in its Fall 2022 report.</p> <p>See also Agreement Requirement 24.</p>	

AGREEMENT REQUIREMENTS 39.1 & 39.2	
<p>Ensure... that those in the target population ages 18-20 receive [ACT] timely. ACT teams can substitute for child and family teams, in which case ACT teams will develop the individualized service plan and provide/ensure access to in-home and community-based services...</p>	
Compliance Rating	Partial Compliance
<p><i>Chapter 503</i> describes ACT as “a very specialized model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals.” There is also language regarding the expected caseload for ACT: “The maximum number of members served by an approved ACT Team is 120. The team must preserve a staff/member ratio of at least 1:10 (i.e., one staff person to ten members, not counting the Physician, PA, or APRN when the number of ACT members served by the team exceeds 50.”</p> <p>The material the State provides only briefly mentions ACT substituting for Wraparound. On its CSED Waiver Enrollment Pathway, there is a box that notes those 18 and older will be offered ACT as an as alternative to the CSED waiver. However, no SOPs or other documentation that reflect this choice was included in time for this reporting period and there are only limited data measures on this point (the <i>Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables</i> includes only “Number/ proportion of youth over age 18 offered the choice of ACT or Wraparound” and “Number/ proportion of youth over age 18 who chose ACT versus Wraparound.”).</p> <p>The State will need to provide SOPs and other documentation regarding the guidance it offers providers and/or training on the differences between ACT and Wraparound, and considerations for</p>	

when a youth may benefit from one or the other; and how it monitors that providers are following that guidance and measures how families and youth are offered the choice of ACT versus Wraparound, as well as any CQI plans or corrective processes it uses to correct deficiencies.

Training must also reflect the expectation that families and youth have a choice of ACT or Wraparound. Such training should include initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

See also Agreement Requirements 24 and 28.

AGREEMENT REQUIREMENT 40

Provide **timely, high quality** in-home and community-based mental health services **individualized** to each child’s needs.

Compliance Rating	Partial Compliance
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Chapter 503 requires ACT to have the following five services: medication management, counseling/psychotherapy, housing support, substance abuse treatment, and employment rehabilitative services. The definition notes that “ACT is an inclusive array of community-based rehabilitative mental health services for members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization and therefore, require a well-coordinated and integrated package of services, provided over an extended duration, to live successfully in the community of their choice.”

The *KEPRO Assertive Community Treatment Behavioral Health Retrospective Review Tool* includes Question 14: “Are the activities appropriate and individualized to the assessed need and functional level of the member?”

However, it is unclear how the State monitors the timely provision of ACT itself and of its service components—including access to individualized services—except as part of certification, re-certification, and fidelity monitoring. (Certification occurs after the initial application and is in effect for one year. Thereafter, recertification occurs every two years.) The State will need to provide SOPs and other documentation regarding how it monitors and measures how providers are appropriately and timely offering all of the required service components, and that the mix of services delivered is sufficiently individualized, as well as any CQI plans or corrective processes it uses to correct deficiencies. The SME notes that such monitoring or corrective processes could include establishing data benchmarks related to timeliness and individualization of services and then developing and monitoring performance improvement plans based on providers’ ability to meet and maintain those data benchmarks.

Training must also reflect the expectation that ACT is robust service requiring a varied mix of service components. Such training should include initial and continuing education; coaching;

curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

The SME did receive *ACT Utilization and Average Length of Episode (ALoS) by Service Year for Individuals 18-20*. The number of young adults served is quite small (47 from 2018 through Sept. 2021). The document notes that unique youth – the total youth served each year under fee-for-service and managed care – are not additive because the same youth may disenroll and re-enroll in a different plan in the same year.

In reviewing the number of service units delivered, it appears that young adults who receive ACT under managed care have longer lengths of stay (average 166 days) and receive more units of service (just under 119 units per youth) than those in fee-for-service (average 117 days and 81 units per youth). As part of DHHR submitting data and/or documentation to ensure that care is truly individualized for youth enrolled in ACT, DHHR will need to provide data or documentation to explain the variance in service delivery by payer.

See also Agreement Requirement 28.

AGREEMENT REQUIREMENT 40.1

Ensure that children receive, as needed, all of the home and community-based services described in this agreement.

Compliance Rating	Partial Compliance
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Explanation: See Agreement Requirements 24, 26, and 28.

AGREEMENT REQUIREMENT 40.2

DHHR shall ensure that each of these services is available and accessible statewide to children in the target population in the necessary, amount, location, and duration.

Compliance Rating	Partial Compliance
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Explanation: ACT is not yet available statewide. See also Agreement Requirements 24 and 39. Additionally, ACT data is not yet available to support further compliance assessment specific to amount, location, and duration of services; the SME understands this data is forthcoming.

AGREEMENT REQUIREMENT 40.3

Provide families and children with accurate, timely, and accessible information regarding in-home and community-based services available in their communities.

Compliance Rating	Non-Compliance
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In the *CSED Waiver Pathways* and draft *Chapter 531* documents, the State has messaged its intention to provide information to families. However, at this time the SME has not received any documentation of the outreach and education efforts related to ACT for youth and families, including those related to youth transitioning from residential facilities, choosing between ACT and Wraparound, and related oversight and monitoring activities. To fully comply with this requirement, the State will need to provide additional documentation for the SME to review. See also Agreement Requirement 24.

AGREEMENT REQUIREMENTS 41D, 41E, 52, AND 52A

DHHR’s implementation plan shall contain the steps DHHR will take to address workforce shortages relating to services under this agreement. DHHR’s implementation plan shall contain the steps DHHR will take to evaluate the provider capacity needed to address the agreement. Implementation of services in paragraphs [requirements] 24-40 will be phased in regionally across the State according to a timeline detailed in the implementation plan. Initial statewide implementation should occur by 10/1/20.

Compliance Rating	Partial Compliance
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The State’s implementation plan contains information regarding its plans to address workforce shortages in the northern and eastern panhandles of the states. This includes an anticipated date of service for the last remaining unserved region by August 2022.

The SME notes that as more children, youth, and families enter the Assessment Pathway, there may be an increased demand for ACT services and, as such, the State will need to monitor demand for services. In conversations with the State, the SME learned that, thus far, existing ACT providers have sufficient capacity with providers staffing multiple teams (e.g., Prestera). Retention of existing ACT providers and staff was described as good, but some difficulties related to the COVID pandemic were noted, particularly with regard to willingness to provide in-home services.

In the *ECOVID* document, the State noted that Mountaineer was “struggling to fill multiple nursing staff positions, even after starting to advertise a sign-on bonus of \$5,000 for RNs.” This document noted difficulty recruiting and retaining staff in the eastern panhandle due to competition from the District of Columbia, Maryland, and Virginia, “which offer significantly higher salaries just across the state borders.”

Evaluating provider capacity requires more than noting when a provider is not available for a specific area. It also cannot be dependent upon the state relying on verbal reports of waitlists or wait time issues. It requires ongoing, consistent process for monitoring of access and sufficient availability of appropriately trained staff to meet need. As noted with DHHR’s efforts to assess provider capacity for Wraparound, a similar systemic monitoring effort is needed for ACT. To that end, the State will need to provide a detailed plan or SOP related to initial and ongoing monitoring of provider capacity, including recruitment, retention, training, monitoring, and quality oversight.

See also Agreement Requirement 39.

Documents Reviewed:

- Achieving Safety, Permanency and Well Being For West Virginia’s Children, A Knowledge and Skills-Based Curriculum
- ACT Utilization and Average Length of Episode (ALoS) by Service Year for Individuals 18-20* (2018-Sept. 2021)
- Awareness and Implementation Plan for Bureau for Social Services (BSS) Staff on the Pathway to Children’s Mental Health Services and Reducing the Reliance on Residential Services (Draft, March 11, 2022)
- Bureau of Medical Services, 2022 Spring, 2021 Spring & Agenda and attendee count
- Chapter 503, Licensed Behavioral Health Centers, WV Medicaid Policy Manual (effective Jul. 15, 2018)
- Chapter 531, Psychiatric Residential Treatment Facility Services, WV Medicaid Policy Manual (redlined copy, undated)
- Children’s Mental Health Assessment Pathway - Data Collection and Analysis Plan (March 9, 2022)
- Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document)
- ECOVID Program Report Excerpts about Assertive Community Treatment (ACT) Start-up in the Eastern Panhandle (EPH) (March 9, 2022)
- Families to Success (Jan. 2022)
- Grant Agreement, Mountaineer Behavioral Health PLCC (Aug. 10, 2021-May 31, 2022)
- The Implementation Plan of the Memorandum of Understanding between the State of West Virginia and the United States Department of Justice, Year 3
- KEPRO Assertive Community Treatment Behavioral Health Retrospective Review Tool
- Mountain Health Promise Request for Proposal (with attachments and appendices)
- Pathway to Children’s Mental Health Services (Feb. 9, 2022)
- Quality Assessment and Performance Improvement (QAPI) Update (March 10, 2022)
- Updated Pathway Process Flow Diagrams (March 11, 2022) (R3 Model of Care; CSED Waiver; HCBS for non-CSED Waiver Youth; Assessment, Diversion, and Transition)
- Earlier Subject Matter Expert Reports and related documentation provided.

The following examines compliance related to **assessment only**. The Subject Matter Expert (SME) notes that screening and assessment are inextricably linked; that is, the capacity, training, outreach and education, policies, procedures, data collection, and monitoring and oversight related to screening affects assessment. Compliance ratings for screening will be added in the Fall 2022 and will provide a clearer, more complete picture of how children and youth are initially identified and become part of the target population.

ASSESSMENT

AGREEMENT REQUIREMENT 24

Ensure timely, statewide access to [assessment for] in-home and community-based services sufficient to meet the needs for every child in the target population, including Wraparound facilitation, behavioral support services, children’s mobile crisis response, therapeutic foster family care, and assertive community treatment.

Compliance Rating	Partial Compliance
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Ensuring timely access to HCBS requires a clear pathway to care.

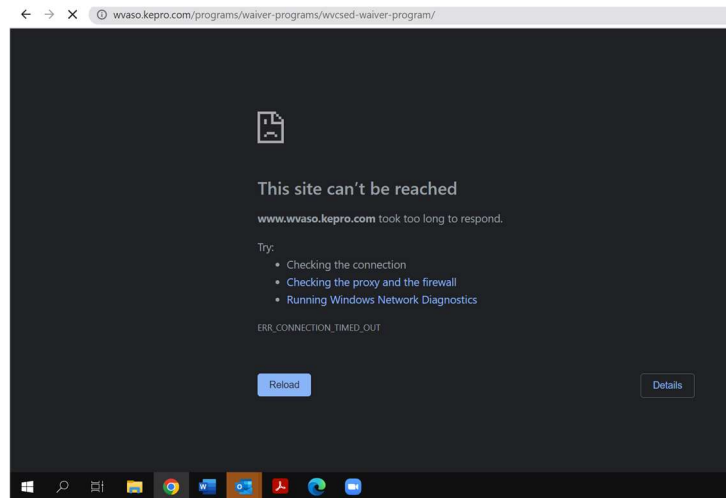
The *Bureau for Behavioral Health (BBH) Pathway to Children’s Mental Health Services Phase 1 Reference Guide* includes information on how children and families may be connected with the Assessment Pathway directly or via their primary care provider, children’s crisis line, or Children’s Mobile Crisis Response and Stabilization team. The SME wishes to acknowledge the State’s extensive efforts to define the pathway, and that the State began its roll-out in late January 2022.

Families with behavioral health concerns are directed to complete the CSED Waiver application and email or mail it to KEPRO. Upon receiving a CSED Waiver application, KEPRO will email BBH at bbhreferralquestions@wv.gov to notify BBH the application was received within one business day of application receipt. KEPRO will then review the application, contact the child, family, BSS worker, or other legal guardian to complete the Child and Adolescent Functional Assessment Scale (CAFAS) within an approximate three-business-day period, and notify BBH at bbhreferralquestions@wv.gov within three business days whether the individual will be further evaluated for the CSED Waiver, based on the CAFAS score.

As per *Chapter 502*, if a child meets initial criteria, KEPRO asks the family to select a provider from the independent evaluation network and contact the independent evaluator [IE] to schedule an evaluation. If the IE is unable to schedule and complete the evaluation within 14 days, KEPRO will assist the family in choosing an alternative IE. The final determination of eligibility must be made within seven (7) days of receipt of the completed independent evaluation using the CAFAS or PECFAS. Eligibility determinations are communicated to the family who chooses a Wraparound

provider. If the CAFAS score is 90 or above, KEPRO will assign an evaluator to complete the CSED Waiver evaluation process to determine eligibility, which typically takes 21-45 days.

The State has not yet provided a count of the number of independent evaluators available to conduct CAFAS/PECFAS assessments. A search of the [PC&A website](#) (the State’s contractor) did not produce a list of those specific to the CSED waiver. It appears there is a temporary list on KEPRO’s website but it notes it was last updated March 2021 (see <https://www.wvaso.kepro.com/media/3021/temp-ipn-list-updated-march-2021.docx>); separately, KEPRO’s website was inaccessible for periods during this review.



DHHR has indicated data will be available for future compliance evaluations regarding the independent evaluations.

In addition to access to independent evaluators to determine CSED Waiver eligibility, DHHR has indicated that behavioral health assessments include use of the CANS tool. The State has not yet provided a list of CANS-trained individuals and their locations or the total number of CANS assessments to date. The preliminary CANS data plan (*Utilizing Child and Adolescent Needs and Strengths (CANS) Data to Assess Outcomes and Functional Improvement in Children Receiving Mental Health Services*, undated) reports “an outline of how CANS data will be used to evaluate functional outcomes and be incorporated into quality improvement efforts is anticipated to be developed by August 2022. Efforts are still underway to integrate all CANS data scores into the CANS Automated System. Data is expected to be reviewed quarterly both at the program and quality committee level as part of the indicators reviewed through CQI related processes for mental health services.”

The State has expended considerable effort in creating assessment pathways to direct children and youth into these services. The State shared their *Children’s Mental Health Assessment Pathway - Data Collection and Analysis Plan* which includes measures related to referral source and timeliness (e.g., “timeliness of first family contact by BBH”). That document notes data collection began in January 2022 and will continue monthly through July 2022. Preliminary data from November and December 2021 did not include timeliness. However, the State has messaged that data will be available for future compliance evaluations.

The *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document)* includes measures related to timeliness (“timeliness of referral to Assessment Pathway”; “timeliness of completion of the CAFAS/PECFAS”; “timeliness of completion of the CANS”; “number of referrals to BBH Assessment Pathway for Wrap Facilitator Assignment”; etc.). However, the majority are missing the following information in the table (1) frequency of review; (2) who is responsible for review; and (3) guidance for review. The State notes this document will be updated in the future. As the KPIs have not yet been finalized, no data has been provided to the SME to review.

The [link](#) to the CSED waiver application on the State’s website includes the following: “If you have not heard back from KEPRO within 5 business days, please call (304) 343-9663 ext. 4483 or 4418.” DHHR will need to provide information and documentation on how it is tracking the number of applications that report difficulty after submission and any corrective actions it is taking to ensure children are timely assessed.

The SME notes that families are advised to contact KEPRO if they had not heard back **within 5 days**, but it is unclear how the State is monitoring and overseeing the number of families contacting KEPRO and the timeliness of resolution, as well as any corrective action plans. Additionally, as noted under Agreement Requirements 24 and 28 “KEPRO will then review the application, contact the child, family, BSS worker, or other legal guardian to complete the Child and Adolescent Functional Assessment Scale (CAFAS) within an approximate **three-business-day period...**” KEPRO has three business days to respond to families. The SME recognizes the distinction between calendar days and business days in the referenced time periods but raises that waiting five days before a second attempt adds delay, and both time periods should be the same.

To fully comply with this requirement, the State will need to provide additional documentation for the SME to review such as the West Virginia Wraparound manual and/or other provider manuals, SOPs, training curriculum, bulletins and other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring, and any audit and sampling reviews of the master POC or other records; and plans or documentation of conveyance to providers and stakeholders.

Training must also reflect the expectation that timely assessment is provided statewide, including initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

AGREEMENT REQUIREMENT 26

Aforementioned services [assessment] will be delivered at times and locations mutually agreed upon by the provider and the child and family to assist in practicing skill development in the context of daily living.

Compliance Rating

Partial Compliance

The *BBH Pathway to Children’s Mental Health Services Phase 1 Reference Guide* does not provide details on completing the CAFAS such as language regarding how an assessment with the independent evaluator will be completed at times and locations mutually agreed upon by the providers and family.

Chapter 502 includes some language regarding family choice (“the ASO helps the applicant child/family select an IE [independent evaluator] within the applicant’s geographical area or otherwise convenient for the member and their family”) but there are no policy or operational documents outlining how the State is monitoring this requirement such as family satisfaction surveys, random auditing, or regular reporting.

The materials do not specify how the CAFAS and CANS are introduced and explained to families along with their different purposes and frequency of completion. Families should receive this information in an accessible manner to ensure they understand what is happening throughout the assessment process.

The *Children’s Mental Health Assessment Pathway - Data Collection and Analysis Plan* includes timeliness measures but nothing specific to measure and evaluate whether initial and ongoing assessment (e.g., CANS) is delivered at mutually agreeable times and locations, such as surveys or interviews with families to determine if families felt that the assessments were completed in collaboration with the family at a time and location that was convenient to them.

To fully comply with this requirement, the State will need to provide additional documentation for the SME to review such as SOPs and/or other documentation such as that mentioned above regarding how it monitors and measures this requirement, as well as any CQI plans or corrective processes it uses to correct deficiencies; the West Virginia Wraparound manual and/or other provider manuals, SOPs, training curriculum, bulletins and other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring, and any audit and sampling reviews of the master POC or other records; and plans or documentation of conveyance to providers and stakeholders.

Training must also reflect the expectation that assessment is provided in a mutually agreeable manner, including initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

Note: Assessment does not assist in skill development in the context of daily living.

AGREEMENT REQUIREMENT 28

Ensure timely provision of mental health services to address any urgent need for services.

**Compliance
Rating**

Partial Compliance

Assessment, as with other services, needs to have clear standards regarding timeliness for that service. For example, a CSED Waiver assessment versus a CMCR assessment would have different timeliness standards to access assessment. Specific timeliness standards and related oversight and monitoring are not available for all services.

Chapter 502, the CSED manual, notes that “The BMS contracts with a MECA to determine initial and re-determination eligibility of prospective and active persons and to recruit and train licensed clinicians to participate in the Independent Evaluator Network (IEN). The ASO and the MECA work together to process initial applications and re-determination packets.” *The Achieving Safety, Permanency and Well Being For West Virginia’s Children, A Knowledge and Skills-Based Curriculum* includes information that children must be independently evaluated but does not include timeliness for the assessment itself.

The *State of West Virginia Department of Health and Human Resources (DHHR) Bureau for Behavioral Health (BBH) Pathway to Children’s Mental Health Services Phase 1 Reference Guide* notes that for the CSED Waiver, “KEPRO will then review the application, contact the child, family, BSS worker, or other legal guardian to complete the Child and Adolescent Functional Assessment Scale (CAFAS) within an approximate three-business-day period, and notify BBH at bbhreferralquestions@wv.gov within three business days whether the individual will be further evaluated for the CSED Waiver, based on the CAFAS score. If the CAFAS score is 90 or above, KEPRO will assign an evaluator to complete the CSED Waiver evaluation process to determine eligibility, which typically takes 21-45 days.”

The *CMCRS Draft Manual* notes that “MCRS services will be provided up to eight weeks; will take place in family homes, schools, group care, and other settings that are natural to the youth and family; and will include such services as: crisis intervention, **crisis assessment**, the development of a crisis plan which will include presumptive eligibility for crisis services (i.e., the family and youth determine whether it is a crisis), engagement, de-escalation, **assessment**, planning, and the coordination of supports and other services as needed” [emphasis added]. The *Children’s Crisis and Referral Line Data Update January – December 2021* notes that as of January 2022, “staff are trained to incorporate the Assessment Pathway screening into calls when appropriate to help individuals further connect to key services to meet their needs.”

The *Bureau of Juvenile Services (BJS) Detention Referrals to Children with Serious Emotional Disorder (CSED) Waiver Standard Operating Procedure (SOP)* details the steps needed to refer children to the assessment pathway but does not include explicit timelines. In that document the State notes “DHHR is in the process of designing a data plan template for all related data tracking, such as for referrals for youth involved in BJS, to include indicators such as data source, frequency, owner,

and any guidance on reviewing data. In the interim, BJS will track data manually with spreadsheets, which can then be compared with KEPRO data, as an example of tracking youth who applied for CSED Waiver enrollment.” The SME expects to review this data in the next report cycle.

The *Pathway to Children’s Mental Health Services Bureau for Social Service* specifies that “When a child is placed immediately in an emergency shelter or directly into a residential mental health treatment facility (RMHTF) prior to the completion of the FAST/Ongoing Assessment or any screening for mental health needs, the child welfare worker will immediately complete a CSED Waiver Application for the child (within 24 to 48 hours of placement) and submit to KEPRO for a thorough assessment of needs.” The same document requires an Aetna managed care coordinator “[to] ensure the child welfare worker has access to all relevant data to be reviewed and will schedule a meeting to occur within seven business days with the Aetna managed care coordinator, the child welfare worker, and the residential provider. The Aetna managed care coordinator and the child welfare worker will review the results of the CANS, CAFAS/PECFAS, Monthly Progress Report, treatment plan, and any other relevant data.” The SME requests documentation of how the State is monitoring these timelines, as well as any CQI plans or corrective processes it uses to correct deficiencies.

Timeliness indicators are noted above in Agreement Number 24. In addition, the *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document)* also includes measures related to mobile crisis services (see Table 6) but lacks information on frequency of review, who is responsible for review, and guidance for review. As the KPIs have not yet been finalized, no data has been provided to the SME to review.

Training must also reflect the expectation that assessment is provided to address urgent needs, including initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

AGREEMENT REQUIREMENT 28.1	
Aforementioned mental health services [assessment] will be provided in consultation with the child and family.	
Compliance Rating	Partial Compliance
The <i>West Virginia Wraparound, A Network of Wraparound Facilitation for WV Families</i> notes “[c]hoice is at the center of this service for children having serious mental health or behavioral health needs. The child or family decides whether to seek the service. Once approved, the child and family voices guide the Wraparound team structure and planning. The child and family work with the Wraparound Facilitator to build their Wraparound team, which can include the family’s	

friends and people from the wider community (sometimes called ‘natural supports’), as well as providers of needed services and supports.” Further discussion of family voice and choice is included in “Section 6.0, Child and Family Rights.”

Although this language is included in the manual, no data has yet been reported to demonstrate that children, youth, and families are afforded voice and choice. The *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables* (Working Document) includes family satisfaction surveys (Table 13) as part of the WVU Evaluation Plan. The *WV Children's In-Home and Community-Based Mental Health Services Evaluation* document indicated that family and youth surveys were impacted by the COVID pandemic and would be launching in “late fall/winter [2021].” As per its Year 3 Implementation Plan, these surveys “have been initiated. The first report of results from the evaluation is anticipated in the first half of 2022 with a second report to follow later in the year.” The SME anticipates reviewing these surveys in its next reporting period.

Finally, included in the March 2022 QAPI Update were two points: “DHHR recognizes the importance of stakeholder feedback relative to continuous quality improvement” and “Processes for establishment of two-way communication and involving stakeholders in the quality improvement process still need to be developed.”

See also Agreement Number 26.

AGREEMENT REQUIREMENT 28.2

Aforementioned mental health services [assessment] will include in-home and community-based services and linkage to other service providers.

Compliance Rating

Partial Compliance

The *Pathway to Children’s Mental Health Services Phase 1 Reference Guide* includes information on referrals and linkages to the CSED Waiver (which includes in-home and community-based services) and this information is displayed on the Updated Pathway Process Flow Diagrams. The *QAPI Update* notes that “data capture at the child/encounter level to tie data together across systems and service entities” and “measure penetration of services (Comparison populations may include Medicaid eligible, Children in Foster Care, Children Adopted, Children Served by Entity)” and messages the future cadence of future cross-bureau quality reviews. Similar information is included in several other documents, including draft manuals, outreach materials, QAPI materials, and other items listed under “Documents Reviewed.”

The SME anticipates receiving data related to the assessment pathways linkage to in-home and community-based services in the next report cycle.

See also Agreement Numbers 24, 26, and 28.1.

AGREEMENT REQUIREMENT 32

All youth whose screening indicates a need for further evaluation, who have been recommended for or are currently in a residential mental health treatment facility, or who have received mental health crisis interventions, receive a timely intake and assessment process, including a face-to-face meeting with a community provider, child, and family to identify needs for in-home and community-based services.

Compliance Rating	Partial Compliance
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For timeliness, see Agreement Number 28.

For children and youth who have received CMCR services, the draft Children’s Mobile Crisis Response and Stabilization (CMCRS) manual notes, “The family decides how they would like MCRS to respond, which includes: in-person, telephone, or telehealth. In-person response provides face-to-face response and interaction with the family on location, within an average of one hour. MCRS will include the completion of the Crisis Assessment Tool (CAT) and the development of the Individualized Crisis Plan (ICP) as coordinated by the MCRS team during the first 72 hours.” The same document includes a performance measure, “Number of crisis assessments completed.” The SME requests documentation of how the State is monitoring these timelines, as well as any CQI plans or corrective processes it uses to correct deficiencies.

The State developed two relevant assessment pathways: (1) the R3 Model of Care Pathway; (2) Assessment, Diversion, and Transition Pathway; and (3) R3 New Referral Front Door. The R3 Model of Care Pathway directs youth with an identified mental health need or those without an assessment who are in a shelter or have been court ordered to a residential mental health treatment facility (RMHTF) will be referred to the assessment pathway and CSED waiver. Youth without an identified mental health need who are at risk of RMHTF placement will be referred to the Safe at Home Waiver for CANS assessment. The R3 New Referral Front Door includes a check on optimal setting based on referral from the assessment pathway. The SME understands that data is forthcoming that will convey if the planned pathways are resulting in timely access to the right care.

Training must also reflect the expectation that positive screens lead to timely assessment, including initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

The QAPI Update notes that monthly program level reviews will begin in May 2022. The SME anticipates receiving data related to this requirement in the next report cycle.

AGREEMENT REQUIREMENT 32.1

It is presumed that all children who reside in or are placed in in a residential mental health treatment facility need home and community-based services.

Compliance Rating	Partial Compliance
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Since November 2021, Aetna has been reporting CAFAS scores and data to DHHR monthly, beginning with youth who have a CAFAS scores under 90 who are currently in residential placements. Having up-to-date assessments will assist the State in realizing the vision in its R3 Model of Care Pathway (Step Down or Transitions to Community Settings) which includes monthly evaluation and discharge planning, and a supposition that children and youth are connected to care upon discharge, including the CSED waiver, if eligible.

The State has expanded its current contract with KEPRO. In the *KEPRO Scope of Work Level of Care Assessment for Residential Placement Expansion of the Assessment Pathway*, the State has allocated additional resources to KEPRO through April 30, 2022, to perform level of care assessments for children at risk of residential placement or referred for residential placement. The Scope of Work notes several duties, including data collection and analysis, but does not include any mention of monitoring or oversight by the State for the estimated increase in volume of 900 children. The SME requests documentation of how the State is monitoring and overseeing the revised scope of work, as well as any CQI plans or corrective processes it uses to correct deficiencies.

The *Awareness and Implementation Plan for Bureau for Social Services (BSS) Staff on the Pathway to Children’s Mental Health Services and Reducing the Reliance on Residential Services* notes that “BSS training began in early 2022, beginning with training of BSS YS and CPS field-level staff. BSS developed a phase-in training for pathway implementation to ensure that BSS staff are appropriately and comprehensively trained and monitored on screening and referrals to the assessment pathway.” The SME request these training materials for review in the next report cycle. The same document also notes “BSS Deputy Commissioners and program leadership strategized on how BSS enters screening data, track the data, and monitors the success of pathway implementation each month” but does not include timeliness standards or indicators used to demonstrate “success of pathway implementation.” The SME requests the monitoring plan and indicators for success related to this document to review in the next report cycle.

The *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document)* also includes measures related to residential (see Table 4) but lacks information on (1) frequency of review, who is responsible for review, and guidance for review. As the KPIs have not yet been finalized, no data has been provided to the SME to review.

AGREEMENT REQUIREMENT 35.1

A mutually agreed upon, qualified individual defined in the implementation plan will conduct an assessment of the child’s needs with the CANS.

Compliance Rating	Partial Compliance
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The *West Virginia Wraparound, A Network of Wraparound Facilitation for WV Families* discusses the CANS, including that “DHHR is working on a standardized Wraparound care plan template for use by all Wraparound Facilitators.” The same document notes that Marshall University provided training and certification for CANS assessors ([Marshall University CANS Training Opportunities](#)) and Section 2.1 includes language on family voice and choice.

The KPI document (Table 2) includes several measures related to CANS assessment but not any data collection, monitoring, or oversight.

In addition, to CANS, the State is using the CAFAS tool to determine eligibility for the CSED Waiver. As mentioned in related requirements below, while this provision specifically mentions the CANS, it is the opinion of the SME that any assessment requirements in the Agreement apply to any assessment tool used by DHHR.

To fully comply with this requirement, the State will need to provide additional documentation related to both the CAFAS and the CANS, such as West Virginia Wraparound manual and/or other provider manuals, SOPs, training curriculum, bulletins and other transmittals; credentialing /provider requirements; billing and reporting requirements; Marshall University fidelity monitoring, and any audit and sampling reviews of the master POC or other records; and plans or documentation of conveyance to providers and stakeholders that demonstrate how they will use data to monitor quality, and their oversight of training and other contractual requirements. The State will need to include KPIs specific to both assessment tool, including its plans for data collection, monitoring, and oversight.

Specific to the CAFAS tool and freedom of choice, training must also reflect the expectation that assessment is provided by a mutually agreed upon individual, such as initial and continuing education; coaching; curricula, competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

See also Agreement Number 28.

AGREEMENT REQUIREMENT 36

For any child who has a Multidisciplinary Treatment Team (MDT), DHHR shall provide the child’s screening, assessments, and Individualized Service Plans to the MDT.

Compliance Rating

Partial Compliance

The West Virginia Department of Health and Human Resources Pathway to Children’s Mental Health Services and Awareness and Implementation Plan for Bureau for Social Services (BSS) Staff on the Pathway to Children’s Mental Health Services and Reducing the Reliance on Residential Services documents include information on sharing assessment materials with a child or youth’s care team, including child welfare case workers. The Pathway document also notes that “BSS training began in early 2022, beginning with training of BSS YS and CPS field-level staff. BSS developed a phase-in training for pathway implementation to ensure that BSS staff are appropriately and comprehensively trained and monitored on screening and referrals to the assessment pathway” and lists training through July 2022, with a note that completion of training is tracked by the agency.

To ensure full compliance with this requirement, the SME requests to review the training materials and operational/tracking documents and processes for BSS staff related to the assessment pathway, including documentation of how DHHR ensures that screening, assessments, and individualized service plans are provided timely to the MDT and any corrective action plans to correct deficiencies.

See also Agreement Number 31.

AGREEMENT REQUIREMENT 40

Provide timely, high quality in-home and community-based mental health services individualized to each child’s needs.

Compliance Rating

Partial Compliance

Timely provision of assessments is addressed in preceding requirements.

Given the State is using both the CAFAS and CANS tools as part of assessment processes, to fully comply with this requirement, the State will need to provide additional documentation explaining how it ensures high quality assessments, such as credentialing/provider requirements, SOPs and other policies that specify what an assessment should contain; consistent, high-quality training and coaching specific to CAFAS for independent evaluators and the CANS for other behavioral health professionals; data collection and analysis of CAFAS and CANS assessments and scores across the state to regularly monitor and oversee any disparities or outliers; quality sampling

methodologies such as chart reviews or audits; CQI processes and/or corrective action plans to correct deficiencies as they may arise.

Training must also reflect the expectation that CAFAS and CANS assessment must be administered correctly and consistently, including initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

AGREEMENT REQUIREMENTS 40.1 & 40.2

Ensure that all in-home and community-based services [assessment] described in the agreement are available and accessible statewide to children in the target population in the necessary amount, location, and duration. Ensure that children receive all needed services [assessment] described in the agreement as needed.

Compliance Rating

Partial Compliance

Accessibility of assessments is addressed in preceding requirements.

The State amended its CSED waiver to expand who may conduct an independent evaluation (IE) from licensed psychologists to supervised psychologists, licensed independent clinical social workers, and licensed professional counselors. This expansion improves accessibility statewide by widening the potential independent evaluation network. The *WV CSED Waiver Frequently Asked Questions Updated 1/1/2022* document includes a question regarding accessibility: “There are no Independent providers listed in my area, the closest one is over an hour away! How can I get my child evaluated? OR The provider in my area can’t evaluate my child within the 14-day timeline, now what?” with the response “Please contact PC&A [Psychological Consultation & Assessment, Inc.] to assist you to find a provider in their network at 304.776.7230.” However, it is unclear how the State monitors and oversees calls to PC&A to ensure that families seeking an independent evaluation are being assisted such as quality reviews, call tracking, complaints, etc. It is also unclear how this information is conveyed to families; the FAQ does not appear on the CSED website (<https://dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx>) which is linked to from the WV Child Welfare Collaborative website (<https://childwelfare.wv.gov/initiatives/Pages/WV-Wraparound.aspx>).

Chapter 502 states, “At times, the ASO, in collaboration with BMS, will provide answers to policy questions, which will serve as policy clarifications. These policy clarifications will be posted on the [CSEDW website](#)” but no such policy clarification have yet been posted.

To fully comply with this requirement, the State will need to provide additional documentation regarding how it ensures statewide accessibility to assessment. Such documentation could take the form of a list and map of IEs locations; operating hours of IEs, including those that offer

evening and/or weekend hours or transportation assistance; methodologies for measuring and ensuring time and distance by region or county; recruitment and retention efforts of IEs; provider contracts; SOPs; family surveys of accessibility; and CQI processes and/or corrective action plans to correct deficiencies as they may arise.

AGREEMENT REQUIREMENT 40.3

Provide families and children with accurate, timely, and accessible information regarding in-home and community-based services available in their communities. [Assessment].

Compliance Rating

Non-Compliance

The ABHWV MHP Training and Engagement Report lists over 40 events, with attendee counts. However, only the title of the event is listed, making it difficult to impossible to discern which events may have provided families and children with accurate, timely, and accessible information. No evaluation or feedback forms related to the events were included. Similarly, there are several spreadsheets of “community outreach” events by date and title, with brief notes, but no attached materials that demonstrate that accurate, timely, and accessible information was provided to families and children.

The State has developed an Internal Communications Standard Operating Procedure (SOP) that describes the processes by which public-facing documents must be approved by the Office of Communications but not the information itself. The SME did receive a trifold, *West Virginia Children with Serious Emotional Disorder Waiver* meant for the public, but it is listed as “not approved.” An identical document saved under a different name was included in the review documents. In response to a review of a draft of this report, BMS indicated that the flyer and trifold were shared with other State bureaus, the Child Welfare Collaborative, and during WV Wraparound provider meetings; however, the SME did not receive any documentation related to the distribution or details regarding the stakeholder review process to ensure accessibility. Details regarding when documents were shared, with whom, and in what formats, as well as DHHR follow-up to ensure that individuals used the materials in their respective roles are examples of the type of compliance information sought to reflect compliance with this requirement.

The only information sharing plans listed on slide 13 of the QAPI update under “Plans for Stakeholder Involvement and Two Way Communication” are “DHHR recognizes the importance of stakeholder feedback relative to continuous quality improvement” and “Processes for establishment of two-way communication and involving stakeholders in the quality improvement process still need to be developed” with no further detail.

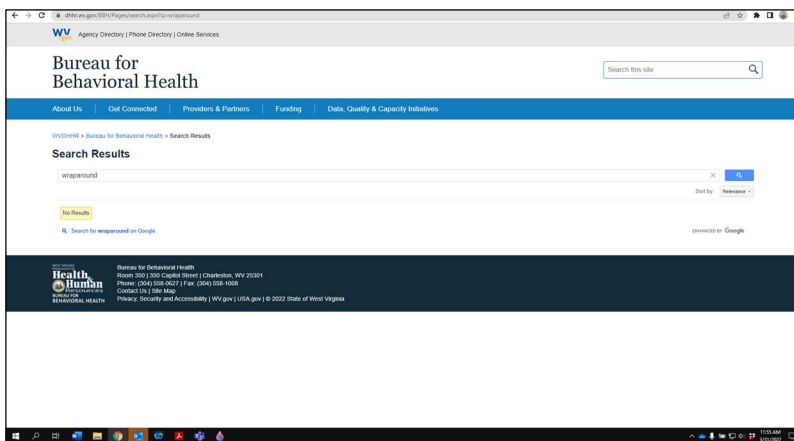
Table 12 in the KPI document includes only “Outreach by Audience (needs further definition as preliminary data from the Outreach Tracker is evaluated)” and the only guidance is “Monitor impact of specific outreach to judges on referrals to CSED Waiver or other services and reductions in court ordered RMHTF placements against the recommendation of MDT.” There is no detail

regarding how information on the revised assessment pathway or assessment itself is being shared with children and families, and how the accuracy and timeliness of that information is being assessed or monitored.

The *DHHR Stakeholder meeting list* includes lists of meetings in 2021 and 2022, by topic, as well as links to the Child Welfare Collaborative Quarterly Meeting Notes and Commission on the Study on Residential Placement of Children Quarterly Meeting Notes. Meetings that initially appear applicable to Assessment include (1) July 29, Pathway Review; (2) Nov. 9, Plan for Stakeholder Education Discussion; and (3) Feb. 8, Family Engagement Brainstorming and Discussion. These meetings included representatives from the State, providers, and Casey Family Partners but not families or children. Additionally, the link to the meeting notes for the Child Welfare Collaborative is not accessible as of March 21, 2022 (see screen grab, below; the website requires a password to access the notes).



Similarly, the link from the WV Child Welfare Collaborative page to the BBH page on Wraparound is broken and returns a “404/the page you requested could not be found.” When one searches for “Wraparound” on the BBH page, the search function returns zero results.



See also, Agreement 26, above, regarding surveys.

AGREEMENT REQUIREMENT 52d

Any children residing in residential mental health treatment facilities on 12/31/24 must have been assessed by a qualified professional and determined to be in the most integrated setting appropriate to their individual needs.

**Compliance
Rating**

Partial Compliance

See Agreement Number 32, above.

Documents Reviewed:

- Aetna Better Health of West Virginia (ABHVV) Partner Provider Investment: Phase I (Dec. 2021)
- Aetna Discharge Planning for Providers (Jan. 2022)
- CANS Data Plan – Preliminary
- Chapter 502 Children with Serious Emotional Disorder Waiver (CSEDW) (July 1, 2021), including Appendix A, Initial Plan of Care and Appendix B, Master Plan of Care
- Chapter 503, Licensed Behavioral Health Center (LBHC) Services
- Children with Serious Emotional Disturbance Brochure, Approved
- Children with Serious Emotional Disorder (CSED) Waiver Discussion during West Virginia Department of Health and Human Resources' (WVDHHR's) Monthly Call with the U.S. Department of Justice (DOJ), including Subject Matter Expert (SME) and BerryDunn (December 8, 2021)
- Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document) (March 6, 2022)
- CSED Application Renewal: 2022 Stakeholder Engagement
- CSED Flier (Jan. 25, 2022)
- CSED Waiver Appendix K
- CSED Waiver Enrollment Updated Stats, July 21 to Dec 21
- CSED Waiver FAQs (Feb. 2, 2022)
- CSED Waiver Utilization Updates (July 21-Sept. 21)
- Draft CSED Trifold Not Approved (March 3, 2022)
- Draft Non-CSEDW Wraparound Eligibility
- Draft CSED Amendment Eff. July 1, 2022
- KEPRO Scope of Work Level of Care Assessment for Residential Placement Expansion of the Assessment Pathway
- Master Plan of Care WV Wraparound Draft (March 11, 2022)
- Quality Assessment and Performance Improvement (QAPI) Update (March 10, 2022)
- Updated Pathway Process Flow Diagrams (March 11, 2022)
- WF Capacity Deployed Across BBH CSED and SAH (March 2022)
- Wraparound Fidelity Update (March 7, 2022)
- West Virginia Wraparound A Network of Wraparound Facilitation for WV Families (Draft, March 9, 2022)
- WF Capacity Deployed Across BBH CSED and SAH (March 2022)

- [WV Wraparound FAQs \(Feb. 22, 2022\)](#)

WRAPAROUND

AGREEMENT REQUIREMENT 12

“Child and Family Team” is a group of people, chosen with the family and connected to them through natural, community, and formal support relationships, that develops and implements the Individualized Service Plan. The Child and Family Team is led by the Wraparound Facilitator.

Compliance Rating	Partial Compliance
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Chapter 502 notes, as part of Section 502.16.1 that “Members and/or their legal representatives have the right to... Choose who they wish to attend their CFT meetings, in addition to those attendees required by regulations.”

A West Virginia Wraparound Manual, marked draft and dated March 9, 2022, notes that “[t]he Wraparound Facilitator leads the Child and Family Team and supports the family in getting connected to the services that best meet the child and family needs in order for the child to remain in the home, or if the child is temporarily in residential services or other out of home placements, to return home as soon as possible... With support from a team of professionals and natural supports, the family’s ideas and perspectives about what they need and what will be helpful drive all of the work in Wraparound... The child and family work with the Wraparound Facilitator to build their Wraparound team, which can include the family’s friends and people from the wider community (sometimes called ‘natural supports’), as well as providers of needed services and supports... The Child and Family Team develops an individualized Wraparound plan of care, puts this plan into action, and works toward the family thriving with its plan after the service ends. The Wraparound plan often includes formal services to build skills and meet child and family needs, community services, and interpersonal support and assistance provided by friends, kin, and other people in the family’s social networks.”

To fully comply with this requirement, the State will need to provide additional documentation such as a finalized West Virginia Wraparound manual and/or other provider manuals, SOPs, training curriculum, bulletins and other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring, and any audit and sampling reviews of the master POC or other records; and plans or documentation of conveyance to providers and stakeholders; and evidence of the materials use with Providers, such as meeting minutes with providers, provider quality reviews, feedback from providers on programmatic issues that are later reflected in subsequent versions of provider related materials.

The State will need to ensure there is cross-referencing and clarification between Child and Family Teams and MDT, the latter being referred to throughout the *West Virginia Department of Health and Human Resources Pathway to Children’s Mental Health Services* document.

AGREEMENT REQUIREMENT 16

“Individualized Service Plan” is the comprehensive plan developed by the Child and Family Team that is person-centered and includes the child’s treatment goals and objectives, methods of measurement, the timetables to achieve those goals, a description of the services to be provided, the frequency and intensity of each service, and which service providers will provide each service.

**Compliance
Rating**

Partial Compliance

Chapter 502 and the Safe at Home Program and Policy Manuals detail this requirement.

The State provided a document, the *WV Wraparound Individual Plan of Care (POC)* with an effective date of March 1, 2022, that is intended to be used with children and youth enrolled under interim Wraparound Services with BBH or BSS, Safe at Home (BSS), the CSED waiver, or Children’s Mental Health Wraparound (BBH). However, it is unclear if the document is currently in use, and if so, how the State is ensuring that each agency is using the master form. A West Virginia Wraparound Manual, marked draft and dated March 9, 2022, indicates that a common Plan of Care (POC) across bureaus is forthcoming.

The State will need to provide additional documents to reflect this requirement, including West Virginia Wraparound manual and/or other provider manuals, SOPs, training curriculum, bulletins and other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring, and any audit and sampling reviews of the master POC or other records; and plans or documentation of conveyance to providers and stakeholders.

AGREEMENT REQUIREMENT 22

“Wraparound Facilitator” is the leader of the Child and Family Team and is responsible for coordinating provision of services for children under this agreement. Wraparound Facilitators have knowledge of in-home and community-based services and experience serving children with Serious Emotional Behavioral Disorders or Disturbances.

**Compliance
Rating**

Partial Compliance

Chapter 502 details this requirement. However, page 7 of the manual states “All required documentation forms and links to CSEDW required trainings are available on the [CSEDW website](#).” When one clicks on the link, the website displays the CSED waiver itself, the application, CMS approval of the waiver, a link to flier on public forums (discussed in Agreement Number 40.3, below) and public comment. There is a link to documentation forms; however, the website does not include a list of the required trainings.

To fully comply with this requirement, the State will need to provide additional documentation such as the finalized West Virginia Wraparound manual and/or other provider manuals, SOPs, training curriculum, bulletins and other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring, and any audit and sampling reviews of the master POC or other records; and plans or documentation of conveyance to providers and stakeholders.

Training must also reflect the expectation that Wraparound Facilitators have knowledge of in-home and community-based services, including initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals. *Chapter 502* states “Approved trainings, including Direct Care Ethics, First Aid and CPR training resources, are posted on the DHHR’s website for the [CSED waiver](#)” but such trainings are not in fact posted on that website.

AGREEMENT REQUIREMENT 24

Ensure timely, statewide access to in-home and community-based services sufficient to meet the needs for every child in the target population, including **Wraparound facilitation**, behavioral support services, children’s mobile crisis response, therapeutic foster family care, and assertive community treatment.

Compliance Rating

Partial Compliance

Wraparound for children with SED is available statewide through the CSED Waiver, and BBH; and through Safe at Home only as an interim service while a child completes their eligibility assessment for the CSED Waiver. Provider lists in WF Capacity Deployed Across BBH CSED and SAH (March 2022) show statewide coverage. The SME notes that for children enrolled in the CSED waiver, the *West Virginia Wraparound/Assessment Pathway Frequently Asked Questions (FAQ)* from Wraparound Providers Question 23 states there is a single Wraparound provider available to children and families in the eastern panhandle (Homebase) (Question 26 says three providers have signed contracts with Aetna but only one is providing services). During the review period of a draft of this report, DHHR verbally indicated that a second provider, KVC, became available in the Eastern Panhandle as of April 1, 2022, but the SME has not yet received documentation related to this provider.

Chapter 502 notes that “In order to facilitate coordination of care, the ASO will notify the MCO administering the CSEDW when a new waiver member is determined eligible so that the member may begin receiving services within three business days of the eligibility determination for waiver enrollment as long as there is not a waitlist for services.” The manual requires the independent evaluator to complete the evaluation within 14 days of the kept appointment and for the contracted agency to make a final medical eligibility determination within seven days of the

completed independent evaluation. Appendix A required the Initial Plan of Care to be developed within seven days of intake.

The *CSED Waiver Enrollment Updated Stats July 21-Dec. 21* shows that average (mean) days from the time an application was received to determination (approved, closed, or denied) is 34.5 days. The SME notes the significant improvement in this timeline.

While the *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document)* includes indicators related to timeliness (Table 2) and provider capacity (which is inextricably linked to timeliness), many of those indicators lack details on the frequency of review, who is responsible for review, and guidance for review.

The *Quality Assessment and Performance Improvement (QAPI) Update* notes that monthly reviews data are set to begin later this spring. The SME anticipates receiving data related to indicators for provider capacity and timeliness in the next report cycle.

DHHR has also begun tracking wraparound facilitators in a multi-tab Excel spreadsheet (*WF Capacity Deployed Across BBH CSED and SAH (March 2022)*) that over time can be paired with youth access data to inform sufficiency of the provider network and regions where expanded capacity is needed.

To fully comply with this requirement, the State will need to provide additional documentation such as the finalized West Virginia Wraparound manual and/or other provider manuals, SOPs, training curriculum, bulletins and other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring, and any audit and sampling reviews of the master POC or other records; and plans or documentation of conveyance to providers and stakeholders.

AGREEMENT REQUIREMENT 24.1 & 24.2

Aforementioned services will be provided in a manner that enable the child to remain with or return to the family (or foster/kin/independent living where applicable) whenever possible to prevent crises and promote family stability.

Compliance Rating	Partial Compliance
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The *Updated Pathway Process Flow Diagrams* display the way Wraparound services will be provided to children. These diagrams include specific pathways to divert from residential placement (R3 Model of Care Pathway; HCBS Pathway for Non-CSED Waiver Youth; and Assessment, Diversion, and Transition Pathway). *Chapter 502* notes that the waiver “prioritizes children/youth with serious emotional disorder (SED) who are: (1) in Psychiatric Residential Treatment Facilities (PRTFs) or other residential treatment providers either out-of-state or in-state; and (2) other Medicaid-eligible children with SED who are at risk of institutionalization.”

Similarly, the *West Virginia Wraparound, A Network of Wraparound Facilitation for WV Families* states that “The Wraparound Facilitator leads the Child and Family Team and supports the family in getting connected to the services that best meet the child and family needs for the child to remain in the home, or if the child is temporarily in residential services or other out of home placements, to return home as soon as possible.

However, while the *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document)* includes Wraparound indicators (Tables 2 and 7) and CMCR (Table 6) indicators related to crisis, many of those indicators lack details on the frequency of review, who is responsible for review, and guidance for review.

The Quality Assessment and Performance Improvement (QAPI) Update notes that monthly reviews of CSED Waiver are scheduled to begin in May. The SME anticipates receiving data related to these indicators in the next report cycle.

To fully comply with this requirement, the State will need to provide additional such as the finalized West Virginia Wraparound manual and/or other provider manuals, SOPs, training curriculum, bulletins and other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring, and any audit and sampling reviews of the master POC or other records; and plans or documentation of conveyance to providers and stakeholders.

See also the Assessment Compliance ratings.

AGREEMENT REQUIREMENT 25

Aforementioned services are intended to advance the state’s compliance with ADA, and will be provided in the most integrated setting appropriate to meet the needs of the target population.

Compliance Rating

Partial Compliance

Chapter 502, Section 502.18, which is specific to the CSED Waiver, describes ten Wraparound principles, including that it is “... community-based. The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings.” Similar, the SAH notes that the program is design to ensure that youth remain in or return to their community setting whenever safely possible. This language sets an expected standard for services to be provided in home- and community-based settings, which are a proxy for integrated setting.

However, while the *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document)* includes Wraparound indicators (Tables 2 and 7) there are not

indicators explicitly related to the delivery of services and supports in the most integrated setting appropriate to meet child and family needs.

The Quality Assessment and Performance Improvement (QAPI) Update notes that monthly reviews of CSED Waiver are scheduled to begin in May. The SME anticipates receiving data related to the in the next report cycle.

To fully comply with this requirement, the State will need to provide additional documentation such as the finalized West Virginia Wraparound manual and/or other provider manuals, SOPs, training curriculum, bulletins and other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring, and any audit and sampling reviews of the master POC or other records; and plans or documentation of conveyance to providers and stakeholders.

Training must also reflect the need to provide care in the most integrated setting, including initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

See also Agreement Number 26.

AGREEMENT REQUIREMENT 26

Aforementioned services will be delivered at times and locations mutually agreed upon by the provider and the child and family (or foster or kinship care family where applicable) to assist in practicing skill development in the context of daily living.

Compliance Rating	Partial Compliance
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Chapter 502 includes language regarding family choice (“the ASO helps the applicant child/family select an IE [independent evaluator] within the applicant’s geographical area or otherwise convenient for the member and their family”); however, there are no policy documents outlining how the State is monitoring this requirement such as family satisfaction surveys, random auditing, or regular reporting. Neither the manual nor any other documentation details how the State determines that the young adults and family are receiving Wraparound services at mutually agreed upon times. To meet this requirement, the State will need to provide SOPs and/or other documentation regarding how it monitors and measures this requirement, as well as any CQI plans or corrective processes it uses to correct deficiencies.

Training must also reflect the expectation that services are provided in a mutually agreeable manner, including initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is

sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

The West Virginia Wraparound, A Network of Wraparound Facilitation for WV Families notes “[c]hoice is at the center of this service for children having serious mental health or behavioral health needs. The child or family decides whether to seek the service. Once approved, the child and family voices guide the Wraparound team structure and planning. The child and family work with the Wraparound Facilitator to build their Wraparound team, which can include the family’s friends and people from the wider community (sometimes called ‘natural supports’), as well as providers of needed services and supports.” Further discussion of family voice and choice is included in “Section 6.o, Child and Family Rights” but that section does not include specific language regarding day and time of service delivery.

The State has provided information on Freedom of Choice (FOC) in its presentations to date. The State has noted that some children and youth are awaiting services because they have not yet returned the FOC form to complete enrollment. The SME notes that that delays in receipt of this form has caused delays in the initiation of services; as such, to fully comply with this and other requirements, the State will need to provide SOPs or other documentation regarding how it plans to expedite or facilitate the timely submission of FOC forms, including its plans for data collection (e.g., common reasons for delay; familial experiences with obtaining and submitting the form, etc.), monitoring, and CQI. The SME recommends that DHHR reconsider its waiver enrollment process specific to completion of the FOC form, and like other states, receive verbal confirmation of choice, with follow-up signature to that verbal confirmation of choice occurring at the time of the first appointment.

The Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document) includes family satisfaction surveys (Table 13) as part of the WVU Evaluation Plan. The *WV Children's In-Home and Community-Based Mental Health Services Evaluation* document indicated that family and youth surveys were impacted by the COVID pandemic and would be launching in “late fall/winter [2021].” As per its Year 3 Implementation Plan, these surveys “have been initiated. The first report of results from the evaluation is anticipated in the first half of 2022 with a second report to follow later in the year.” The SME anticipates reviewing these surveys in its next reporting period.

Finally, included in the March 2022 QAPI Update were two points: “DHHR recognizes the importance of stakeholder feedback relative to continuous quality improvement” and “Processes for establishment of two-way communication and involving stakeholders in the quality improvement process still need to be developed.”

AGREEMENT REQUIREMENT 27

The child in the target population, or his or her guardian for a child under 18, maintains the right to refuse offered services.

Compliance Rating

Partial Compliance

The State's [Your Guide to Medicaid 2020](#) notes that "You have the right to choose and/or make decisions about health care for you and your children."

Chapter 502, Section 502.17 also includes language regarding the right to discharge (end) services: "The member has the right to transfer or discharge wraparound facilitation and other services from the existing provider to another chosen provider at any time for any reason. Transfers and discharges must be addressed on the POC and approved by the member or parent/legal representative and a representative from the receiving provider as evidenced by their signatures on the POC signature sheet, in ink or in an electronic documentation system."

To meet this requirement, the State will need to provide SOPs and/or other documentation regarding how it monitors and measures this requirement, as well as any CQI or corrective processes it uses to correct deficiencies. It should also collect and provide data regarding the number, demographics, and geographic locations of families declining to participate in Wraparound to actively monitor any barriers to service accessibility and availability.

Training must also reflect the expectation that families have the right to refuse services, including initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

AGREEMENT REQUIREMENTS 28, 28.1, AND 28.2

Ensure timely provision of [wraparound] mental health services to address any urgent need for services. Aforementioned mental health services will be provided in consultation with the child and family. Aforementioned mental health services will include in-home and community-based services and linkage to other service providers [via the individualized plan of care].

Compliance Rating

Partial Compliance

The West Virginia Wraparound, A Network of Wraparound Services for WV Families notes that "the family will be contacted with 48 hours of request" when "BBH receives a request for Wraparound and other community-based services for youth/family with SED or SMI from the Children's Crisis and Referral Line, KEPRO, other professionals working with families, residential providers, or the families themselves." *The Continuous Quality Improvement Plan – Proposed Key Performance*

Indicator (KPI) Tables (Working Document) Tables 2 and 7 include indicators of timeliness and engagement for services but many of those indicators lack details on the frequency of review, who is responsible for review, and guidance for review. *The Quality Assessment and Performance Improvement (QAPI) Update* notes that monthly reviews of CSED Waiver are scheduled to begin in May. The SME anticipates receiving data related to the in the next report cycle.

The *West Virginia Wraparound/Assessment Pathway Frequently Asked Questions (FAQ)* from *Wraparound Providers* Question 6 notes that “Mobile Crisis Response and Stabilization Teams may refer families directly to BBH for interim services, including Wraparound, because they have already worked with the families in crisis, the families may have contacted the agency directly for crisis services, or the Children’s Crisis and Referral Line may have quickly connected with the regional Mobile Crisis Response and Stabilization Team without time to discuss or connect the families with the Assessment Pathway.”

Question 32 asks about the provision of services, including those delivered as part of CMCR, which responds to urgent need. The State writes, “If approved for Interim services, the child/family unit will begin implementation of services upon the time period of the de-escalation of the immediate crisis.”

To fully comply with this requirement, the State will need to provide additional documentation such as SOPs and/or other materials regarding how it monitors and measures the provision of urgent services in addition to and apart from CMCR, as well as any CQI plans or corrective processes it uses to correct deficiencies. It should also collect and provide data regarding the number, demographics, and geographic locations of families requesting and receiving urgent services to actively monitor any barriers to service accessibility and availability.

Training must also reflect the expectation that children and families enrolled in Wraparound will have urgent needs and providers must have sufficient capacity and expertise to meet them outside of normal business hours. This includes initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

See also Agreement Numbers 26, 33.2/35.2, and 40.

AGREEMENT REQUIREMENT 33

Ensure statewide access to Wraparound facilitation for every child identified as needing in-home or community-based services

Compliance Rating

Partial Compliance

Wraparound is available statewide through the CSED Waiver, BBH, and Safe at Home. Provider lists in WF Capacity Deployed Across BBH CSED and SAH (March 2022) show statewide coverage. The

SME notes that for children enrolled in the CSED waiver, the *West Virginia Wraparound/Assessment Pathway Frequently Asked Questions (FAQ)* from Wraparound Providers Question 23 states there is a single Wraparound provider available to children and families in the eastern panhandle (Homebase) (Question 26 says three providers have signed contracts with Aetna but only one is providing services). A single provider may not now limit timely access but as waiver enrollment grows, the State will need to provide data demonstrating their ability to comply with this Agreement Number when CSED waiver provider capacity is limited.

To fully comply with this requirement, the State will need to provide additional documentation detailing how it is identifying children and youth through screening and directing them to the Assessment Pathway from which they will be enrolled in services that match identified need, including Wraparound. See also Agreement Number 24 and the Assessment Compliance review.

AGREEMENT REQUIREMENTS 33.2 & 35.2

As part of Wraparound facilitation, the Child and Family Team will manage the child’s care, led by the Wraparound facilitator, who will also lead development of the individualized service plan.

Compliance Rating

Partial Compliance

Consistent with this Agreement requirement, *Chapter 502, Section 502.18.1* details the responsibilities of the Child and Family Team and Wraparound facilitator as they develop the POC. Appendices A and B provide templates for creating the POC. Similar language is contained in the CSED waiver, provider contracts, and Wraparound provider manual.

The Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document) Table 2 includes indicators related to the POC. The Quality Assessment and Performance Improvement (QAPI) Update notes that monthly reviews of CSED Waiver are scheduled to begin in May. The SME anticipates receiving data related to CFT and POC the in the next report cycle.

The SME requests to receive training materials that support this requirement submitted prior to the next SME report. Such materials include curricula, training evaluation, and participation by region to ensure statewide participation. The SME also requests the latest version of the Aetna contract to verify that this language is present.

AGREEMENT REQUIREMENTS 34

Ensure each child and family team operates with high fidelity to the National Wraparound model.

Compliance Rating	Partial Compliance
<p>The BBH and CSED waiver service descriptions are consistent with this requirement.</p> <p>Marshall University has been contracted to monitor fidelity. Marshall University is contracting with the National Wraparound Implementation Center for wraparound training and coaching. The Marshall University contract with the State includes this requirement. Marshall University’s <i>Wraparound Fidelity Update</i> (March 7, 2022) notes that the final fidelity and outcomes plan is expected May 1, 2022. The SME expects to review that plan in our next report cycle.</p> <p>The <i>Wraparound Fidelity Update</i> includes data collection and reporting for baseline data, the Wraparound Fidelity Index, and the Document Assessment and Review Tool (DART). The Update document notes contracting issues with the getting the Fidelity Index in place but anticipates evaluation cycles beginning in July 2022 and reporting in August 2022. The DART requires training prior to implementation; training is slated to begin summer 2022 with reporting in December 2022. The SME anticipates receiving data, reports, and training materials (curricula, evaluation of training, participation, etc.) in the next report cycle.</p> <p><i>The Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables</i> (Working Document) Tables 12 and 13 includes indicators related to fidelity. The SME anticipates receiving materials and data related fidelity in the next report cycle.</p> <p>To fully comply with this requirement, the State will need to provide additional documentation such as the finalized West Virginia Wraparound manual and/or other provider manuals, SOPs, training curriculum, bulletins and other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring, and any audit and sampling reviews of the master POC or other records; and plans or documentation of conveyance to providers and stakeholders.</p>	

AGREEMENT REQUIREMENTS 35 AND 35.1	
<p>Use the CANS (or similar mutually agreed upon tool) to assist child and family teams in development of individualized service plans for each child identified as needing in-home and community-based services. A mutually agreed upon, qualified individual defined in the implementation plan will conduct an assessment of the child’s needs with the CANS.</p>	
Compliance Rating	Partial Compliance
<p>Use of the CANS is required in <i>Chapter 502</i> (“The wraparound facilitators must be certified to perform the CANS assessment, which is a comprehensive trauma-informed behavioral health evaluation and communication tool. CANS assessments help decision-making, drive service planning, facilitate quality improvement, and allow for outcomes monitoring... Wraparound facilitation activities include, but are not limited to the following: Administers the CANS to the</p>	

member at any identified ‘significant life event(s),’ and in preparation for formal POC development at least every 90 days, but not more than one time in a calendar month.”); BBH, and SAH materials, the *Children’s Mental Health Assessment Pathway - Data Collection and Analysis Plan*, the *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables* (Working Document), the Quality Assessment and Performance Improvement (QAPI), and as a performance measure in the Concord University Collaborative Center for Positive Behavior Support (PBS) Education Program Supplemental Funding agreement.

The *Wraparound Fidelity Update* from Marshall University anticipates conducting quality improvement chart reviews “to ensure CANS/FAST raters are competent in moving CANS/FAST items into an action plan for the children and families they are serving” concurrent with the DART but notes “All of this is contingent on the finalization of the fidelity plan and the signing of the contract.” Training is scheduled to commence summer 2022 with a report to follow in Dec. 2022.

Although *Chapter 502* requires the use of the CANS, the *Utilizing Child and Adolescent Needs and Strengths (CANS) Data to Assess Outcomes and Functional Improvement in Children Receiving Mental Health Services* notes that “efforts are still underway to integrate all CANS data scores into the CANS Automated System.”

The *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables* (Working Document) Table 2 includes indicators related to CANS. The *Quality Assessment and Performance Improvement (QAPI) Update* notes that monthly reviews of CSED Waiver are scheduled to begin in May. The SME anticipates receiving data related to the CANS in the next report cycle.

See also Agreement Number 26.

AGREEMENT REQUIREMENTS 40, 40.1, AND 40.2

Provide timely, high quality in-home and community-based mental health services individualized to each child’s needs. Ensure that all in-home and community-based services described in the agreement are available and accessible statewide to children in the target population in the necessary amount, location, and duration. Ensure that children receive all needed services described in the agreement as needed.

Compliance Rating

Partial Compliance

The State shared data regarding Wraparound utilization in CSED Waiver Utilization Updates July 2020-September 2021. Figure 16 in the spreadsheet records Wraparound units by child from July 2020 through Sept. 2021. Although the number of children receiving Wraparound is increasing (from 9 to 74), the units per child have been slowly and steadily decreasing since early 2021 to 11. At 15 minutes per unit, that is equivalent to 2.75 hours of Wraparound facilitation per month. Overall service utilization under the CSED waiver also declined beginning in May 2021 after rising the first

quarter of the year. Overall service units in the CSED waiver are 46 per child; at 15 minutes per unit, that is about 11 hours per month, per child.

The service units are described statewide, without regional disaggregation. To ensure that all children, regardless of region, are receiving all needed services, it would be useful for future data reports to include more granularity for compliance review, particularly as the eastern panhandle has had a single operating provider (Homebase, see Agreement Number 24). As noted during DHHR's review of a draft of this report, DHHR indicated a second provider was slated to begin services April 1, 2022 (KVC). This is especially important given the aforementioned apparent decrease in units of service provided to enrolled children. It will be important for DHHR to assess whether an increase in enrollment is resulting in a general, statewide decrease of units which could indicate a workforce issue (as providers try to serve more children with limited staff, children may receive fewer units of services) or such decreases are present in only some regions of the State, or that units of service are appropriately reflective of the intensity of service that children need. Additionally, such decreases could be the result of one or two services not being as readily available, resulting in an apparent decline in units. When DHHR presents future data that clearly shows what each child is receiving (vs. overall units by service), that data will inform and help clarify this issue.

The State amended the CSED Waiver in March, with an effective date of July 1, 2022. Among the changes included in the amendment are "extend[ing] the timeframe an eligible member must begin HCBS before an unused waiver slot is discharged from 180 days to 365 days, unless the member ages out of eligibility." The State did not provide documentation or justification regarding this change such as how holding one of the capped waiver slots open for a full year before a child and family receive home- and community-based services assists them in complying with this and other provisions of the Agreement.

The waiver amendment also (1) requires the use of evidence-based approaches for family therapy and in-home family support (both home- and community-based services) but there is no additional detail about how fidelity will be monitored for those evidence-based approaches; (2) permits non-licensed clinicians to deliver these services but offers no detail as to how the State intends to ensure appropriate supervision and ratios of supervision consistent with *Chapter 503* ("The purpose of clinical supervision is to improve the quality of services for every member while ensuring adherence to WV Medicaid policy; therefore, the provider must have a policy for clinical supervision including guidelines for the responsibilities of the supervisor, credentialing requirements of the supervisor, and the minimum frequency for which supervision must occur. Each agency shall have a chart demonstrating clinical chain-of-command and responsibility. Each agency shall have a documented process for ensuring all staff are aware of clinical and administrative supervision structure. The clinical supervisor must have an equal or higher degree, credential, or clinical experience than those they supervise. If a clinical supervisor is responsible for a Medicaid funded program, the supervisor must be able to demonstrate familiarity with Medicaid requirements and relevant policy. This applies to all LBHC services rendered.") These changes are promising efforts to improve the quality of services available to children and their families. As the

State moves to implementation of EBPs, it will need to carefully monitor data related to timeliness and quality to ensure neither is adversely affected as providers focus on using EBPs.

The State shared a document, *Aetna Better Health of West Virginia (ABHWV) Partner Provider Investment: Phase I* which notes that “[t]hrough cost saving measures Aetna was able to re-invest money into supporting further development and expansion of intensive community-based services and in state residential programs.” These investments include additional CSED staff and Wraparound facilitators. Increasing staff capacity in areas of need assists the State in complying with these Agreement requirements (e.g., Diversified Assessment used additional funds to expand into Doddridge, Harrison, Marion, Monongalia, Preston, Randolph, and Upshur counties.)

The *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables* (Working Document includes indicators related to service delivery. *The Quality Assessment and Performance Improvement (QAPI) Update* notes that monthly reviews of CSED Waiver are scheduled to begin in May. The SME anticipates receiving data related to these requirements in the next report cycle.

To fully comply with this requirement, the State will need to provide additional documentation that details how services are individualized to each child’s needs and accessible such as the finalized West Virginia Wraparound manual and/or other provider manuals, SOPs, training curriculum, bulletins and other transmittals; staffing requirements; billing and reporting requirements; Marshall University fidelity monitoring, and any audit and sampling reviews of the master POC or other records; and plans or documentation of conveyance to providers and stakeholders.

Training must also reflect the need for individualized services, including initial and continuing education; coaching; curricula, including seat-time and competency-based requirements; and training evaluation practices to ensure the training is sufficiently robust and specific as to deliver the services in a manner that is likely to accomplish the Agreement goals.

See also Agreement Requirements 24-29, 33.2, 35, and 35.2.

AGREEMENT REQUIREMENT 40.3

Provide families and children with accurate, timely, and accessible information regarding in-home and community-based services available in their communities. [Wraparound]

Compliance Rating

Non-Compliance

The *ABHWV MHP Training and Engagement Report* lists over 40 events, with attendee counts. However, only the title of the event is listed, making it difficult to impossible to discern which events may have provided families and children with accurate, timely, and accessible information. No evaluation or feedback forms related to the events were included. Similarly, there are several

spreadsheets of “community outreach” events by date and title, with brief notes, but no attached materials that demonstrate that accurate, timely, and accessible information was provided to families and children. A [link on the State’s website to public forums](#) regarding the CSED Waiver appears out-of-date as the three forums lists occurred in late November 2021; no new information is accessible.

The State has developed an Internal Communications Standard Operating Procedure (SOP) that describes the processes by which public-facing documents must be approved by the Office of Communications but not the information itself. The SME did receive a trifold, *West Virginia Children with Serious Emotional Disorder Waiver* meant for the public, but it is listed as “not approved.” An identical document saved under a different name was included in the review documents. In response to a review of a draft of this report, BMS indicated that the flyer and trifold were shared with other State bureaus, the Child Welfare Collaborative, and during WV Wraparound provider meetings; however, the SME did not receive any documentation related to the distribution or details regarding the stakeholder review process to ensure accessibility. Details regarding when documents were shared, with whom, and in what formats, as well as DHHR follow-up to ensure that individuals used the materials in their respective roles are examples of the type of compliance information sought to reflect compliance with this requirement.

The only information sharing plan listed on slide 13 of the QAPI update under “Plans for Stakeholder Involvement and Two Way Communication” are “DHHR recognizes the importance of stakeholder feedback relative to continuous quality improvement” and “[p]rocesses for establishment of two-way communication and involving stakeholders in the quality improvement process still need to be developed” with no further detail.

Table 12 in the KPI document includes only “Outreach by Audience (needs further definition as preliminary data from the Outreach Tracker is evaluated)” and the only guidance is “Monitor impact of specific outreach to judges on referrals to CSED Waiver or other services and reductions in court ordered RMHTF placements against the recommendation of MDT.” There is no detail regarding how information on the revised assessment pathway or assessment itself is being shared with children and families, and how the accuracy and timeliness of that information is being assessed or monitored.

The CSED Application Renewal: 2022 Stakeholder Engagement document lists meetings with state agencies and partners but there are no details related to child and family engagement. “Public engagement” is listed under “Future Stakeholder Engagement Sessions” with dates listed as “TBD.”

To fully comply with this requirement, the State will need to provide documentation of outreach and engagement efforts with children and families, such as in-person and virtual events; consultation with those with lived experience; and incorporation of feedback from children and families in developing and revising materials to ensure full accessibility.

AGREEMENT REQUIREMENT 41C

DHHR’s implementation plan shall contain the steps DHHR will take to evaluate the fidelity of child and family teams to the National Wraparound model.

Compliance Rating

Partial Compliance

The State’s Year 3 Implementation Plan notes on p.11 that it will “monitor ongoing fidelity of wraparound services to NWI model” in collaboration with Marshall University beginning Jan. 2022. Steps needed to monitor the ongoing fidelity are not included in the Implementation Plan. The Jan. 2022 date in the Implementation Plan differs from that shared in Marshall University’s update document which notes that fidelity outcomes and monitoring is not expected until May 2022 with the Fidelity Index and DART training coming before the end of the calendar year.

The SME anticipates reviewing these activities in the next reporting cycle. See also Agreement Numbers 34, 40, 40.1, and 40.2.

AGREEMENT REQUIREMENTS 41D AND 41E

DHHR’s implementation plan shall contain the steps DHHR will take to address workforce shortages relating to services under this agreement. DHHR’s implementation plan shall contain the steps DHHR will take to address workforce shortages relating to services under this agreement.

Compliance Rating

Partial Compliance

The State developed a multi-tab Excel spreadsheet, *WF Capacity Deployed Across BBH CSED and SAH* (March 2022), that tracks individual Wraparound facilitators by bureau (BBH, BSS, BMS CSED Waiver), the number of children served by each facilitator across each bureau, and the child’s county of residence. This data allows DHHR to see where capacity is shared across bureaus (when a provider operates with more than one bureau). This spreadsheet will also allow DHHR to see which providers in which counties are approaching full enrollment and as such where to direct their efforts to build additional provider capacity to maintain the ratios required by NWI fidelity standards and those in the CSED waiver.

The State’s Year 3 Implementation Plan notes on p.35 tasks related to workforce capacity, including “develop[ing] a written plan for completing a routine analysis of provider capacity and workforce data” beginning April 2022 and “complete provider capacity reviews, as reflected in DHHR’s CQI Plan. If applicable, recruit for additional providers to meet needs” beginning in Jan. 2022. There are not detailed steps in the Implementation Plan for either item. However, there is a contract beginning April 1, 2022 with Marshall University to assist the State in addressing secondary traumatic stress in their workforce. In addition to the contract with Marshall, Aetna Better Health of West Virginia (ABHWV) Partner Provider Investment: Phase I includes some

bolstering of the workforce via cost savings reinvestment (see Agreement Numbers 40, 40.1, and 40.2).

The *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables* (Working Document includes indicators related to workforce in Table 12. The SME anticipates reviewing this provision and related documentation and data in the next report cycle.

AGREEMENT REQUIREMENT 52

Implementation of services [Wraparound] in 24-40 will be phased in regionally across the State according to a timeline detailed in the implementation plan.

Compliance Rating

Partial Compliance

Wraparound is included in the State’s Year 3 Implementation Plan. However, some of the sequencing raises questions about consistency. For example, the Implementation Plan lists “finalize West Virginia Wraparound manual” for BBH by March 2022 but has “initiate ongoing training on the above policies and process for relevant staff/entities” beginning in January 2022, before all the policies will be completed. The Implementation Plan does detail a timeline for “reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services” beginning April 2022, with further details in the CQI and QAPI documents.

See also Agreement Requirement 24.

AGREEMENT REQUIREMENT 52a

Initial statewide implementation [Wraparound] should occur by 10/1/20.

Compliance Rating

Partial Compliance

See Agreement Requirement 24.

Documents Reviewed:

- Aetna Better Health of West Virginia (ABHWV) Partner Provider Investment: Phase I (Dec. 2021)
- Aetna Discharge Planning for Providers (Jan. 2022)
- CANS Data Plan – Preliminary
- Chapter 502 Children with Serious Emotional Disorder Waiver (CSEDW) (July 1, 2021), including Appendix A, Initial Plan of Care and Appendix B, Master Plan of Care
- Chapter 503, Licensed Behavioral Health Center (LBHC) Services
- Children with Serious Emotional Disturbance Brochure, Approved

- Children with Serious Emotional Disorder (CSED) Waiver Discussion during West Virginia Department of Health and Human Resources' (WVDHHR's) Monthly Call with the U.S. Department of Justice (DOJ), including Subject Matter Expert (SME) and BerryDunn (December 8, 2021)
- Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document) (March 6, 2022)
- CSED Application Renewal: 2022 Stakeholder Engagement
- CSED Flier (Jan. 25, 2022)
- CSED Waiver Appendix K
- CSED Waiver Enrollment Updated Stats, July 21 to Dec 21
- CSED Waiver FAQs (Feb. 2, 2022)
- CSED Waiver Utilization Updates (July 21-Sept. 21)
- Draft CSED Trifold Not Approved (March 3, 2022)
- Draft Non-CSEDW Wraparound Eligibility
- Draft CSED Amendment Eff. July 1, 2022
- KEPRO Scope of Work Level of Care Assessment for Residential Placement Expansion of the Assessment Pathway
- Master Plan of Care WV Wraparound Draft (March 11, 2022)
- Quality Assessment and Performance Improvement (QAPI) Update (March 10, 2022)
- Updated Pathway Process Flow Diagrams (March 11, 2022)
- WF Capacity Deployed Across BBH CSED and SAH (March 2022)
- Wraparound Fidelity Update (March 7, 2022)
- West Virginia Wraparound A Network of Wraparound Facilitation for WV Families (Draft, March 9, 2022)
- WF Capacity Deployed Across BBH CSED and SAH (March 2022)
- WV Wraparound FAQs (Feb. 22, 2022)

Section Two: Progress on Meeting DOJ Agreement Requirements and SME Recommendations:

Workforce

Target Population

CSED Waiver

Screening

Children's Mobile Crisis Response

Behavioral Support Services

Therapeutic Foster Care

Outreach & Education

Residential Interventions

QAPI

Workforce

The Agreement requires the State to take steps to (1) address workforce preparedness to deliver services; (2) ensure availability of sufficient providers; and (3) address any workforce shortages. Inherent to fulfilling the Agreement is the need to identify and implement strategies to understand current capacity, as well as to recruit, retain, train, and coach a behavioral health workforce to understand West Virginia’s vision for reforming its system and deliver services to children and families consistent with this Agreement.

Activities

Consistent with an August 2021 SME recommendation, DHHR has made inroads to understand the availability of sufficient providers to provide Agreement services. In the August report, the SME recommended that DHHR engage in specific tasks to quantify providers, given that the number of providers across bureaus was not known. Specifically, given the number of services, the SME recommended that DHHR begin assessing capacity one service at a time, beginning with Wraparound since sufficient Wraparound capacity is essential to reducing residential interventions.

August 2021 SME recommendation: A plan for availability of sufficient providers . . . would include . . . current utilization by provider by service and by county to understand provider volume/where children are receiving services in the State, including Medicaid claims/encounters and BBH and BSS funding.

DHHR has developed a detailed, multi-tab Excel spreadsheet tracking individual Wraparound facilitators by bureau (BBH, BSS, BMS CSED), the number of children served by each facilitator across funding bureaus, and by the child’s county of residence. Data across bureaus also allows DHHR to see where capacity is shared across bureaus (when a provider serves more than one bureau).

As an example, Table 3 below shows March 2022 redacted provider information summarized at a provider level for the number of youth enrolled in Wraparound, by bureau. This is an example of the type of information now available to DHHR, allowing it to view, by provider, the specific facilitators, the number of youth each provider is serving, the funding bureau, when an individual facilitator is working with children across multiple bureaus or providers, and the county where a child resides.

TABLE 3. ACTIVE WRAPAROUND ENROLLMENT, BY PROVIDER AND AGENCY

Provider	BBH	SAH	CSED	Grand Total
A		160		160
B		160		160
C	25	67	44	136
D		67	62	129
E	8	88	9	105
F			103	103
G		72		72
H		53		53
I		23	21	44
J	14	14	9	37
K		29		29

L	27			27
M			23	23
N	13			13
O			7	7
P			5	5
Grand Total	87	733	283	1,103

DHHR indicated that this data will be revised monthly.

DHHR shared documents outlining their recent investments addressing the need for additional workforce. Table 4 below summarizes documents shared by DHHR regarding investments made via American Rescue Plan Act (ARPA) funding. While these efforts are not specific to children’s behavioral health or tied to specific services in the Agreement, these investments are inclusive of children’s behavioral health providers, and are important investments that DHHR is making in their delivery system.

TABLE 4. WORKFORCE RELATED ARPA FUNDING INVESTMENTS

#	Title	Purpose	Dates	Partner
1	Medicaid Home & Community Based Services Public Education & Outreach	Develop a plan for a public education initiative regarding West Virginia Medicaid Waiver programs to potential recipients of Medicaid waivers	11/15/21-3/31/22	WVU Office of Health Affairs (OHA)
2	Integration of a Person-Centered Trauma Informed Approach for Medicaid Home and Community Based Services Front Line Workers	Develop a plan for Patient-Centered Trauma-Informed Care Trainings	11/15/21-3/31/22	WVU OHA
3	Evaluation of ARPA Home & Community Based Services Workforce Training and Public Education & Outreach Initiatives	Evaluate the plan for Outreach & education (#1) and Plan for patient-centered trauma informed care (#2)	11/15/21-3/31/22	WVU OHA
4	Medicaid Home & Community Based Services Workforce Training Curriculum and Learning Management System Update	Develop a plan for Medicaid - waiver requirements training to be transferred to BMS’s internal Learning Management System (LMS)	11/15/21-3/31/22	WVU OHA
5	Safe Interactions for Law Enforcement and Persons with Intellectual or Developmental Disabilities and Mental and Behavioral Health Disorders	Develop a plan for training law enforcement regarding interactions with persons with behavioral health or IDD needs	11/15/21-3/31/22	WVU OHA
6	Mindfulness Based Resilience Training for Front Line Health Workers and Law Enforcement Personnel	Multiple activities including: 1. Enroll 200 law enforcement and front-line workers into training Mindfulness Based Resilience Training 2. Train 20 people to serve as Peer Coaches to support regionally based teams	11/15/21-3/31/22	WVU OHA

		3. Evaluate effectiveness of training		
7	Developing a Trauma-Sensitive Workplace	A multi-year investment to develop a plan and initiate training to address secondary traumatic stress for workers, supervisory skills to support staff; address critical incidents.	4/1/22-3/31/24	Marshall University

In addition to use of ARPA funding, DHHR provided materials and a presentation regarding its Statewide Therapist Loan Repayment (STLR). This loan repayment program has made two cycles of awards. The November 2019 cohort had 23 recipients (15 Social Workers, 7 Counselors, and 1 Psychologist); a December 2021 cohort will be selected in 2022.

Recipient awards are expected to cover \$20,000 of awardees’ eligible student loan expenses in exchange for a two-year service obligation with a qualified employer in the State. The STLR is a broader behavioral health system investment, so while not specific to children’s behavioral health, it does prioritize clinical professions including counseling, psychology, and/or social work master’s level therapists or counselors, with children’s mental health listed as one of the priority areas. Child psychiatrists and psychiatric nurse practitioners will also be included to meet the needs of West Virginians. Priority is given to candidates with lived experience and to candidates willing to work in areas of the State more heavily impacted by workforce shortages, including the Eastern Panhandle, Southern West Virginia, or other underserved rural settings.

Recommendations

1. Specific to workforce capacity, the SME acknowledges DHHR’s significant effort to develop the Wraparound Facilitator capacity data consistent with our August 2021 recommendation, and DHHR’s plans to maintain the data. Consistent with our prior recommendations, this data is an important component to ensure sufficient Wraparound capacity, as it displays provider and facilitator at a county level, thus allowing the state to monitor changes and act accordingly to ensure sufficient statewide capacity.

a. The SME recommends that the State assess the ability to expand the number of CSED Waiver facilitators, given the number of Wraparound facilitators working in the State and the current lower than expected enrollment in the CSED Waiver. We recognize DHHR’s requirement that SAH providers become CSED waiver providers as an important step in expanding the availability of Wraparound. The SME also understands that BBH providers will be required to enroll as CSED providers.

b. The SME recommends that DHHR document how it is using this data on an ongoing basis, including as part of its CQI processes, to improve capacity such as HCBS/Wraparound Workgroup meeting minutes indicating the data was reviewed, actions taken, lessons learned, and planned improvements, if any. For example, DHHR has made great efforts to leverage its trained Wraparound workforce by requiring BSS and BBH Wraparound providers become CSED waiver Wraparound providers. One important area for DHHR to monitor: As the workforce will now be shared across bureaus, each bureau cannot assume that a stated number of staff are wholly dedicated to its program. It will be important for DHHR and it

constituent bureaus to differentiate actual capacity (total Wraparound slots) from shadow capacity (assuming the total number of Wraparound slots are solely dedicated to a single bureau).

c. The SME notes that this data will also provide important quality information to DHHR, including the number of youth served by each facilitator and when assignments exceed National Wraparound Initiative (NWI) standards, as that will often indicate a need for more staffing in certain geographic areas. The SME recommends that this data also be coupled with other quality and fidelity data to monitor fidelity to NWI standards.

d. The SME notes that this data is currently gathered by hand and recommends DHHR consider ways to automate this data to reduce staff burden in collection and analysis and to support the expansion of data collection to services in addition Wraparound.

2. Monitoring workforce capacity specific to other Agreement services is also necessary. The SME recommends that DHHR indicate its planned approach to monitor capacity for the other services, and initiate work on that approach prior to the next SME report in October 2022.

a. The SME recognizes that DHHR may choose to monitor the capacity of other services using a different approach. Whatever approach(es) the State selects, we encourage the State to adopt methods that clearly display data, use common data and terms where possible, and link such collection and analysis to its CQI plans.

3. In the August 2021 report, the SME recommended that the State create a pipeline for a well-prepared workforce with a focus on educational and training partnerships. The ARPA-funded initiatives are an important investment to support home and community-based workers. As it relates to the Agreement, the ARPA investments have varying relevancy to child and family services. As such, the SME recommends:

a. The SME recommends that ARPA-funded initiatives differentiate any specific approaches or modifications relevant to children and youth. For example, Safe Interactions with Law Enforcement is a very important training topic that has varying relevancy and applicability for adults and children. As such, training for law enforcement officers would have to include information, for example, on intellectual and developmental differences (I/DD) and behavioral health, as well as clear scenarios for addressing the needs of children and youth with such conditions, to be relevant to the State's efforts in this Agreement.

b. Where ARPA-funded efforts report data, the SME recommends such data be disaggregated to clearly display efforts related to children and youth. In some instances, these efforts will be easily quantifiable (e.g., efforts related to BSS caseworkers and supervisors clearly impacts children and youth). Where some efforts focus on front-line workers more broadly, surveys of front-line workers could include questions that ask about the population served, by age.

c. Following DHHR's review of each ARPA-funded initiative, the SME recommends that DHHR provide a written plan regarding what DHHR learned from the effort that is applicable to

children and families, and steps regarding moving from planning to implementation to sustainability.

4. The STLR initiative is an important investment to build and retain qualified personnel. The SME recognizes that the STLR appropriation was intended to enhance behavioral health providers more broadly and is not solely dedicated to children and youth. Like the recommendations in item #3 above, the SME recommends that DHHR qualitatively and quantitatively detail any STLR efforts specific to children and youth and share any specific plans and lessons learned.

5. As noted in the last SME report, DHHR has made considerable investments in provider training. DHHR has indicated that training for CANS, Wraparound, CMCR, and BSS will commence summer/fall of this year. The SME requests to receive all training materials including training dates, who will be trained, and the actual training curriculum, with adequate time to review and make any recommendations, as needed, prior to being implemented.

6. The SME recommends that DHHR update its work plan to reflect revised dates, new and amended tasks, and CQI measures and processes.

Target Population

Agreement Requirements

The Agreement defines that the target population *shall include all children under the age of 21 who:*

- a. Have a Serious Emotional or Behavioral Disorder or Disturbance that results in a functional impairment, and (i) who are placed in a Residential Mental Health Treatment Facility or (ii) who reasonably may be expected to be placed in a Residential Mental Health Treatment Facility in the near future; and*
- b. Meet the eligibility requirements for mental health services provided or paid for by the Department of Health and Human Resources.*

Activities

While the Agreement describes the target population definition, and the population captured by provision a(i) is clear, the State needs to translate the population defined in provision a(ii) into operational parameters for data reporting and compliance oversight. The August 2021 report described the state's planned definition (noted in Table 5 below) which included a proposal to eliminate children with a sole diagnosis of ADHD from the at-risk subpopulation of the target population. In October 2021, the State presented its plan for how it planned to test this definition, and in January 2022, the State presented these findings. DHHR's analysis compared children with the state's proposed definition of SED to a group of children that only had ADHD in the claims.

TABLE 5. PROPOSED OPERATIONAL DEFINITION TO DEFINE YOUTH AT-RISK OF RESIDENTIAL INTERVENTIONS FROM DATA SOURCES

Proposed Operational Definition to Define Youth At-Risk of Residential from Claims or Administrative Data Sources		
Children under 21 with an SED and a CAFAS/PECFAS score greater than or equal to 90 (≥90), and at least one of the following: Mobile Crisis Response incidence CPS involvement (e.g., foster care) YS involvement AND expected to need a residential intervention in the next 30 days or less.	OR	Children under 21 with an SED and one of the following in the past 90 days: Incidence of acute psychiatric care hospital stay Incidence of ED visit for psychiatric episode AND expected to need a residential intervention in the next 30 days or less.
<p>Definition for Serious Emotional Disturbance (SED): Children with ICD-10 F Diagnosis Codes, excluding the following standalone diagnoses.</p> <p>F90 series (ADHD) F10 – F19, F55 (SUD) F71 and F80 series (neurodevelopmental disorders) G25.6, G25.7 (medication-induced movement disorders) Z55-65 (health hazards related to socioeconomic and psychosocial circumstances) Z69-Z76 (persons encountering health services in other circumstances)</p>		

As mentioned in previous reports, DHHR has verbally indicated that this analytic translation of the target population definition will only be used to pull data for reporting and would not be used to determine service eligibility or medical necessity criteria for services defined in the Agreement. Additionally, DHHR has stated that any child who accesses any DOJ Agreement service would be included in any data set, even if that child did not meet these at-risk criteria. This distinction is important, as it is expected that some children will need to access CMCR, behavioral support services, and other Agreement services who would not meet these criteria.

The analysis the State conducted in late 2021 and presented to the SME and DOJ in January 2022 examined the numbers of children in various types of out-of-home placements, including children in custody and children parentally placed. Children were stratified by diagnostic groups: children with a SED diagnosis (all diagnoses except I/DD, SUD alone, and ADHD alone), children with an ADHD only diagnosis, and children with an SUD only or SUD and ADHD diagnosis. The report also included average length of stay for each of the diagnostic groups, service utilization rates and service units by diagnostic group, emergency department rates by diagnostic group, and CPS and YS involvement by diagnostic group.

Table 6 shows the total number of children and youth in each diagnostic population in each time period.¹

¹ Table 6 was taken from a January 5, 2022 PowerPoint presentation by DHHR to the DOJ and SME titled “At-Risk Target Population Definition Testing Results.”

TABLE 6. CHILDREN IN DIAGNOSTIC GROUPING BY YEAR

	2019	2020	2021
SED	37,763	33,663	22,255
ADHD only	9,112	8,403	6,070
SUD only	767	525	256
Total Users with Medicaid Behavioral Health utilization	47,642	42,591	28,581

Table 7 shows the types of residential interventions received by youth in state custody by diagnostic group.²

TABLE 7. STATE CUSTODY RMHTF UNDUPLICATED USER COUNTS BY MOST RECENT LEVEL OF CARE, DIAGNOSTIC GROUPING, AND YEAR

	SHORT-TERM ACUTE			PRTF			GROUP HOME		
	2019	2020	2021	2019	2020	2021	2019	2020	2021
SED (all other except ADHD, IDD, SUD)	194	163	77	162	183	136	1423	1321	845
ADHD alone	1	1	0	3	7	5	32	29	29
SUD alone	1	1	1	1	0	0	16	17	9

In summary, the State’s first analysis of data to determine the “at-risk of residential” subpopulation focused on diagnostic categories. The State indicated that functional data from the CAFAS/PECFAS or CANS was not available, and that data regarding service utilization for certain services in the proposed definitions (i.e., CMCR) was not yet available. DHHR indicated that when the data is available, analysis of functional need from standardized tools and utilization of specific services to inform the “at-risk of residential” population would occur. From its analysis, DHHR indicated that the data analysis supported that youth with a sole diagnosis of ADHD could be considered for exclusion from the definition of “at-risk for residential subpopulation of children,” given that the population “of children with an SED diagnosis are much more likely to access these residential services than children with standalone ADHD,”³ and that the ADHD only diagnostic group had lower rates of behavioral health service utilization. DHHR indicated it had not reached a conclusion regarding eliminating children with ADHD-only from the at-risk of residential data set. It acknowledged information from the SME regarding the federal definition of SED, and the 2014 expert panel reaffirming the inclusion of ADHD within the SED federal definition. DHHR requested an additional opportunity to review the data, and to discuss the issues raised by the SME at the next scheduled parties meeting (DOJ-DHHR and the SME.). Finally, within the analysis, DHHR noted the higher-than-expected numbers of the SUD only population, and the high rates of behavioral health emergency department utilization among that group and indicated it would review this subgroup further.

² Table 7 was taken from a January 5, 2022 PowerPoint presentation by DHHR to the DOJ and SME titled “At-Risk Target Population Definition Testing Results.”

³ *Id.* at slide 11

Recommendations

1. The SME is concerned about any focus to eliminate children with a diagnosis of ADHD only from the “at-risk of residential” population. The DOJ Agreement target population is youth with an SED. The term “SED” is defined in the Federal Register,⁴ and the federal agency responsible for the definition, SAMHSA, has convened expert panels and issued various papers on the topic. The 1993 federal definition, 2014 expert panels, and related federal documents have stated that SED includes ADHD diagnoses.^{5,6} The original Federal Register definition that included ADHD is dated 1993 and the SAMHSA federal panel endorsing ADHD is dated 2014.⁷ The SME does not find anything in DHHR’s analysis to suggest that the well-established definition of SED, which is inclusive of ADHD, cannot or should not be maintained. It is the SME’s opinion that the State must follow the federal definition of SED for the “at-risk of residential” group.
2. The SME recognizes that the federal definition of SED excludes standalone substance use disorders unless they are concomitant with other complex mental health conditions. The SME also recognizes that the data analysis completed by DHHR indicated that a high number of youth with SUD-only diagnoses in claims and administrative data are seeking and receiving care in emergency departments and residential settings. Given the high use of EDs and residential services, this population of youth will challenge DHHR’s efforts to redirect youth from residential placement. DHHR has conveyed its plans to review this subpopulation further, particularly given the high co-occurrence of mental health and substance use issues among youth. The SME commends DHHR for reviewing this data further to understand the co-occurrence of mental health conditions, and to ensure that these youth are connected to the appropriate services to address their needs.
3. The State’s analysis in January 2022 did not include analysis of functional assessment data, as CAFAS/PECFAS scores were not yet available, but has indicated its plan to so once the data is available. The State’s proposed definition for “at-risk” also requires a youth to meet functional CAFAS scale score of 90 or above to be considered “at-risk” of residential. It is the SME’s opinion that the proposed definition for “at-risk” remains unresolved until such time that the State can demonstrate through analysis that the CAFAS/PECFAS score at or above 90 is the right score to capture the “at-risk of residential” group, and that children with scores below 90 are not generally at serious risk for residential placement. The SME notes that the developers of the CAFAS/PECFAS tool⁸ stratified score by the types of services that youth may

⁴ <https://www.samhsa.gov/sites/default/files/federal-register-notice-58-96-definitions.pdf>

⁵ <https://www.samhsa.gov/data/sites/default/files/SED%20Expert%20Panels%20Summary%20Report.pdf>

⁶ Note: 1993 Federal register definition references the Diagnostic and Statistical Manual current in 1993, DSM-III-R.

⁷ Referencing DSM-V.

⁸ Rosanbalm, K. D., Snyder, E. H., Lawrence, C. N., Coleman, K., Frey, J. J., van den Ende, J. B., & Dodge, K. A. (2016). Child wellbeing assessment in child welfare: A review of four measures. *Children and youth services review*, 68, 1–16.

need. There are no specific cutoff scores, but the tool developer provided the following guidance for interpreting total scores:

- 0-10 - no noteworthy impairment
- 20-40 - treatment on an outpatient basis would likely be appropriate dependent upon the presence of risk behaviors
- 50-90 - additional services beyond outpatient care may be needed
- 100-130 - more intensive care and sources of support beyond outpatient services are indicated
- 140 or more - intensive treatment may be warranted.

As such, it is the SME's opinion that a CAFAS/PECFAS score of 90 is a reasonable starting point for consideration but that further analysis is needed. The SME recommends that DHHR retrospectively analyze CAFAS/PECFAS data on youth, including the services utilized by these youth across BBH, BMS, and BSS.

4. The State's analysis in January did not include utilization of CMCR services. The State's proposed definition of "at-risk" requires that, in addition to having an SED diagnosis and a score of 90 or above on CAFAS/PECFAS, a child or youth must also have used CMCR, or be in foster care or Youth Services. Consistent with recommendation #3 above, it is the SME's opinion that the proposed definition for "at-risk" remains unresolved until:
 - a. such time that the State can provide analysis addressing that children and youth with a CAFAS/PECFAS score 90 or above but who are **not** using CMCR, **not** in foster care, or **not** in youth custody are **not** at risk for residential intervention. As noted in the August 2021 report, because the definition of "at-risk" is predicated on use of certain services (CMCR, foster care, Youth Services), the SME is concerned that this definition may exclude children who are unable to access services; and
 - b. that the State includes in its methodology considerations of accessibility to services necessary to be deemed "at risk." Per the SME's August 2021 report, such accessibility concerns include CMCR, and the independent evaluation required in the assessment pathway to receive a CAFAS/PECFAS score.
5. The current definition includes a provision that in addition to a SED diagnosis, utilization of certain services, and a CAFAS/PECFAS score at or above 90, the youth must also expect to need residential "in the next 30 days or less." As stated in the August 2021 report, it is the opinion of the SME that this language should be removed from the definition. The definition itself is a proxy for risk of residential within 30 days. This line implies the imposition of another requirement in addition diagnosis, functional assessment score, and use of certain services, and it unclear what other criteria will be used to determine whether this expectation exists or not.
6. Consistent with an August 2021 recommendation, regarding change over time, the SME recommends that the State clarify how long a child remains in the data set. DHHR will need to propose whether a child remains in the target population data set indefinitely, or whether DHHR will refresh data based on an annual re-determination process. There will be

circumstances in which a child would not remain in the data set, such as moving out of state. The SME does not recommend that children are dropped from the data set solely because their diagnosis changes, or because they no longer have a CAFAS at/above 90. We recommend children and youth remain in the data set in some form for at least 12 months following an annual re-determination process that deems them no longer eligible. This approach will allow the State to follow children and youth in the immediate post-at-risk determination period to see if they continue receiving HCBS, at what intensity, and whether the provision of certain services is associated with improved outcomes. It will be that set of children that can retrospectively provide important information about whether the at-risk definition captured the right group of children.

7. As recommended in the August 2021 SME report, as the State tracks and reports on the families who decline to pursue the CSED eligibility determination process, DHHR will need to determine if those numbers are large enough to eliminate significant data from the “at-risk of residential” data set. The SME recommends continued monitoring and reporting of families that decline the CSED waiver, and a revisiting of this issue in the State’s semi-annual reports, including any outreach or engagement activities associated with families who decline (e.g., surveys, focus groups, needs assessment).

CSED Waiver

Activities

BMS received approval for Appendix K emergency preparedness and response for its 1915(c) waiver programs on [April 20, 2021](#). Specific to the CSED waiver, BMS sought and received approval for three important modifications to enhance capacity:

1. Eligibility based on child’s income,
2. Temporary rate increases for all CSED waiver services through March 31, 2022, and
3. Ability to use non-licensed master’s trained clinicians to provide in-home family therapy.

The K is set to end April 2022 unless the federal public health emergency is extended.

BMS [issued public notice](#) on February 3, 2022 regarding its draft amendment to the CSED Waiver with a closing period for comments on March 5, 2022. The SME requested and received a summary regarding the proposed changes in the Amendment via email on March 23, 2022, indicating the following six changes:

1. Permanently expand Medicaid eligibility group (1902(e)(3)/42 CFR §435.225) under 42 CFR §435.217 option.
2. Permanently expand the list of eligible degree types for providers to include non-licensed clinicians delivering these services, when meeting the requirements for clinical supervision required for Licensed Behavioral Health Centers, the provider type that delivers CSED services, G0176 HA Extended Professional Services and H0004 HO HA Family Therapy.
3. Extend the timeframe an eligible member must begin HCBS before an unused waiver slot is discharged from 90 days up to 365 days, unless the member ages out of eligibility.

4. Adjust the numerator for performance measure A.a.i.7 to help ensure that waiver performance measure reporting is clear.
5. Remove the “in-home” requirement for Family Therapy to increase service setting options to align the waiver with the State’s Wraparound initiative.
6. Add Evidence-Based Therapy requirements [in the family therapy and in home family support definition] to align with CMS and evidence-based practices.

BMS has indicated that it plans to finalize the CSED Waiver policy manual in the coming months. In December 2021, DHHR shared draft enrollment data. As Table 8 indicates, as of early December, 298 children were enrolled in the Waiver, with 180 receiving services. Eighty-three (83) children have been approved for the Waiver but not yet discharged from residential and a remaining 35 must complete the required Freedom of Choice (FOC) notice before commencing services.

TABLE 8. CSED WAIVER ENROLLMENT – DECEMBER 8, 2021. (DRAFT DATA PRESENTED TO THE DOJ AND SME)

Total Enrolled	298
Total receiving services	180
Total On Hold (Child currently in PRTF/Residential pending discharge)	83
Total with a Freedom of Choice Notice signature not yet obtained/provided	35

For this report, DHHR provided updated Excel charts, “CSED Waiver Enrollment Updated Stats” and “CSED Waiver Utilization Updates.”

As described in Table 9 below, children and youth received a mean of 13.2 hours of CSED Waiver services per month for the period from August 2020 through September 2021.

TABLE 9. CSED UTILIZATION, BY MONTH, EXCLUDING INDEPENDENT EVALUATIONS, JULY 2020-SEPTEMBER 2021

Service Month	Number of Children	Average Units per Child	Hour per Child*
Aug-20	20	33	8.19
Sep-20	27	64	15.96
Oct-20	28	77	19.26
Nov-20	34	56	13.91
Dec-20	45	40	9.92
Jan-21	61	46	11.40
Feb-21	67	49	12.32
Mar-21	85	49	12.23
Apr-21	82	61	15.28
May-21	94	59	14.70
Jun-21	96	52	12.90
Jul-21	106	53	13.17
Aug-21	116	56	13.98
Sep-21	123	46	11.42

*SME calculated

As described in Table 10 below, children and youth received a mean of 4.05 hours of Wraparound Facilitation per month for the period from July 2020 through September 2021. If we remove October 2020—which has hours roughly twice as high as other months—then the mean hours received per month is 3.81.

TABLE 10. CSED WAIVER WRAPAROUND FACILITATION, JULY 2020-SEPTEMBER 2021

Month	Number of Children	Units per Child	Hours Per Child*
Jul-20	9	16	4.06
Aug-20	18	19	4.81
Sep-20	20	13	3.13
Oct-20	24	30	7.48
Nov-20	23	19	4.63
Dec-20	30	18	4.43
Jan-21	50	15	3.66
Feb-21	53	18	4.38
Mar-21	72	16	4.04
Apr-21	69	16	3.92
May-21	70	14	3.61
Jun-21	68	12	3.04
Jul-21	84	14	3.54
Aug-21	87	13	3.35
Sep-21	74	11	2.74

*SME calculated

As described in Table 11 below, children and youth enrolled in the CSED Waiver received a mean of 6.06 hours of In-Home Family Therapy for the period from July 2020 through September 2021. As with Wraparound Facilitation, units were higher in November 2020 than many other months but removing it lowers the mean only slightly to 5.91 hours.

TABLE 11. CSED WAIVER IN-HOME FAMILY THERAPY UTILIZATION, JULY 2020-SEPTEMBER 2021

Month	Number of Children	Units per Child	Hours per Child*
Jul-20	7	30	7.43
Aug-20	14	20	4.89
Sep-20	22	27	6.65
Oct-20	25	26	6.44
Nov-20	25	33	8.24
Dec-20	33	23	5.83
Jan-21	45	27	6.63
Feb-21	52	22	5.49
Mar-21	64	24	5.93
Apr-21	67	26	6.51
May-21	70	25	6.13

Jun-21	73	23	5.63
Jul-21	76	23	5.79
Aug-21	79	20	5.06
Sep-21	91	17	4.27

*SME calculated

As described in Table 12 below, children and youth enrolled in the CSED Waiver received a mean of 5.65 hours of In-Home Family Support per month for the period from July 2020 through September 2021.

TABLE 12. CSED WAIVER IN-HOME FAMILY SUPPORT, JULY 2020-SEPTEMBER 2021

Month	Units of Service	Number of Children	Units per Child	Hours per Child*
Jul-20	36	4	9	2.25
Aug-20	32	4	8	2.00
Sep-20	277	13	21	5.33
Oct-20	392	15	26	6.53
Nov-20	468	16	29	7.31
Dec-20	301	17	18	4.43
Jan-21	673	25	27	6.73
Feb-21	565	29	19	4.87
Mar-21	1,238	44	28	7.03
Apr-21	1,513	47	32	8.05
May-21	1,352	46	29	7.35
Jun-21	1,170	42	28	6.96
Jul-21	1,002	48	21	5.22
Aug-21	1,204	55	22	5.47
Sep-21	1,153	56	21	5.15

*SME calculated

As described in Table 13 below, a total of 54,130 units of service were provided to 194 children during the July 2020-September 2021 15-month period, with a mean total of units provided per child of 279 units. Removing from the calculation services that are not 15 minutes increments such as assistive equipment (262 units) and transportation (213 units), and independent evaluation (283 units), youth received an average of 70 hours of service over 15 months through the CSED Waiver.

TABLE 13. CSED WAIVER BY SERVICE, JULY 2020-SEPTEMBER 2021

Service Description	Units Provided	Unique Youth	Units per Child	Cumulative Total Hours per Youth For the 15 month Period*
CSEDW Assistive equipment	1,309	5	262	---
CSEDW Wraparound Facilitation	11,327	167	68	17
CSEDW Community Transition	2,370	1	2,370	593
CSEDW In-home family Support	11,376	107	106	26.5
CSEDW In-home family Therapy	17,174	148	116	29

CSEDW Mobile response	228	20	11	2.75
CSEDW Peer parent support	681	16	43	10.75
CSEDW Respite (in home)	2,047	14	146	3.5
CSEDW Respite (out of home)	1,993	17	117	29.25
CSEDW Independent Evaluation	283	278	1	---
CSEDW Spec Therapy	297	1	297	74.25
CSEDW Supported employment, individual	8	1	8	2
CSEDW Transport	5,320	25	213	--
All CSEDW Services	54,413			
All CSEDW Services excluding Independent Evaluations	54,130	194	279	69.75

*SME calculated

Note: Rows in blue are services that appear in the tables above. Monthly average hours of service in tables 10, 11, 12 will not match the 15-month **cumulative** total hours of service in Table 13 due to differences in monthly totals and cumulative totals of children served.

Recommendations

Note these recommendations are specific to the CSED Waiver process, operations, or materials; additional recommendations specific to services approved in the CSED Waiver are addressed in the service sections that follow.

1. Specific to the State's draft CSED Waiver amendment, the SME was made aware of the amendment following its release. During an April monthly status meeting with DHHR and DOJ following the parties' receipt of a draft of this report, BMS verbally provided additional updates to its proposed 1915(c) waiver changes.
 - a. Two of the changes, population eligibility and use of non-licensed clinicians, consistent with the Appendix K approval, expand who may be eligible for the Waiver, and expand the workforce by using non-licensed master's trained clinicians. The SME supports both changes as positive, productive steps to increase Waiver accessibility. The SME notes that most jurisdictions allow the use of non-licensed master's trained clinicians to provide in-home and office-based therapy while under the supervision of a licensed clinician and the SME supports the expansion of the workforce in this way. BMS indicated *Chapter 503* revisions were made to reflect these changes, and *Chapter 502* changes are forthcoming. The SME recommends that the State's CQI plan be amended to include how the state will monitor and ensure quality oversight of these non-licensed roles, including appropriate supervision and ratios of supervision as mandated in *Chapter 503*.
 - b. The SME notes the efforts by DHHR to determine Waiver eligibility in advance of a youth's discharge from a residential service. This is an important step to ensure activation of needed HCBS services prior to discharge. The SME notes that the State has extended the waiver eligibility timeframe for residential youth from 180 to 365 days prior to a youth beginning any HCBS service. The SME assumes this is intended for youth who are receiving a residential intervention and have not yet been deemed

ready for discharge by the residential provider or Aetna. The SME infers that it will also raise enrollment counts and reduce the gap between actual enrollment and Year 3 expected enrollment. The Waiver has CMS approval for 2,000 overall slots in Year 3 with 250 Waiver slots specifically dedicated to enrollment of youth in residential. The SME can also envision a scenario in which extending the timeframe for initiation of services may help Aetna, providers, BSS caseworkers, and families to understand available resources, and for those resources to be activated or initiated prior to the child's discharge. Given that the 250 dedicated slots could fill up under this scenario, the SME recommends close monitoring of this figure to ensure that the State retains priority capacity for residentially placed youth or seeks CMS approval for added capacity if necessary. Additionally, the SME flags that enrollment figures without utilization will skew Waiver data. If this proposed change occurs, the SME recommends a specific data plan to ensure that a child enrolled in the Waiver but not engaged in any service continues to be tracked and reported separately.

- c. Specific to replacement of the in-home requirement for family therapy with the language that services are to be delivered “in the setting most appropriate for the member to meet their service needs and goals,” during a meeting with the DOJ and SME following receipt of a draft of this report, BMS clarified that the removal of the language from the 1915(c) Waiver was not a removal of the requirement for home- or community-based service delivery but that it allowed delivery of the service in the family's preferred location – in their home or in a different community setting. BMS indicated that they learned from families that they wanted this option to allow for circumstances such as enhanced privacy during a service given other children in the home. BMS indicated this would be based on family or member choice and not provider convenience. The SME is concerned this change could negatively impact the State's ability to demonstrate compliance with Agreement requirement 37c.⁹ Additionally, most evidenced-based family therapy programs include an in-home component.¹⁰ Given DHHR's planned approach, the SME recommends that the DHHR provide details regarding its plan to monitor family choice, including how DHHR will monitor that service location is not occurring at the convenience of the provider. Additionally, the SME recommends that DHHR track and report place of service data to report and monitor the place of service, including the specific community locations that families are selecting as more private and convenient locations for this service than their own homes. Specifically, it will be important to ensure that any use of a provider location is reported in the place of service data.
 - i. Regarding “In-Home Family **Support**,” the SME notes that BMS has retained the in-home requirement for this service and has added an evidence-based

⁹ “DHHR, in cooperation with the Department of Education and the Department of Military Affairs and Public Safety, shall provide services in the child's family home (or foster or kinship care home, where applicable) and in the community . . . includ[ing]: In-home therapy that provides a structured, consistent, strengths-based therapeutic relationship between a licensed clinician, the child, and family (and foster or kinship care family, where applicable) for the purpose of effectively addressing the child's mental and behavioral health needs.”

¹⁰ <https://www.cebc4cw.org/>, <https://preventionservices.acf.hhs.gov/>,

practice (EBP) requirement. The SME seeks to discuss BMS' consideration for this distinction between the importance of requiring paraprofessionals in the home but not clinicians to deliver effective family therapy services.

- d. The SME commends BMS for requiring use of an EBP. This is an important component to ensuring the quality of therapy services provided, and it elevates West Virginia's requirements. The SME has five recommendations specific to this proposed requirement. They are offered not to dissuade DHHR from this commitment but rather to provide a roadmap to bolster its success.
 - i. The SME seeks to understand how DHHR plans to implement the requirement that all family therapy be provided consistent with an EBP. Many requirements are often left to the provider to self-attest with the potential that, upon audit, they risk corrective action. Or, like DHHR's commitment to other evidence-informed practices such as Wraparound, will the State plan a training and vouching approach specific to this EBP requirement? EBPs require infrastructure and funding to initiate and sustain fidelity to the practice model through data collection and analysis; recruiting, training, and coaching to improve clinical acumen; and achieving and maintaining supervision ratios. Typically, providers are not able to maintain fidelity to multiple EBPs, so the assumption that a given provider will be able to offer many is incorrect. To ensure compliance with any EBP requirement, the State will likely need to provide technical assistance to providers and will need to develop quality oversight plans specific to EBPs.
 - ii. BMS/DHHR will need to add greater specificity regarding what constitutes an evidence-based approach. This could include listing specific EBPs or identifying an approved clearinghouse from which providers could select an EBP.
 - iii. Any language needs to ensure that the EBP used is consistent with the needs of the youth and family, and not offered at the convenience of the provider. Specifically, the state will need to ensure that the child has access to the right EBP based on their assessment (e.g., PECFAS/CAFAS and/or CANS).
 - iv. Many providers may have attended a training on an EBP, but few receive the ongoing coaching and support necessary to consistently apply the EBP in practice. Most states that have required EBPs have been hindered by provider capacity to offer and sustain fidelity to a given EBP unless the State provides infrastructure support, training, and financial resources. DHHR will need to assess providers' capacity and develop a plan to support providers to hire and retain certified/EBP trained staff, and carry out the necessary supervisory, ongoing coaching, and fidelity data collection to successfully deliver EBPs.
 - v. DHHR's CQI must address how it will ensure that EBPs being offered to children and families consistent with assessed needs and how providers are achieving and sustaining fidelity to the model(s) they offer.

- e. The SME notes similar questions as above regarding EBPs. Specifically, the SME seeks to understand how the State will monitor provider selection of EBPs consistent with the service, as many but not all EBPs incorporate such a role.
 - f. Additionally, with this role requiring service provision in the home, the SME wonders if the State is assuming this will be a staff extender role, with the ability to support the family in the home, while providing master's level therapists greater flexibility to provide services in the office, school, or other locations.
 - g. The SME notes the change in performance measure numerator and denominator and looks forward to receiving performance measure data in the future.
2. The SME notes a FAQ dated January 1, 2022 was submitted for SME review for this report. The SME notes that communicating with providers via FAQs is useful and this version addresses important issues. The SME appreciates the work of BMS to address an important quality issue flagged by the SME: that children enrolling in the Waiver would have been required to discontinue work with a pre-existing therapist. As noted in this FAQ, the State has created a pathway forward for children and youth to maintain an ongoing therapeutic relationship while in the Waiver while eliminating State concerns of an audit risk with CMS. The SME recommends that this issue be included in CQI activities to ensure that providers understand this continuity is not only allowed but expected (based on the youth's and family's wishes), and that quality review processes ensure that disruptions to therapeutic relationships are not occurring.
 3. In this same FAQ, the SME noted a requirement for children to receive a functional behavioral assessment prior to the Child and Family Team (CFT) meeting. The SME requests that the State provide clarity on how this requirement fits with the role of the independent evaluator and completion of the PECFAS/CAFAS for Waiver eligibility, the BSS assessment service which serves the same purpose, and the planned modifiers that will be attached to existing Medicaid claims for BSS services delivered in the course of providing related services (e.g., outpatient therapy.)

From submitted document titled WV CSED Waiver FAQ Jan. 1, 2022: **28. A Functional Behavior Assessment is the foundation procedure for applied behavior analysis therapy. It is a gathering of information from record reviews, interviews, and direct observations to identify environmental variables contributing to socially inappropriate behaviors in a child. This information is then used to identify the function of the behaviors. This is a process that must occur before the Child and Family Team (CFT) can assist in writing the treatment plan. With the new wraparound model, can we bill for this process?**

[Response:] *This is not billable and is considered an administrative function per CMS.*

4. The State's data is improving in both detail and timeliness. We recognize the considerable effort by DHHR to access, analyze, and report data. In reviewing the CSED Waiver data provided by the State, CSED Waiver enrollment has improved but remains lower than the number of enrollees projected in the initial waiver application. Even with the more recent enrollment figures available as of December 2021, West Virginia remains far below the projected enrollees of 500 in Year 1, 1,000 in Year 2, and 2,000 in Year 3. The SME recognizes

that enrollment is likely to increase as reductions in residential occur and as BMS is able to have more of its listed CSED Waiver providers actively provide services (currently 12 of 22 are providing services.) The SME further recognizes the effect of the COVID-19 pandemic on limiting enrollment. Additionally, utilization within the Waiver remains low. This is also likely impacted by DHHR's current network of 12 active providers, and that all 22 providers are trying to hire personnel.

- a. Data is currently presented by service which is useful to DHHR as it looks at service capacity and utilization. In addition to data presented by service, it is necessary for DHHR to also examine data by youth. Consistent with prior recommendations, the SME recommends that behavioral health utilization across all behavioral health services—both CSED Waiver and state plan—aggregated monthly and yearly—so that DHHR can understand the types of services and amount of service each child is receiving.
 - b. Consistent with a previous SME report recommendation, the SME recommends reporting Waiver data by service hours rather than units of service, so that the type, amount, and duration of services received per month is clear. As noted above, the SME converted all units provided to hours to better understand the scope of service delivery.
 - c. The hours of service provided per child remain low. For example, for the most recent month available, September 2021, 74 children received on average two hours and 45 minutes of Wraparound support in a month; that figure is lower than expected given this population's complex needs. There may be several different reasons underlying low service provision, including an insufficient number of Wraparound facilitators to meet need; unclaimable (and therefore unreported) service hours such as convening a care plan team meeting, developing a care plan, or responding to after-hours calls; or inconsistent practice to DHHR's Wraparound standards and/or NWI standards. The SME recommends that DHHR review this data, and other available fidelity and quality data, using its new CQI process, to determine what factors may be contributing to relatively low service provision.
 - d. In addition to low hours of service provided, it appears that a prior issue flagged by the SME has not changed: that some services have little to no utilization at all. Given that this is an ongoing issue, the SME recommends that DHHR use its new CQI plan and develop a plan for how it will review, analyze, correct, and monitor this issue.
5. The SME understands that the State is currently developing its waiver renewal as it is entering its third year of its current three-year approval. The SME requests information regarding the State's planned changes, if any, to the waiver or other Medicaid delivery systems and strategies.
 6. As recommended in the August 2021 SME report, the SME has requested information regarding how the CSED Waiver entertains service limits. The SME requests to review the standard operating procedure (SOP) regarding how BMS is monitoring Waiver service utilization. Specifically, BMS has indicated that additional units will be granted if determined medically necessary. The SME also requests to review BMS's SOPs on topics including but not

limited to how it communicates to providers that additional units beyond the caps can be sought, information required by the provider to be submitted for review, and how the State reviews these requests, along with the number of such requests received annually. Additionally, the CSED Waiver manual does not appear to address the process by which providers can seek additional units beyond the stated caps; this information should be added to the manual. The SME requests to know the process BMS will use to know if a child reaches these limits, and that any data related to service utilization caps be shared with the SME.

7. As recommended in the August 2021 SME report, the SME has requested and has not received the SOP for how the MCO monitors the service utilization. BMS has indicated that its vendor must monitor overutilization. Given the needs of the population, and the available data, which indicates potential underutilization of services, the SME recommends that the MCO be tasked by BMS to also monitor underutilization of Medicaid services for these children given their degree of complexity, the historical patterns of initiating and sustaining access to services, and the reality that families eligible for and/or enrolled in the CSED Waiver may need additional support and ongoing engagement to access services.
8. As recommended in the August 2021 SME report, the State's CQI Plan does include an indicator for determining that plans of care are individualized using Marshall University's fidelity reviews and sampling. However, under "Guidance for Review," the State notes that this item "needs further discussion." The SME recommends that DHHR and its vendor develop a sufficiently detailed SOP to monitor and ensure that services are individualized to meet the needs of children and youth and not a standard, one-size-fits-all approach. Additionally, the SME recommends that DHHR indicate in an SOP or other document how it monitors and provides oversight of its vendor's tasks.
9. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, including related CQI measures and processes.

Screening

Agreement Requirements: The Agreement requires the State to ensure that all eligible children are screened to determine if they should be referred for mental health evaluation or services and that DHHR adopt a standardized set of mental health screening tools. Additional provisions require the screening of children entering child welfare and juvenile justice, as well as outreach and training on the use of the screening tools for physicians of children who are Medicaid-eligible.

Activities

Regarding screening, DHHR is implementing mental health screening specific to each department, agency, bureau, or division (Bureau of Social Services (BSS) Care and Protection Unit and Youth Services Unit, Division of Corrections and Rehabilitation (DCR), Division of Probation Services (DPS), Department of Education (DOE), and Bureau of Medical Services (BMS) with Office of Maternal Child Family Health (OMCFH)), with each bureau using a different standardized screening tool and standard operating procedure (SOP). Additionally, BMS requires its MCOs to perform certain screening-related activities. Activities are summarized by bureau.

Specific to **BSS**, three BSS-specific documents related to screening were submitted for this report: *Awareness and Implementation Plan for Bureau for Social Services (BSS) Staff on the Pathway to Children’s Mental Health Services and Reducing the Reliance on Residential Service, draft, dated March 11, 2022*; *Pathway to Children’s Mental Health Services Bureau for Social Services, dated Feb. 2, 2022*; *Achieving Safety, Permanency and Well Being For West Virginia’s Children, A Knowledge and Skills-Based Curriculum, January 2022*. These resources include policies and training materials for BSS personnel to understand the shift towards HCBS options, the Assessment Pathway, the CSED Waiver, the expectations for BSS workers to conduct mental health screening, how to refer youth with a positive screen to the Assessment Pathway, and how this screening activity occurs within the context and requirements of BSS’s mandates to ensure the safety, permanency, and well-being of children.

The SME had been under the impression that the Family Advocacy and Support Tool (FAST) tool was used throughout BSS, both in the Care and Protection Service (CPS) units and the Youth Services (YS) units. In reviewing the three BSS documents, language stated that an initial or ongoing assessment or a FAST could be used. The SME had understood the language of “Initial Assessment” or “Ongoing Assessment” to be all the necessary steps that BSS staff used to assess needs, including use of the FAST, when they are engaging a new family or reviewing the progress of an existing family referred to BSS for care and protection issues. This reference to initial or ongoing assessments or FAST is used in multiple places in the documents. In discussions with DHHR a few days before this report was submitted, DHHR clarified that it is the “Ongoing Assessment,” and not the FAST, that is used by CPS to conduct mental health screenings.

Additionally, two handouts referenced in the training curriculum but not submitted to the SME for this report are job aides (i.e., companion materials) developed to support BSS workers to identify the mental health needs of children. These job aides are listed as optional.

Example 1: page 11, Connecting Families to Success

*A tool has been created to assist you in assessing the needs of a child. (Refer workers to Handout 2 – Mental Health Screening Tool (ages 0-4) and Handout 3 – Mental Health Screening Tool (ages 5-18). **This optional tool** can be used as a resource in asking meaningful questions related to identifying the needs of a child. [Emphasis added.]*

Specific to **Youth Services**, which is responsible for providing support services to youth and families referred by the court following juvenile offenses, the SME notes the clarity regarding the use of FAST for all children involved with Youth Services.

Example 2: slide 12, Connecting Families to Success document

*For YS, we use the Family Advocacy and Support Tool (FAST). This is a communications tool designed to understand the complex needs of families for Youth Service clients. The FAST focuses on the entire family and identifies each member’s unique needs and potential strengths. The purpose of the FAST is to identify safety threats and treatment needs which may exist within families, and support families in meeting needs and reducing safety threats and support effective interventions. The FAST tool is designed to be continuously modified based on new information learned throughout the life of the case. The FAST should be revisited and updated regularly as other assessments are completed and to reflect the current status of the case. **The FAST must be used in***

all cases involving Youth Services, including the assessment requirements of juvenile Multidisciplinary Treatment Team meeting, and in the case planning process. [Emphasis added.]

The SME notes that the three aforementioned BSS documents contain helpful information, consistent with the Agreement, to increase BSS workers' awareness of the shift from residential, and how to access the HCBS to support that redirection.

The SME notes one error in the Pathway to Children's Mental Health document, specific to CMCR in the sub header 3.2 Children's Crisis and Referral Line and Mobile Mental Health Crisis:

*When child welfare workers have contact with families involved with CPS [child protective services] or Youth Services and a child is having a mental health crisis, the child welfare worker must assist the family by providing information for the Children's Crisis and Referral Line, **if that service is available in the family's area.*** [Emphasis added.]

The SME assumes the BSS author of the document may have inadvertently confused the availability of the statewide crisis and referral line with regional mobile response teams that are not yet available in two areas of the state.

Specific to DCR's **BJS**, the SME received a document titled *Detention Referrals to Children with Serious Emotional Disorder (CSED) Waiver Standard Operating Procedure (SOP)* dated February 24, 2022, with a footnote that the document is a BJS SOP. This SOP notes that a companion BJS protocol is forthcoming by the end of March 2022. The document provides step-by-step guidance for how youth exiting BJS Detention or a Commitment program will be referred to the CSED Waiver. This document was submitted to the SME for this report, but the SME has not yet had an opportunity to discuss the document with DHHR, or understand if it is in use, in draft, and the plan to implement and monitor. The document references the BJS required MAYSI-2, and the need to discuss a CSED referral for any identified youth with the MDT. The SME notes that the document includes reference to the future development of a data plan template for related data tracking. As the document states a companion BJS protocol is forthcoming, the SME asks DHHR to clarify if this is a BJS issued SOP, or another document with a different purpose, and what a companion protocol would address.

Specific to **DPS**, the SME received two documents titled *Juvenile Mental Health Screening Policy*, dated February 24, 2022 and *Probation Screening Tracking Spreadsheet*, dated February 28, 2022. The SME notes the clarity in this mental health screening policy including specific reference to the screening of all youth with the MAYSI-2 at intake, with additional information about the Agreement and how to refer to the Assessment Pathway. The SME notes that this policy requires that the probation staff read the manual and information listed on the proprietor's website, and that any questions about administration or scoring of the MAYSI-2 are to be directed to the proprietor's website. It further notes that virtual training on the CSED Waiver will be made available for Probation Officers by KEPRO. It is unclear how the State and Court system intends to monitor that probation officers read the manual, that questions are answered timely, and oversight of the training provided by KEPRO.

Previously, DHHR indicated that **DOE** follows requirements established for HealthCheck. No additional information was submitted for this report.

Specific to **BMS**, the Bureau has several requirements specific to West Virginia's EPSDT, or Health Check, including for its MCOs. In addition to contractual requirements with its health plans, BMS partners with OMCFH to conduct chart reviews in primary care to ensure HealthCheck Screens are conducted. No MCO reports regarding screening were submitted for this report. Previously, DHHR submitted four health plan reports but noted that only one of the four was populating the fields. BMS indicated that it was engaging with the MCOs to improve their EPSDT screening rates and reporting more broadly and improving mental health screening rates and reporting within EPSDT specifically. No new information was submitted pertaining to BMS's work with MCOs on improving screening for this report.

In a prior report, the SME noted that BMS and the OMCFH are assessing the ability to add modifiers within the Medicaid Management Information System (MMIS) to indicate a positive or negative screen, and the timeline and actions steps needed. BMS indicates it will determine the viability of using modifiers in the fall 2021. No new information was submitted for this report.

The SME reviewed the State's CMS Form 416, extracted by the SME from the CMS website, which details EPSDT screening for FY2019. As per CMS 416, the State's screening participant ratios are above 52% for children aged 0-9. However, as with many states, they are significantly lower for older age groups: 50% for those aged 10-14, 42% for those aged 15-18, and 20% for those aged 19-20.

Regarding activities within the HealthCheck program, four activities were noted in the previous report:

- Regarding quality reviews, the SME notes that the last OMCFH report was issued December 2020 (based on 2019 claims); and it anticipates, from prior discussions, that the next report cycle is December 2022 (reporting 2021 claims). Additionally, OMCFH had planned to conduct chart reviews on two subpopulations of children not included in the first report: under 5 and 18-21. No update was provided for this report.
- Regarding efforts to work with primary care to improve mental health screening rates, HealthCheck Program Specialists were meeting with primary care providers about their own provider-specific data; sharing primary care blinded comparison data; and developing heat maps, new SOPs, and information packets about EPSDT and referral sources. No update was provided for this report.
- Regarding quality improvement, OMCFH was developing a broader quality improvement plan would be developed in consultation with primary care providers, stakeholders, and the Pediatric Medical Advisory Board (PMAB), a 28-member workgroup that advises OMCFH on HealthCheck matters. No update was provided for this report.
- Regarding efforts to promote enhanced referrals to the Assessment Pathway, HealthCheck was piloting additional SED specific questions, developed by the State, and informed by the CAFAS, to better help primary care identify children who may have SED for referral to the CSED Waiver. Additionally, at the time of the last report, DHHR was still developing related questions for children under 7 based on the PECFAS. No updates were provided regarding these efforts for this report. No update was provided for this report.

DHHR submitted two other screening related documents that have not yet been discussed with the SME:

- An undated graphic titled Accessing the Children's Crisis and Referral Line (CCRL) and

- Screening Data Plan-Progress Report dated March 11, 2022.

The graphic for accessing the CCRL appears to be a draft of a document intended for medical professionals describing how to make a referral via a new electronic portal for any youth with a behavioral health need. The SME notes that the graphic appears to indicate that all medical professional referrals go to the CCRL as opposed to DHHR's prior plan described in the August 2021 report to separate the referral locations based on whether a child may have had SED or not.

Regarding the Screening Data Plan-Progress Report dated March 11, 2022, the document summarizes a series of internal steps to collect screening data across bureaus, as recommended by the SME in previous reports.

- Specific to Health Check mental health screening data collection, the draft document indicates that as of March 10, 2022, access to OMCFH's database for the Office of Quality Assurance analyst is in-process and that additional OMCFH indicators and the process for their collection was under discussion.
- Specific to BSS mental health screening data collection, a meeting was held on March 2, 2022 to discuss the needed screening data and the process to gather and monthly share with the Office of Quality Assurance. Implementation is planned to begin April 1. A BSS-specific SOP is forthcoming. The SME notes that this document also referenced that YS uses the FAST and that CPS uses the Ongoing Assessment.
- Specific to BJS mental health screening data collection, the progress report noted that BJS provided MAYSI-2 data for January 2022 and that a discussion occurred March 7 to review the data and analysis.
- Specific to DPS, the document notes a meeting was held February 28 to discuss the DPS web-based collection of MAYSI-2 data and that DPS policy requiring MAYSI-2 screening took effect March 1, 2022. Data will be provided monthly to the Office of Quality Assurance monthly beginning April 15, 2022.

The progress report indicated that the Office of Quality Assurance would create reports based on the data; however, the State neither provided any details regarding the report or timeline for production nor discussed it with the SME.

Recommendations

1. In the August 2021 report, the SME recommended that DHHR develop a written plan and implement a process to monitor DHHR staff compliance with screening policies, including what data will be collected and how that data will drive DHHR actions to improve quality and compliance. The SME requests screening data be reported, including clarity on the timelines when reporting will begin. The SME reiterates this recommendation and further recommends scaling these types of efforts across all bureaus/departments with coordination in approach and consistency in data collection, analysis, and reporting. The SME notes that the document submitted for review, *Screening Data-Progress Report*, addresses several prior recommendations. The SME recommends that updates to the screening-specific data plan include who is responsible for review once the Office of Quality Assurance generates data, the frequency of that review, and plans to monitor staff compliance. The SME also notes that the *Continuous Quality Improvement Plan – Proposed Key Performance Indicator (KPI) Tables (Working Document)* Table 1 includes

measures related to screening but lacks information on (1) frequency of review, (2) who is responsible for review, (3) and guidance for review that ensure a consistent standard across all bureaus for all children.

2. Regarding the Ongoing Assessment screening tool used by BSS's CPS units, the SME requests to review the Ongoing Assessment tool used by CPS to screen for mental health needs, and to discuss with DHHR whether the tool is a recognized mental health screening tool with data to demonstrate its reliability and validity or whether it is a tool developed by BSS. Consistent with Agreement Requirement 31, *DHHR shall adopt a standardized set of mental health screening tools for use to identifying who may be in the target population*. The SME recommends that every mental health screening tool used by DHHR be a recognized tool for the purpose of screening for mental health needs with demonstrated reliability and validity for the population it is screening.
3. The SME requests to review the two job aids specific to the mental health screening questions mentioned in the training curriculum. We recommend that any job aid supporting workers to identify children with behavioral health benefits be required for training purposes and that supervision and ongoing quality oversight ensure that workers are consistently and correctly using the job aids.
4. The SME notes the three BSS documents were submitted for this report but the SME and DHHR have not yet discussed these documents. The SME recommends that DHHR clarify if these documents are drafts or have been implemented. If they have been implemented, we request feedback from any participants, plans for revisions based on that feedback, next steps for how materials will be used, and how quality oversight and monitoring is occurring or will occur. The SME is interested to learn the processes by which DHHR considers adding content not yet addressed.
5. Additionally, regarding the training reference to CMCR, the SME recommends that the documents be revised to correct the error. If training has already occurred, the SME recommends that additional information specific to CMCR be provided as follow-up to those trained.
6. The SME requests that DHHR clarify if document titled *Detention Referrals to Children with Serious Emotional Disorder (CSED) Waiver Standard Operating Procedure (SOP)* dated 2/24/22 is an internal DJS SOP or if it is a document for a different purpose; and clarify the referenced BJS protocol that is forthcoming.
7. The SME recommends that DHHR submit information related to how DOE is carrying out mental health screening and what, if any, data is available.
8. The SME recommends that DPS provide information on how it ensures that staff review the MAYSI training manual and seek clarity to their questions on administering the MAYSI, as well as collection of data on its use, and processes to ensure that children who screen positive are timely connected to HCBS.

9. The SME recommends that BMS submit information prior to the next SME report regarding all BMS related screening activities and data, including its efforts with its MCOs to improve mental health screening data. Additionally, the SME seeks an update on BMS plans to implement a modifier attached to screening codes.
10. The SME recommends that OCMFH submit information prior to the next SME report regarding its screening activities including implementation of the new screening questions, quality improvement activities and development of a quality plan, and plans for additional quality record reviews, including analysis of 0-5 and 18-21 populations. Additionally, the SME requests clarification if all medical professional referrals are now made to the CCRL as the Assessment Pathway graphic appears to indicate; and if that is a draft, or already implemented.
11. The SME recommends that screening workgroup activities and outreach and education workgroup activities be coordinated, particularly given the Agreement requirement to “(1) conduct outreach to and training for physicians who serve children who are Medicaid-eligible on the use of the screening tools; (2) develop outreach tools for medical professionals who treat Medicaid-eligible children.”
12. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, including related CQI measures and processes.

Children’s Mobile Crisis Response

Agreement Requirements: The Agreement requires the State to develop Children’s Mobile Crisis Response (CMCR) statewide for all children, regardless of eligibility, to prevent unnecessary acute care. The CMCR must operate 24/7, via a toll-free number, and must have plans to respond to crises by telephone or in-person and to report data related to timeliness of response and families’ engagement in HCBS following a crisis.

Activities

CMCR services are funded by BBH and through the CSED Waiver. BBH and BMS have been working to minimize the differences between the two funders’ expectations for CMCR to ensure a seamless service. One area that the State has focused on for this consistency across funders is a common CMCR provider manual. In September 2021, the SME received and commented on a draft CMCR manual that would apply to both BBH and BMS funded services; we noted that it was a well-written manual, consistent with national best practices for CMCR services. The SME comments in response recommended greater clarity regarding who could access the services, inclusion of Agreement requirements 30a-d in the data,¹¹ and clarity regarding the relationship between the CMCR service and

¹¹ At a minimum, the implementation plan will contain: a. Criteria for how the hotline staff will assist with immediate stabilizations; b. Requirements that hotline staff have access to needed information regarding the child and family when the family provides consent (including any existing crisis plans and the Individualized Service Plan); c. Guidelines for hotline staff to assess the crisis to determine whether it is appropriate to resolve the crisis through a phone intervention or a face-to-face intervention; d. A requirement that each region of the

the Children’s Crisis and Referral Line. A second draft dated February 2022 was shared with the SME for this report. The SME notes that most of the SME recommendations were included or addressed, including inclusion of Agreement requirements 30a-d.

CMCR is supported by a statewide call center called the Children’s Crisis and Referral Line (CCRL) which is part of a broader West Virginia call center system focused on various public and behavioral health issues (e.g., gambling), with a dedicated line and staff specific to child and family issues. This statewide number provides triage and warm hand-offs to local CMCR service providers for youth and families calling with a self-identified behavioral health crisis, and resource and referral information for non-urgent behavioral health needs. A document titled CCRL-DHHR Grant Agreement was submitted for this report. It is the State’s contract with the First Choice, the vendor for the CCRL. The SME notes that contract language requires 24/7 availability of qualified and trained staff, clinical supervisor availability, and requirements specific to call response, handling of crisis calls and warm transfer to the CMCR providers, and performance and outcome measures and administrative data.

A document titled Children’s Crisis and Referral Line Data Update January-December 2021 was submitted for this report. The report indicates that the CCRL has received a total of 408 calls, approximately 34 a month, with at least one call from 45 of West Virginia’s 55 counties. Data reported included referral source, showing 33% were family/friend, nearly 24% from a website (website not indicated), nearly 13% from a mental health professional, and almost 2% from a medical professional. Twenty-five percent of the referral sources were not identified, and a small number of other categories were captured including legal, billboard, poster, and public event. In terms of the methods used, 85% of the contacts came via call and 15% came via text or chat functions. The listed need for the call varied including referrals, peer/warm line access.

The document acknowledges that the 2021 data reflects data prior to the Assessment Pathway being established, and therefore CCRL data does not yet include CSED waiver or other referrals that will be available in subsequent data. Data indicates that tracking of warm transfers to CMCR providers began in May 2021. Warm transfer is when CCRL staff remain on the line until a live connection is made with the CMCR provider and introductions are completed. Forty-one percent of calls were connected to CMCR, 1% with 911 emergency services, 1% with crisis stabilization units, 1% with short- or long-term treatment, leaving 56% of the calls addressed by the CCRL provider directly. The document also reported response time for those warm transfers (44% occurring in under 1 minutes, 18% occurring within 1-5 minutes, 9% unable to reach CMCR provider, and 29% with no indicated data), and DHHR’s own assessment of areas for response time improvement. This document also notes plans to expand the CCRLs reach to underserved populations including lesbian, gay, bisexual, transgender, questioning, and other youth (LGBTQ+) and black, indigenous, and people of color (BIPOC).

An Excel spreadsheet titled CCRL Outreach Inventory July-December 2021 was shared with the SME for inclusion in this report. It tracks dates, areas of the state, events, and numbers of persons reached to inform people about the availability of the CCRL. The document lists monthly efforts July-December

state has sufficient crisis Response Team(s) to serve the entire region and to respond face-to-face to a call within an average time of one hour

to inform people about the availability of the CCRL, from displays and presence of staff at in-person events to mailing of information.

The SME also received a copy of an email titled CCRL Outreach Annual Plan FirstChoice February 2022. The email is to the CEO of FirstChoice, and after communication with the State, the SME learned it refers to a contract spanning September 2021 through September 2022. The SME notes the email lists planned dollar investments for specific outreach methods such as billboard ads, conference exhibit fees, and social media costs.

Recommendations

1. Regarding DHHR’s contract with First Choice vendor, the SME notes that many Agreement requirements are addressed in the contract language. As DHHR prepares for the compliance review of this service in Fall 2022 (as described on page 2), the SME recommends that CCRL operational policies be provided for compliance review to demonstrate consistent compliance with Agreement provisions, as well as documentation about how BBH monitors and oversees those CCRL requirements. As one example, the contract does include language requiring the vendor to have clinical personnel available, but it does not specifically state the Agreement requirement 29¹² that callers will be connected to a trained mental health professional with expertise or competency-based training in working with children in crisis. However, the State has indicated that the connection would be to mobile response and stabilization team personnel who are specifically trained mental health professionals with clinical supervision. Additionally, CCRL operational policies will be particularly important for demonstrating compliance of Agreement requirements 30¹³ for the CCRL including call line guidelines, access to information data and reporting. Discussions with the SME to date have indicated that the CCRL vendor is following these Agreement requirements; as such, the SME looks forward to reviewing operational documents demonstrating compliance.
2. Regarding the CCRL outreach, the SME acknowledges the efforts by the vendor to increase awareness of the CCRL. The SME notes that the CCRL is part of a broader Help4WV call center system. The SME recognizes that the vendor is likely educating the public regarding all of the available call lines, including the CCRL. The SME supports including CCRL in that broader effort. Noting that some locations for the outreach are not specific to children, adolescents, and families, the SME recommends that BBH monitor outreach and engagement activities to ensure that efforts to inform families about the CCRL specifically are included at each event, with particular focus on those likely to reach or include children, youth, young adults, and their

¹² “29. C[MCR] shall be available to all children, regardless of eligibility, to prevent unnecessary institutionalization of children with serious mental health crises. C[MCR] shall provide toll-free crisis hotline services and Crisis Response Teams that are available throughout the state and staffed 24-hours per day, seven days per week. Callers will be directly connected to a trained mental health professional with experience or competency-based training in working with children in crisis.”

¹³ See footnote 11 above for the text of requirement 30a–d. Requirement 30e states “At a minimum the implementation plan will contain . . . data collection to assess and improve the quality of crisis response, including the timeliness of the crisis response and subsequent intake process, and effectiveness of engaging families in home and community based services following the crisis.”

families. Additionally, the SME recommends that these outreach efforts be coordinated with the Outreach and Education workgroup.

3. Specific to the document showing data from January-December 2021, the SME acknowledges efforts consistent with our prior SME recommendation to more clearly quantify activities and that that the data reflected pre-dates the implementation of the assessment pathway. Beginning in May 2021, BBH instituted CCRL reporting changes to enhance the data reported. The SME also acknowledges DHHR's self-assessment in the report regarding challenges and areas for improvement, such as increasing referrals from medical professionals to the assessment pathway. The SME recommends:
 - a. Continued assessment and monitoring of county-level data, particularly as some counties are not yet using the service. It will be important to determine if some counties are unaware of the CCRL, or if they continue to use historically available crisis resources such as the ED. In addition, we anticipate that some counties may be calling the CMCR provider directly.
 - b. Continued efforts to diversify referral sources and deepen referrals from key groups such as mental health professionals and pediatric primary care providers. Given the role of the judicial system, it will also be important to increase referrals from judges and the judicial system, including probation services.
 - c. Continue to improve completion rate of data, noting that during a crisis call, it is clinically appropriate to not focus on the collection of administrative data; therefore, some data will continue to be missing in any data set. DHHR will need to ensure that the vendor has policies and training in place that address these issues.
 - d. Many warm transfers between the CCRL and the CMCR provider occur quickly; but DHHR's own review note calls that did not occur or waits that were longer than expected. The SME recommends that the vendor have a clear operational policy for handling those situations and that BBH detail how it is addressing situations in which the CMCR was not available to the CCRL in a timely way.
 - e. The SME looks forward to learning more about DHHR's planned enhancements to better serve the LGBTQ+ and BIPOC children and families.
 - f. The SME recommends that BBH continue to monitor regional variation, and through its CQI processes, address any variations.
4. The SME commends the inclusion of text and chat features for the CCRL line and encourages BBH to continue to monitor their use. Additionally, the SME recommends that BBH ensure its vendor has clear operational policies specifically addressing text/chat scenarios they may encounter given that less information is sometimes known about those individuals and that warm transfers can be hindered in those instances. Specifically, the SME recommends that

BBH establish a protocol by which an individual could be transferred to the phone from chat if the individual opts to do so.

5. The SME acknowledges the work by BBH and BMS to develop a common CMCR provider manual and acknowledges DHHR's intent to develop a coordinated report. Consistent with prior SME recommendations, the SME recommends that BBH and BMS coordinate their reporting for CMCR services utilization by region, length of CMCR engagement, and presenting needs, with additional stratification by age and other factors.
6. As recommended in the August 2021 SME report, the SME requested the training plan, proposed timeline, approach, and training content for the CMCR service. The SME recommends CMCR training include an overview of all DOJ Agreement services and all other behavioral health services funded by DHHR; how CMCR services work with other services, schools, BSS caseworkers, MCOs/ASO, and the FirstChoice crisis and referral line; use of any standardized tools such as the CANS, CAFAS/PECFAS, the Crisis Assessment Tool (CAT), etc.; expected outreach and education efforts; and required quality, outcomes, and data reporting.
7. As indicated in the August 2021 SME report, in addition to the statewide, standardized training for CMCR that will be provided through Marshall University. In addition to the required training from Marshall University, current scopes of work require each CMCR provider agency to offer its own training. If there are training requirements that DHHR has for agencies apart from completion of the statewide Marshall University training, the SME recommends that the State review and approve the training content(s) offered by each provider agency to ensure it is of sufficient quality and consistent with the State's goals in providing CMCR. Although this step would add to the administrative burden for State staff, it would ensure consistency in training elements across the State and expedite the introduction of new materials or competencies that the State deems necessary.
8. As recommended in the August 2021 SME report, consistent with other data recommendations in this report, the SME recommends that the State incorporate CMCR data into its other workgroups to inform interconnected tasks and decision points, such as the assessment pathway work, redirection from residential interventions, and coordination with Wraparound.
9. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, including related CQI measures and processes.

Behavioral Support Services

Agreement Requirements: The Agreement requires the State to implement statewide Behavioral Support Services, which include mental and behavioral health assessments, the development and implementation of a positive behavioral support plan as part of the individualized treatment plan, modeling for the family and other caregivers on how to implement the behavioral support plan, and skill-building services.

Activities

The State has envisioned behavioral support services as both a service to be delivered to eligible youth, and as a philosophy for how providers engage and deliver other services (e.g., Wraparound, in-home therapy) to youth and their families.

As mentioned in prior reports, BBH has engaged two different contractors to support the work of behavioral support services:

1. West Virginia University (WVU) Center for Excellence in Disabilities (CED) Positive Behavior Support (PBS) Program is contracted to provide PBS services directly to children; and provide consultations to providers of other services on how to incorporate a behavioral support plan into their services (e.g., outpatient, Wraparound, CMCR).
2. Concord University is contracted to develop the Collaborative Center for Positive Behavioral Support Education Program to provide comprehensive workforce training and coaching on PBS approaches, and coordination of certification for providers.

Regarding the work of the CED, no new data regarding direct services provided or consultations to other providers was submitted for this report. The most recent PBS data can be found in the DHHR's semi-annual report,¹⁴ which reports data from July 2020-June 2021. This data is specific to services provided by WVU's CED program. The number of children served monthly has increased to 41 youth in June 2021 when compared to 21 youth served July 2020. The average number of interactions per child has been steady, with between four and six interactions per child per month, except for November 2020.

Regarding the work with Concord University (CU), meeting minutes submitted to the SME for this report from the DHHR DOJ HCBS internal workgroup meeting on February 28, 2022, indicate that CU's work had yet to begin due to the State grant process. Funds were approved July 1, 2021, and the grant was finalized in January 2022. A document titled "Concord University Coordinator of the Collaborative Center for Positive Behavior Health (PBS) Training Plan" was submitted to the SME, which outlines CU's key activities from April 2022 through January 2023. This document indicates that from April-July 2022, CU will focus on building infrastructure to provide training and certification including the hiring of CU personnel, transferring of some responsibilities from WVU PBS to CU regarding its prior workforce endorsement process, building its planned infrastructure to provide workforce certification, and developing an online platform to deliver training. Beginning in August 2022, certification training will begin, with additional training content added through January 2023. Additionally, meeting minutes indicate that WVU is in the process of hiring five (5) contract-supported personnel.

Regarding DHHR's efforts to add modifiers to existing Medicaid billing codes to clearly identify or differentiate and track behavioral support services from other similar services already available in the State plan, the meeting minutes indicate that the regulations (*Chapter 503*) are drafted, but that BMS has not yet been able to release the regulations for the 30-day public comment period as rules cannot

¹⁴ https://childwelfare.wv.gov/initiatives/SiteAssets/Pages/DOJ-Agreement/WVDHHR%20Semi-Annual%20Report_FINAL%2020220131.pdf

be released during the legislative session, which ended Saturday, March 12, 2022. Meeting minutes do not indicate how soon after the legislative session *Chapter 503* will be posted for public comment. Additionally, meeting minutes indicate that the modifier codes and rates are built into the Medicaid Management Information System (MMIS) system and can be activated when the regulation is approved, which is anticipated no later than July 1, 2022.

Recommendations

1. The SME notes that the semi-annual report indicated that currently behavioral support services is accessed “as a result of referrals from other organizations.”¹⁵ As recommended in the August 2021 SME report, the SME recommended but has not yet received information regarding how the assessment pathway clarifies connection to behavioral support services, both for youth who may and those who may not meet CSED Waiver eligibility in order to ensure timely access, including how families, schools, behavioral health providers, courts/judges, and staff from all three bureaus can access the service.
2. The SME notes that the semi-annual report indicates that there has been a waitlist (as of January 2022, 12 youth) for CED services and a process to prioritize access to the service for those waitlisted. The SME appreciates the transparency regarding the waitlist. Given the current waitlist, the SME recommends that a protocol be established that would include the offer to consult with a waitlisted child’s current provider to help the provider develop a plan, and that any child waiting for behavioral support services be referred to a non-CED provider that is already providing these services under Medicaid.
3. The SME recognizes that the reported utilization of behavioral support services is based on services provided by the WVU CED contract and that any behavioral support services provided through Medicaid are not yet captured. As requested in the August 2021 SME report, the SME recommended but has not yet received a draft of the behavioral support services’ specific changes to the provider billing manual to allow for discussion and incorporation of any SME comments before it is finalized.
4. The SME notes that CU’s contract runs until March 14, 2023. The State has indicated that CU will receive a new grant beginning March 2023. The SME requests that a revised training plan for the full 2023 year be submitted for review and discussion. Additionally, the SME requests access to the online training platform to review the actual curricula.
5. As noted in the August 2021 SME report, the behavioral support services vendor uses a “Risk of Out of Home Placement” with rankings from 1-10 for each redacted child. In the follow-up query to DHHR, the SME was informed that this ranking is the response to a question posed to families in which they self-identify their perceived risk. The SME seeks to understand if information of a family’s perceived risk is being used for other purposes, and how it will relate to the use of the CAFAS/PECFAS and criteria for CSED Waiver eligibility, if at all. Engaging families to rate their perceived need is a helpful measure to re-administer over time; the SME

¹⁵ Semi-annual report, link, pg 46

is seeking to confirm that this question has no broader implications for access to CSED waiver or other services.

6. The SME notes that the State's Assessment Pathway and CQI plan include tracking referrals from schools. This element is particularly important as it connects an earlier finding from Marshall University's West Virginia Wraparound Review report which noted that 51% of referrals were from schools. We look forward to reviewing data further connecting these findings in future report cycles.
7. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, and CQI measures and processes.

Therapeutic Foster Care (TFC)

Agreement Requirements: The Agreement requires the State to develop therapeutic foster family homes and provider capacity in all regions and ensure that children who need therapeutic foster care are placed in a timely fashion with trained foster parents, ideally in their home community.

Activities

West Virginia continues to develop its proposed model for TFC and identify how it will secure providers to deliver TFC services.

[H.B. 4092](#), which took effect June 5, 2020, expands the State's foster care system to provide higher payments for "foster parents providing care to, and child placing agencies providing services to, foster children who have severe emotional, behavioral, or intellectual problems or disabilities, with particular emphasis upon removing children in congregate care and placing them with suitable foster parents."

As noted previously, BSS has a contract with KEPRO to authorize certain services, including TFC and out-of-state residential interventions, and has established policies and processes for the oversight of TFC placements. Additionally, the State has identified its intention to establish a future policy by which providers will not be able to move children between treatment foster care homes independently to manage their own contracted homes, but only in conjunction with BSS after review of what is in the best interests of the child.

The SME has provided considerable technical assistance to the TFC workgroup, including the following during this reporting period:

- Multiple conversations regarding how TFC is defined within the broader benefit array to ensure differentiation across services and levels of need/intensity;
- Review and feedback on the proposed approach to TFC, including the model, criteria for enrollment, process for aligning with other services, reimbursement models, and more;
- Detailed input on the target population definitions and pathways to enrollment, including initial eligibility and continued stay and discharge criteria;
- Exploration of how to differentiate foster care and TFC both historically and going forward;

- Preliminary feedback on the proposed Stabilization and Treatment Home (STAT) model and Standard Operating Procedure

BSS is striving to distinguish traditional foster homes from TFC homes and from homes serving children with medical complexity. The proposed TFC model includes assessments that are reviewed to determine eligibility for TFC, including behavioral health assessments (e.g., CANS and CAFAS); psychosocial summary; educational documentation, including special education services; existing plans of care or treatment plans, etc. Additionally, the model includes draft performance measures and clarification of roles and expectations for TFC providers. It further details the services funded by BSS child welfare and differentiates them from those provided in the CSED Waiver which is funded via BMS.

The State issued a Therapeutic Foster Care (Treatment Home) SOP in February 2022, which was updated in March 2022 with a Therapeutic Foster Care (Stabilization and Treatment Home) SOP. This model is designed to be implemented alongside the current tiered model of foster care. The State has defined a STAT home as a family alternative to residential placement for children requiring a behavioral health intervention. DHHR reported that the adoption of the name STAT Home was the result of input from Child Placing Agencies (CPAs), which occurred over the course of bi-weekly meetings held from January 7-March 4, 2022. The name is meant to convey that the STAT home is a short-term, stabilizing intervention, with a goal of the child returning home or to another family setting.

Children and youth served in the three tiers of foster care will be evaluated for STAT home eligibility if there is a “disruption.” This model makes slight updates to the definition of eligible STAT home participants. Children and youth are eligible if they meet all of the following criteria:

- Age 4 through 20;
- In state custody;
- Approved CSED Waiver participant;
- Cannot be safely served in their own (or kinship) home and require a STAT Home setting to receive behavioral health interventions; and
- Not an immediate danger to others or self, or a habitual flight risk which cannot be safely addressed through a safety plan/flight risk plan.

The most updated SOP provides a scenario for how children may enter a STAT home after receiving services in a RMHTF.

BSS has developed a proposed rate of \$220 per day for its STAT homes. Of that, \$135 would be allocated to the provider to reimburse them for oversight and supervisory activities, training, data collection, and general services to support and retain the foster family. The remaining \$85/day would go directly to the STAT Home Family to cover treatment support (participation in meetings, training, and other treatment-oriented appointments) and room and board. This is an increase of \$54 per day above the current highest rate paid to traditional foster families (serving youth 13-21). The BSS rate is a flat rate regardless of the age of the child (versus the tiered rate structure for families in traditional foster care).

BSS has outlined training requirements for STAT homes, including content on working with children with exceptional needs, PBS, working with primary families, and more. The CPAs are expected to provide or facilitate access to trainings on medication administration; Trauma Systems Therapy; LGBTQ+ children and youth; sexual development and pregnancy prevention; and advanced crisis prevention, intervention, and de-escalation. In addition to these pre-service requirements, STAT homes will be required to complete 18 hours of in-service training annually, which is 6 hours more than is required for traditional foster homes.

DHHR intends to develop STAT home provider contracts beginning in March 2022, with training scheduled to be completed on the new model by April 2022, after which the agency will collaborate with CPAs to phase-in the new model. The same month, DHHR plans to identify key performance indicators, initiate monthly reporting, and conduct a capacity review of its STAT homes. DHHR intends to collaborate with youth and families receiving STAT home services to evaluate performance in December 2022.

Recommendations

1. Per prior SME reports, the SME recognizes that the State and DOJ are discussing differences in the interpretation of which children are required to be provided TFC services under the terms of the Agreement: whether it is all children in the target population or a subset who are in foster care. The SME has recommended that children, regardless of foster care status, can benefit from therapeutic foster care, especially as an alternative to other out-of-home placement settings.
2. The SME recommends that the State further differentiate STAT homes from traditional foster care homes and homes for children with medical complexity.
 - a. The current STAT Homes SOP has no mention of children with medical complexity. If these children are served in other homes, this should be noted.
 - b. The SME continues to recommend clarification of the difference between Foster Care Tier III and STAT homes. In particular, the SME recommends:
 - i. Detailing when and why a youth would move from a Tier III home to a STAT home, as well as when a youth would move from a Tier II home to a Tier III home versus a STAT home; and
 - ii. Clarifying if there are any training or rate differences between Tier III and STAT homes.
 - c. The SME recommends that DHHR develop and implement a compliance and CQI process to explore which children are served in Tier II, Tier III, and STAT homes and explore differences in demographics, presentation at time of placement, and initial and long-term outcomes among these youth.
3. The SME appreciates that DHHR has integrated language about “managed” versus “unmanaged” behavioral health needs, as it reflects current presentation versus diagnosis or

history of the youth. The SME recommends that DHHR continue to utilize this language in working with CPAs and STAT homes.

4. Some children with complex medical needs may require additional behavioral support from the providers while others may not. The State has indicated that children who meet the specialized family home criteria may also be eligible for additional behavioral health services. The SME recommends that the State explore how different homes for children with medical complexity may look, the requirements and expectations of those providers, and when a child can be served in which environment. The length of stay of the child may also vary, depending on whether the child's admission into that specialized home is driven by medical needs, behavioral needs, or a combination; or if the admission is driven by judicial decisions.
5. The SME continues to recommend that the State develop a clear implementation plan for the phasing in of the new STAT model. The SME commends DHHR for its interest in rapidly implementing the STAT home model. Although the State has indicated the model will phase in and adjusted iteratively as it is implemented, the swift sequencing of activities is likely to limit or highly pressure each iteration as there is little time to incorporate feedback and adjust.
 - a. It seems unlikely that the provider contracts could be completed by the end of March and all training completed by the end of April 2022, with phase-in beginning in April. The STAT Home SOP is still in draft format and the provider capacity review has not yet started. The SME strongly suggests that DHHR re-evaluate its timeline for STAT Home Model Implementation to account for the existing workload of DHHR staff and CPA agencies, the need to recruit STAT home families, and the documented challenges facing WV related to the pandemic and workforce shortages.
 - b. The SME recommends that this plan prioritize minimizing disruptions to children who currently are in TFC homes but may not meet the criteria under the new TFC model. (The State notes that there is no expected disruption for children who are successful in their current home.) It may cause more trauma and harm to children to change living arrangements suddenly than to create a thoughtful approach to transitioning that is focused on implementation of the child's permanency plan. Specifically, a plan to implement STAT homes will need to assess and monitor capacity, with an accounting of currently placed children's planned length of stay so the State will understand when existing capacity could be available and the timing of new TFC homes that may be available.
 - c. The SME recommends DHHR define what is meant by "should there be a disruption" in its STAT Home SOP Draft of March 2022. Scenario 2 and Appendix B detail this further, but the term "disruption" is unclear in its meaning. It also suggests a reactive approach. The SME recommends DHHR identify a proactive review process during the transition to the use of STAT homes to ensure that children currently in traditional foster care can gain access to a STAT home prior to needs escalating to the level of an RMHTF. The SME recommends DHHR outline examples of what this could look like and

why a prolonged need for intensive interventions (Appendix 2) would necessitate a STAT Home.

- d. Providers will need to be supported during this transition plan. The SME recommends the State work closely with the provider community and identify key champions that will assist with the direct messaging to CPAs and, most importantly, to the TFC families. It will be critical to emphasize that the TFC families have been doing what was asked of them, they are valued, their efforts are valuable, and more, and that it is the *State* that is revising and clarifying its expectations and requirements to ensure that children are in the least restrictive setting possible while receiving treatment interventions.
 - e. The SME continues to recommend the State expect it to be challenging for TFC caregivers to have a child leave their care when they no longer meet that level of need for TFC; this is an area where support should be given.
 - f. The State has indicated that the rate for the new model will not change from the current model. The SME notes that the STAT model includes additional expectations and as such requests the State's rationale for not differentiating its rate from the rate of other homes, including any anticipated difficulties recruiting and retaining families if the rate remains the same.
6. The SME encourages the State to meaningfully engage families and youth in this model development, refinement, and ongoing implementation.
- a. The SME appreciates that WV Foster Adoptive & Kinship Parents Network (WVFAKPN) submitted a series of questions and recommendations about the new treatment home approach in January 2022. The SME recommends DHHR provide responses to each of the questions and recommendations, which could include responding to specific questions, identifying where a concern or suggestion has been addressed or noted for future consideration, or is not being addressed at this time. Communication with families and youth must be bi-directional and ongoing to be genuine and meaningful.

The SME continues to recommend that biological, kinship, and foster families *and* youth should share their experiences, including what it looks like when TFC families and agencies are partnering and helpful. They should share recommendations for what can be harmful or result in challenges to engagement and partnership. The SME recommends identifying some families and youth involved with foster care and some TFC parents to co-develop tip sheets about what works and what does not work and include them as co-trainers in the STAT home training.

- b. The SME continues to recommend the State utilize resources from the HHS Children's Bureau's National Quality Improvement Center on Family-Centered Reunification (<https://qicfamilyreunification.org/>), including its best practices guide, to help identify strategies to support effective treatment and reunification.
- c. The SME encourages the State to identify families with lived experience, youth or young adults currently or formerly involved with foster care, and TFC parents to

provide input on the model and its implementation, both initially and on an ongoing basis. The SME encourages the State to compensate the families and youth financially for their participation.

7. The SME appreciates the work that the State has done to detail the roles and functions across BSS, CPAs, TFC parents, the ASO, and behavioral health providers, but more remains to be done.
 - a. The SME notes that the State has engaged the CPA providers to offer feedback on the proposed model. The State should continue to listen to CPA and CSED Waiver providers to find out the existing barriers to integrating services and issues with role clarification and develop an intentional training and technical assistance approach to address those issues, including clear, written expectations and review protocols.
 - b. The SME recommends that the State engage in a transparent and ongoing process to obtain feedback on the proposed TFC approach. This will enable the State to adjust both the approach and the associated training and ongoing technical assistance provided. This could include enabling interested providers and other stakeholders to automatically receive alerts that updates have been made to the WV Child Welfare Collaborative website, including news and meeting information.
8. The SME recommends that the State review all assessment pathway materials to ensure that STAT homes are included as an option and further support redirection from residential interventions during the phase-in process and in the future. The SME notes that the State previously asserted that 100 children required TFC because that was the current capacity. The SME recommends that the State review the children in residential care to determine how many may meet eligibility for TFC and determine a pathway to TFC out of residential care whenever possible. The SME notes that there may be children currently in TFC who do not meet clinical and functional eligibility and recommends that the State track capacity as these children reunify with families, otherwise achieve permanency, or leave these homes.
9. The SME acknowledges the work that the State has done to-date on outlining performance and outcome measures. However, the SME recommends the State create a detailed plan for how it will collect, review, analyze, and report on timely access to TFC, per the terms of the Agreement.
 - a. The SME encourages the State to align this monitoring and reporting process with the other processes under the Agreement, as well as with reporting necessary for the Family First Prevention Services Act implementation. The SME encourages the State to watch for any concerning trends, particularly regarding psychiatric emergency department use and hospitalizations, residential interventions, re-entry into foster care, and entry into the juvenile justice system.
 - b. The SME encourages the State to develop consistent definitions of terms, numerators, and denominators, to ensure transparency and accuracy in data collection and reporting.

10. The SME appreciates the work that DHHR has done to outline the training requirements and support needed for STAT homes.
 - a. The SME recommends that DHHR consider how the identified STAT Home Training differs from what is provided to all foster families. The SME understands that PRIDE training is used for all foster families but encourages DHHR to include training specific to the needs of youth served by STAT homes. PRIDE trainings are important but not necessarily specific to the needs of youth in STAT homes.
 - b. The SME notes that BSS is requiring that CPAs provide advanced trauma informed trainings for all STAT homes. The SME commends BSS inclusion of advanced trauma responsive care and services. The SME recommends that DHHR develop a plan to support CPAs, including how it will assess the impact of the training, and any ongoing training needs.
 - c. The SME appreciates that DHHR intends to complete a compliance review of training completion by STAT homes, that the ASO will review the CPA performance indicators and interview STAT homes, and that DHHR will provide STAT homes with an annual survey on whether their training and other needs are being met. However, the SME continues to recommend that the State incorporate an evaluation methodology to assess whether its training is effective in assisting STAT parents in acquiring, retaining, and utilizing the skills necessary to maintain children in their STAT home and transition successfully to a family home. This could involve the use of pre- and post-training assessments of knowledge and skill acquisition, as well as follow-up assessments 3-6 months after completion of training.
11. The SME recommends that the State conduct a needs assessment that includes agency and organizational factors that may bolster or hinder training and coaching at DHHR, the ASO, and the CPAs, such as staffing needed for training and supervision; the recruitment and retention of foster parents willing to meet training standards; the infrastructure needs to maintain training and coaching, including whether such a program would be State-led or if the State would rely on an outside purveyor to develop training materials; and development of a monitoring and evaluation plan.
12. The role, functions, and expectations of the DHHR's ASO, KEPRO, who contractually provides oversight for TFC, may need further refinement based on the final model determined, clarifications of functions and roles, oversight expectations, and data collection and reporting. The SME recommends that DHHR provide written guidance to its ASO on all functions it is expected to perform on behalf of the State. It is not sufficient to assume that the ASO will monitor these youth; it is necessary for DHHR to specify how it wants KEPRO to monitor youth and the reports it is to receive to support DHHR in overseeing the ASO's monitoring.
13. The SME recognizes that progress on this DOJ Agreement service was slowed because this service is inextricably linked to its broader procurement for its foster care system. With the foster care procurement completed, the SME recommends that DHHR develop a clear, consistent workplan with measurable and actionable goals, each with a clear owner, and firm deadlines to begin implementation of the intended TFC service. Further, several tasks from

previous workplans remain uncompleted and will need to be revised to reflect decisions, including the targeted recruitment and evaluation activities related to TFC. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, including related CQI measures and processes.

Reductions in Placement

Agreement Requirements: The Agreement requires the State to reduce the unnecessary use of residential mental health treatment facilities (RMHTFs) for children relative to the number of children living there on June 1, 2015. The expected goal by December 31, 2022, is a 25% reduction from the number of children living in residential mental health treatment facilities as of June 1, 2015, with additional benchmarks to be established and met over time.¹⁶

Activities

Per the terms of the Agreement, DHHR has committed to reducing the number of children receiving residential interventions. Table 14 below summarizes the June 2015 *Foster Care Placement Report and* calculates the 25% reduction that the State must achieve by December 31, 2022.

TABLE 14. FOSTER CARE PLACEMENT REPORT JUNE 2015¹⁷

Facility Type	Youth in an In-State Facility	Youth in an Out-of-State Facility	Total Youth in Any Residential Placement
Group Care	678	174	852
Psychiatric Facility (short-term)	63	86	149
Psychiatric Facility (long-term)	28	1	29
Parentally-placed in a psychiatric facility**			66 ¹⁸
2015 Totals	769	261	1096
Youth Receiving Residential Interventions With a 25% Reduction by December 31, 2022			822*
Youth Receiving Residential Interventions With a 35% Reduction by December 21, 2024¹⁹			712*

*Rounded to the nearest whole child.

**Specifics for parentally-placed youth in in-state or out-of-state, or short- or long-term facilities in 2015 is not available.

¹⁶As discussed in the SME's December report, the State has proposed reductions for additional years of the Agreement, including a 35% reduction compared to the 2015 date by 2024 and a commitment to propose further goals for reductions beyond the Agreement.

¹⁷<https://dhhr.wv.gov/bcf/Reports/Documents/2015%20June%20Legislative%20Foster%20Care%20Report.pdf>

¹⁸The number of children placed by their parents in psychiatric residential facilities as of June 1, 2015.

¹⁹As discussed in the SME's third reported dated December 2020, the State has proposed reductions for additional years of the Agreement, including a 35% reduction compared to the 2015 date by 2024 and a commitment to propose further goals for reductions beyond the Agreement.

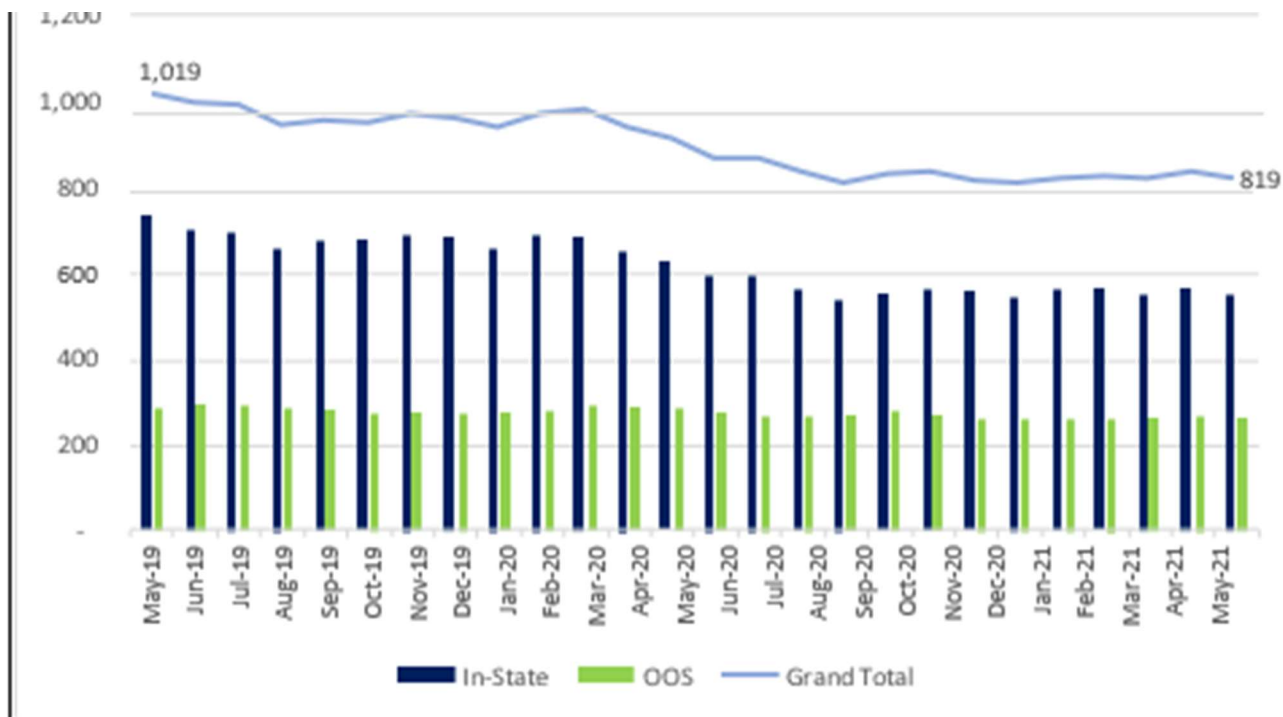
For this report, DHHR provided the SME with the *Children’s Mental Health and Behavioral Health Services Quality Outcomes Report*, published January 31, 2022, for the reporting period of July 2020-June 2021. DHHR reports that its priority focus is to reduce the overall census in RMHTFs and to:

- Ensure children currently placed in RMHTFs are appropriately placed;
- Reduce the average length of stay for children once residential placement occurs; and
- Reduce the number of children placed out of state to allow children to receive treatment closer to their homes and communities.

The data provided do not include any children who are “parentally placed,” which DHHR reports comprise less than 1% of overall placements.

Data from DHHR for the period May 2019 through May 2021 shows that the total number of children served in RMHTFs decreased. Data from DHHRs monthly reports to the state legislature show this trend has continued December 2021.²⁰ During the reporting period, most of the children served were ages 13-17 (79.4%), with 14.8% of children ages 9-12. Almost 6% of children served in an RMHTF during this period were ages 0-8. The majority of children served were male (61%).

FIGURE 1. AVERAGE MONTHLY RMHTF BED UTILIZATION (FIGURE 55 FROM 2022 REPORT)



The utilization of in-state RMHTFs has decreased while out-of-state RMHTF utilization has remained stable during this time.

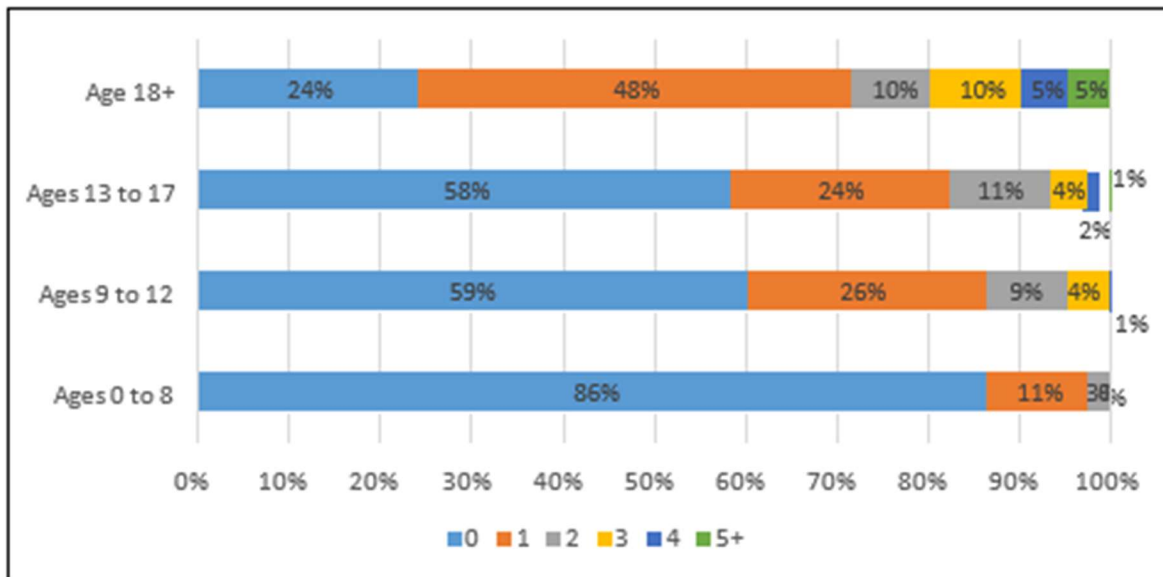
DHHR reports that the average length of stay for RMHTFs is 270 days, or 8.9 months. Short-term acute psychiatric hospitalizations average 62 days, while group residential care averages 298 days and

²⁰<https://dhhr.wv.gov/bcf/Reports/Documents/2022%20January%20Legislative%20Foster%20Care%20Placement%20Report%28Saved%20Versions%29.pdf>. NOTE: these reports do not include parentally placed figures.

psychiatric residential treatment facilities average 294 days. Average lengths of stay are longer for children discharged from out-of-state providers (352 days) compared to in-state providers (244 days).

During the reporting period, 4% of children ages 9-17 and 10% of youth 18+ who were placed in an RMHTF had experienced three prior RMHTF placements; 5% of youth ages 18+ experienced admitted in an RMHTF had experienced five prior RMHTF placements.

FIGURE 2. PRIOR RMHTF PLACEMENTS AMONG YOUTH PLACED IN AN RMHTF FROM JULY 2020-JUNE 2021 (FIGURE 58 IN DHHR 2022 REPORT)



DHHR observes that the statewide capacity for RMHTFs is sufficient to serve the total number of children requiring placements but that the individual needs of children may not always be able to be met in-state.

DHHR has worked to revise its service definition for residential mental health services. Through various revisions and comments offered by the SME, DHHR has developed a draft model that has been discussed with residential providers and anticipates sharing it after it is approved by DHHR’s Executive Steering Committee. This model emphasizes the therapeutic/clinical treatment intent of residential (as opposed to placement) and describes admission, continuing stay, and discharge criteria; program requirements; and standards for practice, engagement of families, and staffing requirements, including role responsibilities and expected staffing ratios. The DHHR Team is planning to include these changes from the model across its residential continuum including PRTF and Group Residential. DHHR has indicated plans to develop a residential Services provider manual in collaboration with Mountain Health Promise (MHP) similar to its efforts with a Wraparound provider manual.

As detailed in prior SME reports, the State contracts with Aetna Better Health to provide MHP, a specialized MCO providing managed care to children in the CSED Waiver and children in foster care. One role of MHP is to authorize medical necessity for in-state residential services. Additionally, a second vendor, KEPRO, authorizes out-of-state residential care (and TFC).

Aetna MHP reported that its Integrated Tiered Care Management Program and several new review processes had gone live in March 2020. Since November 2021, Aetna MHP has been reporting CAFAS scores and other data to DHRR monthly, beginning with CAFAS scores under 90 for children in residential placements. (See Job Aid: CAFAS Score Workflow for Foster Care.) In March 2022, Aetna MHP reported that there were 735 children enrolled in the intensive integrated care management (ICM) program, which includes weekly contact. An additional 1,026 children were enrolled in the supportive ICM, which includes contact every 30 days. The Population Health ICM contact every 90 days) had 25,222 children enrolled.

In the December 2020 SME Report, the SME indicated that the State shared documents for a new process outlining a policy for the review of out-of-state residential placements and requirements for Commissioner-level signoff on out-of-state placements. The policy described a protocol for a Deep Dive workgroup to “*assess the cause of youth spending extended periods of time in a residential (type) environment, explore all alternatives, make recommendations, and follow through as needed to ensure the least restrictive, family-like environment is utilized.*” DHHR provided data from a March 2022 Aetna MHP review of youth, called “deep dive” reviews. DHHR submitted information indicating that 170 special reviews of emergent placement disruptions occurred. In February 2022, Aetna MHP initiated provider-specific reviews, which are monthly provider-specific case presentations to move youth into lower levels of care.

Aetna MHP reported that 38 children have been in an out-of-state residential placement for more than one year and 44 children in an in-state residential placement have had a length of stay for more than one year. Although most youth have experienced a lower length of care,²¹ some youth did move to higher lengths of care and others moved laterally after that one year in an in-state residential placement. One youth went to jail and three went to detention from an out-of-state residential placement of greater than one year. There are 16 youth in out-of-state PRTFs and 10 youth in in-state PRTFs who have had a length of stay for over one year.

Aetna MHP reports that, from March 2020 through January 2022, there was a 14% reduction in re-admission and a 7.2% total reduction of youth in residential care.

In January 2022, DHHR issued a memorandum to all child welfare staff on the release of the Pathway to Children’s Mental Health Services Policy and outline the phased approach to implementation. This memorandum emphasized the role of child welfare staff in screening for mental health needs of children and completing the application for the CSED Waiver. It outlined the staggered rollout of the process as well as the training and start dates among counties and districts. The memorandum noted that only the screening and referral sections of the policy are being implemented; the sections of the policy related to placement in a residential program, the 30-day evaluation process, and the discharge of a child from an RMHTF are not being implemented at this time. The *Awareness and Implementation Plan for Bureau for Social Services (BSS) Staff on the Pathway to Children’s Mental Health Services and Reducing the Reliance on Residential Services* document outlines the process and timeline for providing information to BSS staff, with weekly emails from the BSS Commissioner’s Office beginning February

²¹ The term “lower length of care” is used by Aetna MHP; the SME assumes that this is being used to mean a lower level of restrictiveness of care given the description provided.

2022. Monthly R3 Stakeholders meetings occurred from May 2021 through the beginning of March 2022 with varied topics.

As mentioned in other sections of this report, workgroups have been jointly engaged in the development of an assessment pathway and linkages to all the DOJ Agreement services. Specific to residential services, the workgroup has focused its assessment pathway design in three areas:

- How to connect youth to the assessment pathway when families, judges/courts, providers, or bureau caseworkers are seeking residential services;
- How to connect youth to the assessment pathway when a judge/court orders a youth into a specific residential placement without an assessment; and
- How and when to connect a youth in a residential placement to the assessment pathway proactively in anticipation of their discharge.

DHHR is continuing to work through details for these three scenarios with additional decisions forthcoming.

In collaboration with DHHR, Aetna MHP developed a data tracking spreadsheet for monthly reporting. It is designed to capture information on all children in residential services at any point through the month. Examples of data collected from the 52 columns in the spreadsheet are:

- Reason the individual cannot be served in the community for new placements (drop-down list)
- Date of Clinical Review for Appropriateness for Placement in RMHTF
- Date of Admission to Facility
- Reason for Out-of-State Placement
- Is there a discharge plan?
- Date of Waiver Application
- Primary Discharge Barriers (Drop-Down List)

Questions that remain to be answered prior to implementation of the spreadsheet include: (1) how to handle errors discovered in past records and (2) how to follow-up with youth post-discharge from a residential setting. Additional questions include the contents of some of the drop-down lists as noted in the recommendations below.

Additionally, Aetna MHP is collaborating with DHHR on development of the residential provider manual and on training materials for discharge planning. A draft of the discharge planning materials has been provided along with a draft outline of the provider manual.

The SME received a scope of work executed between DHHR and its vendor KEPRO for a two-month contract (March-April 2022) to conduct level of care assessments for children at risk of residential placement and/or referred for such placement. Two-month activities include:

- Face to face eligibility assessments with the CAFAS and CANS within 30 days;
- Refinement of guidelines for assessments;
- Education, training, and technical assistance to providers, families, and BSS personnel;
- Individualized written reports with recommendations regarding level of care placement;

- Data collection, analysis, and reporting.

The SME received a document from Aetna on its reinvestment of \$11 million to develop and expand intensive community-based services and in-state residential programs. Referred to as Phase 1, these funds have been identified to:

- Expand specialized, small cottage residential care for youth currently out-of-state, with an emphasis on serving youth with Autism Spectrum Disorder, high acuity trauma, and borderline IQ;
- Develop and expand CSED statewide;
- Expand therapeutic foster care; and
- Expand community-based care and aftercare.

The SME has provided assistance to DHHR during this reporting period on best practices in residential interventions and reducing reliance on residential settings, including:

- Presenting a presentation on residential interventions and the continuum of services, including draft staffing standards;
- Sharing outcomes data on youth in residential care;
- Providing examples of medical necessity criteria, referral review protocols, provider requirements, transition planning tools, and flow charts for PRTFs and residential interventions in several other states;
- Developing a brief on treating conduct disorder as a treatable mental health diagnosis;
- Providing information on peer support in residential settings, child welfare, and systems of care;
- Discussing the role of the Family First Prevention Services Act and the requirements for Qualified Residential Treatment Programs/Qualified Individuals to ensure alignment; and
- Providing feedback on the proposed RMHTF model of care, services, and clinical criteria.

Recommendations

1. Regarding recommended action steps from review of available residential placement data, the SME recommends:
 - a. As recommended in prior SME reports, in addition to tracking the required reduction in the number of youth, other data relevant to quality needs to be analyzed, including lengths of stay and repeated admissions or changes in admission facility type during a single episode of care. This data should be stratified by provider, age, race/ethnicity, gender, LGBTQ+ identity, and county of origin. The SME is available to provide technical assistance as DHHR develops new reports, refines existing reports, and implements the child welfare data dashboard. This will facilitate DHHR's ability to establish targets for its future reductions in residential placement, lengths of stay, repeat admissions, and rapid readmissions, all of which are important to achieving positive outcomes for youth.
 - b. As recommended in the SME August 2021 report, the State should collect data on which system children are entering residential interventions from and the decision source of the child's residential placement to identify additional diversion, engagement, and outreach and education strategies needed.

- c. Specific diversion plans should be developed for the two primary sources for residential admissions: judges/courts and BSS MDTs. A sizeable number of children are ordered by a judge/court to a specific placement type, often without a formal behavioral health assessment indicating need for that placement. Additionally, given the role of BSS's Multidisciplinary Teams (MDTs) to determine and secure needed services, including residential interventions, it is important to collect and analyze the number of youth recommended for residential from the MDTs and the rationale for why home- and community-based services cannot meet the child's needs. The goal for both of these system specific diversion plans should be a reform of the entire children's system of care and overall utilization of residential interventions, regardless of the system referring to or paying for the residential placement. Ultimately, data could inform specific strategies with judges/courts, DHHR personnel, MDTs, and external stakeholders. For example, which Judges/court systems are actively working with HCBS services to redirect children from residential; and which MDTs have had higher diversion rates. It is incumbent upon DHHR to have a clearer picture of which children actually need residential interventions. This is critical to not only understand the formal *policies* under which a child may be referred to a RMHTF, but also to discern the informal *practices* through which a child may be referred to an RMHTF. Both policy and practice will need to be addressed, and modified or corrected, if the State is to successfully address the "front door" through which children are first referred to and secondarily authorized for residential care, including out-of-state placements. Once the State has a thorough understanding of the various entry points, and which children tend to follow those pathways, it can be clearer on what it wants and needs to purchase and begin reforming both policy and practice to align with these realities.
- d. As recommended in prior SME reports, the SME recommends that DHHR further explore data to identify disproportionalities in the number of children who are Black, Indigenous, or People of Color in the numbers served in group residential interventions and PRTFs, both in-state and out-of-state. This point is further discussed in recommendations stemming from DHHR's cluster analysis below.
- e. As recommended in prior reports, the SME recommends that DHHR receive and report on data that allows it to understand an unduplicated count of parentally-placed children and each child's length of stay on a monthly basis. While the numbers of parentally-placed youth appear much lower than numbers in 2015, this group of youth is receiving residential services approved and managed by DHHR MCOs, and, their data should be incorporated into the recommended suite of reports and quality oversight activities.
- f. The SME recommends DHHR provide data tables in the semi-annual data reports on residential services to assist with ongoing analysis. The graphs are helpful visual tools but the raw data in charts are important to assess changes in the short- and long-term, and to be able to note areas of progress.

- g. The SME recommends the semi-annual report and any other residential specific data report include diagnostic data along with CANS and CAFAS data.
- 2. Regarding the residential model description, development of a provider manual, and related work with providers, the SME recommends that:
 - a. DHHR develop and/or include in its workplans and implementation plan details regarding when the revised service description and criteria will be finalized;
 - b. DHHR outline the steps it will be taking to implement these changes, including timelines, that address support given to providers to deliver the new model (including training and technical assistance), any revisions to rates or provider qualifications, and its intended quality oversight activities; and,
 - c. The SME notes the DHHR language included in the outline regarding family and youth engagement. The SME encourages DHHRs continued elevation of family and youth engagement to ensure that language continues to be integrated across all materials, including the forthcoming RMHTF transition and discharge planning training and the RMHTF provider manual, emphasizing the central role of the family and youth in all decision making relating to them.
- 3. The SME appreciates that DHHR supported Aetna to reinvest funds to support intensive community-based services and in-state services. However, the SME recommends further discussion between DHHR and the SME on this effort, and that DHHR work with Aetna to:
 - a. Define “specialized” and “small cottage” residential programs and develop clear criteria for children to be served in those settings to ensure that DHHR does not undermine its goal of reducing use of residential placements. If youth are served in these placements, does DHHR expect to reduce capacity elsewhere?
 - b. Identify sustainable approaches to the use of the reinvestment funds. For example, several providers used the incentive funds to hire new staff. The SME would recommend a plan from these providers and Aetna as to how these staff will continue to be maintained.
- 4. The SME was unaware of the work established in the two-month contract with KEPRO to conduct level of care assessments. The State has indicated this work will continue beyond the initial two-month contract, but the second contract has not yet been finalized. The SME requests to receive additional information regarding the process and criteria KEPRO will use to provide level of care assessments, including efforts to partner with Aetna to divert children and gain access to HCBS, all related forms and documents, including KEPRO’s suggested refinements to assessment processes, redacted reports regarding level of care assessments, training materials, and data reports.
- 5. Consistent with prior recommendations, the SME acknowledges prior documents received indicating a policy for BSS Commissioner-level signoff for out-of-state placements, a policy for Aetna’s “deep dive” reviews of children in in-state residential placements, and its accompanying summary of those reviews.

- a. The SME recommends an update be provided on the process for Commissioner level sign-offs for out of state placements, including sharing with the SME any policy and procedure, and lessons learned since the policy was implemented.
 - b. The SME recommends that DHHR review data be reviewed from Aetna's deep dive process and from the Commissioner-level reviews to understand what impact the reviews are having, what action steps are resulting in positive change in placement for a youth, what actions are not resulting in any change, differences across placement, and youth needs. Given that in-state residential placements could also benefit from similar processes, an understanding of what is/is not working for the out-of-state process could support use of effective strategies for in-state placements.
 - c. The SME strongly urges the State to ensure that Aetna MHP's clinical reviews are collaborative with the child, family, and members of the child's team to ensure that plans are not developed for children and families without their input and engagement.
 - d. As a starting point, The SME recommends that DHHR review each child under age 13 placed in an RMHTF to ensure that it is the most appropriate, least restrictive environment for that child.
6. The SME recommends that, as Aetna and DHHR implement the use of the RMHTF spreadsheet, instructions do not tell workers to delete youth from the spreadsheet when they are discharged to the community. The SME recommends that line of data be moved to a different tab on the spreadsheet to preserve the data and assist with continuity of care planning and tracking.
 7. The drop-down list for "Reason Individual Cannot be Served in the Community" be reviewed and revised to ensure alignment with the Agreement. In particular, the SME notes that some of the reasons provided are specific to what a particular provider can offer versus the needs of the youth. A diagnosis or prior behavior is not a reason for a child not to be served in the community (e.g., "aggressive behavior with no community-based supports available to address the need or the needs of the child are beyond the ability of the provider to support." Similarly, reasons that reflect the inability of someone to find an alternative family-based placement are not justification for a placement in an RMHTF (e.g., "Parent is unable or unwilling to care for the child/youth and no alternative family settings is immediately available. Child/youth is a victim of abuse by someone else in the home and no alternative family-based setting is immediately available").
 8. The SME commends the State for its focus on gathering and analyzing new data to guide its policy decisions through the new semi-annual data report, as well as through the prior ad hoc reports it initiated, the cluster analysis, and the provider survey. The SME understands from discussions with DHHR, and as reflected in its work plans, that the State continues to synthesize results from these two ad hoc analyses to determine its policy action steps. The SME recommends that the State conclude with its synthesis, policy planning, and decision-making about action steps, so it can present and share these findings with providers, families and youth, stakeholders, DHHR caseworkers, and other relevant personnel to solicit input and recommendations. Further, the SME recommends that DHHR determine its planned actions steps based on what DHHR learned

from the cluster analysis, provider survey, and discussions with stakeholders and incorporate these lessons into its plan to redirect youth from residential interventions.

9. As DHHR considers next steps resulting from the cluster analysis, the SME continues to recommend the following:
 - a. The report clearly states that the class analysis describes the behavioral health needs of youth and not level of interventions needed. This is an important distinction, and one that the SME recommends the State makes in its action plan resulting from this analysis. DHHR needs to emphasize in its plan a decoupling of intensity of intervention needed from a placement location. The State has a long history of viewing a residential placement as the location to receive intensive interventions. However, intensive interventions can often be provided in the community or a family home; residential placements should not be used unless the child's clinical or behavioral health needs cannot be met in a home- or community-based setting due to the particular intensity or frequency of treatment. As this shift occurs, West Virginia should ensure that emergency shelter placements are not used as a substitute for other residential placements and are accessed solely when it is in the best interest of the child and is the least restrictive, most community-based setting available.
 - b. Given the numbers of youth in all classes that are wards of the State, adjudicated, or deemed status offenders, DHHR will need to develop a plan to work across bureaus and departments to develop specific plans specific to each population of children, including those involved with the Department of Homeland Security. For example, there are 31 judicial districts in West Virginia. The cluster analysis shows differences in use of residential for the different classes of children by jurisdiction. As indicated in recommendations above, this work will involve understanding the perceptions of judges, aligning visions of the purpose of residential interventions, ensuring that judges and courts understand the behavioral health services that are available, and building a clear mechanism for how those behavioral health service providers and judges communicate. The SME recommends that DHHR more closely explore the differences in philosophy and approach that may drive decision-making.
 - c. Further discussion and review of the population labeled as class one—youth with low behavioral health needs—is needed. This population, 85 youth out of a total of 368 in the analysis, appears to be receiving residential interventions without any indicators of complex behavioral health necessitating a residential intervention, with 68 of those in in-state group care and 13 in out-of-state group care. As such, this population is presumably receiving residential interventions solely for a placement location and not a treatment need. The State must carefully review how this population found its way to a residential intervention, particularly for the youth placed out-of-state, to determine all of the pathways that need to be redirected; this process will likely include engagement with caseworkers, judges, and other systems that may perceive residential interventions as an appropriate placement location versus a behavioral health intervention. A high number of these youth are placed in out-of-state placements. A plan to discharge to the most

appropriate home setting and connect to treatment needs is essential, particularly for those youth in out-of-state locations for whom connection to in-state services prior to discharge will not be possible.

- d. It appears that children across all classes, but notably classes one and two, are Youth Service-involved, with smaller numbers involved with CPS or foster care. As such, factors specific to the Youth Services system and the role of judges and courts in deciding treatment locations needs to be addressed. The SME recommends that DHHR develop, in coordination with the Department of Homeland Security, a strategy and written plan to actively engage the judicial system in committing to a reduction in residential placements. While this plan will need to be informed by the data recommended above, a plan can be initiated while data are gathered that considers the following:
 - i. a priority on only considering congregate care settings when there is a clear demonstration of why a child *cannot* be treated in the community with home- and community-based services (i.e., treating HCBS as the default approach);
 - ii. the role of evidence-based residential interventions as a behavioral health intervention versus a placement;
 - iii. regular and ongoing meetings with judges regarding DHHR’s commitment and their perspective, including presentation and discussion of the latent class analysis showing that these children do not have clinical reasons for being in these placements, the service needs of youth in their courts, their concerns about ensuring children or communities are safe, identification of HCBS champions within the judiciary—both within West Virginia and nationally—that can provide examples of the positive impact of engaging home- and community-based options for youth in their courts; and
 - iv. support to parents and youth to advocate for HCBS services instead of placement.

DHHR may gain traction in reducing residential usage by seeking judges to commit to a “pilot” approach, thereby building new/renewed connections to home- and community-based services between judges, families, caseworkers, and behavioral health providers.

- e. Further review of class two—described as youth with legal issues, substance use, and anger control issues—is needed. This appears to be a grouping of children who may be receiving residential interventions for reasons similar to class one, where presentation to other systems led to a decision for residential as a placement versus as a treatment need. It also appears that a sizable number of youth in this class have substance use needs. While the SME recognizes that the DOJ Agreement is specific to mental health, national prevalence data indicate that estimated rates of co-occurring mental illness among adolescents with substance use disorders range from 60–75 percent.²² Therefore, the SME recommends that youth with substance use be carefully assessed to determine concomitant mental health needs. Finally, for any child in class two, this review provides an opportunity to determine if services are adequately available to meet these needs and

²² Turner, W. C., Muck, R. D., Muck, R. J., Stephens, R. L., & Sukumar, B. (2004). Co-occurring disorders in the adolescent mental health and substance abuse treatment systems. *Journal of Psychoactive Drugs*, 36(4), 455–462.

what additional services may need to be developed. It also may be that some services do already exist that could meet these needs, but that behavioral health clinicians will need additional training and support to work with these populations effectively.

- f. The SME recommends that DHHR carefully review the data on the youth included in class two (Youth with Legal & Conduct Issues), which had the highest percentage of youth who are Black. Class two youth were more likely than other classes to have been diagnosed with a conduct disorder (53%) and most likely to have borderline intellectual functioning (almost 15%). They had the highest rates of substance use, with a very high percentage of cannabis use, and were more likely to be an adjudicated delinquent or status offender. These figures could indicate disproportionality and overrepresentation of youth who are Black in residential care, particularly for conduct disorder. Through examination of data, DHHR will be able to identify action steps including examining policies across DHHR and courts for implicit bias; training for behavioral health professionals, judges/court personnel, and DHHR personnel; and engaging families and Youth of Color in identification of challenges and opportunities for improvement. The SME also encourages the State to utilize the brief on conduct disorder to assist with information-sharing with stakeholders.
- g. The data provided indicated an average length of stay of 291 days, with a clear note that these data represented a single placement, and that for children who had multiple placements in succession, total days in out-of-home placements are not included. Given this, the SME recommends stratifying this data by class to understand length of stay by the four classes. While the length of stay is longer than best practice for any class, it delineates additional factors that may be maintaining residential interventions. For example, have CPS workers been unable to locate alternate placements, have judges decided to continue residential interventions as a punishment for unlawful behavior, are residential intervention programs wanting to discharge children or stating that residential interventions are still medically necessary? This process will help DHHR identify specific factors to address to inform engagement strategies with key stakeholders, inform policy and procedure changes, develop or modify training and coaching to support improved practice, and inform system-level indicators to monitor the system.
- h. The report notes that of the 372 youth in the review, 27% had an autism spectrum disorder or a developmental disability. Meeting the complex needs of youth with both mental health and developmental disabilities can be challenging. The SME recommends that a specialized working group, with additional outside consultation if needed, be implemented to review the data specific to this group, assess current and additional service needs, and develop recommendations specific to meeting the needs of this group of youth.
- i. The SME notes that almost all children in the cluster analysis were impacted by trauma. The SME notes efforts to address trauma through existing training and coaching efforts and recommends that specific training and coaching are needed for residential providers in order to ensure that treatment and supports are trauma-responsive and recognize

chronic, community, and inter-generational trauma and their impacts on goal-setting, engagement, treatment planning, and outcomes.

10. Regarding action steps resulting from DHHR's survey of residential providers, the SME continues to recommend the following:
 - a. DHHR should determine its actions steps resulting from its analysis of provider responses and include these actions steps in its coordinated reductions in residential plan.
 - b. The survey indicated that a number of residential providers are offering other services that may be of benefit to children transitioning from residential interventions, though notably, less than one third offer outpatient behavioral health services or Wraparound. It will be necessary to further understand the specific services available, as this capacity could make it easier to partner with residential providers to redirect youth from residential interventions and reduce lengths of stay. It will also be necessary to understand the remaining group of residential providers, approximately half, who indicated that they did not provide aftercare or transitional services when a child returns home; increasing providers' capacity to deliver these services is essential. Both from a best practice and continuity perspective, and given the limited trained and knowledgeable workforce, leveraging the expertise of providers of residential interventions to provide community-based services is key. Providers indicated several reasons why their continuum of services is not well-utilized, including challenges becoming Medicaid providers and payment rates. Many indicate they do not receive Medicaid funding. The SME recommends that future work include rate analysis and an assessment and action plan to determine how to include residential providers as Medicaid providers. This step is particularly important given the dearth of aftercare services provided and the need to evolve residential providers to utilize and/or expand their capacity to provide services in home and community settings.
 - c. Providers repeatedly noted a consistent theme of a skilled, credentialed workforce as a barrier to their ability to improve residential interventions and aftercare services. The SME recommends that DHHR ensure that its efforts regarding workforce and training are connected to the R3 workgroup, including opportunities for providers to share additional feedback on the changes and resources needed to address workforce issues that are impacting the quality of residential care.
 - d. Meeting notes between DHHR and Residential Providers indicated that some providers cited a lack of infrastructure or a single coordinating entity to whom referrals for socially necessary services or behavioral health services could be made. The SME recommends that DHHR seek clarity on this issue to determine if it is confusion among a few providers or a larger issue for many providers. Either way, these responses indicate that some providers need more technical assistance support from DHHR. As DHHR finalizes its assessment pathway, the SME recommends clarity on how the assessment pathway can facilitate access to both behavioral health services and other socially necessary services.
 - e. Consistent with results from the cluster analysis, the provider survey indicates that the most common reasons for long lengths of stay were lack of ability to return home or find

- an alternate placement and court mandates. Interestingly, lack of community services ranked as a less of an issue than these others. This speaks to the need for the State to not assume that its focus on building services will result in reduced residential placements. Rather, working with the courts and within the BSS bureau to support caseworkers, increase foster care homes, and strengthen MDT's focus on community services and discharge planning are instrumental to achieving these goals. The SME recommends that the State develop and implement a specific plan to address these factors.
- f. Residential providers noted difficulties in obtaining previous assessment data on youth in a timely way. Reducing lengths of stay for youth receiving residential interventions is predicated on a continuity of information on the whole child versus snapshots of a child while receiving residential interventions or a snapshot of a child while in community services. A coordinated single plan of care built upon a standardized assessment must provide the foundation for understanding and intervening for any behavioral health need. If DHHR continues to have siloed assessments and siloed treatment plans, children will not be redirected from residential interventions, and residential interventions will not become part of a continuum of home- and community-based approach. The SME recommends that DHHR develop a specific policy on this issue and monitor the data to ensure that all DHHR assessment information across providers and bureaus be shared with residential providers. Additionally, it is important that exchanges of information are not limited to assessments at the start of residential interventions but are treated as regular touchpoints during treatment and transition planning.
 - g. Several residential programs indicated that children were not discharged because program levels were not completed. This may point to the issue that residential providers perceive residential interventions as needing to address *all* behavioral health needs versus the State's intended use of residential interventions to stabilize a child, initiate treatment, and then continue high intensity services in the community. The SME recommends that the DHHR clarify with providers what it means to complete a level. It seems this approach could be at odds with what the State wants to pursue under a new system. Additionally, a growing body of neuroscience research, along with both clinical and lived experience, demonstrates that prescriptive point and level systems applied universally to a group do not typically result in enduring behavior change for the 10–20% of youth with serious behavior challenges.²³ It will be important for DHHR to understand the extent of use of point system approaches by providers of residential interventions, as it will inform its efforts to identify and adopt evidence-based practices, and training and coaching to personnel.
 - h. One program noted that there were no shelters available to discharge a child to after nine months. The SME would not expect a child that had received a residential intervention for nine months to move anywhere other than a family-based or independent living setting. No child known to DHHR or its providers for nine months should be stepped down to a

²³ [ACRC_position-paper-15.pdf \(togetherthevoice.org\)](#)

- shelter, which by its design is a temporary setting. That step unnecessarily elongates temporary settings for a child that has already been in one for a considerable time. This is an area that the SME recommends be monitored via data to ensure that it does not occur.
- i. There appears to be a disconnect between what residential providers do for discharge planning and the expectations of BSS staff. It would seem that residential providers should play a larger role in transition planning, particularly QRTPs, since this type of planning is required in the FFPSA for these programs.
11. The SME recognizes that DHHR is implementing its [Family First Prevention Services Act \(FFPSA\) Prevention Plan](#)²⁴, which includes several strategies and opportunities for alignment across West Virginia, particularly among families likely to engage with multiple child- and family-serving agencies.
 - a. The SME recommends that DHHR align its PRTF, residential, and HCBS efforts with its FFPSA plan to ensure consistency and minimize gaps in care, including how the pathway to HCBS services and FFPSA Act services connect, and are coordinated, for certain populations of children and families.
 - b. The SME recommends that the service pathway include how families may receive referrals to FFPSA services, particularly for youth experiencing behavioral health needs who may be appropriate to receive Functional Family Therapy (FFT) services.²⁵ A referral to determine eligibility for FFPSA could be in addition to or instead of a referral for Wraparound services, depending on the needs of the child and family.
 - c. The SME recommends aligning performance and outcomes data collection and reporting activities with those being implemented for FFPSA, including the approach that is being designed to align with the federal Child and Family Services Review and the data being collected by KEPRO, including for socially necessary services (see p. 38–39 of the Prevention Plan).²⁶
 12. Consistent with paragraph 32 indicating that all children are presumed to need HCBS, the SME recommends that the State presume that all children ready for discharge from residential interventions would benefit from Wraparound specifically. As such, the SME recommends that any child leaving residential treatment be offered Wraparound with the exception of those who would benefit from or choose ACT. The SME recognizes, based on the cluster analysis, that not all children would meet CSED Waiver eligibility. But given the lengths of stay for youth in residential settings, the detrimental impact of long lengths of stay on children and the challenge in developing aftercare plans for children, Wraparound providers would be uniquely

²⁴https://childwelfare.wv.gov/Documents/20200914_Family_First-5_Year_Prevention_Plan-Final%20Approved_by_ACF.pdf

²⁵Defined in the Prevention Plan as “11 to 18-year-old youth who experience behavioral or emotional problems that bring them into contact with the juvenile justice system and meet the criteria to be defined as a foster care candidate” (p.22).

²⁶ https://childwelfare.wv.gov/Documents/20200914_Family_First-5_Year_Prevention_Plan-Final%20Approved_by_ACF.pdf

qualified to assess the whole child, engage the family, establish a plan, and support successful transition to community. This could operate much the same way as the planned “interim services” operate at the beginning of the assessment pathway. Similarly, as noted above, families may benefit from a referral to FFPSA services. Families with young children may benefit from the home visiting services available, while families with children 11–18 may benefit from FFT and other services.

13. As noted in prior SME recommendations, the SME has recommended that the State develop a pathway that redirects children from residential care. The State has engaged in considerable work to develop one. Efforts to date have focused on important issues, such as access to assessment and services like Wraparound. The SME recommends that future work expand on its assessment pathway to orient the pathway to demonstrating why a child cannot be treated in the community. The pathway will also need to demonstrate its interface with MDT processes and incorporate use of system flags for referral to the pathway when residential decisions by caseworkers, judges, and providers are made to demonstrate why a child cannot be treated in the community. This work may need to center on aspects of the pathway not yet developed, such as establishment of a coordinated process across certain providers—including CMCR, in-home family therapy, Wraparound, and BSS providers—who can proactively create a plan of care for a child to remain in the community. The SME recognizes that DHHR is phasing in the model with a focus on initial screening and assessment. However, it is critical that child welfare workers and providers consider transition and discharge needs from the start of any placement to ensure that all parties are working toward a shared goal.

Outreach and Education

Agreement Requirements: The Agreement requires the State to (1) conduct outreach to and training for physicians who serve children who are Medicaid-eligible on the use of the screening tools; (2) develop outreach tools for medical professionals who treat Medicaid-eligible children; (3) develop an outreach and education plan for stakeholders in the State of West Virginia on the importance of the stated reforms prescribed in the Agreement; and (4) provide timely, accurate information to families and children regarding the in-home and community-based services that are available in their communities.

Activities

Since the last SME report, the State has engaged in stakeholder meetings regarding several of the in-home and community-based services, including four meetings with CPAs regarding TFC, five meetings regarding residential services, and six meetings regarding application renewal for the CSED Waiver.²⁷ The State also held two Child Welfare Collaborative meetings during this report period in August and November of 2021. Ms. Cammie Chapman, Assistant General Counsel, attended the September 2021 meeting of the Commission to Study Residential Placement of Children to update the Commission on work on the Agreement’s evaluation component, the assessment pathway, and House Concurrent

²⁷ See “2022 CSED Renewal Stakeholder_Engagement_Dates” and “DHHR Stakeholder Meeting List” documents.

Resolution 35 activities and opportunities to collaborate with the Commission on the children’s mental health system.²⁸

In late 2021, DHHR executed a contract with the WVU Office of Health Affairs to increase public awareness of HCBS services. The scope for this work includes performing an environmental scan of current Medicaid HCBS system public education resources and developing a public education and outreach strategy plan regarding the Medicaid HCBS system.²⁹

The State submitted for this SME report a document titled “Internal Communications Standard Operating Procedure (SOP) (Draft 03/2022)”. This document is an internal SOP (standard operating procedure) operationalizing a memo from leadership developed in July 2021.

The workgroup has also engaged in work to develop an outreach data tracker, to be used by DHHR staff, which will track outreach activities “associated with services for children with serious emotional disturbance, including encouraging use of HCBS and diverting children from residential placement.” Specifically, in December 2021, the workgroup developed a list of draft data inputs that will be used in the tracker.³⁰ This work is aligned with the general QAPI work of the agreement.

Aetna engaged in outreach to MHP members³¹ about their EPSDT benefit through postcards, texts, and/or case manager outreach. Aetna reports that it sent 25,803 mailers and 28,106 texts to members with reminders about their EPSDT exams (which includes a mental health screening component). UniCare also provided some data on case manager outreach to Medicaid members who have not completed their EPSDT visit; since implementing the case manager outreach process in December 2021, 172 members were contacted in a three-month period. It is unclear from the data provided the total figure of Medicaid members that UniCare provides case manager outreach to.

The SME received five individual excel spreadsheets related to community outreach³² with separate tabs for each month of the year. Each monthly tab listed outreach events, dates/times, numbers of people reached, and the type of outreach activity performed. Most of these do not appear to be summary reports but individual staff reports, as months overlap but activities differ. It was unclear based on the materials provided to what extent these outreach activities focused on agreement services, HCBS, EPSDT, and/or other subjects.

²⁸ See “West Virginia Commission to Study Residential Placement of Children Summary Notes” from September 2021 available at http://www.wvdhhr.org/oos_comm/minutes/9-2-2021.pdf.

²⁹ See “Medicaid Home and Community-Based Services Public Education and Outreach – Phase 1” contract (“ARP_Edu&Out-SOW”).

³⁰ See “Edited_Outreach Tracker Data Inputs draft” document.

³¹ The materials provided do not indicate the current number of MHP members. The last data provided for the August 2021 report indicated that there were 27,447 MHP members. Based on these figures, it appears likely that the majority of MHP members were contacted through one or more communication methods, although the lack of a total membership figure prevents further analysis on this point.

³² The documents are titled “HealthPlan 2021 Outreach Events Tracking,” “HealthPlan 2021 Community Outreach,” and “Health Plan 2022 Community Outreach” (three versions).

Aetna also engaged in a range of outreach activities, including 12 judicial meetings, although it was unclear based on the materials provided to what extent these outreach activities focused on agreement services, HCBS, EPSDT, and/or other subjects.³³ Similarly, the State reports that Aetna conducted a number of trainings to a wide range of audiences during the reporting period, but, with a few exceptions, it is unclear whether these trainings or events were focused on agreement services or were more general in scope.³⁴

The materials provided to the SME for this report did not include any updates on specific outreach to physicians about the use of the screening tools or outreach to medical professionals who treat Medicaid eligible children.

DHHR released the Year 3 Implementation Plan for public comment on the West Virginia Child Welfare Collaborative website and other locations in February 2022. The State indicated it did not receive any public comments regarding its Year 3 implementation plan.

Recommendations

1. The State's 2020-2024 Outreach and Education Plan, developed in November 2020, notes that it is "a 'living document' that will continually evolve and expand" to support the buy-in of the full range of stakeholders in this work. The State has not shared any revised versions of this document with the SME (or publicly). The SME encourages the State to consider how it can put this evolving, "living document" approach into action, particularly in response to any stakeholder feedback that results from the WVU evaluation and the Marshall University fidelity evaluation.
2. The SME also echoes earlier recommendations that the State must ensure that two-way communication methods with youth and families are central to the State's outreach and education work. For example, in the service-specific stakeholder meetings mentioned above, families and youth (or affiliated groups) are notably absent from the stakeholders list (e.g., R3 and TFC meetings lists) or are listed as a future group to reach out to only after many other meetings have already been conducted (e.g., CSED renewal meetings list); it is unclear whether youth and families are not present because they were unable to attend or because they were not invited. If the former, the State should consider whether the time/date/frequency of the meetings can be adjusted to accommodate family and youth availabilities (or whether a parallel forum for input may be more suitable). If the latter, the State should ensure that youth and families are explicitly and consistently included as a key stakeholder group in planning, implementation, and evaluation activities. The WV Foster Adoptive and Kinship Parents Network (WVFAKPN) offered a document with a wide range of methods that DHHR might use to bolster its engagement with youth and families;³⁵ the State should review and consider each of these thoughtful suggestions, along with thoughts from other family/youth representatives.

³³ See "Aetna Training and Outreach Report August 2021_Feb2022" document.

³⁴ *Id.* The document does list several events related to Family Finding, five CSED Overview Trainings,

³⁵ See *Methods of Family Engagement in Child Welfare*, developed by the WV Foster Adoptive & Kinship Parents Network (2022).

3. As the State continues to develop its strategies to obtain family and youth engagement and input, the State should consider how to maximize the value of the Child Welfare Collaborative quarterly meetings. For example, the workgroup had originally planned quarterly regional meetings, which shifted to statewide virtual meetings in light of pandemic developments. The workgroup should consider whether there is value to regional meetings (instead of or in addition to the virtual meeting) if/when the state's COVID-19 metrics might allow for such an approach. The State could also consider publishing agendas and related materials well in advance of each meeting so that attendees have a chance to prepare feedback, share the materials with those who may be unable to attend to get their input, and prioritize attendance for quarters when the topics are particularly relevant to a stakeholder's interests. By comparison, as of this writing, there are no agenda and no materials available on the calendar invite or on the Collaborative website for the quarterly meeting only two days away. The WVFAKP shared other ideas about how to alter Collaborative meetings to better engage families and other stakeholders; the SME advises the State to consider these and other suggestions in its approach to the quarterly Collaborative meetings.
4. Aetna's training and outreach report indicates that there have been several judicial meetings, although it is unclear which topics were discussed at these meetings and who was present. The Outreach and Education workgroup, as well as the R3 workgroup, have also been strategizing about the importance of the judiciary to the Agreement's success and have reported in meetings with the SME that they have begun initial outreach to judges. DHHR should ensure that any Aetna outreach to the judiciary regarding agreement services is coordinated with the outreach of these workgroups to confirm consistent messaging and strategic sequencing. For example, Aetna representatives may not be following the same communication guidelines as those included in DHHR memos and standard operating procedures, potentially leading to confusion among judges. On a broader basis, the State should consider how to ensure its internal outreach efforts are coordinated with outreach efforts by other key communicators, especially since the data tracker will not track outreach efforts by any non-DHHR staff (e.g., contracted vendors).
5. Various documents provide detail about community outreach events though it appears that these are general engagement events for the health plan and are not specific to this Agreement or children's mental health. Consistent with DHHR's efforts to capture outreach efforts by its own staff, the SME recommends that future information submitted for this report provide outreach efforts specific to children's mental health. Disseminating information at community events as part of a broader outreach effort is an important strategy to deploy, but clarity is needed regarding information disseminated, specific to children's mental health in order for those submissions to demonstrate compliance.
6. The State provided a postcard that is used to remind MHP members to complete their EPSDT/Health Check exam. The SME believes that this postcard (and other related outreach materials) should explicitly state that the EPSDT/Health Check exam includes a mental health screening component. This approach is consistent with the Agreement requirement that a mental health screen shall be completed when a child or family requests that a screen be conducted (see paragraph 32); clear communication to families and children that mental health screening is

included in the EPSDT/Health Check visit supports their understanding of when/how to request such a screening.

7. Based on the work plan, the provided documents, and discussions between the workgroup and the SME, it does not appear that the State has made any progress on coordinating with the Department of Education and the Department of Homeland Security to incorporate these agencies into the communications plan. The SME made a similar recommendation in its August 2021 report, but the State appears to have just pushed out the target completion date (from April 30, 2021 to June 30, 2022). Coordination with these two state agencies is included in multiple parts of the Agreement, but collaboration on communication efforts have been nearly non-existent to date. As stated in the last report, the involvement of these agencies in the communications process was an alternative solution to modifying the governance structure to involve all three agencies, so the SME urges the State to prioritize substantial involvement of these agencies in future outreach and education work.
8. The SME received the updated work plans after the agreed-upon date for document sharing, so it was unable to fully reflect their contents in this report. However, the SME encourages the State and each of the workgroups to continually update their work plans and regularly review them in order to prioritize ongoing work, including related CQI measures and processes.
9. The SME notes that there is often a flurry of activity related to Outreach and Education shortly before and after deadlines for the SME's semiannual reports; these deadlines appear to serve as catalysts for important work. With the eventual exit from the agreement, the SME encourages the workgroup to consider how it can maintain steady, ongoing progress in this area once these report-related checkpoints are no longer required. For example, the outreach tracker may be one useful tool in monitoring outreach and engagement activities and keeping the work on pace. The workgroup may also want to consider imposing its own form of structure (e.g., regular meetings, quarterly update reports) to provide a stimulus that the SME reports currently appear to create. The SME acknowledges that that DHHR's CQI plan could serve this purpose also.
10. Regarding public comment on the implementation plan, the SME encourages the State to share the comments it received and to incorporate feedback from the public comments into its work moving forward.
11. The SME regularly checks the WV Child Welfare Collaborative website for information. The SME understands this is a primary tool DHHR uses to notify stakeholders, and to post information specific to this Agreement. The SME notes numerous broken links, meeting minutes posted that require passcodes, outdated information, and difficulty locating information. For example, while the new STAT home information was recently posted, the Wraparound section contains information that appears current as of October 2020; it does not reflect the assessment pathway and continues to list three separate Wraparound approaches with no mention of their alignment. Similarly, the STAT Home standard operating procedure link requires a passcode. At a minimum, DHHR needs to implement an ongoing process to test and remedy broken links and posted

information that is not accessible. More generally, DHHR would achieve its broader aims by refining its use of its website to be a tool to convey the important work it is doing.

Quality Assurance and Program Improvement (QAPI)

Agreement Requirements: The Agreement requires the State, within 18 months of the effective date, to develop a QAPI system that facilitates an assessment of service delivery, provides notification of potential problems warranting further review and response, and enhances the State's ability to deploy resources effectively and efficiently.

The State must develop a data dashboard that can be used for performance analysis and for developing and producing semi-annual reports to DOJ within eighteen months of the May 2019 signed Agreement. These reports must include:

- (1) an analysis across child-serving agencies of the quality of mental health services funded by the State, measured by both improved positive outcomes, including remaining with or returning to the family home, and decreased negative outcomes, including failure of foster home placement, institutionalization, and arrest or involvement with law enforcement and the juvenile or criminal courts;
- (2) an analysis of the implementation of the Agreement across and between all child-serving agencies, along with any barriers to effective coordination between these agencies and the steps taken to remedy these barriers;
- (3) data to be collected and analyzed to assess the impact of the Agreement on children in the target population, including the types and amount of services they are receiving; dates of screening; dates of service engagement dates; admission and length of stay in residential placements; arrests, detentions, and commitment to the custody of the State; suspension or expulsion from school; prescription of three or more anti-psychotic medications; changes in functional ability (statewide and by region) based on the CANS assessment and the quality sampling review process; fidelity of CFTs to the NWI model; and data from the CMCR team regarding encounters on the timelines of response and data on connection to services; and
- (4) annual quality sampling of a statistically valid sample of children in the target population to identify strengths and areas for improvement for policies and practices, as well as the steps taken to improve services in response to the quality sampling review. The Agreement requires the State to take remedial actions to address problems identified through its analysis of data.

Activities

On January 31, 2022, the State shared its first semi-annual report per Agreement requirement 48. The report provided summary key activities, initial summary data, and a self-assessment of barriers and opportunities for the period July 2020 – June 2021. DHHR's Semi-annual report can be found <https://childwelfare.wv.gov/initiatives/Pages/DOJ-Agreement.aspx>. The report reflects data that predates several of the recent system efforts to improve access to HCBS such as the Assessment Pathway, recent changes to the CSED Waiver, and efforts to enhance data availability.

The State has acknowledged its ongoing challenge to obtain data; and has described its efforts to develop a data store to house data with the goal of aggregating data from child-serving bureaus. To date, the data store captures data associated with RMHTF services. In 2022, the data store will be expanded to include data elements associated with CSED Waiver services. After 2022, community-based behavioral health data elements will be included in the data store. Additionally, all three bureaus-BBH, BSS, and BMS are in various stages of data system changes. In October 2021, BBH transitioned from use of multiple excel sheets to track data to a new data reporting system that allows collection of record-level child data for all programs. In the future, this information will be in a format that will allow it to be added to the data store. The BSS plans to implement the People's Access to Help (PATH) system to replace the current FACTS system during calendar year 2022. BMS plans to implement an Enterprise Data Solution (EDS) to replace the current data warehouse during calendar year 2022.

In addition to accessing needed data, DHHR had identified it needed additional data analytic and reporting personnel to support its work. It contracted with WVU to provide a part-time data analyst stationed at DHHR; with the new analytic staff person onboard as of December 2021.

As recommend by the SME, DHHR has developed a quality improvement plan, and initiated implementation of the plan. DHHR implemented its CQI plan for children's mental and behavioral health services in December 2021, to include ongoing quality reviews of available data associated with children's mental health services. The CQI plan addresses goals, governance and leadership infrastructure, intended functions of the new Office of Quality Assurance for Children's Programs, bureau-level quality and compliance functions, process for cross-system data monitoring, analysis, action planning, implementation, continued monitoring, and communication and reporting. The document also listed an initial set of performance indicators for each service.

DHHR met with the SME and submitted PowerPoint slides describing updates to its QAPI work (*Quality Assessment and Performance Improvement Update, March 10, 2022*).

The WVU evaluation progresses with a few adjustments to the timeline.

- WVU contracted with Abt Associates to conduct two surveys, one of children's mental health service providers and another of mental health facility and organization administrators. Survey data were collected by web and phone between July 26, 2021 and December 30, 2021 and a survey methodology report shared with the SME in February 2022. WVU indicates that a draft report will be provided to DHHR April 2022.
 - The caregiver and youth surveys were slated to begin for late winter 2021. This is planned to address Agreement requirement 50 specific to an annual quality sampling review process.
 - Surveys and interviews with the residential population were scheduled to begin Fall/Winter 2021 and for the at-risk population in Winter/Spring 2022.

Given the significant role of the WVU evaluation in meeting the State's Agreement requirements, the SME has initiated meetings with the WVU Evaluation Team and DHHR to review and discuss WVUs evaluation methodologies and findings more thoroughly. These direct dialogues with the WVU Evaluation Team more fully support the SME's understanding of the evaluation methodologies, how WVU is addressing common issues that occur in the evaluation process, and how it is interpreting the

raw data and drawing conclusions based on interpretations. The SME and WVU Evaluation Team will continue to meet at regular intervals to coincide with the WVU evaluation deliverable schedule. During this report period, the SME received two methodology reports from WVU titled Children's In-Home and Community-Based Services Improvement Evaluation Project Nonresponse Analysis Report December 30, 2021 Revised: February 21, 2022, and a Survey Methodology [Provider Survey, Organization & Facility Survey] Report February 21, 2022. The SME and WVU Team had one meeting to discuss the provider survey, and organization and facility survey, methodologies. In this meeting, the SME discussed how WVU planned to address the lower-than-expected response rate, its approach to categorizing providers and facilities/organizations, and any plans to "reweight" responses based on the differences in response rate by categories. The SME also received an update on the next steps in the evaluation process with data expected April 2022.

Regarding the data dashboard, as indicated in DHHRs Implementation Plan- Year 3, DHHR commenced user testing of the data dashboard in December 2021 that contained Phase One data elements. DHHR has shared a document titled QAPI User Guide V1.2 and a training survey titled QAPI Dashboard Training Survey. The user group consisted of 26 individuals including nine (9) BerryDunn personnel, six (6) DHHR Leadership, and the remaining presumed to be managers or staff. The training survey was completed by seven (7) individuals. The guide shows the visual displays and ways in which users can filter data (e.g., by county, by date, gender, age, etc.).

The phased in reporting of required indicators continues. DHHR stated that Phase One elements are available as of February 2022; with internal user testing occurring. Phase 1 indicators are:

- Unduplicated monthly head count for children placed in RMHTFs as of May 14, 2019 and beyond
- The average number of children in beds per day during the month
- Average Length of Stay* (ALoS) for children
- RMHTF number of monthly new admissions
- RMHTF number of prior placements* in an RMHTF
- RMHTF number of exits from RMHTF by exit reason and outcome
- Per document submitted titled *QAPI, March 10, 2022*, Phase one indicators also include parental placement data.

As described in the Implementation Year 3, DHHR indicates that Phase 2 indicator development and testing will commence in July 2022.

Specific to the new Office of Quality Assurance for Children's Behavioral Health, DHHR had posted the position, and conducted initial rounds of interviews; and has decided to repost the position to continue to search for an appropriate candidate. In the meantime, DHHR's contractor, BerryDunn, will continue to provide support on CQI activities.

Recommendations

1. Regarding the semi-annual report, the State submitted a first semi-annual report January 31, 2022. The Agreement requires reporting of data consistent with section 48, 49, and 50 within 18 months of the Agreement, which is November 2020. Although the report was not submitted within 18 months of the effective date of the Agreement per requirement 48, and did not

address all requirements in that provision, the first semi-annual report was a useful first report, especially as a foundational update for stakeholders and other external parties seeking an overview of the status of the State's efforts.

- a. The SME recommends that the State continue to develop its capacity to provide data in a timelier fashion.
 - b. With QAPI provisions planned for compliance reviews in the next report Fall 2022, the SME recommends receiving planned data reports prior to the next report, and not as part of submissions for the report, to allow discussion with DHHR; and that an update be provided on the status of each data-related requirement, and its expected availability, across any source such as DHHR generated, WVU-generated, MU-generated, BerryDunn generated, or any other vendor source.
 - c. As DHHRs data availability increases, the SME recommends that future semi-annual reports are more comprehensive to reflect data from all sources, including WVU and other vendors.
 - d. Additionally, the SME, DOJ and DHHR discussed and provided written comments on recommendations for future semi-annual reports. The SME acknowledges DHHR's plan to incorporate those recommended changes into future semi-annual reports.
2. As recommended in the August 2021 report, the SME recommends that the State provide a written plan for reporting of the other measures in 48, 49, and 50 will occur. The SME appreciates the document titled *Quality Assessment and Performance Improvement Update, March 10, 2022*, and the planned Key Performance Indicators that DHHR is working to develop with the bureaus; as well as the Phase 1 and Phase 2 dashboard elements for the dashboard, and the WVU evaluation and MU CANS and fidelity reporting , and notes that deliverable dates for these items are contained across various documents making it difficult to understand when certain data will be available. Additionally, this document could provide clarity regarding items that may not yet have a data source or collection process. Given QAPI is scheduled for compliance reviews in the SME's Fall 2022 report, clarity, and transparency on the status of each specific requirement will be needed, including specificity not only of when work on a requirement commences but when the data will be available to the SME.
 3. Regarding DHHR's compliance plan, the SME commends DHHR for developing a written quality plan reflecting a thoughtful approach to CQI and compliance monitoring. When implemented as described, the approach will support beneficial CQI. The SME submitted comments in February on the January version, and DHHR and the SME began discussing these comments on March 10, 2022. The SME requests to receive a revised CQI plan acknowledging comments accepted or declined. The SME requests to receive this prior to the next report in time to allow discussion leading into the planned compliance review of QAPI provisions. Specific areas where the SME recommends greater clarity in the CQI process are:
 - a. Under what circumstances a Performance Improvement Plan would be required as opposed to a more generalized PDCA (plan, do, check, act) effort to improve data;

including at what point corrective action would occur, whether internal to bureau processes and/or external with vendor processes?

- b. Ensuring engagement of families, youth, providers, and stakeholders in a two-way communication process, including greater specificity regarding how DHHR will obtain and incorporate feedback to strengthen its CQI plan.
 - c. How it intends to train staff in the Office of Quality Assurance for Children's Programs. The State's CQI plan includes many responsibilities for this office but does not explicitly detail training. The CQI plan does include training at the bureau-level, but it is unclear if the Office and its director will be check on that training; that is, if the director will play a role in ensuring training is, to the extent practicable, unified across bureaus to foster cross-agency understanding and collaboration.
 - d. Recognizing that DHHR is still developing its KPIs with and across bureaus, the SME recommends greater specificity regarding its measures, in anticipation of the QAPI compliance review scheduled for the next SME report. For example, KPIs must be clearly defined, with clear numerators and denominators for quantitative measures, must have the data source(s) listed, and must indicate the frequency of review/update.
4. Consistent with August 2021 recommendations, the SME recommends that DHHR present future phases of the dashboard work beyond indicators listed for Phase 1 and Phase 2; the indicators under consideration/planned, and timelines for each subsequent phase
 5. The SME requests access to the data dashboard imminently prior to the next SME report when QAPI will be reviewed for compliance. Similar to the rationale for meeting with WVU to understand its methodology and how it is addressing common issues that arise in the development of a dashboard, the SME requests the opportunity to interact with the dashboard and discuss any items for clarification. The SME requests to receive this access prior to the next report in time to allow discussion with DHHR leading into the planned compliance review of QAPI provisions.
 - a. The SME appreciates DHHR's follow-up regarding a prior SME recommendation for DHHR to clarify the dashboard's availability to external parties versus it being retained as an internal DHHR resource. The SME acknowledges DHHR's questions about the scope of a dashboard, including whether the Agreement requires it to have interactive functional capacity or if the dashboard could be meet the requirement with regularly updated but static graphic and tabular displays of required data. The SME recommends that discussions with DOJ and the SME occur Spring 2022 to address DHHRs concerns about HIPAA and confidentiality to ensure that timely progress on dashboard requirements continue.
 - b. Clarify a prior SME recommendation regarding indicating data source and time period included as each component of the dashboard may be drawn from different data

sources with different refresh rates. The SME has recommended that labeling occur as graphics will not reflect the same time period for every item.

6. Regarding DHHR's new Office of Quality Assurance for Children's Behavioral Health, the SME commends the state's commitment to building this cabinet level office. The SME requests ongoing updates on the status of hiring for this cabinet level position and for the staff within the office.
7. Specific to the meetings with the WVU Team, the WVU Evaluation Team are approaching the evaluation in a thoughtful and thorough manner. The SME looks forward to receiving reports and continuing discussions on methodologies, adjustments to evaluation approach, findings, and conclusions.
 - a. The SME understands that a report is imminent regarding provider, facility and organization surveys; and that quality sampling interviews with youth and families are also forthcoming.
8. As the State's access to data improves, it is anticipated that future reports will include more comprehensive and cross-system data to provide an overall understanding of services received by youth. It is the SME's opinion that Agreement reporting must include behavioral health services that are received by the target population, even if those services are not the newly required services under the Agreement. For example, while behavioral health outpatient services are not a new service required under the Agreement, a child's ability to access that service is an indicator of compliance with the Agreement. The SME has raised this in numerous discussions; and notes particular urgency as the SME and DHHR prepare for the compliance ratings of QAPI in Fall 2022. Data includes overall number of behavioral health utilizers in the system, utilization of other behavioral health service such as outpatient therapy, ED utilization, acute inpatient, BBH and SAH enrollment, to name a few. When new services or new processes such as the assessment pathway are established, monitoring of data in other key areas is needed to ensure that the system is working as intended. In this way, a comprehensive picture of services received by youth in the target population can be understood.
9. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, and CQI measures and processes.

Conclusion

DHHR continues to make progress on Agreement requirements. Notably, as the state is 8 months away from its December 31, 2022 commitment to a 25% reduction in residential placements, DHHR has prioritized its resources to increase its focus on residential. The next several months are critical for DHHR **to realize and maintain** a reduction in residential and continue to reduce use of residential beyond the 2022 commitment. DHHR must continue to engage residential providers on its planned model for PRTF and residential services; and must work with Judges, the courts, and BSS personnel to increase their awareness of HCBS, and to direct decisions about which behavioral health services a child needs to the Assessment Pathway.

One area of the work that needs additional priority is collaboration with families and youth. As noted in the compliance rating section, and the technical assistance sections of this report, there appears to be limited strategies in use to engage families and youth; where processes are in place, such as the West Virginia Child Welfare Collaborative meetings, there is little engagement and dialogue with families or family advocates about the issues and concerns of importance to families, resulting in a process that appears more pro forma in nature. The SME recognizes that the forthcoming WVU evaluation includes interviews with families and youth, and as noted, we commend DHHR for its thoughtful evaluation. The SME views an interview by an evaluator as fundamentally different than an ongoing, bi-directional process directly with DHHR to hear concerns and successes directly, engage in quality improvement, and policy and service decision-making. It is more than only seeking feedback or a reaction to a draft document or draft policy under consideration by DHHR. Engagement of families and youth in all aspects of the work--planning, implementation, quality, and evaluation-- is essential.

Appendices

Appendix A — Reviewed Documents Received During the Report Period

The list below reflects documents received during the current reporting period only.

General

- 20211015 Year 3 IP_WV Implementation Plan_DOJ_DRAFT Rcvd 10-18-21
- 20211108_WV_DHHR DOJ Agreement Master Project Schedule
- 20211119_CQI_Plan_Draft final approved
- 20220105_Target Population Testing Data Results 1-6-22
- IP Y3 Public Comments email announcement
- WVDHHR IP Y3 DRAFT rev 20220209 clc
- WVDHHR IP Y3 DRAFT rev 20220209 clc-for publication
- WVDHHR IP Y3 FINAL

ACT

- ACT EPH Startup Collaboration rev 20220309
- ACT_Units_Users_ALoS
- BMS Provider Workshops
- Chapter 531 Psychiatric Residential Treatment Facility Act Addition
- Chapter_503_LBHC_Services final draft 07.10.18 scb 7.12.18 skyFinalApproved
- DHHR Grant Agreement – G211065

BSS

- 20220228_Notes_DOJ_HCBS
- CRM FY22 G220443 Concord University PBS SOX Supplemental
- PBS Coordinator Training Plan Outline Draft Feb 2022

CMCR

- CCRL – DHHR Grant Agreement – G220699
- CCRL Outreach Annual Plan FirstChoice Feb 2022
- CCRL Outreach Inventory July-Dec 2021
- Childrens Crisis and Referral Line CY2021 Summary Report
- Childrens Mobile Crisis Response Manual (draft) revisions 021822

CSED

- 2022 CSED Renewal Stakeholder_Engagement_Dates_03042022
- ARPA Rate Increase Attestation 9-22-2021 CORRECTED
- CSED Brochure Approved
- CSED Waiver Appendix K
- CSED Waiver Enrollment Updated Stats Jul21_Dec21 and Comparison to Semi-Annual Report
- CSED Waiver FAQ's 2022.2.2
- CSED Waiver Utilization Updates_Jul21_Sep21
- DRAFT CSED Trifold NOT APPROVED RG 03.03.22

- Draft_CSED_Amendment_Eff.07012022
- WV-BMS-CSED-04_Initial Plan of Care
- WV-BMS-CSED-05_Master Plan of Care
- WVDHHR BMS CSEDW Update 20211208

Evaluation

- Confidential Disclosure Agreement_SSW_Original_11.30.21_WVU signed
- CWE_DOJ Agreement and Eval Plan Crosswalk_20210713
- CWE_Gantt_20211008
- CWE_Gantt_20220114
- CWE_Phase2a_FINAL_MethodsReport
- CWE_Phase2a_Revised_NonResponseMemo
- CWE2a_DataAnalysisReferenceDocument_20210719
- CWE2a_DEL_SoftLaunchReport_20210917
- CWE2a_DEL_SurveyDesignReport_20210917
- DOJ Semi-Annual Parties Meeting Sept 2022
- WVU Evaluation Milestone dates CWE_Gantt_20211008 received October 2021

Medicaid

- Appendix 1 – Detailed Specifications
- Appendix 3 – Service Provider Agreement
- Appendix 7 – SNS Foster Care Spend by Category
- Appendix 8 – SNS Utilization Management Guide
- Attachment A – Cost Proposal
- Attachment D – Mandatory Requirements
- Foster Care Data Extract Information
- Mountain Health Promise Request for Proposals
- Section 2 – Instructions to Vendors Submitting Bids and Section 3 – General Terms and Conditions
- Section 7 – Federal Funds Addendum

Outreach and Education

- 2022 CSWED Renewal Stakeholder_Engagement_Dates_03042022
- 20211202_Edited_Outreach Tracker Data Inputs draft
- 20220301_DHHR Stakeholder Meeting List
- Aetna Training and Outreach Report August 2021_Feb2022
- Family Engagement Strategies (*letter from WVKPN; provided by DOJ*)
- Health Plan 2021 Community Outreach
- Health Plan 2021 Outreach Events Tracking
- Health Plan 2022 Community Outreach
- Health Plan 2022 Community Outreach 2
- Health Plan 2022 Community Outreach 3
- Health Plan 79667_epsdt address postcard
- Internal Communication SOP – March 2022

- Unicare Outreach

QAPI

- 20211119_CQI_Plan_Draft final approved SME Final Comments 2-22-2022
- 20220110_QAP_Dashboard Training_Survey
- 20220131_DHHR Semi-Annual Report_FINAL
- 20220306_CQI_Plan_Indicator Tables Draft
- 20220309_QAPI Update_CQI Orientation and Implementation
- Childrens BH Dashboard Companion Slides (March 2021) updated
- Copy of Xwalk_data_WV
- Data Agreement UMB-WVU 12-13-21
- QAPI_User_Guide V1.2
- Wraparound Fidelity Update-09-16-2021
- WV Position description QA office
- WV QA ofc draft position description

Residential

- 20220304_RMHTF_Monthly Reporting
- ABHWV Phase I Provider Investments (Dec 2021)
- Aetna CAFAS job aide
- Aetna Discharge Planning training providers
- Aetna MHP Interventions.20220310
- CAS-CS-PI-22-1 Pathway to Children's Mental Health Services Memo Jan 26 2022
- Kepro Expansion of SOW 3-22
- RMHT Model of Care DRAFT 12.09.2021
- RMHT Services DRAFT rev 20221502
- RMHTF Provider Manual Dev – Progress Update – Draft Mtng Notes to date 20220311

Screening

- 2019EPSDT_NtlRprt_20201112
- 2019EPSDT_StateRpt_20201112

Target Population

- 2021001 Target Population Definition Test Plan FINAL proposed 10-5-21 DOJ mtg
- 20220105_Target Population Testing Data Results 1-6-22
- Analysis of 53 Youth-Recommendations 1-17-22 Final

TFC

- DOJ Treatment Home Update 3.17.22
- Stabilization and Treatment Home SOP DRAFT – March 2022
- TFC SOP DRAFT
- Treatment Home Standard Operating Procedure – Feb 2022
- WVFAKPN Treatment Homes Program Recommendations (*provided by DOJ*)
- WVFAKPN Treatment Homes Questions Jan 2022 (*provided by DOJ*)

Workforce

- ARP_Edu&Out-SOW
- ARP_Evaluation-SOW
- HCBS Training_LMS-SOW
- IDD_Law Enforcement-SOW
- MBRT-SOW
- Statement of Work-MU Trauma-Sensitive Workplace-04-01-2022-signed
- STLR
- TICPCT-SOW

Wraparound and Assessment Pathway

- 20220228_Probation Screening Tracking Spreadsheet_Final
- 20220309_Assessment Pathway Data Plan Draft
- 20220311_Screening Data Plan - Progress Update
- ABHWV Phase I Provider Investments (Dec 2021)
- Accessing Children's Crisis and Referral Line Tool- Internal Final
- ACT EPH Startup Collaboration rev 20220309
- ARPA Rate Increase Attestation 9-22-2021 CORRECTED
- Assessment Pathway Phase 1 Desk Guide rev 20220310
- CANS Data Plan-Preliminary
- CSED Flier 1.25.22 final
- CSED Waiver APPENDIX K
- CSED Waiver Enrollment Updated Stats July21_Dec21 and Comparison to Semi-Annual Report
- CSED Waiver FAQ's 2022.2.2
- CSED Waiver Utilization Updates_Jul21_Sep21
- Discharge Planning for providers
- DOJ 2021 Report - MH Screening in EPSDT Annual Retrospective Analysis of Med Records Linked to Admin Claims 1
- DRAFT CSED Trifold NOT APPROVED RG 03.03.22
- DRAFT Non-CSEDW Wraparound Eligibility
- Draft_CSED_Amendment_Eff.07012022
- Kepro Expansion of SOW 3-22
- Master POC WV Wraparound DRAFT 20220311
- Provider Infographic Children's Crisis and Referral Line 11-3-2021
- WF Capacity Deployed Across BBH CSED and SAH March 2022 Suppressing Record Indicators
- Wraparound Fidelity Update-03-07-2022
- WV Wraparound FAQ 02.22.2022

Compliance Documents Applicable to Multiple Agreement Requirements

- 2022-02-24 Juvenile Mental Health Screening
- 20220306_CQI_Plan_Indicator Tables Draft
- 20220309_QAPI Update_CQI Orientation and Implementation
- 20220309_West Virginia Wraparound_Draft
- BJS Detention referral to Assessment Pathway SOP
- BSS Pathway Implementation rev 20220311

- BSS Pathway to Children's Mental Health Services February 2022
- Connecting Families to Success (approved 2.10.22)
- Updated Pathway Process Flow Diagrams 03112022

Appendix B — Contacts with West Virginia and the Department of Justice

Meetings	Dates
Department of Justice	August 2, 2021; August 27, 2021; September 8, 2021, September 22, 2021; October 19; October 25, 2021; November 2, 2021; December 8, 2021; January 5, 2022; January 26, 2022; February 2, 2022; February 9, 2022; February 24, 2022; March 14, 2022; March 23, 2022; May 6, 2022
WV Implementation Team/Leadership	September 3, 2021; September 8, 2021
Child Welfare Collaborative	August 24, 2021; November 17, 2021; March 30, 2022
Calls with C. Chapman	August 4, 2021; August 26, 2021; September 17, 2021; September 24, 2021; October 1, 2021; October 15, 2021; October 22, 2021; October 29, 2021; November 12, 2021; November 19, 2021; December 3, 2021; December 10, 2021; January 7, 2022; January 13, 2022; January 21, 2022; January 28, 2022; February 4, 2022; February 11, 2022; February 25, 2022; March 18, 2022; April 1, 2022
WVU	September 28, 2021; March 7, 2022
CMCR	October 29, 2021; March 3, 2022
Wraparound	August 27, 2021; March 3, 2022
TFC	September 1, 2021; November 8, 2021
Screening, Assessment	March 3, 2022
PBS	February 28, 2022
Outreach and Education	November 15, 2021; March 1, 2022
QAPI	August 27, 2021; November 16, 2021; March 10, 2022
Residential (R3)	September 1, 2021; September 27, 2021; October 19, 2021; November 23, 2021; January 6, 2022; January 21, 2022; January 26, 2022; February 22, 2022
ACT	March 2, 2022
Workforce	February 25, 2022

Appendix C — SME Compliance Rating Criteria

CATEGORY	CRITERIA
Substantial Compliance	<p>Has undertaken and completed the requirements of the paragraph; no further activity needed OR</p> <p>Has undertaken and completed the requirements of the paragraph--met with updates continuing to occur.</p>
Partial Compliance	<p>Compliance has been achieved on some of the components of the assessed paragraph or section of the agreement, but significant work remains;</p> <p>Has developed deliverables that indicate the state is actively addressing the requirements of the paragraph;</p> <p>Has provided data that indicates the State is actively addressing the requirements of the paragraph;</p> <p>Has implemented activity and has yet to validate effectiveness;</p> <p>Has implemented activity but has not developed procedures to assess the effectiveness of the service or has not taken adequate measures to ensure its sustainability after the agreement terminates;</p> <p>Has begun activities but not completed implementation activities.</p>
Non-Compliance	<p>Non-compliance indicates that most or all of the components of the assessed paragraph or section of the agreement have not been met;</p> <p>Has made little or no progress to meet the targets set forth in the Agreement, Implementation Plan or other plans;</p> <p>Has done no work to meet the date as set forth in the paragraph of the Agreement.</p> <p>Has not provided data or access to staff so that the Subject Matter Expert may properly assess compliance.</p>
Not Rated	<p>Not Rated indicates a paragraph or section of the agreement where the parties have agreed that the Subject Matter Expert shall not rate the State's compliance during the assessment period.</p>
<p>NOTE: All criteria are applied specific to the time period reviewed. For example, a rating of partial compliance in one report period would not necessarily continue to be rated as partially compliant if there is no continued evidence of progress. A rating of substantial compliance in one report</p>	

period would not continue to be rated as substantially compliant if achievements were not maintained.

SUPPORTING DOCUMENTATION

The SME will rely on written information, and data from the Quality Assurance and Performance Improvement (QAPI) System and the quality sample reviews of children, provided by the State to arrive at its evaluation. Deriving compliance from written document has limitations as even the best-intentioned policies do not succeed or fail on their own merits; their progress is dependent upon the processes of implementation. Noting this limitation, the SME's determination of substantial compliance will rely on data from the QAPI and the quality sample reviews of children, and implementation of the State's continuous quality improvement plan in which the State implements changes to policies, procedures, practices, regulations and other relevant State guidance and activities based on trends in QAPI data.

Information reviewed will include, but is not limited to:

1. Standard Operating Procedures and Contracts – contract requirements, policies and related documents such as service descriptions; admissions, continuing stay, medical necessity, and discharge criteria; provider bulletins, communications with providers, manuals, and transmittals; billing and reporting requirements and manuals; staffing requirements; and documentation requirements, meetings with providers and stakeholders.
2. Training – initial and continuing training requirements for services, supports, and staffing; training curricula, including seat-time and competency-based requirements; training specificity (i.e., is the training sufficient to deliver to the service in a manner that is likely accomplish Agreement goals); and training evaluation practices.
3. Oversight and Monitoring – identification of measures and operational objectives; selection and validation of performance measures, benchmarks, and targets for improvement over time; use of measurement and analysis to identify relative areas of success and weakness; measurement of stakeholder and family engagement (e.g., survey instruments, focus groups, independent observation, etc.); case reviews with attached methodology (e.g., random sampling, statistical sampling, etc.); performance improvement plans; audits and auditing procedures.
4. Data-driven Quality Improvement – planning, implementation, and regular use of well documented, structured, iterative processes for reviewing data from #3, above, to drive continuous quality improvement; goal setting, looking at the actual data for performance measures, and acting on results.

Appendix D — Summary of Recommendations and Information Sought

Workforce		
Recommendation		Status Updates
1a	The SME recommends that the State assess the ability to expand the number of CSED Waiver facilitators, given the number of Wraparound facilitators working in the State and the current lower than expected enrollment in the CSED Waiver.	
1b	The SME recommends that DHHR document how it is using this data on an ongoing basis, including as part of its CQI processes, to improve capacity.	
1c	The SME recommends that this data also be coupled with other quality and fidelity data to monitor fidelity to NWI standards.	
1d	The SME recommends DHHR consider ways to automate this data to reduce staff burden in collection and analysis and to support the expansion of data collection to services in addition Wraparound.	
2 & 2a	The SME recommends that DHHR indicate its planned approach to monitor capacity for the other services, and initiate work on that approach prior to the next SME report in October 2022. The SME encourages the State to adopt methods that clearly display data, use common data and terms where possible, and link such collection and analysis to its CQI plans.	
3a	The SME recommends that ARPA-funded initiatives differentiate any specific approaches or modifications relevant to children and youth.	
3b	Where ARPA-funded efforts report data, the SME recommends such data be disaggregated to clearly display efforts related to children and youth.	
3c	Following DHHR’s review of each ARPA-funded initiative, the SME recommends that DHHR provide a written plan regarding what DHHR learned from the effort that is applicable to children and families, and steps regarding moving from planning to implementation to sustainability.	
4	The SME recommends that DHHR qualitatively and quantitatively detail any STLR efforts specific to children and youth and share any specific plans and lessons learned.	
5	The SME recommends that DHHR share with the SME all training materials—including training dates, who will be trained, and the actual training curriculum—with adequate time to review and make any recommendations, as needed, prior to being implemented.	
6	The SME recommends that DHHR update its work plan to reflect revised dates, new and amended tasks, and CQI measures and processes.	
Target Population		
Recommendation		Status Updates

1	The SME recommends that the State follow the federal definition of SED (i.e., inclusive of an ADHD diagnosis only) for the “at-risk of residential” group.	
2	The SME recommends that DHHR complete its plans to review the subpopulation with SUD-only diagnoses further to understand the co-occurrence of mental health conditions and to ensure these youth are connected to the appropriate services to address their needs.	
3	The SME recommends that DHHR retrospectively analyze CAFAS/PECFAS data on youth, including the services utilized by youth across BBH, BMS, and BSS, to determine whether a CAFAS/PECFAS score at or above 90 is the right score to capture the “at-risk of residential” group.	
4a	The SME recommends that DHHR analyze children and youth with a CAFAS/PECFAS score 90 or above but who are not using CMCR, not in foster care, or not in youth custody are not at risk for residential intervention to determine whether the definition of “at-risk” may exclude children who are unable to access services.	
4b	The SME recommends that the analysis in 4a, above, include in its methodology considerations of accessibility to such services necessary to be deemed “at-risk.”	
5	The SME recommends that the provision that the youth must also expect to need residential “in the next 30 days or less” (in addition to a SED diagnosis, utilization of certain services, and a CAFAS/PECFAS score at or above 90) be removed from the definition.	
6	The SME recommends that the State clarify how long a child remains in the data set (i.e., whether a child remains in the target population data set indefinitely or whether DHHR will refresh data based on an annual re-determination process).	
7	The SME recommends continued monitoring and reporting of families that decline the CSED Waiver, and a revisiting of this issue in the State’s semi-annual reports, including any outreach or engagement activities associated with families who decline (e.g., surveys, focus groups, needs assessment). DHHR will need to determine if this group is large enough to eliminate significant data from the “at-risk of residential” data set.	

CSED Waiver

Note: The recommendations in this section are specific to the CSED Waiver process, operations, or materials. Additional recommendations specific to services approved in the CSED Waiver are addressed in the service sections that follow.

	<i>Recommendation</i>	<i>Status Updates</i>
1a	The SME recommends that the State’s CQI plan be amended to include how the state will monitor and ensure quality oversight of the proposed 1915(c) Waiver change to expand the workforce by using non-licensed master’s trained clinicians, including appropriate supervision and ratios of supervision as mandated in Chapter 503.	

1b	The SME recommends close monitoring of the 250 Waiver slots (of 2,000 overall slots in Year 3) dedicated to youth discharging from a residential service to ensure that the State retains priority capacity for residentially placed youth or seeks CMS approval for added capacity if necessary. If the proposed change to permit children to enroll and remain on the Waiver without service utilization for 365 days (from 180 days) occurs, the SME recommends a specific data plan to ensure that a child enrolled in the Waiver but not engaged in any service continues to be tracked and reported separately.	
1c	The SME recommends that the DHHR provide details regarding its plan to monitor family choice, given the adoption of language that services are to be delivered “in the setting most appropriate for the member to meet their service needs and goals.” The SME also recommends that DHHR track and report place of service data, including the specific community locations that families are selecting as more private and convenient locations for this service rather than their own homes.	
1d(i)	The SME recommends that DHHR clarify how it will implement the requirement that all family therapy be provided consistent with an EBP and whether it will provide technical assistance to providers and/or develop quality oversight plans specific to EBPs.	
1d(ii)	The SME recommends that BMS/DHHR add greater specificity regarding what constitutes an evidence-based approach.	
1d(iii)	The SME recommends that all language ensure that the EBP used is consistent with the needs of the youth and family, and not offered at the convenience of the provider. Specifically, the state will need to ensure that the child has access to the right EBP based on their assessment.	
1d(iv)	The SME recommends that DHHR assess providers’ capacity and develop a plan to support providers to hire and retain certified/EBP trained staff, and carry out the necessary supervisory, ongoing coaching, and fidelity data collection to successfully deliver EBPs.	
1d(v)	The SME recommends that DHHR’s CQI address how it will ensure that EBPs being offered to children and families are consistent with assessed needs and how providers are achieving and sustaining fidelity to the model(s) they offer.	
2	The SME recommends that the issue of how children and youth can maintain an ongoing therapeutic relationship while in the Waiver be included in CQI activities to ensure that providers understand this continuity is not only allowed but expected (based on the youth’s and family’s wishes) and that quality review processes ensure that disruptions to therapeutic relationships are not occurring.	
4a	In addition to presenting data by service, the SME recommends that behavioral health utilization across all	

	behavioral health services—both CSED Waiver and state plan—aggregated monthly and yearly—so that DHHR can understand the types of services and amount of service <u>each</u> child is receiving.	
4b	The SME recommends reporting Waiver data by service hours rather than units of service, so that the type, amount, and duration of services received per month is clear.	
4c	The SME recommends that DHHR review Waiver data, and other available fidelity and quality data, using its new CQI process, to determine what factors may be contributing to relatively low service provision (i.e., low hours of service provided per child).	
4d	The SME recommends that DHHR use its new CQI plan and develop a plan for how it will review, analyze, correct, and monitor the issue that some services have little to no utilization at all.	
5	The SME recommends that the State share information regarding its planned changes, if any, to the Waiver or other Medicaid delivery systems and strategies.	
6	The SME recommends DHHR include information on how the CSED Waiver entertains service limits, including how BMS is monitoring Waiver service utilization; how BMS grants additional service units if medically necessary; how BMS communicates to providers that additional units beyond the caps can be sought, information required by the provider to be submitted for review, and how the State reviews these requests, along with the number of such requests received annually; and its processes for data collection and analysis for children who reach service utilization caps.	
7	The SME recommends that the MCO be tasked by BMS to also monitor underutilization of Medicaid services for Waiver-enrolled children.	
8	The SME recommends that DHHR and its vendor develop a sufficiently detailed SOP to monitor and ensure that services and plans of care are individualized to meet the needs of children and youth and not a standard, one-size-fits-all approach. Additionally, the SME recommends that DHHR indicate in an SOP or other document how it monitors and provides oversight of its vendor’s tasks.	
9	The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, including related CQI measures and processes.	

Screening		
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	<i>Recommendation</i>	<i>Status Updates</i>
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1	The SME reiterates an earlier recommendation that DHHR develop a written plan and implement a process to monitor DHHR staff compliance with screening policies. The SME further recommends scaling these types of efforts across all bureaus/departments with coordination in approach and consistency in data collection, analysis, and reporting.	
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	The SME recommends that updates to the screening-specific data plan include who is responsible for review once the Office of Quality Assurance generates data, the frequency of that review, and plans to monitor staff compliance.	
2	The SME recommends that every mental health screening tool used by DHHR be a recognized tool for the purpose of screening for mental health needs with demonstrated reliability and validity for the population it is screening.	
3	The SME recommends that any job aid supporting workers to identify children with behavioral health benefits be required for training purposes and that supervision and ongoing quality oversight ensure that workers are consistently and correctly using the job aids.	
4	The SME recommends that DHHR clarify if the three BSS documents submitted for this report are drafts or have been implemented. If they have been implemented, the SME requests feedback from any participants, plans for revisions based on that feedback, next steps for how materials will be used, and how quality oversight and monitoring is occurring or will occur.	
5	The SME recommends that the Pathway to Children's Mental Health document be revised to correct the error regarding the availability of CMCR. If training has already occurred, the SME further recommends that additional information specific to CMCR be provided as follow-up to those trained.	
6	The SME recommends that DHHR clarify if the document titled <i>Detention Referrals to Children with Serious Emotional Disorder (CSED) Waiver Standard Operating Procedure (SOP)</i> dated 2/24/22 is an internal DJS SOP or if it is a document for a different purpose and that it clarify the referenced BJS protocol that is forthcoming.	
7	The SME recommends that DHHR submit information related to how DOE is carrying out mental health screening and what, if any, data is available.	
8	The SME recommends that DPS provide information on how it ensures that staff review the MAYSI training manual and seek clarity to their questions on administering the MAYSI, as well as collection of data on its use, and processes to ensure that children who screen positive are timely connected to HCBS.	
9	The SME recommends that BMS submit information prior to the next SME report regarding all BMS related screening activities and data, including its efforts with its MCOs to improve mental health screening data. Additionally, the SME seeks an update on BMS plans to implement a modifier attached to screening codes.	
10	The SME recommends that OCMFH submit information prior to the next SME report regarding its screening activities including implementation of the new screening questions, quality improvement activities and development	

	of a quality plan, and plans for additional quality record reviews, including analysis of 0-5 and 18-21 populations.	
11	The SME recommends that screening workgroup activities and outreach and education workgroup activities be coordinated, particularly given the Agreement requirement to “(1) conduct outreach to and training for physicians who serve children who are Medicaid-eligible on the use of the screening tools; (2) develop outreach tools for medical professionals who treat Medicaid-eligible children.”	
12	The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, including related CQI measures and processes.	
Children’s Mobile Crisis Response		
<i>Recommendation</i>		<i>Status Updates</i>
1	The SME recommends that DHHR provide CCRL operational policies for compliance review in Fall 2022, as well as documentation about how BBH monitors and oversees those CCRL requirements, to demonstrate consistent compliance with Agreement provisions.	
2	The SME recommends that BBH monitor outreach and engagement activities to ensure that efforts to inform families about the CCRL specifically are included at each event, with particular focus on those likely to reach or include children, youth, young adults, and their families. Additionally, the SME recommends that these outreach efforts be coordinated with the Outreach and Education workgroup.	
3a	The SME recommends continued assessment and monitoring of county-level data, particularly as some counties are not yet using the service, to determine if some counties are unaware of the CCRL, or if they continue to use historically available crisis resources such as the ED.	
3b	The SME recommends continued efforts to diversify referral sources and deepen referrals from key groups such as mental health professionals; pediatric primary care providers; and judges and the judicial system, including probation services.	
3c	The SME recommends that DHHR work with the CCRL to continue to improve its data completion rate, noting that during a crisis call, it is clinically appropriate to not focus on the collection of administrative data and therefore, that some data will continue to be missing from any data set.	
3d	The SME recommends that the vendor have a clear operational policy for handling CCRL–CMCR “warm transfer” situations and that BBH detail how it is addressing situations in which the CMCR was not available to the CCRL in a timely way.	

3e	The SME recommends that DHHR share more about its planned enhancements to better serve LGBTQ+ and/or BIPOC children and families.	
3f	The SME recommends that BBH continue to monitor regional variation, and through its CQI processes, address any variations.	
4	The SME recommends that BBH ensure its vendor has clear operational policies specifically addressing text/chat scenarios. Specifically, the SME recommends that BBH establish a protocol by which an individual could be transferred to the phone from chat if the individual opts to do so.	
5	The SME recommends that BBH and BMS coordinate their reporting for CMCR services utilization by region, length of CMCR engagement, and presenting needs, with additional stratification by age and other factors.	
6	The SME recommends that CMCR training include an overview of all DOJ Agreement services and all other behavioral health services funded by DHHR; how CMCR services work with other services, schools, BSS caseworkers, MCOs/ASO, and the FirstChoice crisis and referral line; use of any standardized tools such as the CANS, CAFAS/PECFAS, the Crisis Assessment Tool (CAT), etc.; expected outreach and education efforts; and required quality, outcomes, and data reporting.	
7	If there are training requirements that DHHR has for agencies apart from completion of the statewide Marshall University training, the SME recommends that the State review and approve the training content(s) offered by each provider agency to ensure it is of sufficient quality and consistent with the State’s goals in providing CMCR.	
8	The SME recommends that the State incorporate CMCR data into its other workgroups to inform interconnected tasks and decision points, such as the assessment pathway work, redirection from residential interventions, and coordination with Wraparound.	
9	The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, including related CQI measures and processes.	
Behavioral Support Services		
<i>Recommendation</i>		<i>Status Updates</i>
1	The SME recommends that the State clarify and share information about how the assessment pathway clarifies connection to behavioral support services, both for youth who may and those who may not meet CSED Waiver eligibility, to ensure timely access, including how families, schools, behavioral health providers, courts/judges, and staff from all three bureaus can access the service.	

2	The SME recommends that a protocol be established that would include the offer to consult with a waitlisted child’s current provider to help the provider develop a plan, and that any child waiting for behavioral support services be referred to a non-CED provider that is already providing these services under Medicaid.	
3	The SME reiterates its recommendation that it receive a draft of the behavioral support services’ specific changes to the provider billing manual to allow for discussion and incorporation of any SME comments before it is finalized.	
4	The SME recommends that the State submit a revised training plan for the full 2023 year for review and discussion and grant the SME access to the online training platform to review the actual curricula.	
5	The SME recommends that the DHHR clarify how the “Risk of Out of Home Placement” ranking used by a BSS vendor will relate to the use of the CAFAS/PECFAS and criteria for CSED Waiver eligibility, if at all, and specifically whether this question has any broader implications for access to CSED waiver or other services.	
6	The SME notes that the State’s Assessment Pathway and CQI plan include tracking referrals from schools. We look forward to reviewing data further connecting these findings in future report cycles.	
7	The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, and CQI measures and processes.	

Therapeutic Foster Care (TFC)

<i>Recommendation</i>		<i>Status Updates</i>
1	As the parties discuss differences in the interpretation of which children are required to be provided TFC services under the terms of the Agreement, the SME recommends that children, regardless of foster care status, can benefit from therapeutic foster care, especially as an alternative to other out-of-home placement settings.	
2	The SME recommends that the State further differentiate STAT homes from traditional foster care homes and homes for children with medical complexity.	
2a	The SME recommends that the STAT Homes SOP either mention children with medical complexity or, if these children are served in other homes, note this approach.	
2b	The SME continues to recommend clarification of the difference between Foster Care Tier III and STAT homes. In particular, the SME recommends detailing when and why a youth would move from a Tier III home to a STAT home, detailing when a youth would move from a Tier II home to a Tier III home versus a STAT home, and clarifying if there are any training or rate differences between Tier III and STAT homes.	
2c	The SME recommends that DHHR develop and implement a compliance and CQI process to explore which children are served in Tier II, Tier III, and STAT homes and explore	

	differences in demographics, presentation at time of placement, and initial and long-term outcomes among these youth.	
3	The SME recommends that DHHR continue to utilize language about “managed” versus “unmanaged” behavioral health needs in working with CPAs and STAT homes, as it reflects current presentation versus diagnosis or history of the youth.	
4	The SME recommends that the State explore how different homes for children with medical complexity may look, the requirements and expectations of those providers, and when a child can be served in which environment.	
5	The SME continues to recommend that the State develop a clear implementation plan for the phasing in of the new STAT model. Although the State has indicated the model will phase in and be adjusted iteratively as it is implemented, the swift sequencing of activities is likely to limit or highly pressure each iteration as there is little time to incorporate feedback and adjust.	
5a	The SME recommends that DHHR consider whether it should re-evaluate its timeline for STAT Home Model Implementation to account for the existing workload of DHHR staff and CPA agencies, the need to recruit STAT home families, and the documented challenges facing WV related to the pandemic and workforce shortages.	
5b	The SME recommends that the plan to phase in the STAT model prioritize minimizing disruptions to children who currently are in TFC homes but who may not meet the criteria under the new TFC model. It may cause more trauma and harm to children to change living arrangements suddenly than to create a thoughtful approach to transitioning that is focused on implementation of the child’s permanency plan.	
5c	The SME recommends that DHHR define what is meant by “should there be a disruption” in its STAT Home SOP Draft of March 2022. Scenario 2 and Appendix B detail this further, but the term “disruption” is unclear in its meaning. It also suggests a reactive approach. The SME recommends DHHR identify a proactive review process during the transition to the use of STAT homes to ensure that children currently in traditional foster care can gain access to a STAT home prior to needs escalating to the level of an RMHTF. The SME recommends DHHR outline examples of what this could look like and why a prolonged need for intensive interventions (Appendix 2) would necessitate a STAT Home.	
5d	The SME recommends that the State work closely with the provider community and identify key champions that will assist with the direct messaging to CPAs and, most importantly, to the TFC families during this transition plan.	
	The SME continues to recommend that the State anticipate that it will be challenging for TFC caregivers to have a child	

	leave their care when they no longer meet the level of need for TFC and seek support in regarding this issue.	
5e	The SME recommends that the State provides its rationale for not differentiating the rate for the new model from the rate for the current model, notwithstanding additional expectations for the STAT home model, and clarifies any anticipated difficulties recruiting and retaining families if the rate remains the same.	
6	The SME recommends that DHHR provide responses to each of the questions and recommendations presented in the January 2022 WV Foster Adoptive & Kinship Parents Network (WVFAKPN) document about the new treatment home approach.	
6a	The SME continues to recommend that biological, kinship, foster families <i>and</i> youth should share their experiences, including what it looks like when TFC families and agencies are partnering and helpful, as well as what can be harmful or result in challenges to engagement and partnership. The SME recommends identifying some families and youth involved with foster care and some TFC parents to co-develop tip sheets about what works and what does not work and include them as co-trainers in the STAT home training.	
6b	The SME continues to recommend the State utilize resources from the HHS Children’s Bureau’s National Quality Improvement Center on Family-Centered Reunification (https://qicfamilyreunification.org/), including its best practices guide, to help identify strategies to support effective treatment and reunification.	
6c	The SME encourages the State to identify families with lived experience, youth or young adults currently or formerly involved with foster care, and TFC parents to provide input on the model and its implementation, both initially and on an ongoing basis. The SME encourages the State to compensate the families and youth financially for their participation.	
7a	The SME recommends that the State continue to listen to CPA and CSED Waiver providers to find out the existing barriers to integrating services and issues with role clarification and develop an intentional training and technical assistance approach to address those issues, including clear, written expectations and review protocols.	
7b	The SME recommends that the State engage in a transparent and ongoing process to obtain feedback on the proposed TFC approach.	

8	The SME recommends that the State review all assessment pathway materials to ensure that STAT homes are included as an option and further support redirection from residential interventions during the phase-in process and in the future. The SME recommends that the State review the children in residential care to determine how many may meet eligibility for TFC and determine a pathway to TFC out of residential care whenever possible. The SME notes that there may be children currently in TFC who do not meet clinical and functional eligibility and recommends that the State track capacity as these children reunify with families, otherwise achieve permanency, or leave these homes.	
9	While acknowledging the work that the State has done to date on outlining performance and outcome measures, the SME recommends that the State create a detailed plan for how it will collect, review, analyze, and report on timely access to TFC, per the terms of the Agreement. The full text of the report includes specific suggestions for creating this detailed plan.	
10a	The SME recommends that DHHR consider how the identified STAT Home Training differs from what is provided to all foster families. The SME understands that PRIDE training is used for all foster families but encourages DHHR to include training specific to the needs of youth served by STAT homes. PRIDE trainings are important but not necessarily specific to the needs of youth in STAT homes.	
10b	The SME notes that BSS is requiring that CPAs provide advanced trauma informed trainings for all STAT homes. The SME commends BSS inclusion of advanced trauma responsive care and services and recommends that DHHR develop a plan to support CPAs, including how it will assess the impact of the training, and any ongoing training needs.	
10c	The SME continues to recommend that the State incorporate an evaluation methodology to assess whether its training is effective in assisting STAT parents in acquiring, retaining, and utilizing the skills necessary to maintain children in their STAT home and transition successfully to a family home.	
11	The SME recommends that the State conduct a needs assessment that includes agency and organizational factors that may bolster or hinder training and coaching at DHHR, the ASO, and the CPAs, such as staffing needed for training and supervision; the recruitment and retention of foster parents willing to meet training standards; the infrastructure needs to maintain training and coaching, including whether such a program would be State-led or if the State would rely on an outside purveyor to develop training materials; and the development of a monitoring and evaluation plan.	
12	The SME recommends that DHHR provide written guidance to its ASO on all functions it is expected to	

	perform on behalf of the State. For example, it is not sufficient to assume that the ASO will monitor these youth; it is necessary for DHHR to specify how it wants KEPRO to monitor youth and the reports it is to receive to support DHHR in overseeing the ASO's monitoring.	
13	With the foster care procurement completed, the SME recommends that DHHR develop a clear, consistent workplan with measurable and actionable goals, each with a clear owner, and firm deadlines to begin implementation of the intended TFC service. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, including related CQI measures and processes.	
Reductions in Placement		
1a	In addition to tracking the required reduction in the number of youth, the SME recommends analyzing other data relevant to quality, including lengths of stay and repeated admissions or changes in admission facility type during a single episode of care. This data should be stratified by provider, age, race/ethnicity, gender, LGBTQ+ identity, and county of origin.	
1b	The SME recommends collecting data on which system children are entering residential interventions from and the decision source of the child's residential placement to identify additional diversion, engagement, and outreach and education strategies needed.	
1c	The SME recommends that the State develop specific diversion plans for the two primary sources for residential admissions: judges/courts and BSS MDTs. The goal for these system specific diversion plans should be a reform of the entire children's system of care and overall utilization of residential interventions, regardless of the system referring to or paying for the residential placement.	
1d	The SME recommends that DHHR further explore data to identify disproportionalities in the number of children who are Black, Indigenous, or People of Color in the numbers served in group residential interventions and PRTFs, both in-state and out-of-state.	
1e	The SME recommends that DHHR receive and report on data that allows it to understand an unduplicated count of parentally-placed children and each child's length of stay on a monthly basis.	
1f	The SME recommends DHHR provide data tables in the semi-annual data reports on residential services to assist with ongoing analysis.	
1g	The SME recommends that the semi-annual report and any other residential specific data report include diagnostic data along with CANS and CAFAS data.	
2a	The SME recommends that DHHR develop and/or include in its workplans and implementation plan details regarding when the revised service description and criteria will be finalized.	

2b	The SME recommends that DHHR outline the steps it will take to implement these changes, including timelines, that address support given to providers to deliver the new model (including training and technical assistance), any revisions to rates or provider qualifications, and its intended quality oversight activities.	
2c	The SME recommends that DHHR continue to elevate family and youth engagement to ensure that language continues to be integrated across all materials, including the forthcoming RMHTF transition and discharge planning training and the RMHTF provider manual, emphasizing the central role of the family and youth in all decision making relating to them.	
3a	The SME recommends that DHHR work with Aetna to define “specialized” and “small cottage” residential programs and develop clear criteria for children to be served in those settings to ensure that DHHR does not undermine its goal of reducing use of residential placements.	
3b	The SME recommends that DHHR work with Aetna to identify sustainable approaches to the use of the reinvestment funds (e.g., how staff hired through incentive funds will continue to be maintained).	
4	The SME recommends that the State provide the SME with additional information regarding the process and criteria KEPRO will use to provide level of care assessments, including efforts to partner with Aetna to divert children and gain access to HCBS, and all related forms and documents, including KEPRO’s suggested refinements to assessment processes, redacted reports regarding level of care assessments, training materials, and data reports.	
5a	The SME recommends an update be provided on the process for Commissioner level sign-offs for out of state placements, including sharing with the SME any policy and procedure, and lessons learned since the policy was implemented.	
5b	The SME recommends that DHHR review data from Aetna’s deep dive process and from the Commissioner-level reviews to understand what impact the reviews are having, what action steps are resulting in positive change in placement for a youth, what actions are not resulting in any change, differences across placement, and youth needs.	
5c	The SME recommends that the State ensure that Aetna MHP’s clinical reviews are collaborative with the child, family, and members of the child’s team to ensure that plans are not developed for children and families without their input and engagement.	
5d	The SME recommends that DHHR review each child under age 13 placed in an RMHTF to ensure that it is the most appropriate, least restrictive environment for that child.	

6	The SME recommends that, as Aetna and DHHR implement the use of the RMHTF spreadsheet, instructions do not tell workers to delete youth from the spreadsheet when they are discharged to the community. The SME recommends that line of data be moved to a different tab on the spreadsheet to preserve the data and assist with continuity of care planning and tracking.	
7	The SME recommends that the drop-down list for “Reason Individual Cannot be Served in the Community” be reviewed and revised to ensure alignment with the Agreement. For example, reasons that reflect the inability of someone to find an alternative family-based placement are not justification for a placement in an RMHTF.	
8	The SME recommends that the State conclude with its synthesis, policy planning, and decision-making about action steps so it can present and share these findings with providers, families and youth, stakeholders, DHHR caseworkers, and other relevant personnel to solicit input and recommendations. Further, the SME recommends that DHHR determine its planned actions steps based on what DHHR learned from the cluster analysis, provider survey, and discussions with stakeholders and incorporate these lessons into its plan to redirect youth from residential interventions.	
9a	The SME recommends that the State distinguish between youth’s behavioral health needs and levels of intervention in its action plan resulting from the cluster analysis. The plan should emphasize a decoupling of intensity of intervention needed from placement location.	
9b	Given the numbers of youth in all classes that are wards of the State, adjudicated, or deemed status offenders, the SME recommends that DHHR develop a plan to work across bureaus and departments to develop specific plans specific to each population of children (including those involved with the Department of Homeland Security), and more closely explore the differences in philosophy and approach that may drive decision-making.	
9c	The SME recommends that the State carefully review how the population labeled as class one in the cluster analysis found its way to a residential intervention, particularly for the youth placed out-of-state, to determine all of the pathways that need to be redirected and develop a plan to discharge to the most appropriate home setting and connect to treatment needs. This process will likely include engagement with caseworkers, judges, and other systems that may perceive residential interventions as an appropriate placement location versus a behavioral health intervention.	
9d	The SME recommends that DHHR develop, in coordination with the Department of Homeland Security, a strategy and written plan to actively engage the judicial system in committing to a reduction in residential placements. (See	

	page 106 for specific considerations that could be incorporated into this plan.)	
9e	The SME recommends that youth with substance use (i.e., some class two youth) be carefully assessed to determine concomitant mental health needs.	
9f	The SME recommends that DHHR carefully review the data on the youth included in class two (Youth with Legal & Conduct Issues), which had the highest percentage of youth who are Black, to identify action steps to address possible disproportionality or overrepresentation of Black youth in residential care, particularly for conduct disorders.	
9g	Given current data collection practices, the SME recommends stratifying length of stay data by class to understand additional factors that may be maintaining residential interventions.	
9h	The SME recommends that a specialized working group, with additional outside consultation if needed, be implemented to review the data specific to youth with both mental health and developmental disabilities, assess current and additional service needs, and develop recommendations specific to meeting the needs of this group of youth.	
9i	The SME recommends that specific training and coaching are needed for residential providers in order to ensure that treatment and supports are trauma-responsive and recognize chronic, community, and inter-generational trauma and their impacts on goal-setting, engagement, treatment planning, and outcomes.	
10a	The SME recommends that DHHR determine its actions steps resulting from its analysis of provider responses and include these actions steps in its coordinated reductions in residential plan.	
10b	The SME recommends that future work include rate analysis and an assessment and action plan to determine how to include residential providers as Medicaid providers. This step is particularly important given the dearth of aftercare services provided and the need to evolve residential providers to utilize and/or expand their capacity to provide services in home and community settings.	
10c	The SME recommends that DHHR ensure that its efforts regarding workforce and training are connected to the R3 workgroup, including opportunities for providers to share additional feedback on the changes and resources needed to address workforce issues that are impacting the quality of residential care.	
10d	As DHHR finalizes its assessment pathway, the SME recommends clarity on how the assessment pathway can facilitate access to both behavioral health services and other socially necessary services. In addition, the SME recommends that DHHR seek clarity on the issue of infrastructure for referrals for socially necessary services or behavioral health services to determine if it is confusion	

	among a few providers or a larger issue for many providers.	
10e	The SME recommends that the State develop and implement a specific plan to address the factors identified as contributing the most to long lengths of stay (i.e., lack of ability to return home or find an alternate placement and court mandates).	
10f	The SME recommends that DHHR develop a specific policy on continuity of information (e.g., previous assessment data) and monitor the data to ensure that all DHHR assessment information across providers and bureaus be shared with residential providers. Additionally, exchanges of information should not be limited to assessments at the start of residential interventions but should be treated as regular touchpoints during treatment and transition planning.	
10g	The SME recommends that DHHR clarify with providers what it means to complete a “level” within such programs and clarify the extent of the use of point system approaches by providers of residential interventions, which might be at odds with what the State wants to pursue under a new system.	
10h	The SME recommends that the State monitor data to ensure that discharges from residential intervention to shelters do not occur.	
10i	The SME recommends that residential providers play a larger role in transition planning, particularly QRTPs, and that the State address a potential disconnect between what residential providers do for discharge planning and the expectations of BSS staff.	
11a	The SME recommends that DHHR align its PRTF, residential, and HCBS efforts with its FFPSA plan to ensure consistency and minimize gaps in care, including how the pathway to HCBS services and FFPSA Act services connect, and are coordinated, for certain populations of children and families.	
11b	The SME recommends that the service pathway include how families may receive referrals to FFPSA services, particularly for youth experiencing behavioral health needs who may be appropriate to receive Functional Family Therapy (FFT) services. A referral to determine eligibility for FFPSA could be in addition to or instead of a referral for Wraparound services, depending on the needs of the child and family.	
11c	The SME recommends aligning performance and outcomes data collection and reporting activities with those being implemented for FFPSA, including the approach that is being designed to align with the federal Child and Family Services Review and the data being collected by KEPRO, including for socially necessary services (see p. 38–39 of the Prevention Plan).	

12	The SME recommends that the State presume that all children ready for discharge from residential interventions would benefit from Wraparound specifically. As such, the SME recommends that any child leaving residential treatment be offered Wraparound with the exception of those who would benefit from or choose ACT.	
13	The SME recommends that future work expand on its assessment pathway to orient the pathway to demonstrating why a child cannot be treated in the community. This work may need to center on aspects of the pathway not yet developed, such as establishment of a coordinated process across certain providers—including CMCR, in-home family therapy, Wraparound, and BSS providers—who can proactively create a plan of care for a child to remain in the community.	
Outreach and Education		
1	The SME recommends that the State update its Outreach & Education plan as the last provided version is dated November 202.	
2	The SME also echoes earlier recommendations that the State must ensure that two-way communication methods with youth and families are central to the State’s outreach and education work. The WV Foster Adoptive and Kinship Parents Network (WVFAKPN) offered a document with a wide range of methods that DHHR might use to bolster its engagement with youth and families; ³⁶ the State should review and consider each of these thoughtful suggestions, along with thoughts from other family/youth representatives.	
3	As the State continues to develop its strategies to obtain family and youth engagement and input, the State should consider how to maximize the value of the Child Welfare Collaborative quarterly meetings. The WVFAKP shared other ideas about how to alter Collaborative meetings to better engage families and other stakeholders; the SME advises the State to consider these and other suggestions in its approach to the quarterly Collaborative meetings.	
4	DHHR should ensure that any Aetna outreach to the judiciary regarding agreement services is coordinated with the outreach of these workgroups to confirm consistent messaging and strategic sequencing. On a broader basis, the State should consider how to ensure its internal outreach efforts are coordinated with outreach efforts by other key communicators.	
5	The SME recommends that future information submitted for this report provide outreach efforts specific to children’s mental health. Disseminating information at community events as part of a broader outreach effort is an important strategy to deploy, but clarity is needed	

³⁶ See *Methods of Family Engagement in Child Welfare*, developed by the WV Foster Adoptive & Kinship Parents Network (2022).

	regarding information disseminated, specific to children’s mental health in order for those submissions to demonstrate compliance.	
6	The State provided a postcard that is used to remind MHP members to complete their EPSDT/Health Check exam. The SME believes that this postcard (and other related outreach materials) should explicitly state that the EPSDT/Health Check exam includes a mental health screening component.	
7	The SME urges the State to prioritize substantial involvement of DOE and DHS in future outreach and education work.	
8	The State and each of the workgroups need to continually update their work plans and regularly review them in order to prioritize ongoing work, including related CQI measures and processes.	
9	The SME encourages the workgroup to address how it can maintain steady, ongoing progress in this area once these report-related checkpoints are no longer required. The workgroup may also want to consider imposing its own form of structure (e.g., regular meetings, quarterly update reports) to provide a stimulus that the SME reports currently appear to create.	
10	Regarding public comment on the implementation plan, the SME encourages the State to share the comments it received and to incorporate feedback from the public comments into its work moving forward.	
11	The SME regularly checks the WV Child Welfare Collaborative website for information. The SME notes numerous broken links, meeting minutes posted that require passcodes, outdated information, and difficulty locating information. At a minimum, DHHR needs to implement an ongoing process to test and remedy broken links and posted information that is not accessible. More generally, DHHR would achieve its broader aims by refining its use of its website to be a tool to convey the important work it is doing.	
Quality Assurance and Program Improvement (QAPI)		
1a	The SME recommends that the State continue to develop its capacity to provide data in a timelier fashion.	
1b	The SME recommends that it receive planned data reports prior to the next report, and not as part of submissions for the report, to allow discussion with DHHR; and that an update be provided on the status of each data-related requirement, and its expected availability, across any source such as DHHR-generated, WVU-generated, MU-generated, BerryDunn-generated, or any other vendor source.	
1c	As DHHR’s data availability increases, the SME recommends that future semi-annual reports are more comprehensive to reflect data from all sources, including WVU and other vendors.	

1d	The SME recommends that DHHR's incorporate recommended changes from the SME and DOJ into future semi-annual reports.	
2	The SME recommends that the State provide a written plan for how reporting of the other measures in 48, 49, and 50 will occur. Given QAPI is scheduled for compliance reviews in the SME's Fall 2022 report, clarity, and transparency on the status of each specific requirement will be needed.	
3	The SME requests to receive a revised CQI and compliance monitoring plan acknowledging which comments from the SME were accepted or declined prior to the next report in time to allow discussion leading into the planned compliance review of QAPI provisions. See the full report for a list of specific areas where the SME recommends greater clarity in the CQI process.	
4	The SME recommends that DHHR present future phases of the dashboard work beyond indicators listed for Phase 1 and Phase 2, the indicators under consideration/planned, and timelines for each subsequent phase.	
5	The SME requests access to the data dashboard imminently prior to the next SME report when QAPI will be reviewed for compliance.	
5a	The SME recommends that discussions with DOJ and the SME occur Spring 2022 to address DHHR's concerns about HIPAA and confidentiality specific to implementation of dashboard Agreement requirements to ensure that timely progress on dashboard requirements continue.	
5b	Clarify approach to a prior SME recommendation regarding indicating data source and time period included as each component of the dashboard may be drawn from different data sources with different refresh rates. The SME has recommended that labeling occur as graphics will not reflect the same time period for every item.	
6	Regarding DHHR's new Office of Quality Assurance for Children's Behavioral Health, the SME requests ongoing updates on the status of hiring for this cabinet level position and for the staff within the office.	
7	The SME understands that a WVU report is imminent regarding provider, facility, and organization surveys; and that quality sampling interviews with youth and families are also forthcoming; and requests to receive a draft when it is received by DHHR.	
8	It is the SME's opinion that Agreement reporting must include behavioral health services that are received by the target population, even if those services are not the newly required services under the Agreement. See the full report for a list of specific areas where the SME recommends specific data.	

9	The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks, and CQI measures and processes.	
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