



# CHILDREN'S MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES

## Quality and Outcomes Report

Reporting Period: July 2021 – December 2021

Trend Review Period: July 2020 – December 2021

# Table of Contents

<b>1.0</b>	<b>Executive Summary .....</b>	<b>1</b>
<b>2.0</b>	<b>Introduction .....</b>	<b>8</b>
<b>3.0</b>	<b>Systems and Data Sources .....</b>	<b>10</b>
<b>4.0</b>	<b>WV’s Child Population .....</b>	<b>12</b>
<b>5.0</b>	<b>Partner Evaluations .....</b>	<b>14</b>
5.1	DHHR Children’s In-Home and Community-Based Services Improvement Project Evaluation .....	14
5.2	Wraparound and CANS Fidelity Assessment .....	15
<b>6.0</b>	<b>Outreach and Education .....</b>	<b>16</b>
<b>7.0</b>	<b>Screening .....</b>	<b>19</b>
7.1	Review Period, Data Sources and Limitations, Population Measured .....	19
7.2	Review Summary .....	21
7.2(a)	HealthCheck Screening Including Mental Health Screening During Well-Child Visits.....	21
7.2(b)	YS and CPS Screening .....	21
7.2(c)	BJS Screening .....	22
7.2(d)	Division of Probation Services Screening .....	23
7.3	Provider Capacity/Statewide Coverage.....	24
7.4	Strengths, Opportunities, Barriers, and Next Steps .....	24
<b>8.0</b>	<b>Pathway to Children’s Mental Health Services.....</b>	<b>26</b>
8.1	Review Period, Data Sources and Limitations, Population Measured .....	27
8.2	Review Summary .....	28
8.2(a)	Self-Reported Mental Health Diagnoses .....	30
8.2(b)	Timeliness Indicators .....	32
8.2(c)	Overall: From Referral to Assignment to a Wraparound Facilitator – A Family’s Perspective (calendar days).....	33
8.2(d)	Summary of Progression Through the Assessment Pathway.....	33
8.3	Provider Capacity/Statewide Coverage.....	36
8.4	Strengths, Opportunities, Barriers, and Next Steps .....	36
<b>9.0</b>	<b>Children with Serious Emotional Disorder (CSED) Waiver Enrollment and Services .....</b>	<b>38</b>
9.1	Review Period, Data Sources and Limitations, Population Measured .....	39
9.2	Review Summary .....	39

9.2(a) CSED Waiver Applications and Enrollment.....	39
9.2(b) CSED Waiver Service Utilization .....	41
9.3 Provider Capacity/Statewide Coverage.....	48
9.4 Strengths, Opportunities, Barriers, and Next Steps .....	49
<b>10.0 Wraparound Facilitation .....</b>	<b>51</b>
10.1 Review Period, Data Sources and Limitations, Population Measured.....	51
10.2 Review Summary.....	54
10.2(a) Wraparound Services Through BBH .....	54
10.2 (b) Wraparound Services Through CSED Waiver .....	58
10.3 Provider Capacity/Statewide Coverage .....	60
10.4 Strengths, Opportunities, Barriers, and Next Steps.....	60
<b>11.0 Behavioral Support Services .....</b>	<b>63</b>
11.1 Review Period, Data Sources and Limitations, Population Measured.....	63
11.2 Review Summary.....	64
11.3 Provider Capacity/Statewide Coverage .....	67
11.4 Strengths, Opportunities, Barriers, and Next Steps.....	69
<b>12.0 Assertive Community Treatment (ACT) .....</b>	<b>70</b>
12.1 Review Period, Data Sources and Limitations, Population Measured.....	70
12.2 Review Summary.....	70
12.3 Provider Capacity/Statewide Coverage .....	71
12.4 Strengths, Opportunities, Barriers, and Next Steps.....	72
<b>13.0 Stabilization and Treatment Homes (STAT Homes).....</b>	<b>73</b>
13.1 Review Period, Data Sources and Limitations, Population Measured.....	73
13.2 Review Summary.....	73
13.3 Provider Capacity/Statewide Coverage .....	74
13.4 Strengths, Opportunities, Barriers, and Next Steps.....	74
<b>14.0 Children’s Crisis and Referral Line .....</b>	<b>75</b>
14.1 Review Period, Data Sources and Limitations, Population Measured.....	75
14.2 Review Summary .....	76
14.3 Provider Capacity/Statewide Coverage .....	81
14.4 Strengths, Opportunities, Barriers, and Next Steps.....	82
<b>15.0 Children’s Mobile Crisis Response and Stabilization (CMCR) .....</b>	<b>83</b>

15.1	Review Period, Data Sources and Limitations, Population Measured .....	83
15.2	Review Summary.....	84
15.3	Provider Capacity/Statewide Coverage .....	88
15.4	Strengths, Opportunities, Barriers, and Next Steps.....	88
<b>16.0</b>	<b>Residential Mental Health Treatment Facility (RMHTF) Services .....</b>	<b>90</b>
16.1	Review Period, Data Sources and Limitations, Population Measured.....	90
16.2	Review Summary .....	91
16.2(a)	Qualified Independent Assessment.....	91
16.2(b)	Prioritized Discharge Planning.....	92
16.2(c)	Residential Services .....	96
16.3	Provider Capacity/Statewide Coverage .....	104
16.4	Strengths, Opportunities, Barriers, and Next Steps.....	105
<b>17.0</b>	<b>Outcomes .....</b>	<b>107</b>
<b>18.0</b>	<b>Conclusion .....</b>	<b>108</b>
	<b>Appendix A: Glossary of Acronyms and Abbreviations .....</b>	<b>110</b>

## 1.0 Executive Summary

The West Virginia Department of Health and Human Resources (DHHR) is actively working to reform mental and behavioral health services for children with serious emotional disorder (SED) and their families across West Virginia (WV). Beginning in 2019, DHHR has facilitated in-depth discussions and planning meetings with multiple bureaus, community partners and stakeholders to design and develop new pathways, processes, and services to help ensure home and community-based services are available and accessible statewide to reduce the risk of out-of-home placement in institutional or other settings. DHHR has implemented and built upon the existing frameworks and established new processes and pathways meant to identify children's mental health needs, provide families with timely and smooth connections to services, and to transition children currently placed in residential settings back to their family homes or other least-restrictive settings.

DHHR's goal is to reduce the number of children placed in Residential Mental Health Treatment Facilities (RMHTFs) to 822 by December 31, 2022, and to 712 by December 31, 2024. As of July 15, 2022, the number of children placed in an RMHTF was 814; considering continued intervention efforts and some fluctuation in admissions and discharges throughout the year, WV expects to continue to meet or surpass its goal to reduce placements by year-end 2022.

The trend review period (July 2020 – December 2021) for this report was, at least in part, impacted by the COVID-19 pandemic, which reduced the prevalence of some in-person services and caused some individuals and families to be more hesitant to seek care. This impact is noted in the information presented throughout this report. In addition, the Assessment Pathway<sup>1</sup> was also implemented during this period, which is a key turning point for easing children and families' access to home and community-based services.

Data collection, reporting, and quality improvement processes are at the forefront of managing and stabilizing these efforts, with the appointment of the Director for Office of Quality Assurance for Children's Programs made effective in late May 2022. Given the importance of utilizing data to evaluate systems and processes and make policy and program adjustments, DHHR launched its Continuous Quality Improvement (CQI) plan for children's mental and behavioral health services in December 2021, which includes ongoing quality reviews of available data associated with children's mental health services. The purpose of this report is to capture the results of these quality reviews for the period July 2021 to December 2021, including utilization trends for the period July 2020 to December 2021, with some exceptions for newly implemented services.

A multi-level/multi-system process has been built out to ensure families can easily be identified when a mental health need arises and be smoothly connected to services. Screening has been expanding in the last year to reach individuals interacting with primary care providers (through HealthCheck/well-child exams), as well as children interacting with the state's Child Welfare System, Bureau of Juvenile Services

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<sup>1</sup> The Assessment Pathway is the term used to describe the Pathway to Children's Mental Health Services, which connects youth and families to additional evaluation and referral to home and community-based services.

and Division of Probation Services. Once a child is screened for mental health related needs, if the screening results are positive the child is referred to the Assessment Pathway where they are given options for mental health services based on their needs or assisted with completing an application for the Children with SED (CSED) Waiver, which includes Wraparound in home services as well as other mental health services to try to meet the comprehensive needs of the family. Once the application is completed and submitted to the agency responsible for processing applications, an assessment is completed, and a determination is made for preliminary approval for WV Wraparound interim services. The family has the Freedom of Choice to select other services if desired such as Assertive Community Treatment (ACT) if eligible. If preliminary approval is achieved and the family is agreeable to this option, the family is connected to an interim Wraparound facilitator. Otherwise, the family is referred to other available community-based services if their need does not meet eligibility criteria for CSED, this may include non-CSED Wraparound eligibility if the family is interested in Wraparound services. Families are encouraged to utilize the Children's Crisis and Referral Line to connect to Mobile Crisis Response and Stabilization services as needed. Once final approval from the CSED Waiver program is received, for families choosing and eligible for this option, the child can maintain their current WV Wraparound facilitator, and the only change that should occur is the payor source for the service, allowing continuity for children and families.

In addition to the previously mentioned services, children may also be connected to adjacent services or families may choose other options.

- Behavioral Support Services are being expanded statewide through provider training, consultation on high intensity cases, and Positive Behavior Support program utilization for children with greater needs. These services are often used as part of the toolkit to support families in maintaining children in the home.
- Youth 18 and older, meeting eligibility criteria, can choose to engage in ACT as an alternative to Wraparound or CSED services. This service could allow them to engage with the same provider team into adulthood.
- As noted in the cluster analysis by Marshall University in 2021,<sup>2</sup> 46% of children are identified as having mental health needs while interacting with foster care. A new model of treatment homes for children at risk of placement in an RMHTF is being developed to prevent failed foster placements and reduce reliance on residential facilities while children are being connected to community-based services.
- The Children's Crisis and Referral Line is also available to families statewide to help connect them to screening, assessment, and services regardless of varying degrees of need.

In addition to community-based services offered statewide, DHHR is also regularly reviewing information regarding children in RMHTFs.

- Starting in January 2022, children in in-state facilities were reviewed for Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale

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<sup>2</sup> Pearson, T. (2021). *WV Youth in Group Residential and Psychiatric Residential Treatment Facilities*. Marshall University.

(CAFAS/PECFAS) scores less than 90—which is below current criteria to be enrolled in CSED (community-based services). These children were added to a prioritized list to focus on discharge planning and identify any existing barriers through the Continuous Quality Improvement process.

- DHHR is also providing outreach and education to key stakeholders including members of the judicial system to create buy-in to this new process to establish appropriate referrals based on a clinical assessment for level of need. Pieces of this process are still in development and early implementation stages but will include Qualified Individual Assessment (assessment by a qualified third party) and a Decision Support Model utilizing Child Adolescent Needs and Strength (CANS) Assessment scores to use as a guide to determine appropriate level of care for an individual whether that be in a residential or community-based setting. The ultimate goal being no individuals enter RMHTF settings without an appropriate assessment and determination of need performed prior to entering care.

DHHR is still in the early stages of implementing program and process changes; therefore, much of the data included in this report are initial and emerging. Data for each program is reviewed regularly, using both utilization data and partner evaluation reporting, to allow for data informed decision-making and better understanding of the strengths and opportunities in the current system. When necessary, data collection is expanded or adjusted to better assess needs, to allow needs to be more easily identified and addressed. This process will be iterative as DHHR builds and assesses its current systems and identifies needs, with special focus at a county and regional level. Department-level reviews are scheduled quarterly to assess data across programs, prevent silos, and improve opportunities for connectivity across systems.

### **Summary of Key Findings:**

- Similarities in demographic categories for children reached were found across programs, with the exception of crisis services.
  - Programs typically served more male children, consistent with gender proportions identified in the RMHTF setting. However, data from Children’s Mobile Crisis Response (CMCR) and stabilization providers (53% female compared to 45% male) and Children’s Crisis Response Line (CCRL) (54% female compared to 34% male) services showed more female utilization.
  - Programs such as Wraparound and Behavioral Support Services served a greater proportion of children in age categories 9 – 12 and 13 – 17, compared to the largest proportion of children while the vast majority served in RMHTFs are in the 13 – 17 age group. The slightly younger shift in age demographics for community-based programs were identified as a potential early-intervention opportunity for those individuals potentially at risk for placement in an RMHTF.
  - Individuals interacting with CMCR were more comparable than other programs, based on age, to RMHTF services with over 50% of individuals interacting with CMCR ages 13-17—compared to 80% in RMHTFs. This was viewed as both a strength and an opportunity, as this could serve as a point of intervention for diverting inappropriate placements from RMHTFs; however, it is always important to identify additional



opportunities to reach families before a crisis occurs if possible.

- Expansion of mental health screening and data collection to DHHR's Bureau for Social Services (BSS) youth served, Division of Corrections and Rehabilitation-Bureau of Juvenile Services (BJS)-involved youth, youth in the Division of Probation Services, and primary care providers providing well-child exams through DHHR's HealthCheck program [Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)].
  - BJS screenings for the period of review (January – April 2022) found 81% of screens positive for mental health needs, indicating a need for focus on connection to services for these individuals prior to discharge from BJS to allow for continuity of care once the child is able to live in a community-based setting.
  - The Division of Probation Services began screening in March 2022. As these efforts are early in implementation, next steps include further review of screening rates at the county level to assess opportunities for training and awareness of need to screens and refer youth to the Assessment Pathway.
  - Primary care providers will continue to receive training and education based on findings from the chart review sample, to encourage improved rates of mental health screening, appropriate referral to the Assessment Pathway, and increased awareness of the CCRL. Of referrals coming into the Assessment Pathway, 13% were originally referred by primary care providers through this screening process.
  - Additional screening is provided to individuals calling the CCRL with identified needs. Twenty-five percent of referrals to the Assessment Pathway came in via calls, the vast majority (of these calls) were representative of screenings through the CCRL. This intervention was viewed as a key opportunity to engage families who may not otherwise be screened through other avenues.
- Through screening, referral to the Assessment Pathway, and connection to the CSED Waiver application process, 233 kids were approved during the period of July – December 2021 for this community-based service, allowing opportunity for diversion from unnecessary use of RMHTFs when possible. Applications to CSED Waiver increased by approximately 70% from the last six months of 2021 compared to the first half of 2021.
- Since screening has been expanded to the Assessment Pathway, the number of referrals received increased from 37 in January 2022 to 98 in March 2022. At least one referral was received from 38 of West Virginia's 55 counties. Additional outreach will be conducted in the 17 counties without referrals, with special focus on those with high rates of placement in RMHTFs.
- According to the West Virginia University (WVU) Children's In-Home and Community-Based Services Improvement Evaluation – Baseline System and Community Level Report (WVU's Community-Based Services Evaluation), only 38% of providers reported having adequate staffing to serve all youth who need Wraparound Facilitation services. DHHR is currently working to



gather more information on workforce capacity at the provider level and validate this information with providers, given concerns about staffing shortages.

- DHHR's Bureau for Behavioral Health (BBH) CMCR providers are currently undergoing staffing shortages, with only 64% of positions throughout the state filled. BBH will work with providers to offer technical assistance for improving workforce capacity.
- Due to current data aggregation limitations and continued build out of the data store, WV Wraparound and CMCR/CSED Mobile Response data were reported by payor source for this report. However, data collection is currently being aligned to allow aggregation in future reports. This will allow equivalent services provided by various payor sources to be represented at the full utilization level. Consistent training for this service is provided across varying payor sources through Marshall University for both Wraparound and Mobile Response/Crisis services.
- During the last six months of 2021, there were 187 calls to the CCRL, an average of 31 calls per month, which is a 15% increase from the prior six-month period. Calls are expected to increase as awareness is increased and families and providers are encouraged to route calls to the centralized CCRL for coordination of information and services rather than local mobile response lines.
  - CMCR services increased from the third quarter of 2021 to the fourth quarter of 2021 (an increase of 397 to 502 children served).
  - In addition to the aforementioned referrals and awareness efforts for CCRL, DHHR is considering next steps for expanding efforts through emergency departments, medical offices, schools, etc. with special focus in rural areas and areas where residents/providers have not placed calls to the CCRL.
  - Additional outreach will focus on areas with low utilization and high rates of RMHTF placement.
  - Connect families and/or children with SED or serious mental illness (SMI) exiting foster care, whether through adoption or aging out of the foster care system, with appropriate mental health services such as mobile crisis, based on the youth's current or future potential needs. This may be done through two-way communication with families of all types, screening, awareness campaigns, etc.
- Although the greatest awareness needs were identified for ACT services (only 17% of providers surveyed were aware of ACT services according to WVU's Community-Based Services Evaluation, training is already being developed to address key entry points as well as incorporate ACT as an option for discharge planning from RMHTFs.
- From January to April, 133 children were identified in state RMHTFs with a CAFAS/PECFAS score less than 90.
  - Approximately 17% of individuals were 18 – 21 compared to only 1.5% of the full RMHTF

population. This data will continue to be assessed, in addition to discharge barriers to identify needs of this age group, which may be different from younger individuals who are moving toward lower levels of care.

- 26% (35) of these children were discharged to community-based settings that may not have otherwise been discharged without this new prioritized process in place.
  - The top three discharge barriers included: “An appropriate and viable discharge plan is not in place;” “No foster family available when the child does not have family to discharge to;” and “Parent/family is not ready to have the child return but is making progress toward that goal.”
- Given the limited period reviewed for this data, discharge barrier continues to be assessed to determine opportunities for improvement for discharge planning.
- For calendar year 2021, average length of stay for short-term acute psychiatric placement was 37 days. While children may be stabilized within a matter of days or weeks, the lack of a community placement option may result in the child remaining in the short-term acute facility until a placement can be found. This phenomenon represents an opportunity to better understand the specific needs of these children and based on identified needs, continue efforts to expand community-based placement options.
- Based on the rolling average length of stays for discharges from continuous RMHTF stays in 2021, children placed in out-of-state facilities have a 35% longer average length of stay than children placed with in-state providers—nearly three months longer.
  - DHHR has identified model-of-care changes, such as small, specialized community-based group homes, to expand service offerings and help ensure individualized high-quality care is available for children with significant needs in state.
- Outcomes to be assessed over time, including initial outcomes related to functional improvement (CANS assessment). Efforts to collect and connect outcome data is a process that will take time to develop. As of the time of this report, methodology for assessing functional improvement over time is being built out and tested.
- Based on these findings and findings from WVU's Community-Based Services Evaluation, outreach and education should continue to be focused on minorities, high risk groups, and helping families of all backgrounds.
  - DHHR will provide a series of ongoing virtual meetings, known as the Resource Rundown, with families of all types and backgrounds to discuss how to access mental health services and related steps families may encounter. Two-way communication will be offered to allow families a voice in both understanding and reacting to the system as it stands by responding to questions and comments provided from families and following up on individual needs.

- DHHR's Child Welfare Collaborative website has been replaced and rebranded as the Kids Thrive site. This site has been designed to be more family friendly and provide simpler connection to information and services.

DHHR has made meaningful progress in program design and process changes related to serving children with mental and behavioral health needs. The increase in mental health screenings conducted as part of early intervention, increased referrals to the Assessment Pathway for further evaluation and connection to services, and increased use of CCRL, mobile response, and CSED Waiver services are all positive signs. These positive trends demonstrate increased awareness and embracement by families and other stakeholders of the home and community-based options available to divert children from residential placements and are evidence that DHHR's efforts are having the intended effect. Implementation will continue in the months and years ahead. The details of specific service reviews as well as identified strengths, opportunities for improvement, and next steps are included in the full report.

## 2.0 Introduction

DHHR is actively working to reform and enhance programs and services for children<sup>3</sup> with serious mental health conditions.

The primary goals of this reform are as follows:

- Prevent children with serious mental health conditions from being unnecessarily removed from their family homes for treatment.
- Prevent children with serious mental health conditions from unnecessarily entering RMHTFs.
- Transition children with serious mental health conditions who have been placed in an RMHTF back to their family homes.

To support these goals, DHHR is committed to providing home and community-based services to allow children to remain in their homes and communities. Home and community-based services include Wraparound Facilitation, CMCR, Stabilization and Treatment (STAT) Homes as a short-term intervention foster care option, Behavioral Support Services such as Positive Behavior Support (PBS), and ACT. In February 2020, DHHR implemented the Children with Serious Emotional Disorders (CSED) Waiver to expand the array of home and community-based services available for children with SED and their families. Over the last two years, DHHR has worked collaboratively with community partners and stakeholders to design and expand services to better meet the needs of children and families statewide. DHHR is actively implementing these new processes and pathways to improve access to home and community-based services across the state of WV.

In December 2021, DHHR began implementation of the Continuous Quality Improvement (CQI) plan for children's mental and behavioral health services. The purpose of the CQI plan is to take a proactive approach to continually improve child welfare services and services for children with mental and behavioral health needs, including SED. Ongoing quality improvement will help ensure all eligible children and families are provided timely, effective, high-quality, and individualized care that is appropriate in scope, intensity, and duration to meet their needs.

As part of the CQI process, DHHR completes quarterly cross-functional, cross-bureau Quality Committee review meetings to review and analyze data associated with children's mental and behavioral health services. The most recent quarterly meetings were held in May 2022.

Representatives from across DHHR participated in the quality reviews and included the following:

- Representing the Office of the Cabinet Secretary: Cammie Chapman, Associate General Counsel; Shaun Charles, Chief Information Officer; Marilyn Pearce, Assistant to the Cabinet Secretary; Laura Hunt, Director of the Office of Quality Assurance for Children's Programs;

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<sup>3</sup> The terms "child" and "children" will be used throughout this report and are meant to be inclusive of children and youth up to age 21.

Logan Arnold, WVU Embedded Analyst, Office of Quality Assurance for Children's Programs.

- Representing the Bureau for Behavioral Health (BBH): Commissioner Christina Mullins; Sarah Sanders, Epidemiologist; Nikki Tennis, Director for the Office of Children, Youth, and Families; Brandy Byrnside, Director for Office of Compliance; Cassandra Tolliver, Program Manager; Gail Noullet, Program Manager; Lou Weisberg, Health Facilities Surveyor.
- Representing the Bureau for Medical Services (BMS): Commissioner Cynthia Beane; Fred Lewis, Deputy Commissioner; Cynthia Parsons, Program Director for Behavioral Health and Long-Term Care Services; Tonya Cyrus, Chief of Quality and Integrity Officer; Rachel Goff, Program Manager; Tony Richards, Program Manager.
- Representing the Bureau for Social Services (BSS): Commissioner Jeff Pack; Michelle Dean, Deputy Commissioner of Policy; Susan Richards, Deputy Commissioner of Quality Assurance; Carla Harper, Director of Children and Adult Services; Rhonda Larew, Director Office of Quality Initiatives; Christina Bertelli-Coleman, Program Manager for Children and Adult Services Regulatory Management; Terri Miller, Program Manager for IIU/Licensing; Lorie Bragg, Director of Program Support; Andrea Ramsey-Mitchell, Program Manager for Community Partnership.

The discussions during these quality review meetings informed the findings—including strengths, opportunities, and next steps—captured in this report.

### 3.0 Systems and Data Sources

Data and information to evaluate and monitor services and outcomes will be drawn from a variety of sources, including multiple data systems, quality sampling reviews, fidelity reviews, and feedback from staff, children, families, providers, caregivers, and other stakeholders. Data sources used to aggregate data for this report include:

- DHHR's BSS Family and Children Tracking System (FACTS) data for children in DHHR custody
- DHHR's Data Warehouse/Decision Support System (DW/DSS) of Medicaid and WV Children's Health Insurance Program (WVCHIP) data, including data from the CSED Waiver
- DHHR's BBH grantee reporting for PBS, CMCR and stabilization, BBH Wraparound, and CCRL
- DHHR's BBH Assessment Pathway Portal
- DHHR's BMS CSED Waiver applications data from the contracted Administrative Services Organization (ASO) provider, including the results of the application process
- BJS Offender Information System
- Managed Care Organization (MCO) Reporting for Discharge Planning (Aetna Mountain Health Promise is the contracted MCO)
- DHHR's BMS CSED Waiver Enrollment Reporting from the ASO and the contracted assessor, Kepro and Psychological Consultation and Assessment, Inc. (PC&A), respectively
- DHHR's BSS Youth Services (YS) and Child Protective Services (CPS) Screening Reporting

DHHR is currently developing a data store to house data from multiple sources across the Department's child welfare and mental and behavioral health services systems with the goal of aggregating data from child-serving bureaus to review and improve outcomes over time. To date, the data store captures data associated with RMHTF services. Efforts to expand the data store to include data elements associated with CSED Waiver services and RMHTF discharge planning are currently underway. Over time, additional community-based behavioral health data elements will be included in the data store as child-level and interaction-level data becomes more available and accessible.

As the mental health system and programs in the state continue to grow and evolve, so do the data systems that support these activities. DHHR is working toward system changes that will allow increased data collection at the child and encounter level. In October 2021, the BBH implemented a new data collection method which includes the BBH-funded PBS (Behavioral Support Services), Wraparound, and CMCR and stabilization programs. These steps will support greater focus on data quality, program planning, and improvement reviews for these programs. In addition, the information will be in a format that will allow it to be easily added to the data store as build out occurs. BSS plans to implement the People's Access to Help (PATH) system to replace the current FACTS system with implementation projected for October 2022. BMS also plans to implement an Enterprise Data Solution (EDS) to replace the current DW/DSS. Roll out of this new system is projected to begin in November 2022. Both new

systems will improve and expand data collection associated with BSS and BMS services and integration of data across bureaus. BSS, BBH, and BMS have been working with vendors and providers to implement and refine data collection at the child level including addition of regular reporting on RMHTF discharge planning, screening of youth interacting with BSS, BJS and the Division of Probation Services, CSED Waiver enrollment, and the build out of the Assessment Pathway Portal. It is anticipated that the data processes will continue to evolve as the DHHR continues to implement more robust CQI processes.

In addition to internal data systems, DHHR uses the expertise of community partners for support in quality and evaluation initiatives including:

- WVU: Contracted to complete an ongoing evaluation of West Virginia's children's home and community-based services. WVU provided a baseline report reflecting responses and perceptions from providers and facilities statewide in July 2022. A report on feedback from youth, families and caregivers is expected by August 2022. Reports will continue to be provided on a routine basis to DHHR as evaluation is conducted on the implementation rollout. Reference Section 5.0 Partner Evaluations for more information.
- Marshall University: Contracted to complete an ongoing evaluation of service fidelity to the National Wraparound Initiative (NWI) and will provide routine reports to DHHR.

Reports from these contracted vendors will serve as data sources in the Quality Committee review cycle as outlined in the CQI plan for analysis and incorporation in quality improvement recommendations and associated action.

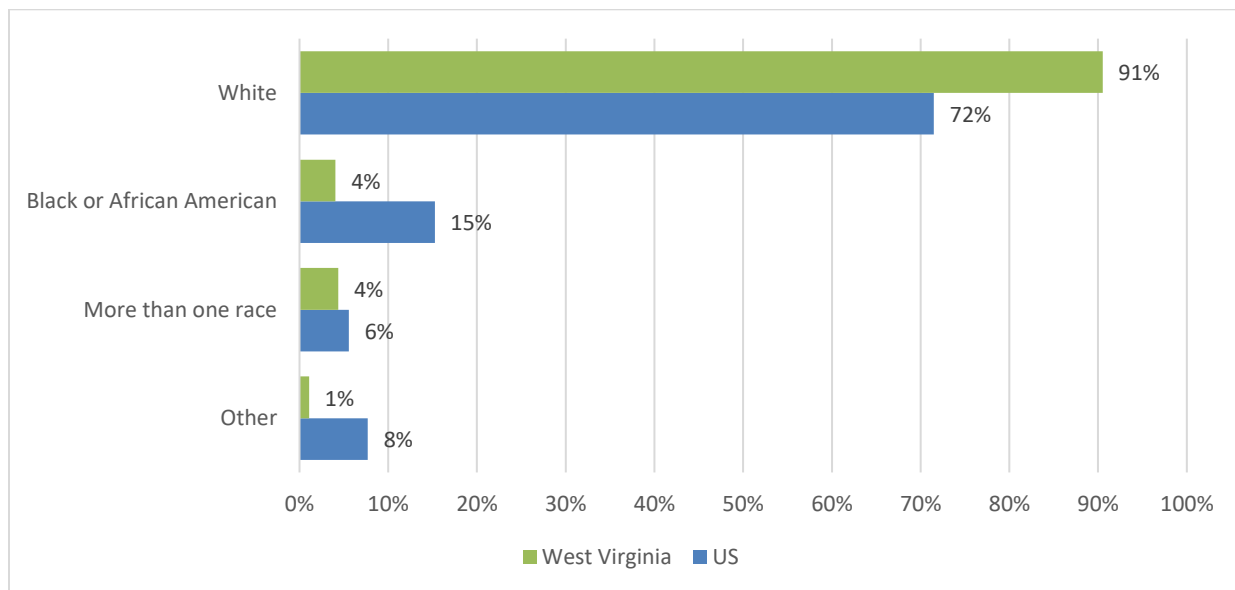


## 4.0 WV's Child Population

WV has a unique demographic and geographic makeup, which varies significantly from most of the rest of the nation. Reference to the state's population is important as DHHR looks at baseline service utilization and for future reports to track whether the populations reached are representative of the state's population.

The state has a large proportion of white children compared to the nation (91% in the state compared to 72% nationwide). Black, Indigenous, and People of Color (BIPOC) represent 8% of the WV population compared to 21% of the nation's distribution of race. See Figure 1.

**Figure 1: Racial Distribution of West Virginians Less Than Age 21 Compared to the Nation<sup>2</sup>**

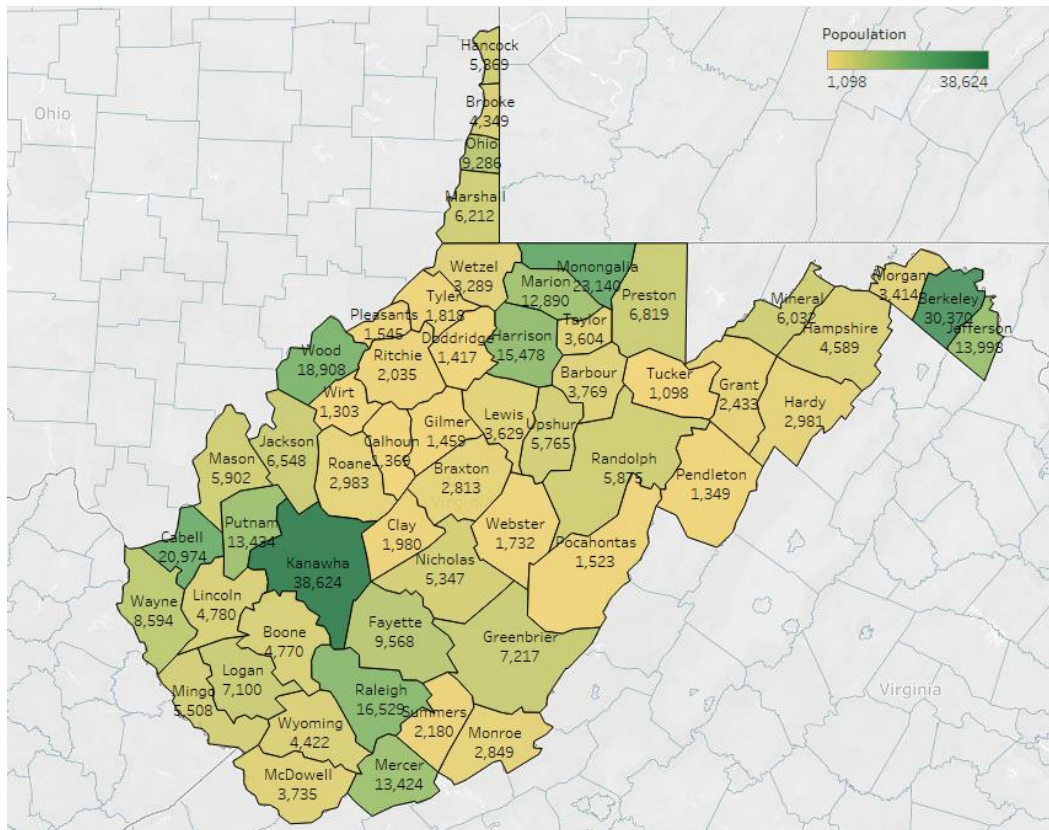


In addition to consideration of racial distribution, geographic makeup of the state is an important consideration for service utilization and outreach. According to the United States Office of Management and Budget, only 21 of WV's 55 counties are considered urban. Children and families who live in rural areas may have additional barriers and considerations to accessing services. Figure 2 represents the population in each county less than 20 years of age for context of service utilization as referenced throughout sections of this report.<sup>4</sup> Please note these totals are an undercount of the county populations for the report's target age group, children and youth aged less than 21 years. The relevant U.S. Census Bureau data are only available by county in age ranges grouping 20-year-olds with individuals outside the target age group.

<sup>4</sup> Single-race Population Estimates, United States, 2020. July 1st resident population by state, age, sex, single-race, and Hispanic origin, on CDC WONDER Online Database. <https://wonder.cdc.gov/>. Vintage 2020 estimates released by U.S. Census Bureau on July 27, 2021. Queried < 21 & All Races & All Ethnicities & All Years & All Genders.

**Figure 2: WV Child Population Under Age 20**

N=398,628



## 5.0 Partner Evaluations

### 5.1 DHHR Children's In-Home and Community-Based Services Improvement Project Evaluation

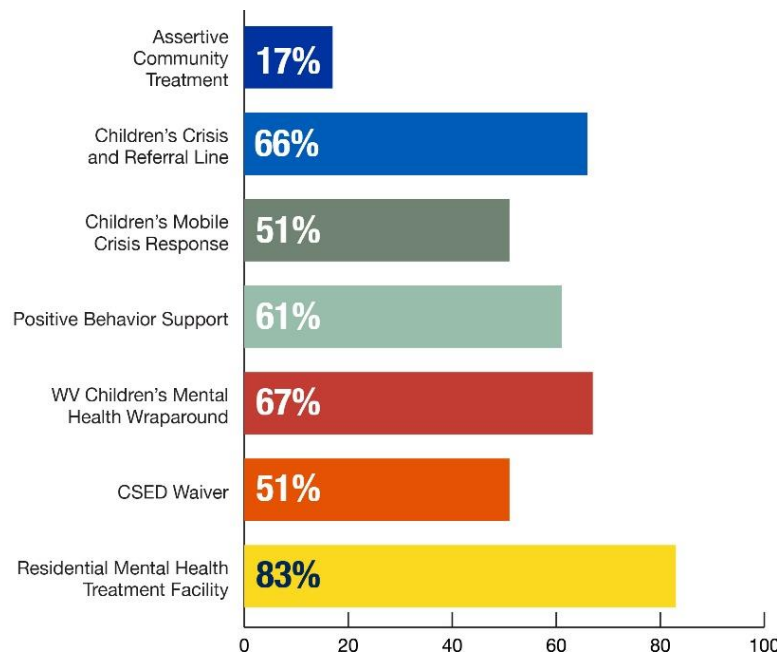
DHHR is partnering with WVU to capture additional outcome measures as outlined in the Department's Children's In-Home and Community-Based Services Improvement Project Evaluation Plan. The evaluation includes performance measures designated by DHHR, child/caregiver level outcomes, community/provider level outcomes, and system level outcomes. WVU has completed a series of caregiver, provider, and child surveys and focus groups.

WVU provides periodic evaluation reports. The first report, which included a baseline evaluation of provider and facility service awareness, ability to provide services, and identification of needs and strengths of the mental health system from May 2021 to April 2022, was finalized in July 2022. A second report reflecting family, child, and caregiver feedback will follow later in the year. DHHR's cross-functional, cross-bureau Quality Review Committee will review these results as part of the CQI process.

Initial review of results indicated several opportunities for improvement in the system as of the period of collection. It should be noted that much of the baseline information was collected during or prior to the implementation of several planned improvements to the system such as the Assessment Pathway and the CSED Waiver (which began in the early months of the COVID-19 pandemic) and planned awareness training to link individuals discharging from RMHTFs to ACT as an option for continued stabilization and maintenance. The report frequently notes that provider perception differed from current policy or fact, stressing the need for increased awareness and education on available services and how to access them in a manner that is provider and family friendly. This information will be reviewed more in-depth at the next Quality Committee review meeting in August 2022. Figure 3 shows the percentage of providers and facilities responding to the survey awareness of each service type.

Some efforts are already underway to improve awareness, such as with ACT through expanded awareness of RMHTF discharge planning options. Education with providers doing screening for the Assessment Pathway is also expected to expand awareness of several of these services. Other considerations of this data include concerns about jargon and semantics, which may result in a provider not connecting the name of a service on the survey with one used under another provider's name (i.e., a provider may be aware of Wraparound or CSED services, but not that nomenclature; instead, they refer to them as intensive in-home services provided through a local provider). WVU and DHHR are working collaboratively to address any confusion related to identifying and defining services in future surveys.

**Figure 3: Provider and Facility Awareness of Services**



\*Note future surveys will refer to both behavioral support services and PBS for clarity.

Providers and facilities perceived those services were not always accessible in a timely manner. Approximately one-third of organizations and facilities note they had waitlists for new clients to receive services. This is most closely associated with concerns about workforce and ability to serve clients in need, a continued issue that must be approached incrementally to address the associated complex issues. Additional areas of strengths and needs have been referenced throughout relevant sections of this report. A summary of the evaluation report will be available by early August 2022 for streamlined strategic planning and action.

## 5.2 Wraparound and CANS Fidelity Assessment

DHHR is partnering with Marshall University to provide Wraparound services training and technical assistance to providers across the state of WV and complete an ongoing evaluation of Wraparound service fidelity to the NWI standards. To date, Marshall University has established a contract with the University of Maryland to provide the Wraparound training to providers as well as to certify Marshall University staff as Wraparound trainers.

Fidelity reviews are anticipated to begin in the final quarter of 2022 utilizing National Wraparound Initiative approved fidelity tools. A data agreement is being put in place to allow reviewers to access data and, as of the time of this report, all reviewers have been trained and began the process to conduct practice fidelity review and score validation. Quality sampling review (i.e., chart reviews) to evaluate the alignment of children and family support plans and services with CANS assessment results are anticipated to begin in late 2022. After routine fidelity and quality sampling reviews are initiated, Marshall University will publish reports on an ongoing basis. These reports will be incorporated into DHHR's Quality Committee review process.

## 6.0 Outreach and Education

Outreach and education continue to be priority areas of focus for DHHR. Some highlights of family and stakeholder engagement efforts in 2021 include the following:

- The YS Family Guide was updated to include a mental health statement noting the importance of screening for mental health.
- The Aetna Mountain Health Promise Governance Council held quarterly information-sharing stakeholder meetings, as well as regular focus groups.
- BBH Program Managers spoke with the WV Department of Personnel (DOP) Parents Group, started as a response to parenting issues that arose during the COVID-19 pandemic, and reviewed services. Upon request of DOP, BBH staff have joined that team to continue to update the Parents Group about community-based children's mental health services.

For 2022, two primary goals related to outreach and education include:

- Establishing data collection to capture outreach and education efforts, then using this data to inform future outreach and education strategies.
- Increasing mechanisms for two-way communication with children, families, and stakeholders.

To establish data collection to capture outreach and education efforts, DHHR developed a web-based tracker, which was soft-launched in April 2022. This tracker allows DHHR staff to input public-facing and community-based outreach activities with external stakeholders. Examples of data elements tracked include the date outreach was completed, purpose/message of outreach, method, audience, county, and number of participants. The goal is to be able to correlate outreach efforts at the county level with service utilization trends, residential placement rates, and other data at the county level. Understanding these relationships will assist DHHR with knowing where to target outreach efforts as well as understand whether current outreach efforts are having the intended impact.

Preliminary, generalized analysis of this new data indicates that:

- Most activities have been virtual (i.e., videoconference) or via the internet/social media.
- Most activities have a general, public audience. Schools/WV Department of Education, general stakeholder groups/associations, and provider agencies are the most common specific audience types.
- Nearly half of all activities had an audience size of over 100 people.
- More than half of all activities had a statewide audience.

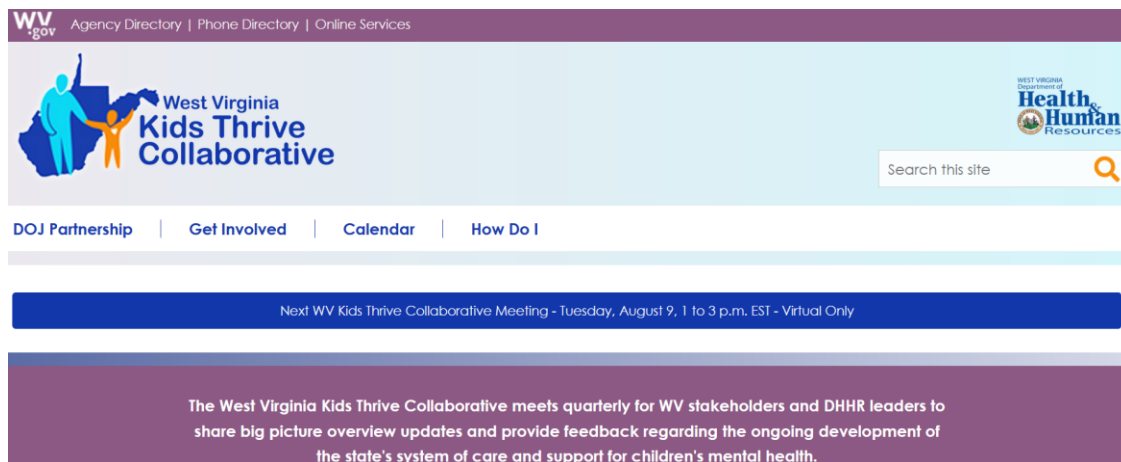
Data collected during the soft launch are not robust enough to inform strategies as of the writing of this report. Following full rollout of the outreach and education tracker, DHHR will monitor data from the tracker to better understand existing outreach and education efforts, including any gaps that may exist, to inform future activities and determine if data collection needs to be expanded or revised.

Based on stakeholder feedback on the Child Welfare Collaborative, now known as the Kids Thrive Collaborative, DHHR engaged with WV Interactive on a website modernization project. Key goals for these updates were to improve access for families by including:

- Brighter colors with more photos and videos.
- Streamlined access to information related to children’s mental and behavioral health services.
- Easier navigation, including direct links to the CCRL and the Assessment Pathway.
- Increased opportunity for two-way communication.

The Kids Thrive website (Figure 4) went live in mid-June 2022, replacing the Child Welfare Collaborative website. The site will continue to evolve in the months ahead as more families and stakeholders access the site and provide feedback.

**Figure 4: Kids Thrive Collaborative Website**



Two-way communication, including but not limited to the website-related communication enhancements, will evolve in 2022-2023 through two additional initiatives. One initiative is a collaboration with the BBH Transformation Transfer Initiative (TTI). This effort provides technical assistance and support for implementing, expanding, and improving crisis services for children and adolescents with SED or Serious Mental Illness (SMI). This partnership includes an emphasis on engaging youth who are lesbian, gay, bisexual, transgender, questioning, and others (LGBTQ+) and/or BIPOC by collaborating with groups with cultural competence in working with LGBTQ+ and BIPOC youth, developing survey and focus groups to gain feedback on setting up two-way communication strategies, and using feedback to inform training for crisis services providers and improve service delivery systems.

A second initiative, Resource Rundown, is a series of weekly virtual information sessions for youth, families, and caregivers. Based off a similar process in New Hampshire, these sessions are designed to be informal, as a conversation rather than a one-way presentation. Information covered in the initial series will include walking parents through the Assessment Pathway process, explaining home and community-based options available, breaking down what an SED is, and providing a step-by-step explanation of what they can expect as they navigate the Assessment Pathway process. A survey will be



sent to participants at the end of each session. The survey is intended to rate their experience and capture additional feedback. Based on feedback, the presentations will be updated, as needed. The video sessions will be recorded and posted on the Kids Thrive website for those who are unable to attend a live session.

DHHR is partnering with the WV Hospital Association on the development of a full day Pediatric Mental Health Summit to bring together WV's leaders in pediatric healthcare. The Summit will be held August 2, 2022. DHHR Cabinet Secretary Bill J. Crouch will kick off the session and share goals of the summit, which include increasing awareness of community-based service options for children and enlisting their partnership in identifying and addressing gaps in the current system of care. Topics include national mental health challenges, awareness of community-based resources, efforts to expand healthcare workforce, and WV's ideal spectrum of care. Afternoon breakout sessions will be held to identify the gaps in the current pediatric spectrum of care and the ideal spectrum of care, pinpoint barriers to addressing the gaps, and agree on action and next steps.

Another key partnership to assist with driving changes in children's mental and behavioral health services is the WV Court Improvement Program (CIP) operated by the Supreme Court of Appeals of WV whose mission is to "advance practices, policies, and laws that improve the safety, timely permanency, and well-being of children and due process for families in child abuse/neglect and juvenile cases." BSS has a long-standing partnership with CIP. Through the various workgroups and activities carried out by CIP, BSS is able to collaborate on current and ongoing initiatives. Regular meetings occur quarterly; however, CIP and BSS communicate frequently to coordinate training topics for attorneys and disseminate important information regarding the Child Welfare and court systems. DHHR plans to share the most recent results of WVU's Community-Based Services Evaluation and DHHR's Semiannual Report on the Quality and Outcomes of Children's Programs at a future quarterly CIP meeting.

The recently published WVU Children's In-Home and Community-Based Services Improvement Evaluation – Baseline System and Community Level Report indicated opportunities to improve outreach and education efforts to help ensure children, families, providers, and other child-serving entities are aware of the array of home and community services available for children with mental and behavioral health needs. The cross-bureau Quality Committee will review this report in the next quarterly meeting (scheduled for August 2022) to assist with identifying continued enhancements to outreach efforts. DHHR will be sharing the results of the WVU evaluation and the July 2022 semiannual report of quality and outcomes for children with the Commission to Study Residential Placement of Children at the next meeting in September 2022. This Commission involves the WV Department of Education, WV Department of Homeland Security, Supreme Court of Appeals of WV, and family and youth representatives—key partners in helping to increase education and awareness of community-based services options across the state.

These combined efforts, along with monitoring the new tracking log for outreach and education, are expected to help increase awareness, education, and two-way communication among provider groups, stakeholders, and families, while identifying opportunities for further improvement.



## 7.0 Screening

Screening for possible mental health needs is a critical first step in identifying children for further evaluation to determine treatment needs, with subsequent referrals to appropriate home and community-based services. To help ensure broad reach to children across the state who may benefit from behavioral and mental health services, the following entities complete screenings:

- Primary Care Providers: Provide screening for Medicaid- and WVCHIP-eligible children through WV's HealthCheck program, within DHHR's Bureau for Public Health (BPH)
- BSS, YS: Provides screening for children referred to DHHR for services related to status offenses or juvenile delinquencies
- BSS, CPS: Provides screening for children in a child abuse and neglect case
- WV Division of Corrections and Rehabilitation, BJS: Provides screening for children in juvenile detention and commitment facilities
- WV Judiciary, Division of Probation Services: Provides screening for children on probation

Children with an identified potential mental health need (i.e., positive screen) are then referred to the Pathway to Children's Mental Health Services (Assessment Pathway) for additional evaluation and referral to home and community-based services.

### 7.1 Review Period, Data Sources and Limitations, Population Measured

Data collection associated with screening for possible mental health needs is in the early stages of implementation; therefore, much of the screening data are limited to more recent periods as outlined in Figure 5 below. As data collection continues, the information will be used to forecast provider capacity needs for Wraparound and other home and community-based services, as well as provide a targeted approach for outreach, education, and training of providers who may have lower screening rates and/or underutilization of community-based referrals.

**Figure 5: Screening Data Overview**

Screening Entity	Data Review Period	Data Source	Limitations	Population Measured
Primary Care Providers HealthCheck (EPSDT)	Calendar Year 2020	Chart Reviews	Reporting on EPSDT with mental health screens is based on medical record reviews. DHHR conducted medical record reviews for a random sample of Medicaid members between ages 0 and 20 who had a well-child visit during calendar year 2020. The	A random sample of children with Medicaid receiving EPSDT with mental health screening during a well-child visit.

Screening Entity	Data Review Period	Data Source	Limitations	Population Measured
			random sample is a subset of the total children screened.	
YS	Early data under review and not included in this report	BSS YS Excel spreadsheet	Data collection was initiated April 1, 2022 and is being rolled out in conjunction with the county-by-county rollout of the Assessment Pathway (Feb – July 2022).	Number of children in YS screened using the FAST.
CPS	Early data under review and not included in this report	BSS CPS Excel spreadsheet	Data collection was initiated April 1, 2022 and is being rolled out in conjunction with the county-by-county rollout of the Assessment Pathway (Feb – July 2022).	Number of children with a CPS case screened using the ongoing assessment.
BJS	January – April 2022	Offender Information System	MAYSI screenings (a type of standardized mental health screening) of children have been conducted in excess of 10 years within BJS. Extracts of MAYSI-2 screening scores from the Offender Information System are being used to calculate positive screens.	Children in juvenile detention and commitment facilities screened using the MAYSI-2 who have a juvenile delinquency offense.
Division of Probation Services	March – April 2022	Probation Web-Based Data Collection Form	Screening and data collection was implemented March 1, 2022 and is still in the early stages of adoption by probation officers.	Children adjudicated as a status offender or delinquent screened using the MAYSI-2.

## 7.2 Review Summary

### 7.2(a) HealthCheck Screening Including Mental Health Screening During Well-Child Visits

In 2020, WV had 94,013 Medicaid members aged 0 – 20 who received HealthCheck (EPSDT) exams during well-child visits. Medical chart reviews were completed for 791 of these children. As evidenced during a retrospective analysis of medical records linked to administrative claims, 80% of children’s medical records indicated a mental health screening was included during the primary care provider exam. The medical record review was expanded in 2020 to include children 0 – 5, in addition to those 6 – 20 years old, effectively establishing a baseline for all children 0 – 20. The percent of children with a completed mental screening increased with age, from 70% for 0 – 5 years olds to 91% for 19 – 20-year-olds. The average age of the children sampled was seven.

The review consisted of an examination of medical records for children with Medicaid who had a well-child visit during calendar year 2020. The review consisted of pulling a random sample, representative of the Medicaid population including demographics such as gender, age, etc. The sample has adequate estimation power overall but was not tested by these specific age groups. The next medical record review is planned for October and November 2022 to review 2021 claims.

**Figure 6: Medical Chart Review Summary**

Screened			Not Screened		
	Number	%	Number	%	Total
0 – 5 years old	264	70.2%	112	29.8%	376
6 – 8 years old	84	80.8%	20	19.2%	104
9 – 18 years old	271	90.3%	29	9.7%	300
19 – 20 years old	10	90.9%	1	9.1%	11
Total	629	79.5%	162	20.5%	791

### 7.2(b) YS and CPS Screening

Screening of children for possible mental health needs is completed when a case is opened in YS and CPS. By way of context, the average number of children with active YS cases for the April – May 2022 period was 2,608. On average for this same period, YS opened 21 new cases per month. The average number of children with active CPS cases for the April – May 2022 period was 4,483. On average for this same period, CPS opened 372 new cases per month.

Data collection was initiated April 1, 2022 and is being implemented across the state in alignment with the CPS and YS phased county-by-county implementation of the Assessment Pathway referral process, which is scheduled February through July 2022. Because data collection associated with the screening

and referral process is still in the early stages of implementation, data are not available for this report. Preliminary data are expected to be presented to the YS and CPS program teams in August 2022 for purposes of identifying irregularities, providing technical assistance, and improving the collection process. DHHR will include data for children screened through YS and CPS in a future semiannual report.

### 7.2(c) BJS Screening

BJS involved children are screened at intake and each time they transition between facilities. Figure 7 below captures screening for children in the custody of the BJS for the period January to April 2022. The total population<sup>5</sup> of children in BJS custody ranged from 221 in January to 242 in April. Unique screenings increased month over month from 96 in January to 132 in March before dropping back down to 115 in April. There was an average of 111.5 unique screenings each month. During the prior reporting period of July 2020 to June 2021, there were an average of 81 unique screenings each month, so unique monthly screenings have increased by 37.7%.

The increase in the number of children in BJS custody and the average number of screenings being conducted is expected. During the pandemic, children were not in their typical school schedules; therefore, school-involved behavior resulting in BJS involvement was not as prevalent and counties were not placing as many children. Given continued easing of restrictions associated with the pandemic, these numbers may increase. DHHR is working with BJS to gain a better understanding of average intakes per month for comparison to screenings to identify any quality improvement opportunities.

Of those screened, the age demographics were fairly consistent with those in residential services, with 88.5% of individuals screened ages 13 – 17.

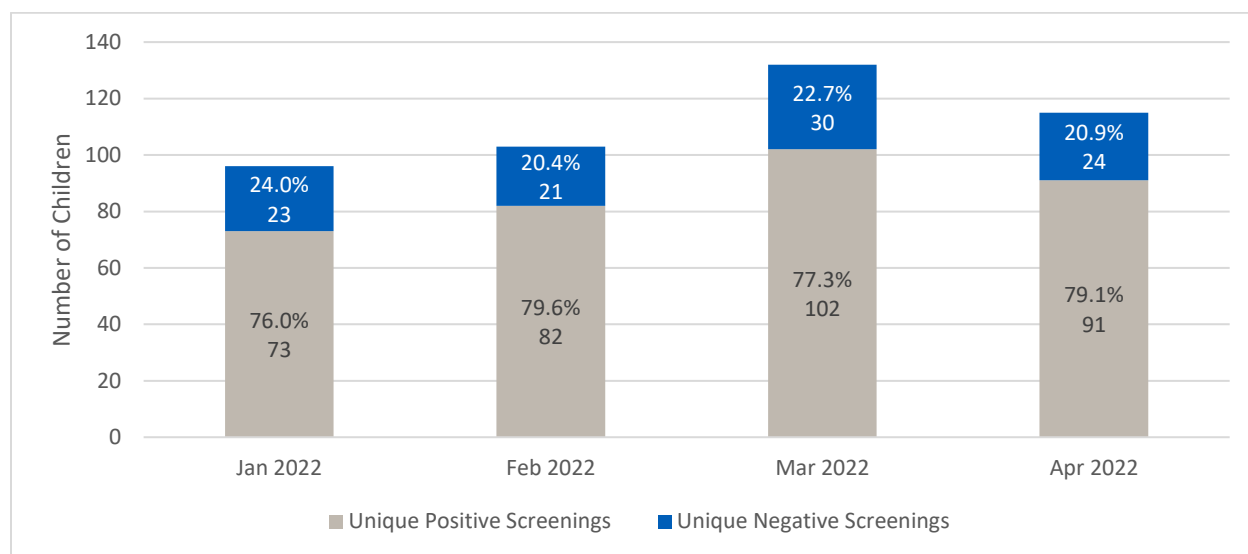
The percentage of unique screenings that were positive remained relatively constant during the reporting period, from a low of 76.0% in January and a high of 79.6% in February. In total, 310 of the 381 unique children who were screened had a positive screen (81.4%). Positive screening data was not available for the July 2020 – June 2021 reporting period and thus no comparison to that time frame can be made.

Given that children in BJS custody cannot access CSED Waiver services while in detention, BJS is not currently making direct referrals to the Assessment Pathway for children screening positive. Based on the high percentage of positive screens, the quality committee recommended DHHR, BJS, and the ASO collaborate to develop a process for BJS to make referrals to the ASO in advance of a child's discharge from detention. While discharge dates are uncertain and can change in some cases without advance notice, since CSED Waiver eligibility is good for one year, a referral process similar to that developed for children discharging from residential settings may be appropriate.

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<sup>5</sup> BJS population data are a point-in-time measure captured on the last day of each month and does not represent the number of unique children in BJS custody during a given month.

**Figure 7: BJS MAYSI-2 Screenings, January – April 2022**



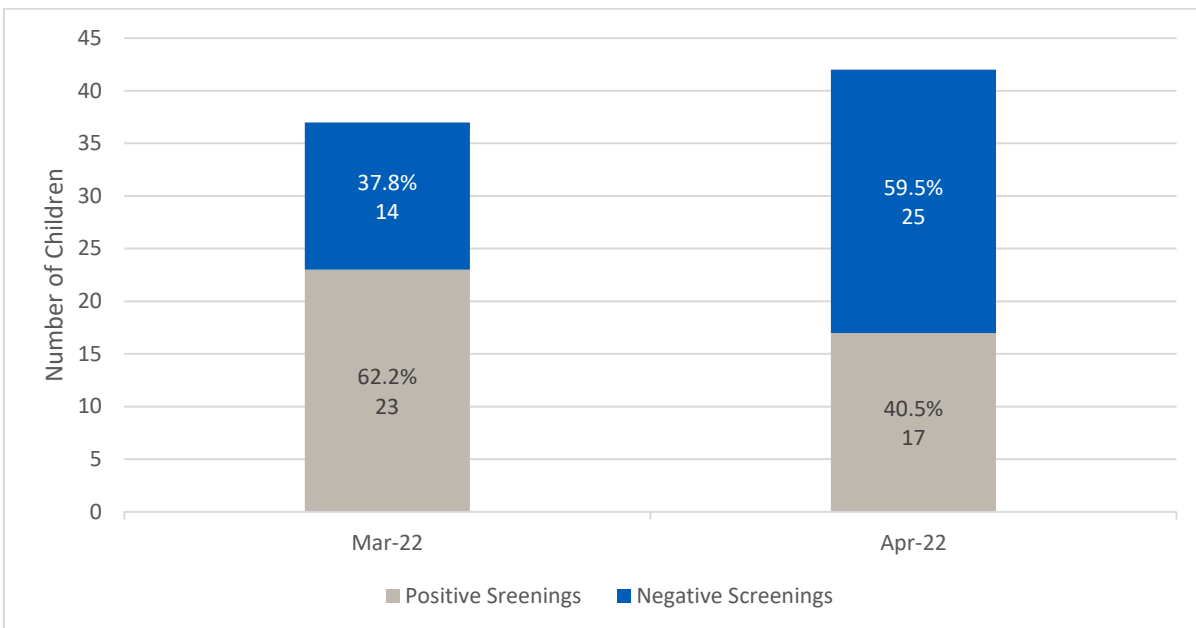
## 7.2(d) Division of Probation Services Screening

Screening of children adjudicated as status offenders or delinquent and the associated data collection was implemented by the Division of Probation Services effective March 1, 2022. These screenings are conducted at intake by the assigned probation officer. Intakes completed for children adjudicated as status offenders or delinquent was 107 for March 2022 and 60 for April 2022. The month-end population of children on formal probation (i.e., adjudicated as status offenders or delinquent) was 1,078 in March 2022 and 1,123 in April 2022.

Given recent implementation, the screening and referral process is in the early stages of adoption by probation officers across the state and is therefore not considered representative of the total screenings anticipated once the process is fully adopted. The data in this section was representative of 11 counties in WV.

Figure 8 shows the number of screenings of adjudicated children in Probation Services for the 11 counties that submitted data for March and April 2022. Seventy-nine screenings were conducted. Of those screened, 60% identified as male and 38% as female. Of the individuals screened, 91% were ages 13 – 17 with the remaining 9% being 9 – 12 years old. These demographics are somewhat consistent with those of children in RMHTFs. There were slightly more screenings in April than in March (42 vs. 37). In total, 40 children (51%) screened had a positive screening, while 39 children (49%) had a negative screening.

**Figure 8: Probation Services MAYSI-2 Screenings, March – April 2022**



Of the 40 children who screened positive, 34 (85%) completed an application and were referred to the Assessment Pathway for further evaluation. For the families who did not complete an application for referral to the Assessment Pathway, some believed their child was already accessing adequate services while others wanted to take the application home and think about it. As more data becomes available across the state, screening rates will be able to be better assessed for quality improvement planning at a county and regional level.

### 7.3 Provider Capacity/Statewide Coverage

To increase the number of primary care providers completing a HealthCheck (EPDST) screen with a mental health screening, outreach to primary care providers about the Assessment Pathway started in November 2021, with all EPDST clinics (approximately 659 clinics) expected to be trained on the Children's Crisis and Referral Line (CCRL, including CMCR services) and the provider referral JotForm (an electronic secure form which is submitted to the CCRL known as a JotForm) by November 2022 (63% have already been trained). Resources have already been distributed to all sites. Enhancement of material and training for screening and referral efforts are planned for early 2023.

DHHR will continue to monitor screening rates over time and assess any needs related to training or staffing capacity with each entity as needed.

### 7.4 Strengths, Opportunities, Barriers, and Next Steps

Data collection associated with screening has been established across all screening entities and is still in the early stages of implementation and adoption across the state. Given the high percentages of positive screens across well-child visits, BJS and probation-involved children, DHHR is collaborating with the ASO to ensure it is prepared to handle the continued increase in referrals that is projected.

As a result of the review of well-child visits, the Preventative Health Screening form was enhanced to collect additional measures related to identification of SED. The updated form has been included in outreach to providers as well as regular site visits. Providers have also been made aware of the CCRL and associated JotForm for making referrals following a positive mental health screen. Additional emphasis should also be placed on a regional strategy to improve screening rates and appropriate referrals among Medicaid providers, which should include collection and assessment of rate of positive screens and number of referrals to the CCRL by region. The Quality Review Committee also recommended that BMS explore the feasibility of implementing a payable procedure code modifier for HealthCheck screening claims to indicate the mental health screening was performed (with separate values established for positive and negative screens) to improve the ability to review and analyze timely data on mental health screenings at well-child visits.

The quality committee recommended DHHR, BJS, and the ASO collaborate to develop a process for BJS to make referrals to the Assessment Pathway in advance of a child's discharge from detention. While discharge dates are uncertain and can change in some cases without advance notice, a CSED Waiver eligibility determination is valid for an entire year, and a referral process similar to that developed for children discharging from residential settings may be appropriate. BJS is also considering implementing the MAYSI screening for any child involved in Youth Reporting Centers.

The Division of Probation Services will be meeting with the Chief Probation Officers to discuss the possibility of implementing screening for youth in the pre-adjudicatory improvement period. The large percentage of referrals to the Assessment Pathway (and other families/youth considering community-based options) via Probation Services screens is a strength of this emerging initiative and will continue to be monitored.

Future reporting is expected to include further assessment of screening implementation and referral needs across provider types. As the data store is being further developed, additional data will be able to be connected and considered across systems.



## 8.0 Pathway to Children's Mental Health Services

WV is improving access to and quality of mental health services by implementing a Pathway to Children's Mental Health Services (Assessment Pathway) in phases. The Assessment Pathway emphasizes in-home and community-based services for children with SED or youth up to age 21 with SMI. The Assessment Pathway comprises multiple initiatives, including the following for children and families involved with CPS or YS:

- Screening
- West Virginia Wraparound which includes and extends to CSED Waiver
- CMCR and stabilization teams
- CCRL
- WV Wraparound
- BSS programs and services
- Connection to home and community-based services

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

Children who enter the Assessment Pathway will be referred to home and community-based services appropriate for their needs including CSED Waiver services for those who are eligible.

The Assessment Pathway is designed to:

- Streamline behavioral and mental health referral and service provision for children and families
- Connect children and families to WV Wraparound and other in-home or community-based services
- Aid families with the CSED Waiver application process
- In future phases, have a qualified individual determine if a child needs a higher level of behavioral healthcare than can be provided in the home or community

Because children can access the behavioral health service system via multiple avenues, DHHR is implementing the Assessment Pathway in multiple phases. DHHR completed a soft launch of the first phase October 31, 2021.

Phase 1 established a mechanism for entry into the pathway for:

- Requests directly from families and children via the CCRL.
  - Call agents are asked to conduct Assessment Pathway screening with callers and assist them with entry into the pathway if the child screens as potentially eligible and consent to proceed is given.
- Referrals on behalf of families from primary care providers to the CCRL, including by a JotForm specifically created for primary care providers.
- Referrals on behalf of families from CMCR and stabilization teams.
- Connection to services (often called “interim services”) during the CSED application process.
  - Direct application to the contracted vendor for the CSED Waiver occurred prior to October 31, 2021, but connection to interim Wraparound and other in-home and community-based services were added in the initial phase of implementation.

Implementation of Phase 2 began February 2022 with a primary focus on BSS, (i.e., CPS and YS) staff beginning to use the Assessment Pathway to divert children from unnecessary out of home placement. BSS has also conducted targeted outreach and education for professionals associated with the judicial system. The phased county-level rollout schedule is on schedule to be completed statewide by July 2022. Data are being collected regarding this outreach, as well as referrals from the bureau’s Safe at Home program and will be available for subsequent reports. Additionally, BSS is collaborating with the Managed Care Organization (MCO) on discharge planning for children currently placed in RMHTFs to determine if they can be transitioned out of residential placements into home and community-based settings and services.

## 8.1 Review Period, Data Sources and Limitations, Population Measured

**Figure 9: Assessment Pathway Data Overview**

	Data Review Period	Data Source	Limitations	Population Measured
<b>Phase 1 Assessment Pathway</b>	January 1, 2022 – March 31, 2022	BBH Assessment Pathway Tracking Portal	<p>The portal is a stand-alone site that allows monitoring of progress but will need to be connected to other data via the data store.</p> <p>Timeliness indicators are calculated using weekdays.</p> <p>Data collection procedures are still being refined and, consequently, some indicators may have a large percentage of missing values but have shown improvement over the recent implementation period.</p>	<p>Number of referrals to BBH and the CCRL.</p> <p>Referrals to BBH include referrals for interim services from the CCRL, CMCR teams, and the ASO for children applying directly for the CSED Waiver who</p>

	Data Review Period	Data Source	Limitations	Population Measured
			Content and format of future reports, including specific indicators and/or indicator definitions, may change, potentially creating difficulties when comparing reports over time.	are not involved with BSS.
<b>Phase 2 Assessment</b>	Unavailable at time of report	BSS Spreadsheet Tracking Log	TBD	Number of CSED Waiver applications to the ASO for children involved with BSS.
<b>Pathway</b>	For CSED data, see the CSED Waiver Enrollment and Services Section. As the data store is built out further, data will be able to be aggregated across provider sources to develop a larger picture of connection to mental health assessment and related services in WV.			

## 8.2 Review Summary

BBH implemented the Assessment Pathway Tracking Portal on January 1, 2022, as a means of data collection associated with the early stages of the Assessment Pathway. Referrals received prior to January 1, 2022, have been added to the portal, but due to enhancement of data collection, previous data fields were not consistent with the updated portal, and referrals prior to the implementation of the portal are not included in this report. The results presented in this section correspond to 193 children referred in January – March 2022. Some figures include a subset of these children, and the number of children included in those figures has been noted accordingly.

Figure 10 shows the breakdown of referrals to the Assessment Pathway by gender. The number of males and females were nearly identical (n = 96 for females, n = 95 for males). As will be seen in other sections of this report, females utilize crisis-related services at a greater frequency compared to males, while other program utilization skews more toward males. These patterns in demographics will continue to be monitored to ensure families are being connected to appropriate level of care before crisis ensues.

**Figure 10: Referrals to Assessment Pathway by Gender**

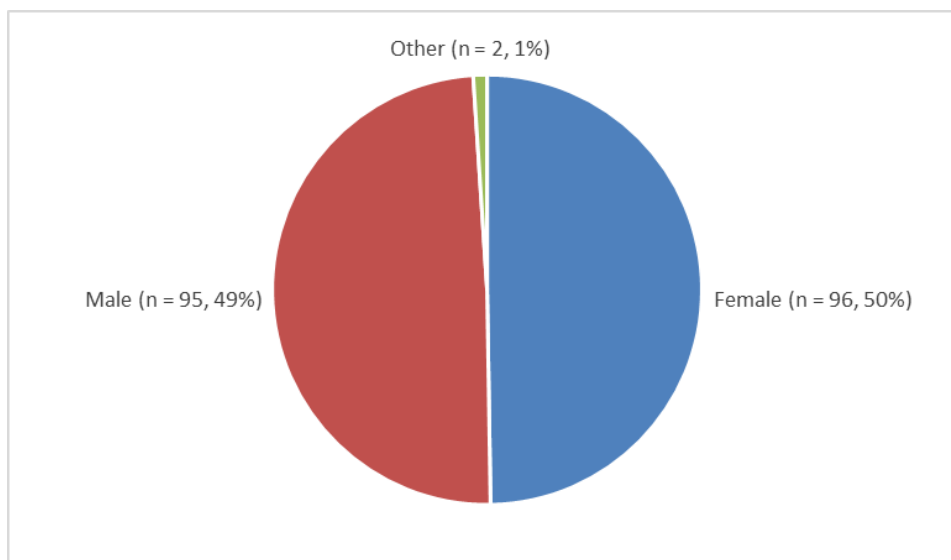
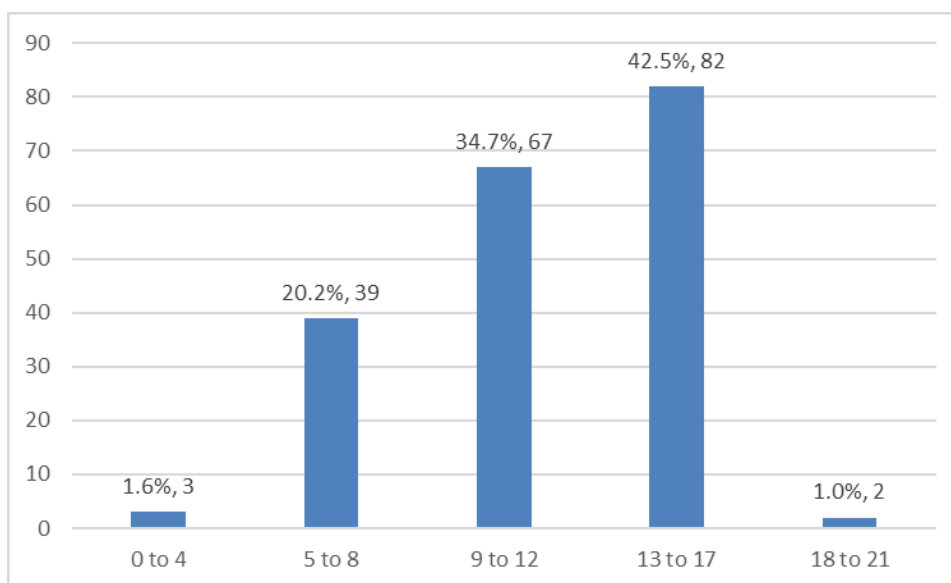


Figure 11 shows the breakdown by age at entry. The largest age group referred to the Assessment Pathway was 13 to 17 (n = 82, 45.2%), also the largest group for RMHTF services. In total, 97.4% of children were ages 5 to 17.

**Figure 11: Age at Entry to the Assessment Pathway**



Racial data was largely unknown, with 66% of data reported for this period without race indicated. During Quality Committee reviews, it was noted Assessment Pathway staff often felt uncomfortable asking about race during the application process.

The Quality Committee reviewed county-level coverage to assess opportunities for outreach; however, the detailed map was excluded from this report due to the low rate of referrals when viewing the information at the county level. The county-level Assessment Pathway referral rates were reviewed per

1,000 children; counties with the highest rates are Hardy (2.3 per 1,000 children) and Fayette (1.7 per 1,000 children). The counties with the highest number of referrals are Fayette (n = 17, 8.8% of all referrals), Berkeley (n = 15, 7.8%), Kanawha (n = 13, 6.7%), and Monongalia and Raleigh (both n = 12, 6.2%). Seventeen counties had no referrals submitted during the period, noted as an opportunity to expand outreach.

## 8.2(a) Self-Reported Mental Health Diagnoses

Figure 12 shows the breakdown by self-reported mental health diagnosis. Forty percent of children reported the presence of a mental health diagnosis. Fifty-six percent of data was either “unknown” or missing. Four percent of children reported the lack of a mental health diagnosis. Note that a “no” response does not necessarily indicate that a child was screened for a mental health condition; rather, a “no” response indicates that a documented mental health diagnosis was not reported for the child. A “no or missing” response for mental health diagnosis may be indicative of a child’s first interaction with assessment or mental health services or a family not understanding the diagnosis. Further review is needed to verify this and to identify if opportunities might exist to assess and assist families sooner.

**Figure 12: Self-Reported Mental Health Diagnosis**

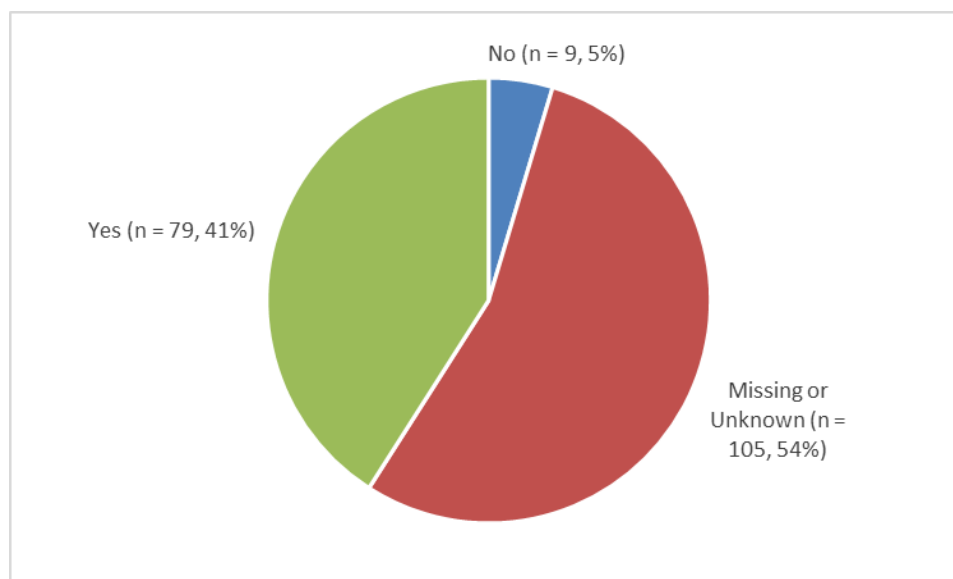


Figure 13 depicts the number of referrals by month for the three months included in the reporting period. Referrals have increased month-over-month, from a low of 37 (19.2% of all referrals) in January, to a high of 98 (50.8%) in March. These trends are encouraging and suggest expanding awareness among professionals and in communities of the Assessment Pathway.

**Figure 13: Referrals by Month**

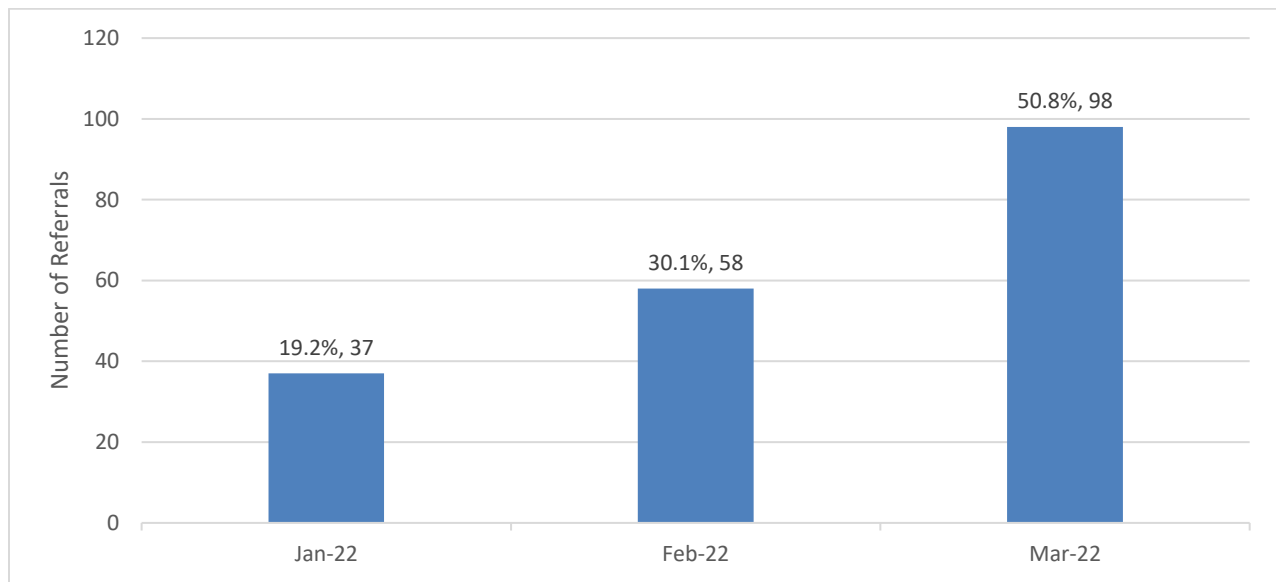
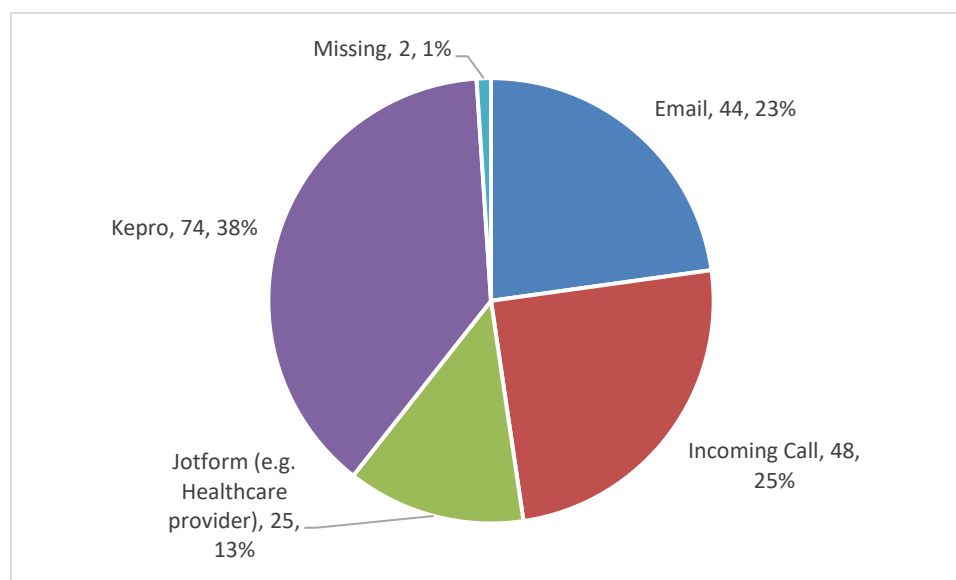


Figure 14 shows the breakdown of referrals by the source of the call/initial referral. The largest source of referrals to the assessment pathway-interim services was from Kepro, the ASO (n = 73, 38%), followed by incoming call (n = 49, 25%) and email (n=44, 23%). Healthcare provider referrals represented 13% of referrals. Of incoming calls, 94% (n =45 of 49 total calls) were representative of screenings performed with callers via the CCRL, an encouraging finding and key opportunity for families to access both crisis and community-based stabilization and intervention. Note, although separated for review purposes, referrals from the ASO can also come via email or call.

**Figure 14: Source of Call or Initial Referral**



*\*Note: There was only one referral from incoming text, coming from the ASO, Kepro.*

## 8.2(b) Timeliness Indicators

There are up to four steps where DHHR is tracking timeliness measures for quality improvement purposes related to the Assessment Pathway process for interim services. This section presents the timeliness values for each of these steps and compares the actual values to the target timelines as outlined in policy. These timeliness measures are helpful in assessing families' experience in accessing services. Steps and associated results are detailed below. Given this represents a 3-month data set (193 referrals), DHHR looks forward to a larger data set before forming conclusions about Assessment Pathway improvements that may be warranted.

1. BBH makes initial contact with family following receipt of referral from CCRL, CMCR, or the ASO.
  - a. Target: Within 5 business days
  - b. Actual Average: 2.8 weekdays
2. If the child has not applied for the CSED Waiver, BBH works with the family to complete the CSED Waiver application and submit the application to the ASO (excluding children declining, failing to respond, or who have already had an application submitted to the ASO and are being referred only for connection to interim services).
  - a. Target: TBD
  - b. Actual Average: 6.9 weekdays (excluding children with missing data, 28% of children's records) with 55% of children's applications submitted in 10 days or less.
3. The ASO receives a CSED Waiver application (from BBH, BSS, or directly from families), completes the CAFAS/PECFAS, and reports results to BBH.
  - a. Target: Within 4 business days
  - b. Actual Average: Currently, data is not being collected in the Portal to assess adherence to these target timelines. This data is being collected by the ASO. DHHR is currently collaborating with the ASO to formalize the data specifications and process for monthly submission to DHHR. This data will be available in future reports.
4. BBH assigns the Wraparound facilitator agency for interim WV Wraparound services if the child is not already receiving Wraparound services.
  - a. For children referred by the ASO (n = 74), this indicator is the number of weekdays between "Date of Referral" and "Date Assigned to Agency (Wraparound tracking)," as children referred by the ASO bypass steps 1 – 3 for data collection in the portal, allowing BBH to begin the assignment of the Wraparound facilitator immediately upon receiving the referral.
    - i. Target: Within 5 business days
    - ii. Actual Average: 4.9 weekdays, 72% occurred within 5 weekdays



- b. For children referred by other entities (n=43), this indicator is the number of weekdays between “Date Application Sent to the ASO” and “Date Assigned to Agency (Wraparound tracking).” The ASO has up to four business days to process applications they receive from BBH before sending CAFAS/PECFAS scores back to BBH to begin the assignment process. However, the date BBH receives this information from the ASO was not collected previously, so this indicator must be approximated for this period by using the “Date Application Sent to the ASO” as a proxy to start the clock, and timeliness values for these children may overstate the actual number of days that it takes to assign the Wraparound facilitator. Therefore, additional days have been added to the target to match this consideration.
  - i. Target: Within 5 – 9 business days (inclusive of application processing with the ASO)
  - ii. Actual: 67% occurred within 9 weekdays, while 53% occurred within 5 weekdays

Note that clients failing to respond to BBH’s contact attempts and clients declining further participation are not included in analysis past step 1, while referrals made by the ASO bypass steps 1 – 3 and begin the Assessment Pathway process at step 4.

### 8.2(c) Overall: From Referral to Assignment to a Wraparound Facilitator – A Family’s Perspective (calendar days)

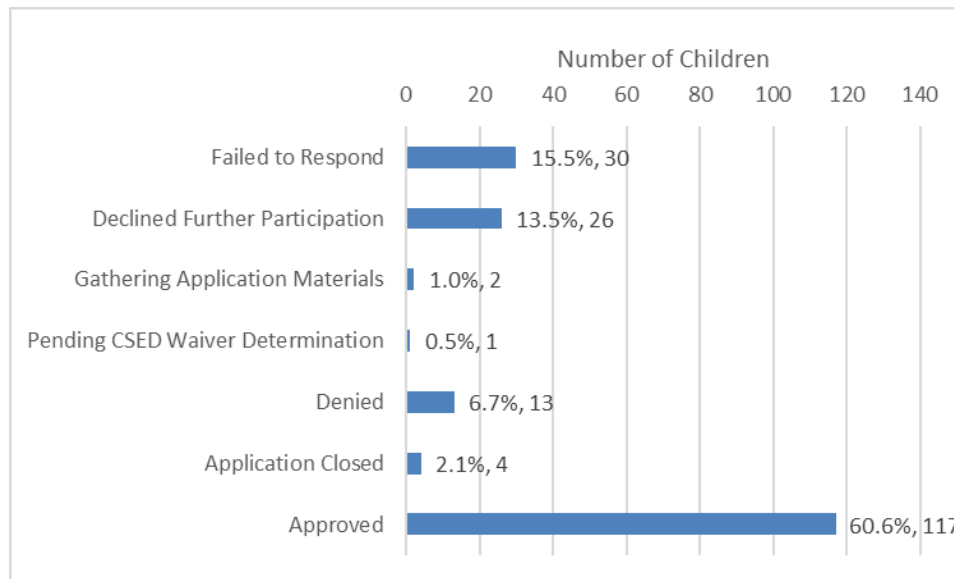
Children referred to BBH upon initial referral, supported with completing the waiver application, and assigned a Wraparound facilitator (n = 43) took an average of 22 days to assignment of a Wraparound facilitator, with 65% completing the process in less than 30 days. This may be a more realistic representation of the process for families, as there may be some additional time in the beginning during the application material collection phase (including potential delays due to family responsiveness), which was not captured in the steps above for individuals whose applications went directly to the ASO. This process needs to be understood better from multiple entry points and steps at both the material gathering and assessment with the ASO phases to identify opportunities for improvement. Future connection of data within the data store build out is also expected to bridge gaps in understanding opportunities to improve timeliness to connection to services.

### 8.2(d) Summary of Progression Through the Assessment Pathway

Figure 15 summarizes the number of children who have made it to each step of the Assessment Pathway. Fifty-six children (29.0%) did not participate because their families either failed to respond after multiple attempts or declined further participation, 13 children (6.7%) were denied due to ineligibility for the CSED Waiver, 4 children (2.1%) had their applications closed, with only 1 child reported with a pending application, and 117 children (60.6%) approved (either preliminary or final approval) for the CSED Waiver. Note that closed applications due to ineligibility are expected; however, families with closed or denied applications are often referred to other community-based services.

Additionally, as of July 1, 2022, the income requirements for the CSED Waiver program were lifted, and BBH has begun a retrospective review of cases closed because the family income exceeded the previous cap. Retrospective review begun in April to contact families meeting non-CSED criteria to offer Wraparound services if the family desired. Two children were listed as still gathering materials at the time of review; policy has now been implemented to help prevent this in the future by encouraging families to complete applications in a timely manner and establishing appropriate time frames for returning materials or closing out the application until the family is ready to proceed.

**Figure 15: Progression Through the Assessment Pathway**



As depicted in Figure 16, of the 117 children who have been approved, 12 children (10% of Assessment Pathway approvals) have not yet been assigned a Wraparound facilitator, while 105 children (90% of approvals) have a Wraparound facilitator. Future reviews will include additional examination of factors influencing individuals not assigned a Wraparound facilitator and those experiencing delays in being connected with a Wraparound facilitator.

**Figure 16: Wraparound Facilitator Status of Children with CSED Waiver Approval  
(Preliminary or Final; n = 117)**

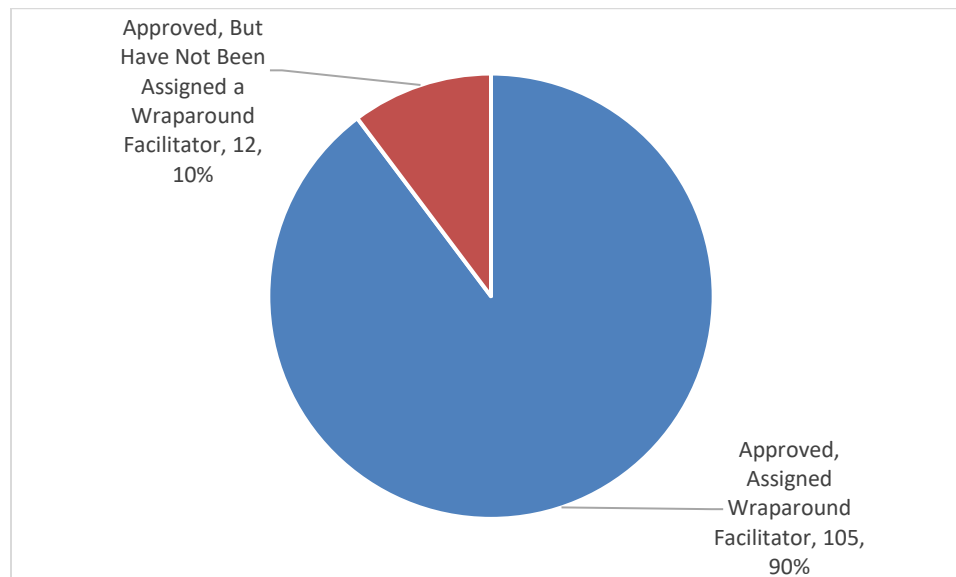
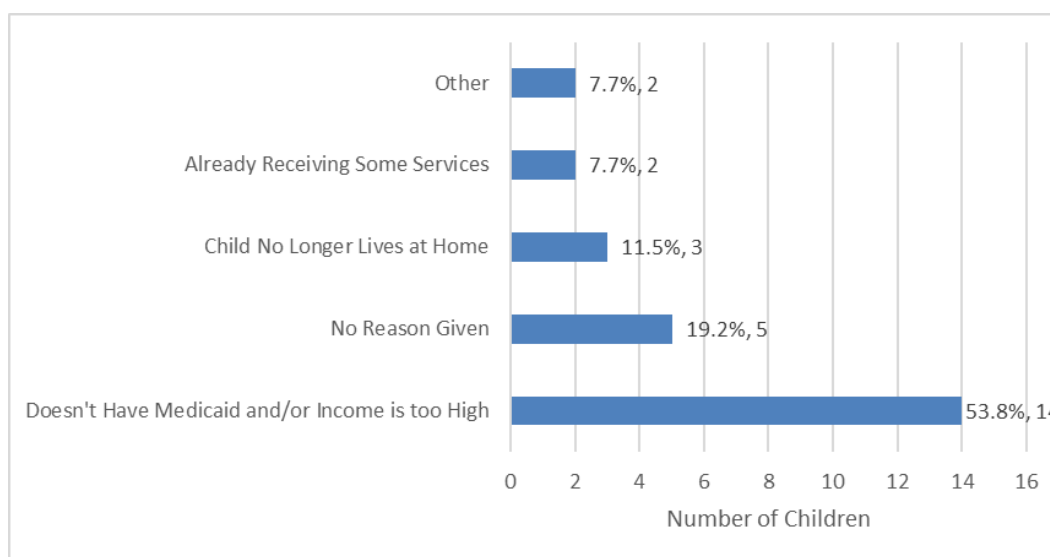


Figure 17 depicts the reasons given by the 26 families declining further participation. The largest reason to decline participation relates to (perceived) Medicaid/income eligibility (n = 14, 53.8%). As of July 1, 2022, BMS has expanded its policy to account for this identified need, allowing children who qualify based on need to apply for Medicaid based on their income as the child, which would allow them to become income eligible. Five children (19.2%) had no reason given. This was noted in quality reviews and BBH will continue to expand attempts to collect this information when individuals decline referral.

**Figure 17: Reasons for Declining Further Participation (n = 26)**



### 8.3 Provider Capacity/Statewide Coverage

Over the past two years, DHHR has emphasized building and expanding the capacity to provide statewide services. This is demonstrated in the enhancements in the number of providers and counties the programs serve. Training has been completed with the CCRL staff members, DHHR staff, and external partners to formalize processes, work toward implementation of the Assessment Pathway, and help ensure accuracy in data collection.

For the Assessment Pathway to be effective, statewide coverage of referring entities is needed as well as sufficient personnel at the provider level who accept and process referrals for Wraparound Facilitation. In addition to this, capacity of assessors (the ASO) to perform CAFAS/PECFAS in a timely manner is also critical to connecting families to timely services. In general, the initial phase of implementation focused on recruiting provider agencies to offer services. DHHR will continue and enhance activities that support providers and agencies being able to attract and retain adequate staffing.

Currently, BBH has nine staff processing referrals, with an additional position added since the last review period. The new position has a focus on follow-up and quality assurance related to the Assessment Pathway, which has significantly improved data collection quality, reducing missing data and enhancing BBH's ability to ensure youth are served in a timely manner. Seven of these nine personnel are BBH employees, and two are at agencies that work on behalf of BBH.

Provider capacity continues to be monitored closely as referenced throughout this report. Additional review is needed to better understand workforce needs including workforce shortages, high-intensity clients impacting expected ratios, and potential regional concerns.

### 8.4 Strengths, Opportunities, Barriers, and Next Steps

- The Assessment Pathway was designed to centralize and streamline entry to services for families. Families are provided assistance in the process to access covered long-term services, as well as other home and community-based services to meet needs while waiting for CSED Waiver determination. Increases in referrals month over month (a nearly 3-fold increase) is viewed as an encouraging gauge of expanding awareness and the Assessment Pathway being an open door to families, as designed.
- The Assessment Pathway offers multiple points of entry, which will allow greater identification of children in need.
- Regardless of CSED Waiver determination, a child is connected to services appropriate to their level of need; if denied for the CSED waiver, the child is referred to other home and community-based services.
- DHHR conducted training for all entities assisting with the Assessment Pathway and the associated data collection and tracking portal. Quality reviews, in addition to new staff focused on quality and follow-up has significantly improved the ability to use CQI strategies to monitor interim service data. Interim services continue to be reviewed monthly, and improvements have

already been made to data collection and procedures to use data to inform planning and improve application completion/submission timeliness with families.

- Seventeen counties were identified as having no referrals to the Assessment Pathway during the period; this will be a focus area for outreach and education, with additional focus on areas with limited CSED referrals and higher rates of RMHTF placement by county of removal.
- Additional analysis on available data for individuals failing to respond or declining services should be conducted to assess opportunities to improve the family experience and ease any potential frustration or misunderstanding with the process.
- Future reporting is expected to include further review of assessment scores regarding both CANS and CAFAS assessments with attention to timeliness, level of need, and outcomes. Methodology for analyzing CANS-related outcomes is being developed and tested with a subset of data; further review and inclusion is expected for future semiannual reports. Further development of the data store will also allow additional data to be connected and considered across systems.

## 9.0 Children with Serious Emotional Disorder (CSED) Waiver Enrollment and Services

DHHR implemented the CSED Waiver effective March 1, 2020. The CSED Waiver provides services that are additions to Medicaid State Plan coverage for members ages 3 up to their 21st birthday who are enrolled in the CSED Waiver program. The CSED Waiver permits DHHR to provide an array of home and community-based services that enable children who would otherwise require institutionalization to remain in their homes and communities. It is anticipated this waiver will reduce the number of children placed in residential and other out-of-home placements. This waiver prioritizes children with SED who are:

- In Psychiatric Residential Treatment Facilities (PRTFs) or other residential facilities either in-state or out-of-state
- Other Medicaid-eligible children with SED who are at risk of institutionalization

The CSED Waiver provides services to children with SED based on the NWI model. This model is strengths-based, meaning it uses the strengths of families and individuals as a starting point for growth and change, with a goal of helping waiver members and their families develop skills to cope with challenges and stabilize children in their homes. The model is also centered on the needs of the child and their family. The child experiencing challenging behaviors is central to the process and engaged in a plan to help develop the skills necessary to achieve stability and improve coping strategies, ideally enabling the child to achieve their personal goals.

The following services are available under the CSED Waiver:

- |                                      |  |
|--------------------------------------|--|
| • Wraparound Facilitation            | • Community Transition                 |
| • Mobile Response                    | • In-Home Family Therapy               |
| • Independent Living/Skills Building | • In-Home and Out-of-Home Respite Care |
| • In-Home Family Support             | • Peer Parent Support                  |
| • Job Development                    | • Non-Medical Transportation           |
| • Individual Supportive Employment   | • Specialized Therapy                  |
| • Assistive Equipment                |  |

DHHR contracts with Kepro, the ASO, to address program eligibility and enrollment. DHHR contracts with Aetna Mountain Health Promise, an MCO, responsible for CSED service authorization and utilization management.

## 9.1 Review Period, Data Sources and Limitations, Population Measured

The period reviewed is July — December 2021, with trends reviewed looking back to July 2020. CSED Waiver enrollment data are sourced from the ASO's data systems. CSED service use is sourced from DW/DSS paid claims for services rendered July 2020 through December 2021 and paid through March 2022. WV Medicaid providers have up to 12 months from the date of service to submit claims; therefore, results for the more recent months in the analysis period may change over time as providers submit or adjust claims. The population measured includes children who may be eligible for the waiver and are going through the application process as well as children accessing CSED Waiver services during the review period.

## 9.2 Review Summary

The CSED Waiver is in its first two years of operation; therefore, the program has not reached maturity and will take additional time to reach routine and ongoing levels of utilization. One notable influence impacting the review period is the COVID-19 pandemic, which affected service use during these early stages of the CSED Waiver implementation. Services are traditionally rendered in-person. Due to the COVID-19 pandemic, many families have opted for services via telehealth when available or have put services on hold until in-person services were considered safer in their community. The use of telehealth services will continue to be monitored and considered for permanent policy change when the public health emergency ends.

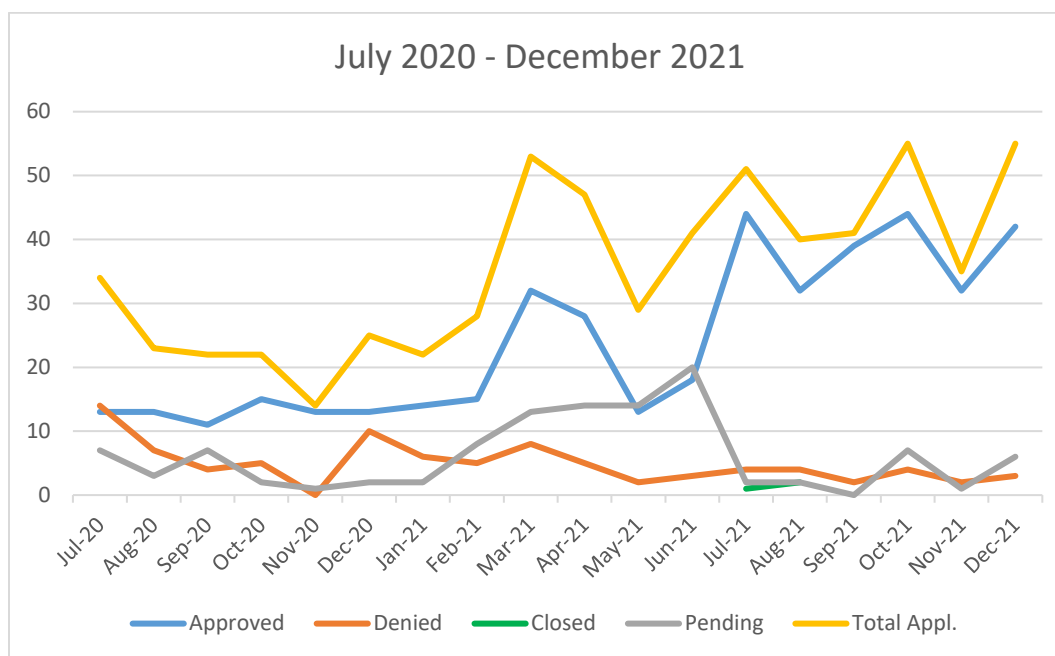
### 9.2(a) CSED Waiver Applications and Enrollment

For the July – December 2021 period, Kepro, the ASO, reports the following for the CSED Waiver:

- 277 applications received
- 233 (84%) applications approved
- 19 (7%) applications denied
- 18 (6.5%) applications pending

For comparison purposes, CSED Waiver application trends over the 18-month period, July 2020 – December 2021, are shown in Figure 18 below. Applications increased by approximately 70% for the period July 2021 – December 2021 compared to the January 2021 – June 2021 period. This increase represents notable improvement given the increasing awareness of the availability of these services. Based on the high level of pending cases observed in the first half of the year, DHHR made process changes to the waiver effective July 2021, including the ASO assisting families with selection of an Independent Evaluator. As a result of these changes, the number of pending applications dropped materially in the second half of 2021 with only 6.5% of applications pending for that period. Reasons for the remaining minimal pending applications include lack of response from family and repeated no calls/no shows for appointments. In limited instances, pending cases were closed based on the children moving out of state or the family no longer being interested in pursuing the services.

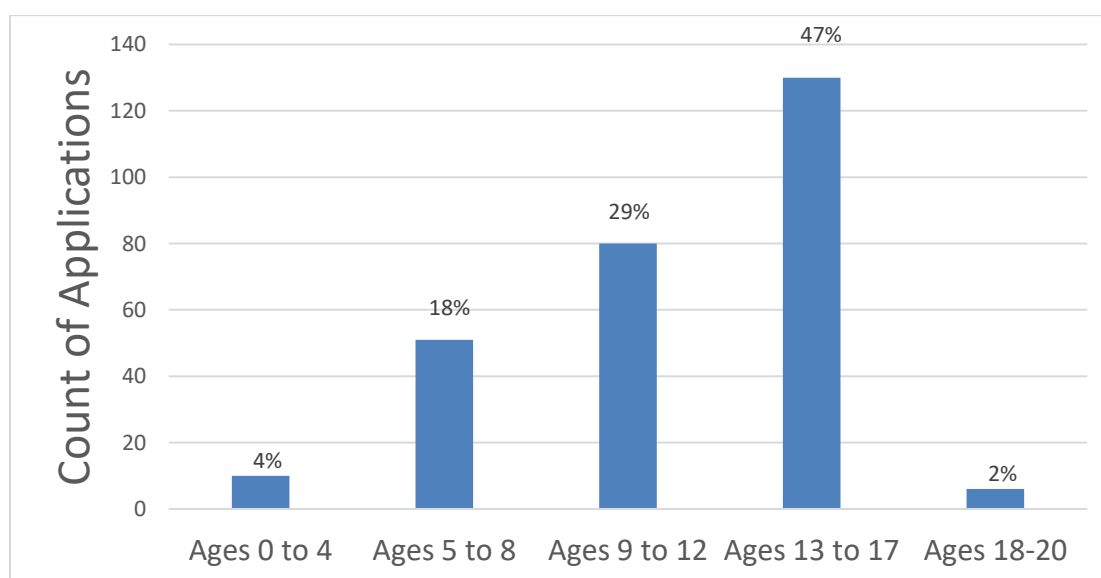
**Figure 18: CSED Waiver Applications by Month, July 2020 – December 2021**



The evaluator provided DHHR with denial reasons for 17 of the 19 CSED Waiver application denials during the period July to December 2021. Ten children, or 59% of denials were for no eligible diagnosis. The remaining seven, or 41%, reported a Basic Assessment System for Children (BASC) or CAFAS/PECFAS score that did not meet eligibility criteria.

Of CSED Waiver applicants, 47% were children ages 13 – 17, followed by 29% of children ages 9 – 12, 18% of children ages 5 – 8 and 4% of children ages 0 – 4. These age demographics are consistent with those for the July 2020 – June 2021 review period.

**Figure 19: CSED Waiver Applications by Age Group, July – December 2021**





One of DHHR's goals is timely access to services. After the data store is expanded allowing alignment of child-level data across systems, DHHR intends to measure and report the timeline from screening to eligibility determination. DHHR continues to monitor the timelines from receipt of the waiver application to eligibility determination. For the prior period July 2020 to June 2021, the timeline from receipt of the application to eligibility determination was an average of 68.3 days. Based on this data and in an effort to improve timeliness, DHHR made changes to the CSED waiver process. Subsequent to these changes, the average time from receipt of application to eligibility determination decreased by approximately 50% to an average of 34 days for the period July – December 2021. The referenced changes implemented in July 2021, include the following:

- Expanding the pool of evaluators to include WV licensed social workers, WV licensed professional counselors, and WV-supervised psychologists for the initial eligibility assessment
- Streamlining the eligibility process
- Modifying eligibility to reflect the statewide referral system, which conducts some screening and evaluations before the applicant is fully evaluated by the Independent Evaluator Network

## 9.2(b) CSED Waiver Service Utilization

Per DW/DSS paid claims for services rendered July 2020 through December 2021 and paid through March 2022, 245 children accessed CSED Waiver services. Two hundred and eight (208) children received independent evaluations for the CSED Waiver but did not access any other waiver services during the review period. During the primary review period, July – December 2021, 205 children accessed CSED Waiver services, excluding children with an independent evaluation only. One hundred and eighteen (118) children received independent evaluations for the CSED Waiver but did not access any other waiver services during the July – December 2021 period. The reasons for completing an evaluation but not accessing services may include the following: timing issues associated with billing for services rendered, children who were evaluated and found ineligible for the waiver, those still pending, or families choosing to pause services due to concerns related to the pandemic. DHHR is currently collaborating with the ASO and the MCO on revised CSED Waiver data specifications, including capturing the reasons for not accessing services following the evaluation and understanding the barriers to accessibility of services.

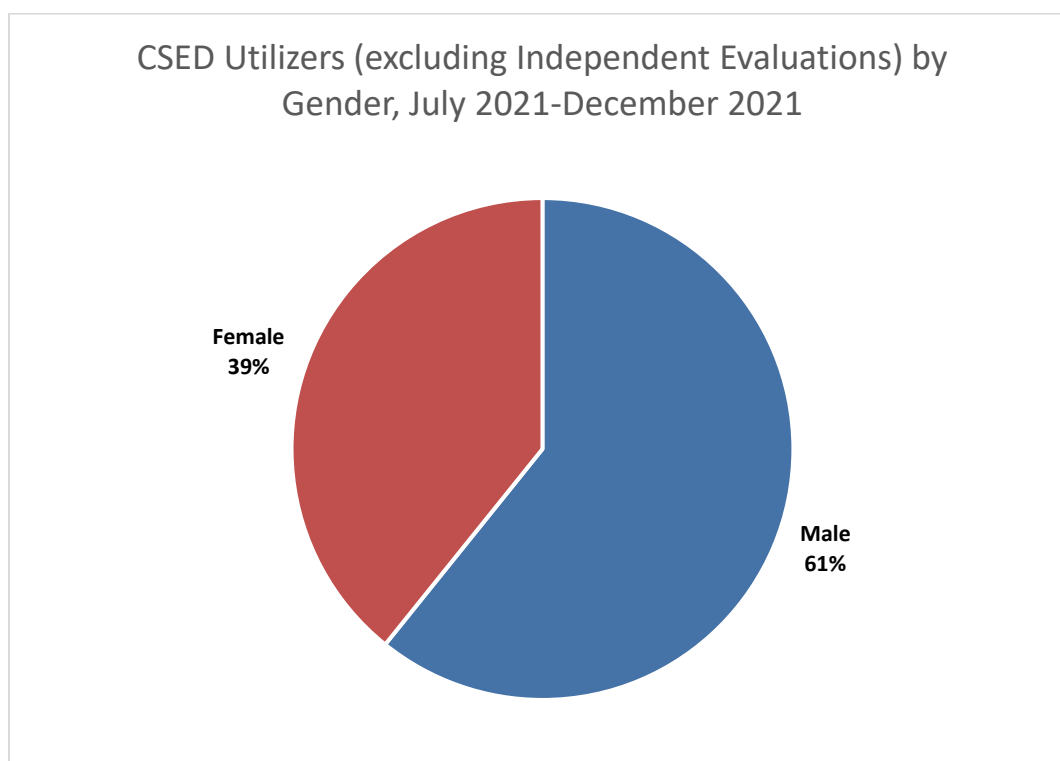
DHHR made the following changes to the waiver to enhance accessibility:

- Rate increases for Wraparound Facilitation, In-home Family Support, Independent Living Skills, and Peer Support effective January 1, 2021
- Rate increases for Mobile Crisis effective July 1, 2021
- Unit increases for Specialized Therapy and Assistive Equipment effective July 1, 2021
- Reduced the Wraparound facilitator case load from 1:20 to 1:15
- Added the requirement for the Wraparound facilitator to be certified in the CANS Assessment

- Removed Approved Medication Administration Personnel requirement as in-home CSED Waiver staff may not administer medications
- Changed the language for the 7-day meeting and the 30-day meetings to be within 30 days of referral instead of intake

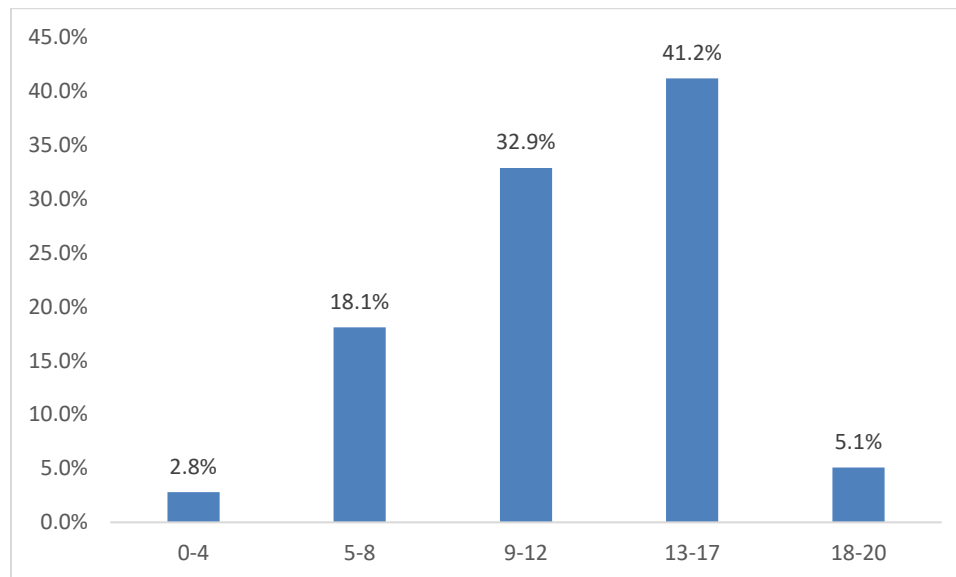
Waiver services continue to be predominantly used by male children compared to female children (Figure 20), although the percentage of females accessing the services increased to 39%, up from the 34% reported for the July 2020 – June 2021 period.

**Figure 20: CSEDW Waiver Services Utilization by Gender, July – December 2021  
(Excluding Independent Evaluations)**



Age demographics for children accessing CSED Waiver services are captured in Figure 21 below with 41% falling into the 13 – 17 age category, skewing this population as younger than the population identified in RMHTFs, indicating an opportunity for early intervention.

**Figure 21: Number of Children Accessing CSEDW Services by Age Group and Gender, July – December 2021  
(Excluding Independent Evaluations)**

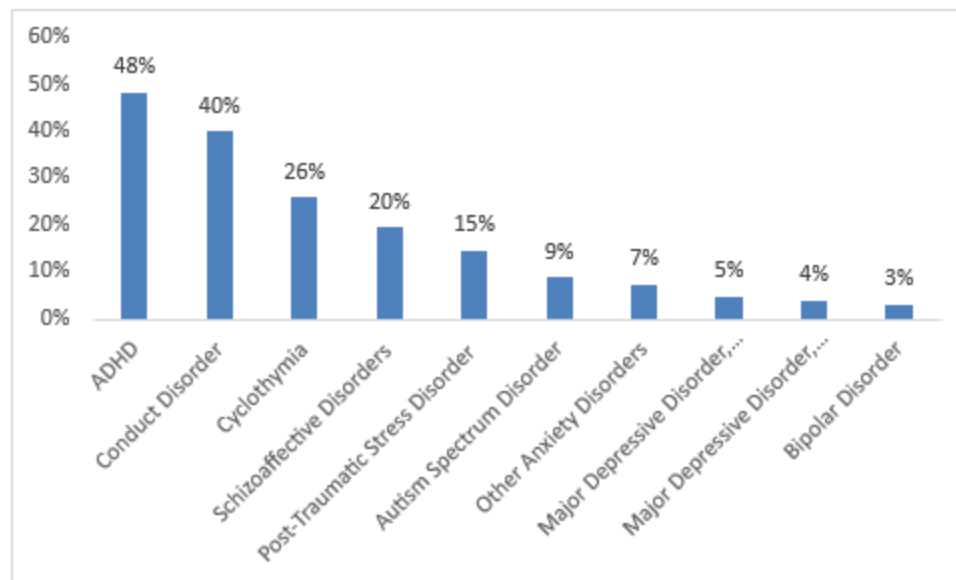


As indicated in Figure 22, 48% of children utilizing the CSED Waiver had a CSED Waiver service claim associated with attention deficit hyperactivity disorder (ADHD) during the last half of 2021 (out of 205 children utilizing services during the period). Other common diagnoses associated with CSED Waiver claims were conduct disorder (40%), cyclothymia (26%), and schizoaffective disorders (20%).<sup>6</sup> Please note that many children have multiple CSED Waiver claims reporting varying primary diagnosis. In Figure 22, therefore, the same child may be counted in multiple diagnosis columns (e.g., ADHD and conduct disorder). However, a given child is counted only once in each diagnosis column. As ADHD is commonly found with cooccurring mental health diagnoses, studies have found that children with both ADHD and oppositional defiant disorder or conduct disorder have earlier onset of symptoms, have more school dysfunction, and are often more aggressive than other children with only one identified mental health disorder.<sup>7</sup> Additional information is needed to be able to understand the prevalence of related disorders among this group of children being served and common co-occurrences, which may lend to increased functional impairment. The Quality Review Committee recommended getting a better understanding of children with autism spectrum disorder (ASD), which was reported on associated claims for 9% of children. Diagnosis information will continue to be monitored to better understand the needs of children utilizing CSED Waiver services. Note diagnoses reported here may not be comprehensive of all diagnoses for an individual, represented here are primary diagnoses given as justification for CSED Waiver claims occurring during the six-month period.

<sup>6</sup> Diagnosis is defined here as the diagnostic category defined by the first three digits of the primary International Classification of Disease (ICD)-10 diagnosis code reported on the paid claim.

<sup>7</sup> Spencer, T. (2006). *ADHD and Comorbidity in Childhood*. *Journal of Clinical Psychiatry*, 67 [suppl 8], 27-31. Retrieved from <https://www.psychiatrist.com/read-pdf/435/>

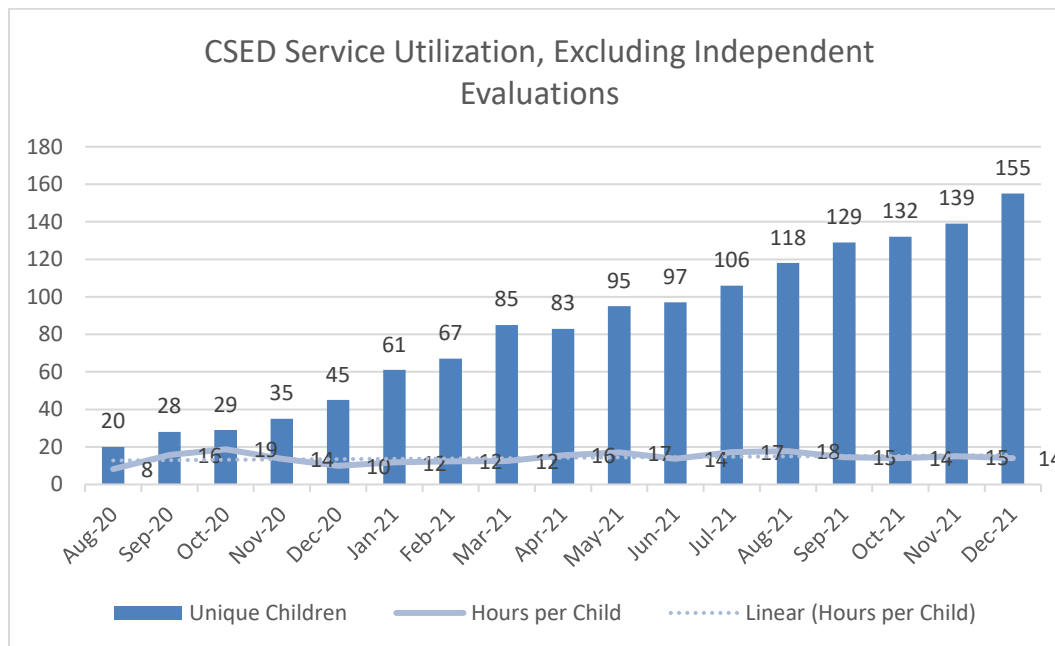
**Figure 22: Percentage of Children Accessing CSED Waiver Services with a CSED Waiver Claim Reporting a Primary Diagnosis in the Top 10 Diagnoses associated with CSED Waiver Claims, July – December 2021  
(Excluding Independent Evaluations)**



The number of children accessing services has continued to increase over time while the hours of service per children has remained relatively consistent,<sup>8</sup> as shown in Figure 23. The quality committee recommended an analysis of service utilization, including indicators for length of service, over the lifespan of enrollment to better understand how the services are utilized throughout a child's access to CSED Waiver services.

<sup>8</sup> The graph truncates the July 2020 data because the July 2020 units-per-user results are skewed by a clearly inaccurate claim record reporting an implausibly large number of units of service.

**Figure 23: CSEDW Service Utilization, July 2020 – December 2021 (Excluding Independent Evaluations)**



A summary of CSEDW services used during the 18-month trend reporting period is captured in Figure 24 below:

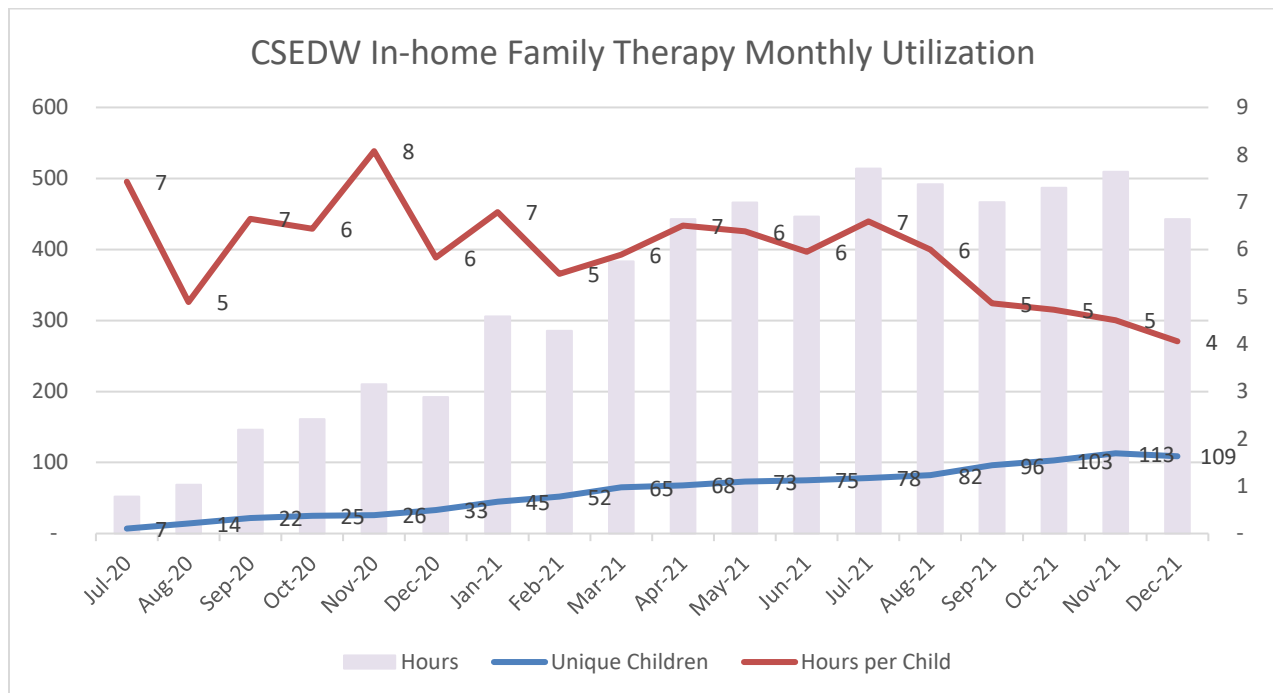
**Figure 24: CSEDW Service Utilization by Service Type, July 2020 – December 2021**

July 2020-December 2021 Totals Service Description	Hours Provided	Unique Youth	Hours per User
CSEDW Assistive equipment	631	9	70
CSEDW Wraparound Facilitation	4,541	220	21
CSEDW Community Transition	593	1	593
CSEDW In-home family Support	4,260	135	32
CSEDW In-home family Therapy	6,070	193	31
CSEDW Mobile response	91	23	4
CSEDW Peer parent support	251	16	16
CSEDW Respite (in home)	1,024	22	47
CSEDW Respite (out of home)	1,008	20	50
CSEDW Independent Evaluation	93	363	0
CSEDW Spec Therapy	74	1	74
CSEDW Supported employment, individual	8	1	8
CSEDW Transport	2,893	28	103
<b>All CSEDW Services</b>	<b>21,535</b>	<b>453</b>	<b>48</b>
<b>All CSEDW Services excluding IE</b>	<b>21,442</b>	<b>245</b>	<b>88</b>

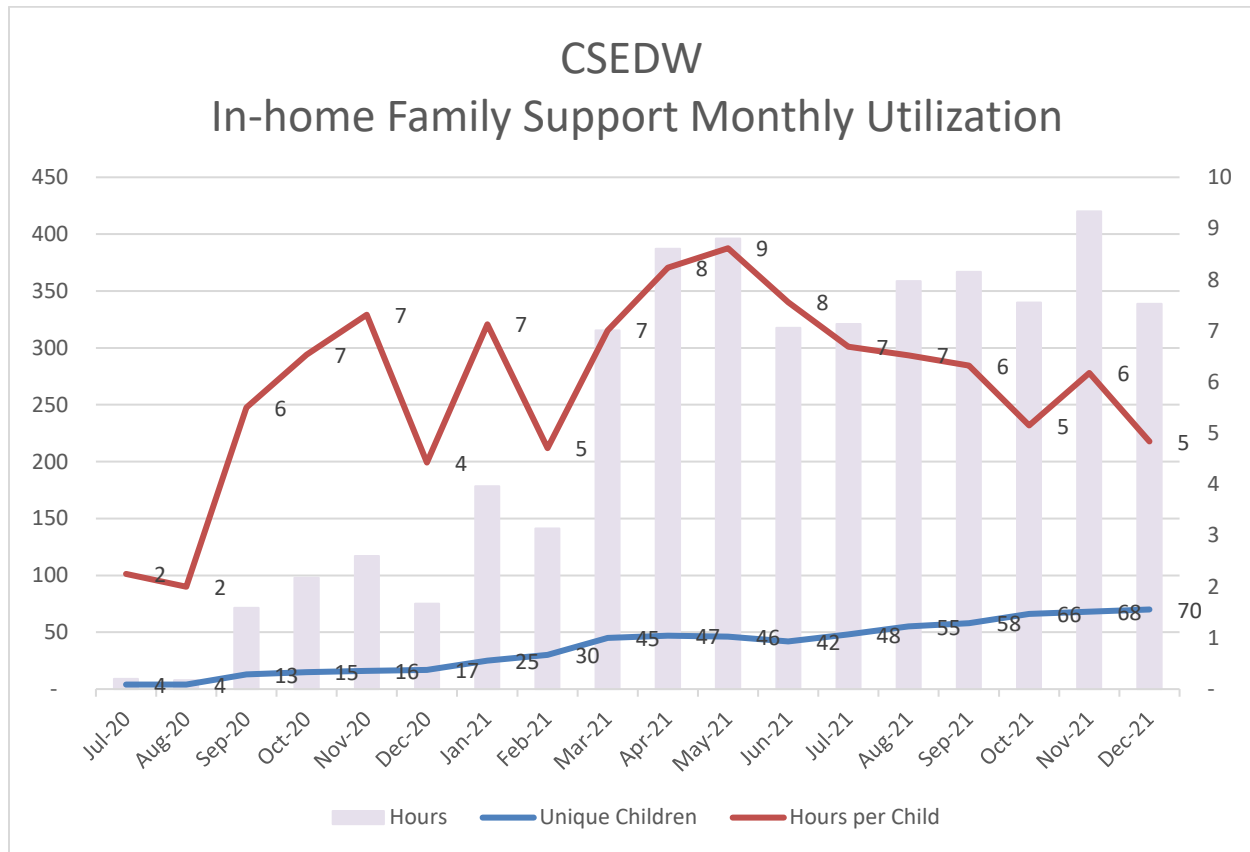
The services most used during the July 2020 – December 2021 reporting period include In-Home Family Therapy (6,070 hours), In- Home Family Support (4,260 hours), and Wraparound Facilitation (4,541 hours). Respite use, although low, may be occurring via other programs. Respite services will continue to be assessed as more data become available and trends become established across programs. Additional focus may be needed on outreach and education regarding the availability of respite services under the waiver.

The charts (reference Figures 25, 26, and 27) below show the trends for the most-used services, including In-Home Family Therapy, In-Home Family Supports, and Wraparound Facilitation, for the period under review. All of these services show an increase in the number of children accessing these services over the review period, which is a positive sign, given the goal of increasing usage of home and community-based services to reduce the risk of residential placement. The Quality Review Committee noted the decline in the average number of hours per child in the last six months of the review period and recommended utilization analysis throughout the lifespan of a child's enrollment in the waiver be completed in order to better understand utilization trends.

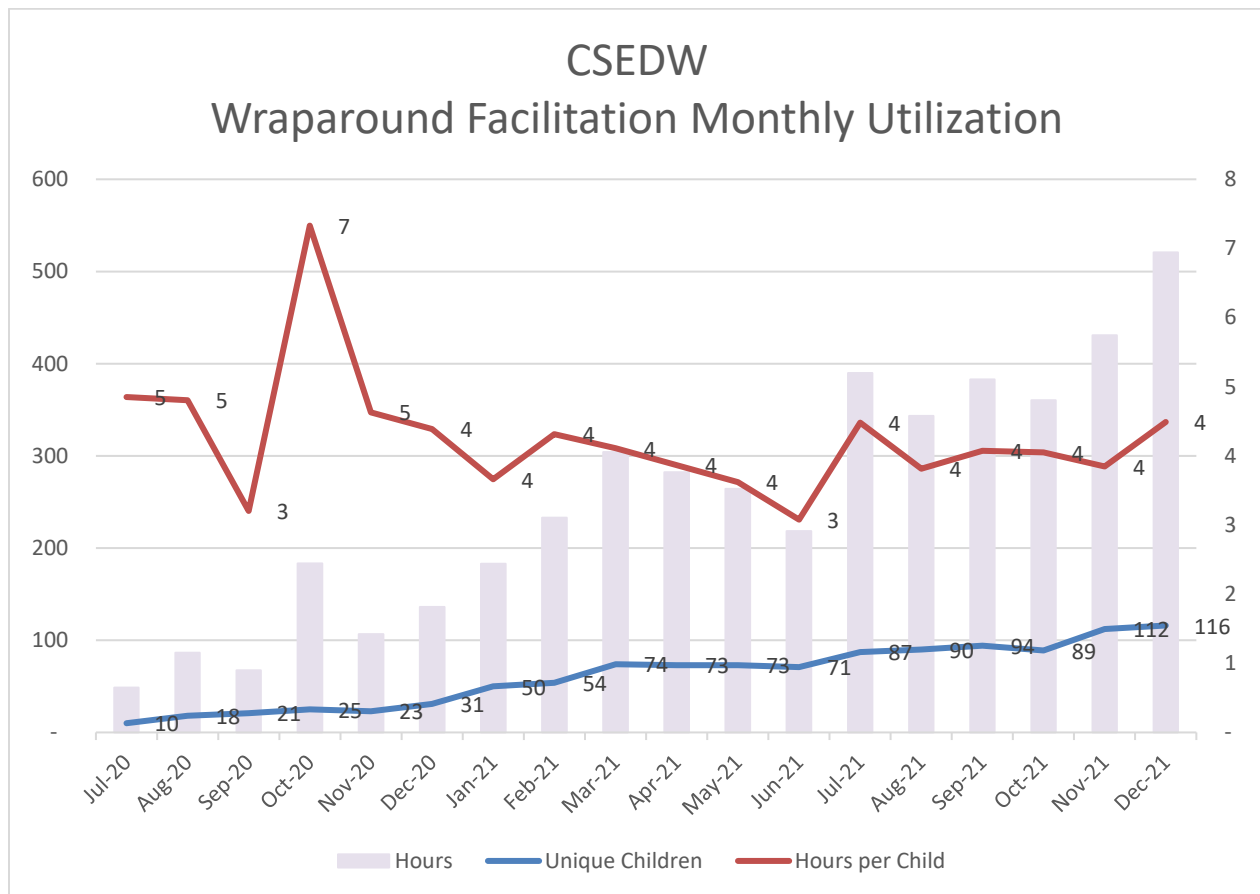
**Figure 25: CSEDW In-Home Family Therapy Monthly Utilization, July 2020 – December 2021**



**Figure 26: CSEDW In-Home Family Support Monthly Utilization, July 2020 – December 2021**



**Figure 27: CSEDW Wraparound Facilitation Monthly Utilization, July 2020 – December 2021**



### 9.3 Provider Capacity/Statewide Coverage

Twelve providers are actively providing CSED Waiver services. Providers have expressed they continue to struggle with staffing challenges due to the pandemic as well as national labor shortages. Providers are continuing recruiting efforts in a difficult labor market and report a lack of applicants. The MCO has offered monetary incentives to providers in an effort to enhance the provider network, given the anticipated continued increase in demand for waiver services as the Assessment Pathway is more fully implemented. As a result of these incentives, additional provider locations were added to increase the network capacity.

DHHR made efforts to expand CSED provider capacity and access to care by implementing the following strategies:

- Effective July 2021, BBH and Safe at Home<sup>9</sup> provider contracts were updated to require these providers to become CSED Waiver providers

<sup>9</sup> Safe at Home is a program for children served by the Child Welfare agency using a wraparound-like model. This program is focused on the safety, welfare, and permanency for the child.



- Effective July 1, 2021, DHHR implemented temporary rate increases for some CSED Waiver services
- DHHR expanded the list of eligible degree types for non-licensed clinicians for two CSED Waiver services to expand the available workforce

## 9.4 Strengths, Opportunities, Barriers, and Next Steps

DHHR continues to refine policies and processes that address ease of access, administrative burden, workforce, and provider capacity by engaging with stakeholders and reviewing data. A streamlined assessment process has made it easier to access Wraparound Facilitation and other necessary CSED waiver services. As enrollment in the CSED Waiver continues to increase over time, the ASO is adding staff to handle the increased volume of referrals, and providers are continuously recruiting staff to accommodate the increase. BMS created a script for the ASO to ensure that those children and families exploring CSED Waiver services are receiving consistent and clear messages as they work through the application process. The standardized script was shared with other bureaus and is being shared with stakeholders, such as judges, in an effort to socialize the timelines, educate on the process, and highlight expectations of the application process.

DHHR is continuing the collaboration with the ASO and MCO to expand CSED Waiver data specifications to enhance the ability to identify and address barriers and access issues.

Based on the decline in utilization in the last six months of the reporting period, the Quality Review Committee recommended as utilization analysis throughout the lifespan of a child's enrollment in the waiver be completed in order to better understand utilization trends.

During the first year of the CSED implementation, stakeholders identified design elements to improve the service delivery and access to care for children to become eligible and enrolled and for those who are currently enrolled. In response to the feedback, DHHR requested an amendment to the CSED waiver to address some of the pit falls identified. An amendment was approved June 3, 2022, to make the following improvements:

1. Permanently expand Medicaid eligibility for the CSED Waiver.
2. Permanently expand the list of eligible degree types for providers to include non-licensed clinicians. Non-licensed clinicians delivering these services will receive clinical supervision as is required for Licensed Behavioral Health Centers, the provider type that delivers CSED services.
3. Extend the time frame in which an eligible member must begin home and community-based services before an unused waiver slot is discharged from 90 days up to 365 days unless the member ages out of eligibility.
4. Remove the "in-home" requirement for family therapy, to increase service-setting options to align the waiver with the state's Wraparound initiative.
5. Add Evidence-Based Therapy requirements to align with Centers for Medicare & Medicaid Services (CMS) and evidence-based practices.

6. Update the conflict-free case management service radius from 25 miles to 15 miles to increase access to home and community-based services and allow members more choice in providers to receive their home and community-based services from. The decrease in radius mileage will also be beneficial to family and caregivers by requiring less travel time to receive home and community-based services.

## 10.0 Wraparound Facilitation

WV offers Wraparound services to children with SED or SMI through the Assessment Pathway described in Section 8.0. WV Wraparound Facilitation is provided through three main funding sources:

- BBH Children’s Mental Health Wraparound grants for:
  - Interim services or
  - Children not eligible for the CSED Waiver but who meet criteria for non-CSED Waiver Wraparound Facilitation
- BMS CSED Waiver
- BSS Interim services for children involved with BSS, provided by a BSS Safe at Home Wraparound Facilitators

To make navigating WV’s system of care easier for families and reduce the reliance on residential placement or court involvement to receive services, DHHR redesigned its Wraparound programs with a planned phased implementation. Phase 1 began on October 31, 2021.

The goals across the agencies funding Wraparound services are:

- To help children and families thrive in their homes, schools, and communities
- To implement a seamless system of care that includes statewide Wraparound services available through a “no wrong door” approach
- To provide consistently trained Wraparound facilitators and high-fidelity Wraparound services
- To reduce the number of children removed from their homes due to SED or SMI
- To provide increased quality of life as evidenced in school, housing, interpersonal relationships, and employment stability

### 10.1 Review Period, Data Sources and Limitations, Population Measured

As DHHR aligns services to meet the NWI model across the agencies, efforts are underway to enhance data collection and upgrade systems to allow interconnectivity of data sets across DHHR for record-level data through the data store. This will allow DHHR to assess WV Wraparound both by payor source and as one consistent and unified service. DHHR has also contracted with Marshall University to assess fidelity, and WVU to provide an overall evaluation of the children’s home and community-based services system. DHHR will incorporate data shared from those collaborations in future reports as the data become available. A major accomplishment over the past year was the implementation of the BBH System of Care Epi Info Interface that captures more service-level data and child-level data that will result in enhanced reporting for subsequent reports. An update to further enhance this system is expected in fall 2022.

**Figure 28: Wraparound Facilitation Data Overview**

WV Wraparound DHHR Provider	Data Review Period	Data Source	Limitations	Population Measured
Wraparound Services provided by BBH Children's Mental Health Wraparound (CMHW) providers	July 1, 2021 – September 30, 2021 October 1, 2021 – December 31, 2021	BBH Grant Reporting BBH System of Care Epi Info Interface	Prior to October 1, 2021, reporting was a combination of de-identified and aggregated data, which prohibited the ability to report unique numbers served across programs. For this reason, only the last quarter of data is presented unless there was a significant change indicated. As previously stated, as of October 31, 2021, BBH Wraparound became considered WV Wraparound and primarily contributes to interim services. Data will need to be reported separately for each payor source until the data store is built out further for connection across data systems.	Interim Wraparound Facilitation while applying for the CSED Waiver and Non-CSED Waiver Wraparound Facilitation with criteria agreed upon with BSS and BMS:  1. As of July 1, 2022, financial ineligibility will no longer be a barrier for the CSED Waiver, due to an approved Waiver amendment; or  2. Clinical ineligibility for CSED Waiver. DHHR's bureaus recognize that some children may be appropriate for high-fidelity Wraparound even if they do not meet clinical eligibility for CSED Waiver in the following circumstances:  <ul style="list-style-type: none"> <li>Significant mental health needs.</li> <li>At risk of out-of-home placement.</li> <li>CAFAS score of 1) 80, or 2) 70 or below with current involvement by DHHR's BSS.</li> <li>Coexisting or co-occurring disorders that do not otherwise meet the criteria or eligibility for a secondary waiver such as Intellectual/ Developmental Disabilities Waiver or</li> </ul>

WV Wraparound DHHR Provider	Data Review Period	Data Source	Limitations	Population Measured
				Traumatic Brain Injury Waiver.
Wraparound Services (provided by SAH WV providers)	Unavailable at time of report	CANS Automated System	This data was unavailable at the time of report but will be included in future reports as a payor source of interim Wraparound service. Services through the agreement between bureaus to allow SAH facilitators to serve WV Wraparound clients went into effect June 10, 2022.	*See description above.
CSED Waiver Wraparound	Utilization trends for July 2020 – December 2021	DW/DSS	Data are based on claims through March 2022, so there may be some claim lag in the data presented.	Children enrolled in the CSED Waiver.

## 10.2 Review Summary

Wraparound services have been divided by payor source for this report due to current data consolidation limitations. Work is underway to allow aggregation of this data to look at overall utilization and outcomes for youth in WV Wraparound. Although data are separated by payor, as of October 2021, the system allows families to seamlessly access Wraparound Facilitation and maintain their current provider in instances where they are already accessing Wraparound services in order to ensure consistency in service provision and maintenance of already established relationships.

Additionally, due to the implementation of the BBH Epi Info data interface and transition from provider reporting forms in October 2021, data for BBH funded Wraparound services was unable to be unduplicated and combined for each quarter represented. Therefore, data are represented for BBH for the most recent quarter (October – December 2021) unless relevant change was seen in the first quarter of the period (July – September 2021) and is referenced for comparison purposes. Data periods reviewed are noted throughout. Changes may be expected, as the Assessment Pathway Phase 1 implementation began during this review period and will be assessed moving forward to understand if there is a shift in children served.

### 10.2(a) Wraparound Services Through BBH

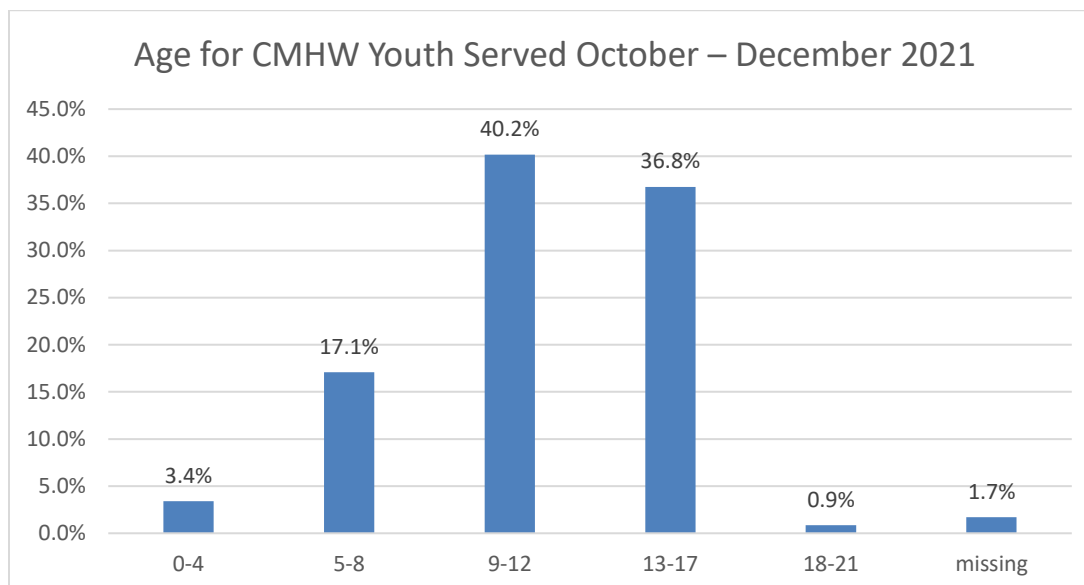
As the CQI processes continue to be implemented, the BBH anticipates further refinement of indicators. A goal of these early semiannual reports is to continue to review and establish baseline numbers of children and services, as well as a baseline profile of who is receiving services and where services are occurring. As reporting becomes more robust and the data store grows, it is anticipated that indicators will also evolve to include more outcome data. BBH has had statewide Wraparound coverage since October 2019.

**Figure 29: BBH Children’s Mental Health Wraparound Summary, July 2021 – December 2021**

BBH Children’s Mental Health Wraparound			
Review Period	Children Served	Total Contacts with Youth/Family	Providers
July – September 2021	138	1,799	5
October – December 2021	117	Unavailable at the time of this report	5

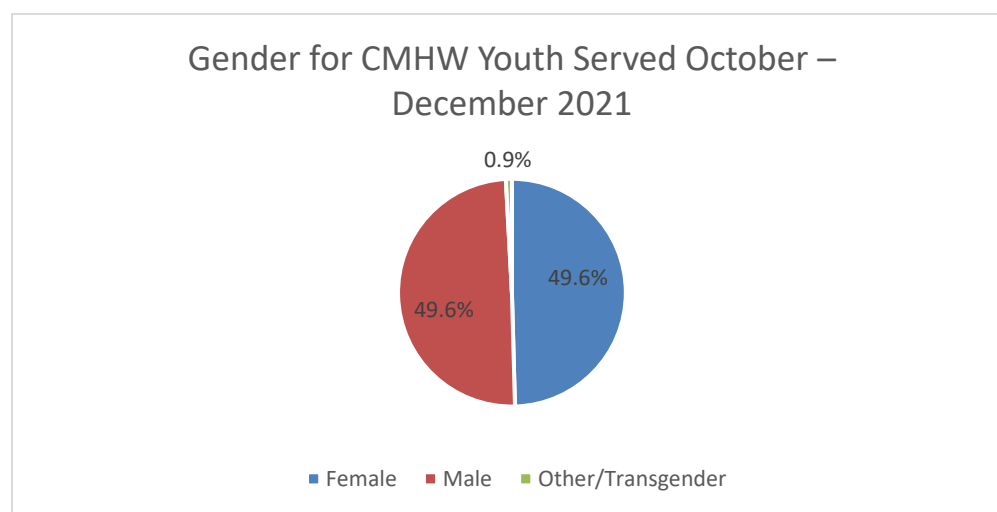
As shown in Figure 30 below, most of the children served were between 9 and 17 years of age. The age groupings of 9 – 12 years and 13 – 17 years reported similar rates of service. From July 2021 – December 2021 reporting period, the majority of children in RMHTFs were 13 – 17 (80%) followed by children aged 9 – 12 (16%). The age groups served by BBH Children’s Mental Health Wraparound are younger compared to those in residential placement, indicating the opportunity for the program to reduce the risk of out-of-home placement. As data processes are enhanced, outcomes will be assessed to demonstrate impact of the program.

**Figure 30: Children Served via WV's Children's Mental Health Wraparound by Age Grouping, October 2021 – December 2021 (n=117)**



Per Figure 31 below, more male children (57%) received services compared to female children (43%) in quarter 3 of 2021. This is also comparable to children receiving RMHTF services. However, in quarter 4, with the implementation of the System of Care Epi Info Interface and Phase 1 of the Assessment Pathway, the population served shifted to a more equal distribution, which may be indicative of additional female youth served and referred to Wraparound services from the CCRL or CMCR services, which tend to serve a larger proportion of females. This change will continue to be monitored to better understand demographic differences in children accessing and entering care through different pathways.

**Figure 31: Children Served via WV's Children's Mental Health Wraparound by Gender, October 2021 – December 2021 (n=117)**

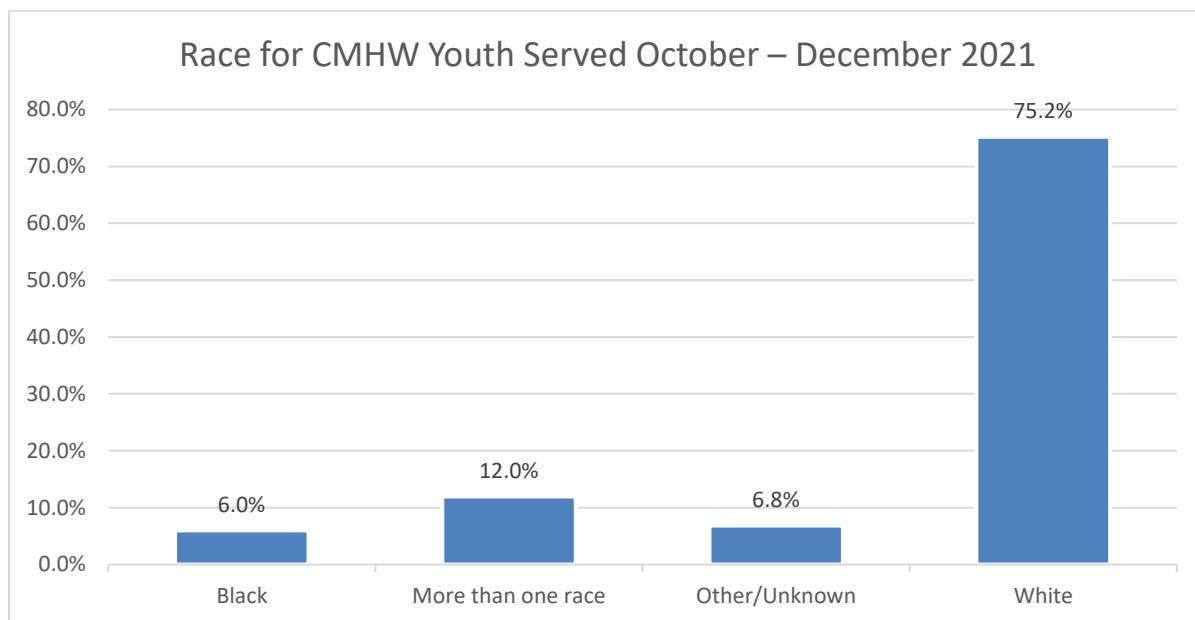


Per Figure 32, race and ethnicity data for quarter 3 was comparable to WV's population less than 21

years of age. However, racial representation shifted significantly after implementation of the System of Care Epi Info Interface and Phase 1 of the Assessment Pathway in quarter 4 of 2021. A higher proportion of BIPOC were reported from October – December 2021 compared to the general population of the same age. This information was discussed in quality reviews as an indicator that the program is reaching a larger proportion of individuals who are BIPOC.

Caution is needed when interpreting race data, due to low numbers of individuals served. The state's low rates of racial and ethnic diversity, introduces data challenges, which include instability of numbers (i.e., the next report could have significantly different proportions, but it could actually only represent a few children). Still, it is important to understand who is accessing services to identify which communities may benefit from increased, targeted outreach and education efforts.

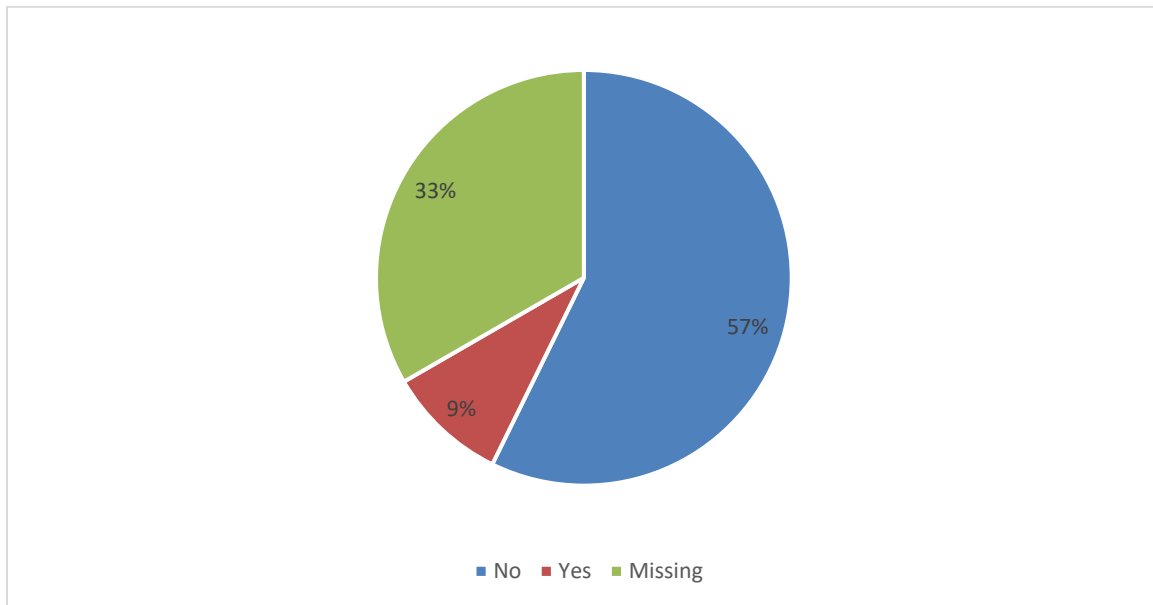
**Figure 32: Percentage of Children Served by Race Compared to WV Population Under Age 21 – Quarter 4 (n=117)**



A new data set added with the System of Care Epi Info Interface upgrade in October 2021 was adoption status, identified as a need by program quality review members (see Figure 33). Although the comparison is not exact, as more than one child could be served per family, it should be noted that only 3% of WV households in 2019 identified as adoptive families according to the American Community Survey. The larger percentage of adopted children served by CMHW is indicative of both a continued need to be met for adoptive families and demonstrative of program reach to an identified at-risk group.



**Figure 33: Adoption Status of CMHW Youth Served October – December 2021 (n=117)**

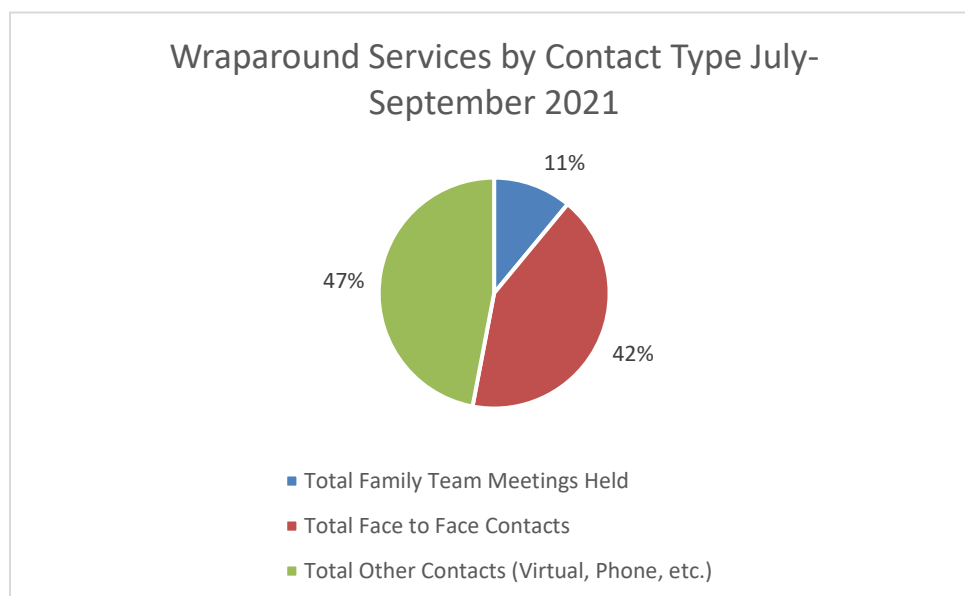


Since the beginning of the pandemic, services have shifted to meet needs and safety concerns. Many families did not feel comfortable having face-to-face visits, which resulted in a heavier reliance on telehealth interactions, represented in the Other Contacts category. At the time of this report, specific service data was unavailable from quarter 4 – 2021. However, data in quarter 3 represents continued potential pandemic-related impacts.

Nearly 50% of contacts for services in quarter 3 of 2021 were made via virtual means, based on the needs and requests of the family. In quarter 3, 1,799 total contacts/interactions were made for the 138 individuals served, or four interactions on average per month. At the time of this report, data interactions with individuals were captured differently for Wraparound Facilitation covered by BBH vs. CSED. For BBH, “interaction” referred to a contact with the individual regardless of time spent, while CSED refers to hours spent with the individuals. Work is underway to align time spent with children and families for future Wraparound data collection updates.

The distribution of contact/interactions remains similar to the January report; however, the average contacts/interactions per child has decreased. Interaction and service types are expected to vary based on the child and family’s level of need and amount of time served through the programs, with a higher number of interactions for newer children. This information will continue to be monitored for potential capacity and technical assistance opportunities, as discussed in quality assurance reviews as well as consideration for more in-depth analyses in the future based on a child’s level of need, time with the program, and other considerations.

**Figure 34: BBH Wraparound Services by Contact/Interaction Type – Quarter 3 (n=1,799 contacts)**



## 10.2 (b) Wraparound Services Through CSED Waiver

Figure 35 indicated 62% of children accessing CSED Waiver Wraparound were male, consistent with other non-crisis services found in this report.

**Figure 35: CSED Waiver Wraparound by Gender, July – December 2021**

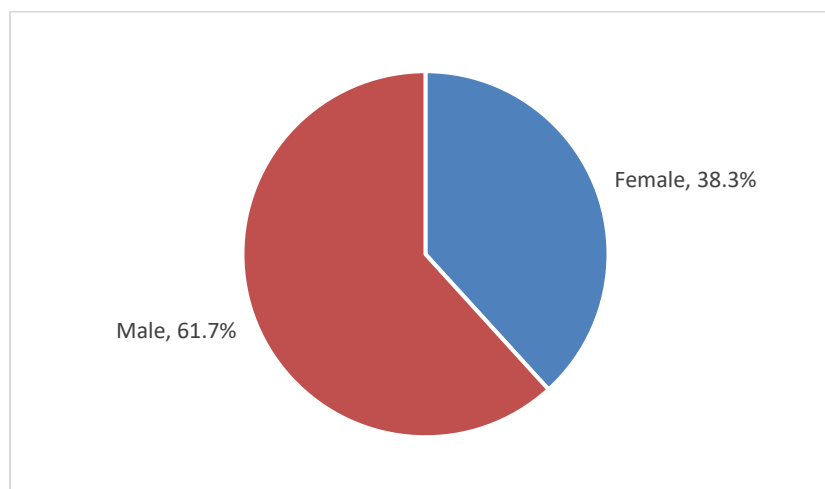
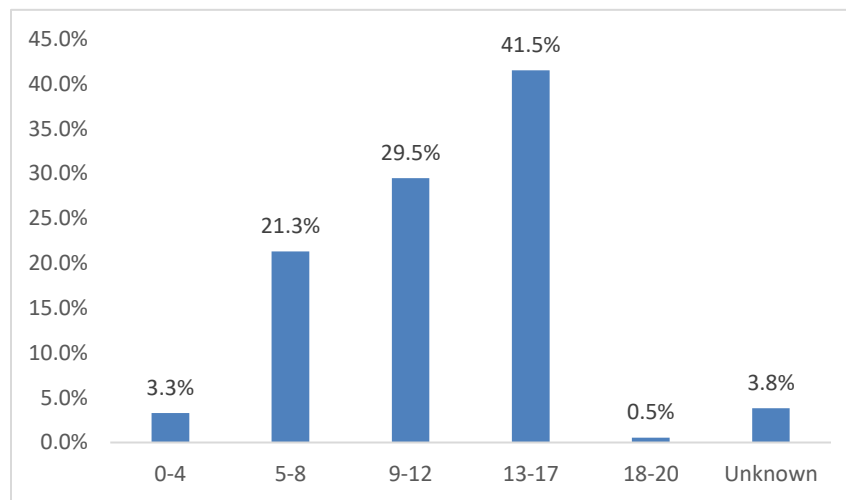


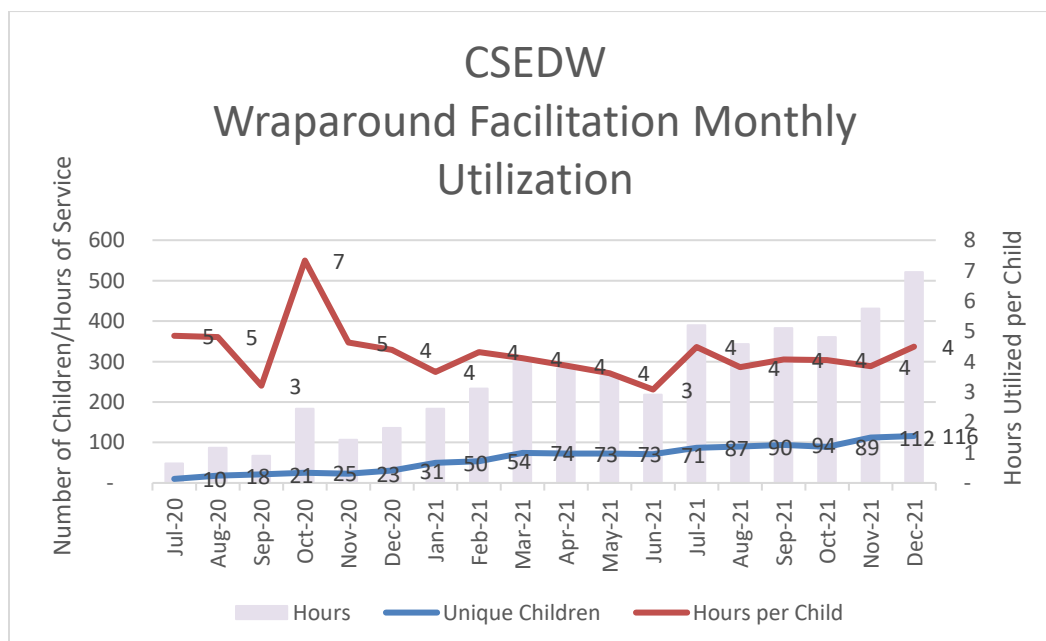
Figure 36 was consistent with other community-based non-crisis programs, with 42% falling in age category 13 – 17 years, which suggests opportunity for early intervention among individuals younger than the population served through RMHTFs.

**Figure 36: CSED Waiver Wraparound by Age, July – December 2021**



CSED Waiver Wraparound utilization from July 2021 – December 2021 is shown in Figure 37 below. Utilization was steady at about four hours per month per child, despite a significant increase in the number of children served. The Quality Review Committee recommended further analysis of what appears to be lower-than-expected hours based on what is required of Wraparound facilitators to meet contract and NWI requirements. Additional provider education on requirements associated with Wraparound service delivery and how to ensure all hours provided are captured via claims is recommended. Of note, this data period is also during the COVID-19 pandemic and in-person contacts continued to be limited.

**Figure 37: CSED Waiver Wraparound Utilization, June 2020 – December 2021**



For all children with a first paid CSED Waiver Wraparound Facilitation claim (noted as the first time the

child has ever received a Wraparound Facilitation service from the CSED Waiver) in the period July – December 2021, the average number of days from CSED waiver eligibility determination to the first provision of CSED Wraparound Facilitation was 58 days, compared to 57 days for the July 2020 – June 2021 reporting period. The quality committee recommended additional follow-up to understand the reasons that utilization is typically delayed nearly two months from eligibility. The implementation of Phase 1 of the Assessment Pathway in October 2021, which expedites the process of assigning a Wraparound facilitator for interim services while CSED eligibility is being determined, should assist with reducing this timeline. Additional time and analysis is needed to understand the impact of the recently implemented Assessment Pathway process.

### 10.3 Provider Capacity/Statewide Coverage

With the implementation of the Assessment Pathway, connection with Wraparound services through multiple entry points has allowed children and families expanded opportunities to more quickly connect to services, including those individuals in need of home and community-based services while applying for the CSED Waiver.

Workforce can overlap between the WV Wraparound programs. DHHR began monitoring provider capacity by agency, county, and service type in November 2021. Since that time, DHHR has continued to build out the monitoring and is exploring more efficient methods for capturing this information. DHHR has a biweekly, cross-bureau meeting with the MCO established to review provider status and recruitment efforts of new providers. However, providers have reported concerns about heavy caseloads and limited availability of facilitators given the number of children being referred.

According to WVU's Community-Based Services Evaluation, only 38% of providers reported having adequate staffing to serve all youth who need Wraparound Facilitation services. DHHR is currently working to gather more information on workforce capacity at the provider level and validate this information with providers, given concerns about staffing shortages.

Aggregate capacity continues to be developed for all WV Wraparound service providers. A process for compiling CSED Waiver, BBH Wraparound, and Safe at Home payor source agencies' Wraparound facilitators and their associated caseloads is in the validation stage. After the aggregated report and process is established and validated, DHHR will be able to better assess and manage statewide capacity for Wraparound services by county and provider, which will assist in facilitating rapid assignment of a Wraparound facilitator for children referred to the Assessment Pathway.

### 10.4 Strengths, Opportunities, Barriers, and Next Steps

Despite unprecedented conditions brought forth by the pandemic, Wraparound providers have continued to provide services to help children stay in their homes and communities. The ability to conduct many of these services via phone or virtual communications has been a strength to the continuation of these important services.

Although data for this report has been reported separately by payor source, improvements have been made to processes for families so transitions of payor source (interim services to CSED Waiver services)

are seamless and consistent for a family, with the intention that the family experiences no change in services despite change of payor source. Actions are underway to align data collection for reporting of aggregate data regardless of payor source for WV Wraparound services. Eventually, data indicators will be reported both in aggregate for total WV Wraparound services, as well as by payor source to identify strengths and opportunities for every step of the process.

The family experience has been at the forefront of discussions and review of these data results. Primary focus areas have included opportunities for outreach for counties without individuals participating in Wraparound services or referred via the Assessment Pathway, as well as opportunities and need for outreach for at-risk groups such as adopted youth, individuals identifying as LGBTQ+, or BIPOC who are seeking services at a greater proportion than compared to the state's population. Discussion also included varying levels of need for youth receiving Wraparound services, which would be expected to impact the utilization rate per child. Additional analysis was discussed to assess service utilization and capacity.

#### Next Steps:

- Continue work with the CCRL to provide referrals to both the Assessment Pathway and Wraparound services.
- Consider data from the CCRL, Wraparound services, and the Assessment Pathway to determine opportunities for outreach, strengths, and needs for all entryways to services for families.
- Consider length of service and varying level of need (CANS, CAFAS/PECFAS scores) with respect to service utilization and capacity for future analyses. This recommendation from the Quality Review Committee may not be able to be addressed immediately given the newness of the services and emerging data availability but should be considered in the build-out of the data store and future analyses after connection of relevant data is available.
- Continue to provide outreach to those in need of Wraparound services with targeted efforts toward BIPOC, individuals identifying as LGBTQ+, and families of adoptees.
  - Via funding from the TTI, implementation and expansion of 988 and crisis services are planned for July 2022 for children and adolescents with SED or SMI, with an emphasis on youth who are LGBTQ+ or BIPOC.
  - The Quality Review Committee recommended that BSS continue to ensure awareness of services with adoptive families (e.g., brochures with adoptive packets and expanding opportunities to have two-way communication with families of all types about availability and accessibility of services).
- Continue efforts to develop and align processes to collect and report data in aggregate for total youth served through Wraparound services.
- Continue validation stage of workforce capacity assessment to ensure understanding and accuracy of NWI standards, data collected, and provider perceptions.

- Additional follow-up will take place to understand the reasons that CSED utilization, as is represented in claims data, is typically delayed nearly two months from eligibility determination. Given the shift in referrals to the Assessment Pathway, trends may be reviewed to better understand if interim services help continuity of care and prevention of delays.

## 11.0 Behavioral Support Services

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

### 11.1 Review Period, Data Sources and Limitations, Population Measured

**Figure 38: Behavioral Support Services Data Overview**

Data Review Period	Data Source	Limitations	Population Measured
July 1, 2021 – December 30, 2021	BBH Children's PBS Grant Reporting		Children served directly through the BBH grant through WVU Center for Excellence in Disabilities (CED) program. Services are provided to individuals with intellectual and developmental disabilities and/or predefined mental health needs.
Not applicable at this time	DW/DSS Warehouse	State Plan Behavioral Support Services data are unavailable at the time of report; process change to collect data via claims is still underway but expected to be implemented with policy change, which is expected to be implemented by January 2023 to be available on future reports, with consideration for claims data lag and provider training. The process change will include a modifier code that will identify Behavioral Support Services provided to Medicaid and WVCHIP members via paid claims.	Services are provided to individuals with intellectual and developmental disabilities and/or predefined mental health needs who are ages 0 – 21 and members of Medicaid or WVCHIP.

In addition to the BBH funded Children's PBS program provided by WVU CED, services are also conducted through trained providers of BBH, BSS, BMS, and WV Department of Education programs. Data are only currently available for direct services provided by WVU CED under the BBH PBS grant;

however, BMS is working to implement a Behavioral Support Services modifier code that will allow Behavioral Support Services-related claims data to be captured for children receiving services through Medicaid (expected in January 2023). In addition to review of information for individuals directly served, training is also being conducted for providers via the WVU CED. As of summer 2022, Concord University has hired and begun the process of developing the training curriculum for the new Behavioral Support Services provider certification. It is anticipated that training will begin in October 2022. This will allow Behavioral Support Services training and certification to be available statewide, with information on certified professionals' capacity to be included in future reports.

## 11.2 Review Summary

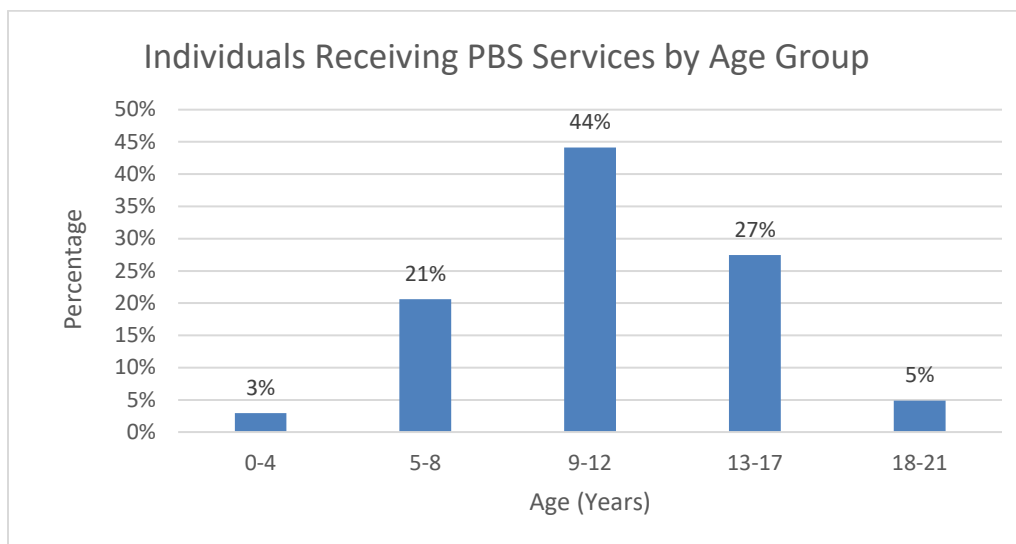
PBS services provided by WVU CED were provided to 102 youth from July – December 2021. This program is not expected to have broad reach for direct services, but instead is meant to provide training to expand provider-level services throughout the state and assist with consultation for youth and families with more intensive needs. Youth provided direct services typically are indicated as having more intense needs, and services can vary from brainstorming with the family to intensive services.

Interactions and caseload needs have increased for PBS direct services, making increase in provider capacity and certification all the more important for delivery of quality and timely services. To better understand geographic need, further assessment of all Behavioral Support Services data via the BMS claims, once available, will be helpful to assess the full scope of children reached through these strategies. As stated, one of the goals of the initial semiannual reports are to establish baseline numbers of children and services, as well as understand who are receiving services and where services are occurring. As reporting becomes more robust and the data store continues to grow, it is anticipated that indicators will also evolve to include more outcome data.

Over 90% of individuals served fall in the 5 – 17 year-old age range, with 44% of individuals served falling in the 9 – 12 age range. The ages of individuals served trended younger compared with individuals served through RMHTFs, demonstrating a key prevention opportunity, consistent with the report from January 2022.

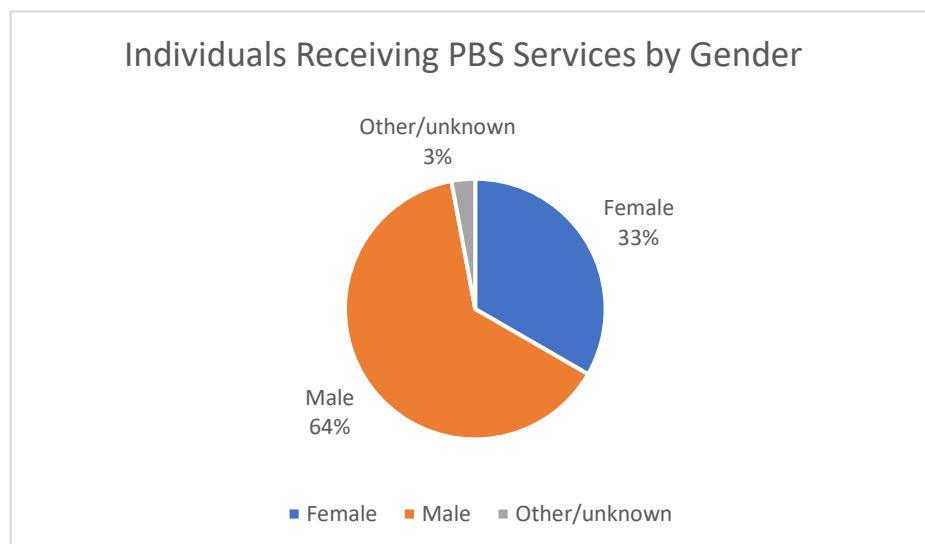


**Figure 39: Individuals Receiving PBS Services by Age Group, July 2021 – December 2021**



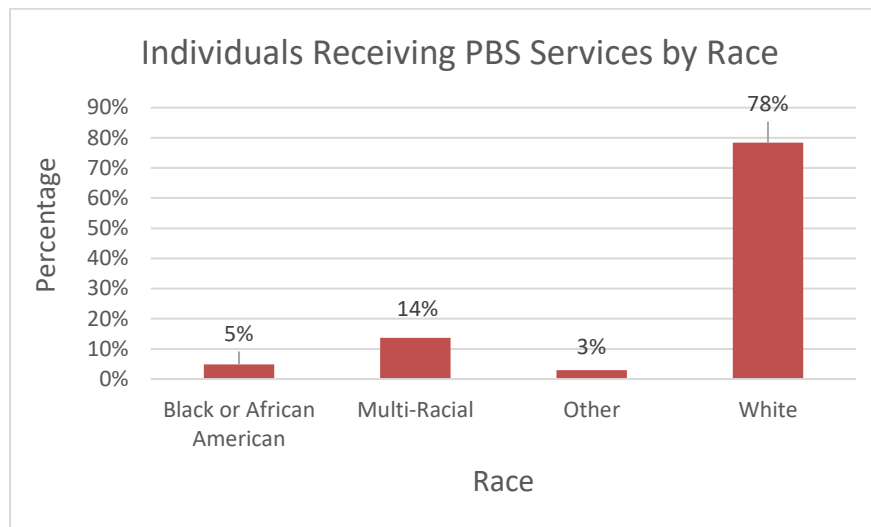
A greater proportion of males were served compared to females, similar as observed with individuals served through RMHTFs (Figure 40).

**Figure 40: Individuals Receiving PBS Services by Gender, July 2021 – December 2021**



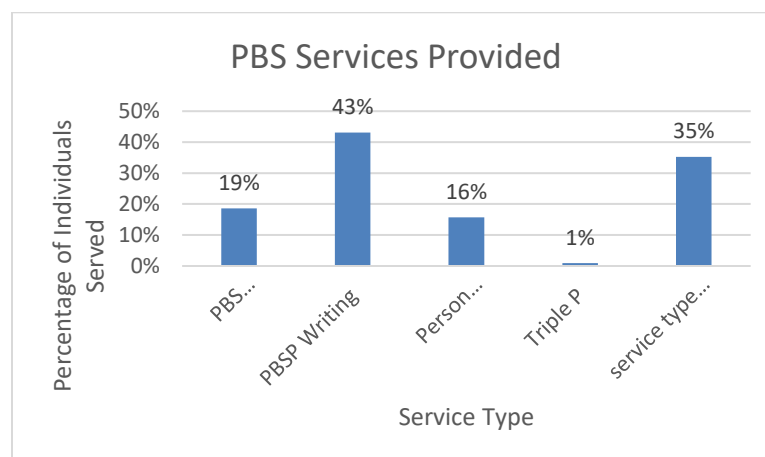
Based on comparisons of race data to the WV population age less than 21, the PBS program served a greater proportion of BIPOC as compared to their representation in the population as a whole — approximately 19% of individuals served compared to 8% of the WV population under 21. The small number served should be noted here, as this could be subject to fluctuation with very little change. Small numbers are common with race and ethnicity data reflecting WV residents, as BIPOC historically maintain a very low percentage of the state’s overall population. Despite the low numbers, the Quality Review Committee recognizes the importance to continue to review this data. A greater proportion of individuals served are BIPOC as compared to the state’s population.

**Figure 41: Percentage of Individuals Served by Race, July 2021 – December 2021**



The most common services provided to individuals were PBS Plan Writing (34%); Brainstorming, a service typically done with lower-need cases to provide ideas and support for families (19%); and Person-Centered Planning (16%). Intensive services were unknown for this period, with 35% of service type listed as unknown.

**Figure 42: PBS Services Provided, July 2021 – December 2021**

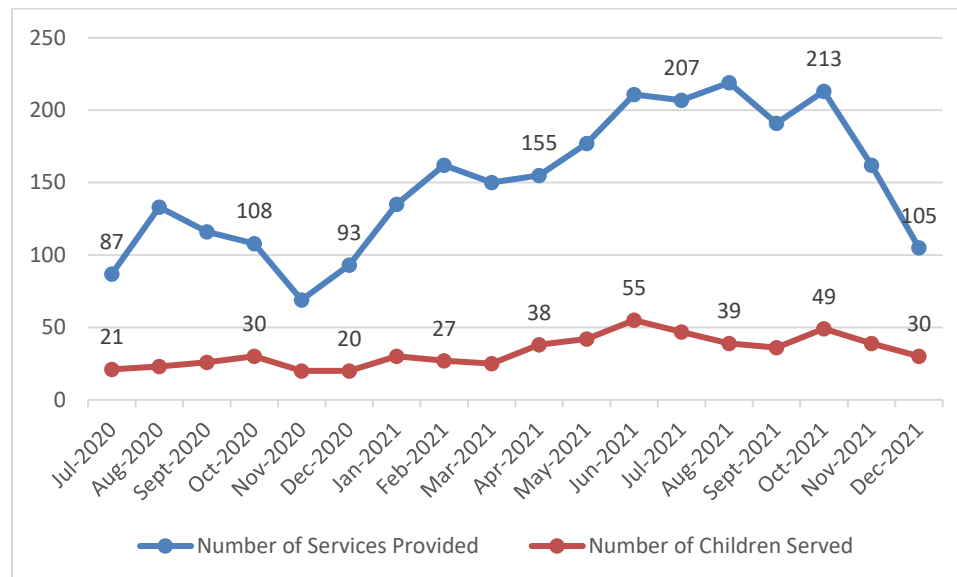


Note: Individuals may have received more than one service or reported more than one diagnosis resulting in totals equaling greater than 100%.

Given the pandemic, there was an increased need for mental health services, and PBS referrals significantly increased. BBH responded by expanding PBS services in July 2021 due to the demand to help meet the needs of the children's mental health crisis. During October 2021, WVU CED experienced additional workforce shortages due to attrition and a staff member being on medical leave, which impacted services throughout the remainder of the year. As of December 2021, there was a waitlist of approximately 12 children for PBS services, but families were prioritized based on need, and BBH continued to meet regularly with the provider to troubleshoot workforce shortages and hiring barriers.

In the past year, the number of children served monthly has doubled, from 21 per month in July 2020 to 47 per month in July 2021. Similarly, the total child interactions monthly have increased, from 87 per month in July 2020 to 207 per month in July 2021. The average number of interactions per child remains fairly steady over the year, hovering between 3.5 to 6 interactions per child per month. In the six month period, 1,097 total services were conducted.

**Figure 43: Children and Interactions, Monthly, July 2021 – December 2021**



### 11.3 Provider Capacity/Statewide Coverage

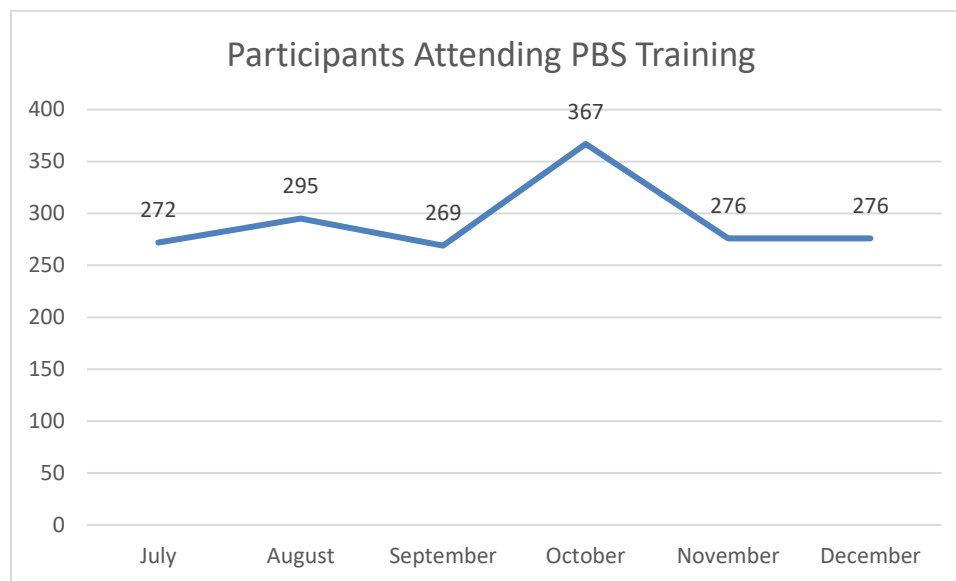
The BBH PBS program through WVU CED has nine full-time equivalent staff and three vacancies. WVU CED is actively focused on recruiting to fill current vacancies.

**Figure 44: PBS Staffing at WVU CED**

	Current Personnel	Budgeted Personnel	Occupancy Rate
Program Manager	1	1	100%
Behavior Specialists	5	8	63%

Efforts are underway to enhance and standardize the certification process for Behavioral Support Services. Concord University will train and certify individuals in the future to offer Behavioral Support Services statewide, directly from local providers, expanding the resources available in a given provider's tool belt. Historically, PBS training has been provided by WVU CED and continues to be provided while Concord University's process is developed and implemented for Behavioral Support Services. Approximately 300 individuals have been trained each month from July – December 2021, with the greatest number of trainings conducted in October (367).

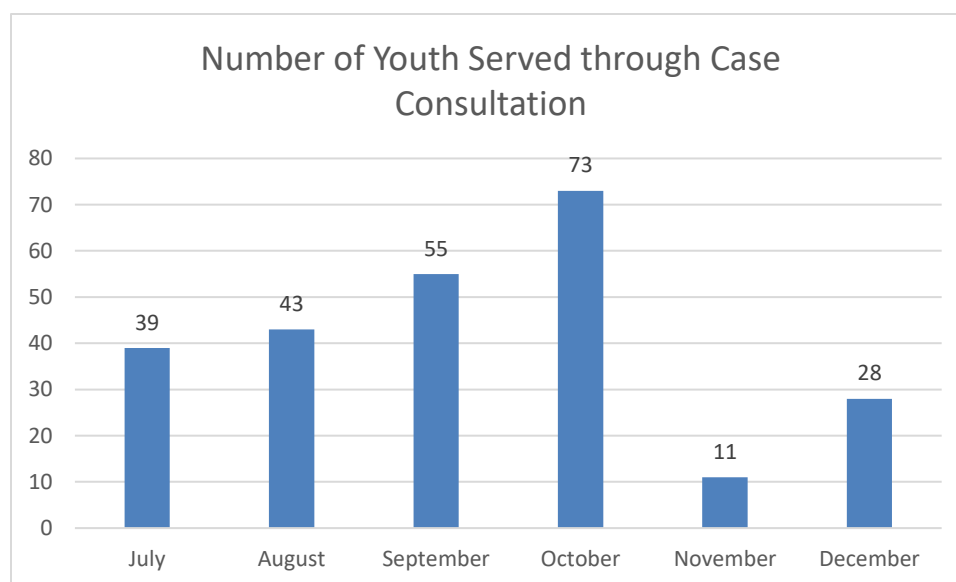
**Figure 45: Participants Attending PBS Training July 2021 – December 2021**



\*Participants can include parents and professionals

The WVU CED PBS program provided consultation for an average of 42 youth per month. Consultation allows a trained provider to continue to support youth while getting technical assistance and consultation from the WVU CED team. October was the month with the highest number of consultations. Consultations in November in December were significantly reduced and may be a result of the holidays as well as staff shortages.

**Figure 46: Number of Youth Served through Case Consultation**



## 11.4 Strengths, Opportunities, Barriers, and Next Steps

Behavioral Support Services allow children with behavioral health needs to receive individual and family supportive services. Children served include those with a range of diagnoses and levels of need. The BBH PBS program allows direct services and case consultation as a result of referrals from other organizations. Over two-fifths of individuals served are 9 –12 years old, and a quarter are 13 – 17, allowing diversion from more intensive out-of-home services. In addition to current data review, the implementation of a modifier code to expand capacity for data collection for Medicaid Behavioral Support Services will help influence future planning and quality improvement from review of additional comprehensive services provided.

### Next Steps:

- Monitor WVU CED PBS program data by month to assess continued needs and consult program staff to identify trends and potential reasons for changes in service utilization.
- Assess missing service indicators and provide technical assistance to provider for improved future collection.
- Provide outreach to BIPOC to meet needs and prevent barriers to accessing mental health services.
  - Steps have already been taken to reach out to the diversity, equity, and inclusion group through the WVU CED. Data are expected to be shared in the future to get input from this group work to identify and lessen disparities based on data review processes and feedback from outreach.
  - Via funding from TTI, implementation and expansion of 988 and crisis services are planned for July 2022 for children and adolescents with SED or SMI, with an emphasis on youth who are LGBTQ+ or BIPOC. These crisis services and outreach can help with referral of at-risk individuals and increased knowledge of quality services in these communities.
- After data are available in BMS claims with the modifier code, further assess training provided to organizations in low-utilization areas as well as rural areas to identify whether needs are being met through direct or indirect services (training).
- Continue to work with Concord University as training and certification is expanded to establish formal data collection and recurring reporting on trainings conducted and individuals certified.

## 12.0 Assertive Community Treatment (ACT)

ACT is an inclusive array of community-based rehabilitative mental health services for WV Medicaid members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization requiring a well-coordinated and integrated package of services provided over an extended duration to live successfully in the community of their choice.

ACT is an option for youth ages 18 – 20 to help prevent unnecessary institutionalization. As part of the Assessment Pathway, youth 18 or older who are eligible are to be offered the choice of ACT or Wraparound services. BMS policy manuals are currently being updated and approved for CSED, RMHTFs, Licensed Behavioral Health Centers, and other providers to include the freedom of choice form for Medicaid members eligible for ACT services. Providers will be trained on the form, expanding knowledge of this freedom of choice, and this offering will be widely implemented in the next year as additional training occurs. The final updates are expected in January 2023, with continued training on the update and awareness of the program. The residential manual will clarify that eligible youth exiting residential placement must be offered the choice of ACT to help them remain in their home and community upon discharge.

ACT is an evidence-based model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which the ACT team provides the majority of direct services in the member's community environment.

ACT combines clinical, rehabilitation, supportive, and case management services, providing direct assistance for symptom management, as well as facilitating a supportive environment with direct assistance in meeting basic needs and improving social, family, and environmental functioning.

### 12.1 Review Period, Data Sources and Limitations, Population Measured

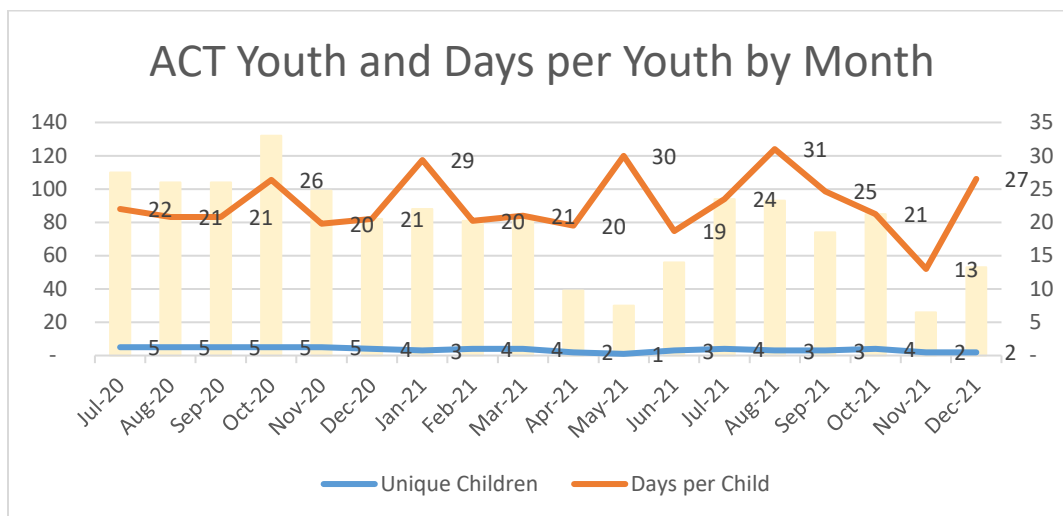
The period reviewed is July 2020 – December 2021. ACT enrollment and utilization data are sourced from the DW/DSS of Medicaid and WVCHIP claims. Eligible members must have a primary mental health diagnosis and may have co-occurring conditions, including mental health and substance use disorder or mental health and mild intellectual disability. Members must also have a history of high use of psychiatric hospitalization and/or crisis stabilization. The population served includes Medicaid members 18 years and older, with no limitation on length of service; however, for purposes of this report, review was conducted for members aged 18 – 20 to reflect transition-age youth potentially at risk for RMHTF placement.

### 12.2 Review Summary

For the review period, ACT enrollment remained low throughout the state. The pandemic created an additional challenge in enrollment and services as many youth either did not enroll or ended services due to not wanting ACT staff in their homes. Results in WVU's Community-Based Services Evaluation indicate a low awareness of ACT services among providers and families, with only 17% of responding providers and facilities indicating awareness of these services.

Overall, an average of 3.6 youth per month received services over the 18 month review period with 11 total enrollments. Of those enrolled, 80% were male. Figure 47 below displays enrollment and the days of service per youth. Number of youth served remain low, which is perceived to be a result of continued pandemic-related concerns among youth in addition to low historic participation rates among transition-age youth. Discharge reason information is not collected, but it is commonly understood that many youth are transient and do not want someone intruding in their lives. As awareness of ACT services increase and individuals in RMHTF have appropriate discharge plans developed, DHHR expects utilization of ACT to increase.

**Figure 47: ACT Youth and Days per Youth by Month, July 2020 – December 2021**



**Note:** 2021 reflects claims paid through March 2022.

### 12.3 Provider Capacity/Statewide Coverage

DHHR has been working to increase ACT availability statewide. In November 2021, DHHR executed a start-up contract with Mountaineer Behavioral Health (Mountaineer) to develop an ACT team in the Eastern Panhandle with expected statewide coverage by September 2022. Once Mountaineer is fully operational, ACT services will be available statewide.

To further expand the availability of ACT services, DHHR intends to require all Certified Community Behavioral Health Clinics to have an ACT team. This requirement is anticipated to go into effect sometime in late 2023 to 2024. In addition, DHHR will continue to seek alternative providers to build ACT teams and offer these services.

ACT team capacity is monitored during retrospective reviews; however, workforce capacity is rarely listed as a concern. ACT teams remain in contact with the state if issues arise to troubleshoot scenarios such as temporary lack of nursing staff.

## 12.4 Strengths, Opportunities, Barriers, and Next Steps

DHHR expects to have statewide ACT availability by September 2022. Provider outreach that was historically conducted via in-person meetings has been on hold since March 2020 due to the pandemic. DHHR will resume in-person outreach meetings in fall 2023 to discuss next steps.

The high number of interactions per member indicates this is a high-intensity program providing services to individuals who might otherwise have to live in a residential placement for needs to be met. The Quality Review Committee recommended a comparison be explored, if available, for utilizing ACT in other states and/or national averages. It was also recommended that DHHR explore collection of discharge reason data to further understand and seek opportunities for transient youth resistant to remaining with ACT services.

As noted above, additional efforts to increase enrollment include revision of the BMS policy manuals for RMHTFs to include language that will require an ACT service staff meeting with eligible youth and their families prior to discharge, including a freedom of choice form to decide between ACT and Wraparound services. Continued reviews of utilization data will help to drive this effort as well.

DHHR will have ongoing communication with residential providers to help ensure ACT is included as an offered service for eligible participants as part of discharge planning. Given recommendations from Quality Committee members, case managers will also be included in future ACT topic area trainings and/or have ACT covered in already existing trainings to ensure all appropriate personnel have awareness of the service.

DHHR will continue to work on educating and promoting availability of community-based services, such as ACT, when appropriate for the needs of the youth.



## 13.0 Stabilization and Treatment Homes (STAT Homes)

The STAT Home<sup>10</sup> model is designed to complement the current WV Tiered Foster Care model, to provide stabilization services for children in foster care or kinship care who are at risk of residential placement. The STAT Home program is a family alternative to residential placement for children requiring a behavioral or mental health intervention. Child placing agencies (CPAs) will be responsible for providing these services statewide. In partnership with CSED Waiver services, STAT Homes provide short-term intervention to provide a stable, family-like setting, with treatment and behavioral interventions so the child can ultimately return to their home or another family setting, proactively diverting from an RMHTF placement. STAT Home parents will be specifically recruited and trained to provide intensive support for these children so they can remain in and actively participate in their home, school, and local community. WV has been building the STAT Home program through development of model standards that clearly define services and activities that support the STAT Home parents, the child, and the family of origin, and clarify the role of the CPAs' case managers.

### 13.1 Review Period, Data Sources and Limitations, Population Measured

No treatment home data were available during the period of review as the model is still in the final stages of development. Data reporting is being planned concurrently with program development, and once available, this information will be included in future reports.

### 13.2 Review Summary

During the period of review, CPAs and a wide array of stakeholders provided valuable consultation and feedback through various face-to-face and virtual engagements on the proposed model and associated performance indicators. The STAT Home workgroup continued to design and refine the new STAT Home model to help assure that children with SED can receive short-term, intensive stabilization services in a family-like setting, ultimately diverting them from RMHTFs.

The STAT Home workgroup has collaborated with all stakeholders to define both the initial monthly and long-term measures necessary to monitor program efficacy and RMHTF diversion rates. Proposed measures include, but are not limited to:

- Trends of RMHTF vs STAT Home placement over time
- STAT Home discharge analysis to understand where children reside after leaving a STAT Home (e.g., higher level of care, home of origin, etc.)
- STAT Home length of stay
- STAT Home recruitment, certification, and capacity

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<sup>10</sup> In the January 2022 semiannual report, the term used for this type of foster care home was Therapeutic Foster Care. This home model has been renamed to Stabilization and Treatment.

### 13.3 Provider Capacity/Statewide Coverage

The STAT Home model continued to be under development during the period of review. The initial implementation phase-in of the new model is anticipated to begin in summer 2022. CPAs have initiated the process of family recruitment to provide STAT Home coverage. While there may be current foster care providers and families that meet the new STAT Home criteria to provide this service, it is expected that recruitment will largely require new families to allow sufficient statewide coverage.

### 13.4 Strengths, Opportunities, Barriers, and Next Steps

DHHR continues to move forward with STAT Home implementation. As the model has developed, DHHR has identified key performance indicators for the STAT Home services that CPAs have reviewed and approved. Data will be collected and monitored routinely, with CPAs contractually required to provide monthly reports that adhere to DHHR data requirements. As performance data are collected, the information can be used for ongoing refinement of the STAT Home model and will help DHHR understand any provider capacity needs. Once available, the data will be reviewed in the quarterly Quality Review Committee meetings and included in future reports.

The support and collaboration of CPAs and other stakeholders has been critical as the STAT Home model has developed. DHHR expects to continue recurring meetings with stakeholders to finalize the program development and closely manage implementation. Recurring meetings or roundtables with CPAs and other stakeholders to provide information and receive feedback will continue to achieve this flow of communication. DHHR will maintain the collaboration and transparency with CPAs as they recruit families to serve as STAT Home parents in this new model. This model serves a specific population with a higher level of need that will require additional skills.

## 14.0 Children’s Crisis and Referral Line

BBH launched the CCRL in October 2020. This line is a centralized access point to connect youth and families with CMCR and stabilization teams and other community-based services, including the Assessment Pathway and WV Wraparound services. Youth, families, and those who work with them can call, text, or chat with the CCRL 24 hours a day, 7 days a week, at 844-HELP4WV, 844-435-7498, or <https://www.help4wv.com/ccl>. Primary care physicians have the option of making referrals through the CCRL by JotForm (electronic secure form) to connect children and families with appropriate services.

DHHR and BBH continued efforts throughout the reporting period to expand awareness and use of the CCRL and address evolving data needs, using CQI processes, including regular review meetings to inform planning and quality assurance.

Since the activation of the CCRL, DHHR has conducted outreach activities, including press releases and media campaigns, presentations, informational booths at events, and information sharing by stakeholders (e.g., WV Department of Education) and other partners. BBH also conducts monthly meetings with the CCRL provider to identify areas of needed refinement and technical assistance. Examples of outcomes of these touchpoints include reporting changes in May 2021 and additional trainings for CCRL staff, conducted in fall 2021 and January 2022, to help ensure consistency in call quality and data collection.

### 14.1 Review Period, Data Sources and Limitations, Population Measured

**Figure 48: CCRL Data Overview**

Data Review Period	Data Source	Limitations	Population Measured
July 1, 2021 – December 31, 2021	Help4WV – iCarol Call Reporting System	CCRL was implemented in conjunction with active Help4WV line October 2020.  Higher rates of incomplete data are expected for demographic information for this call line. When a family/person calls in crisis, it may not be prudent to collect all the desired data fields due to the urgent nature of the call or the need to establish a rapport quickly.  “Calls” include texts and chats unless otherwise noted.	Children served directly through the CCRL.  Services are provided to individuals and families with children 0 – 25 who are in emotional distress or with a diagnosis of an SED or SMI and their families who are in crisis or seeking referrals to related services. For purposes of this report, callers reporting an age over 21 were excluded from the data set.

As noted above, the CCRL officially launched services in October 2020. While the Help4WV call line was in place prior to this launch and allowed callers of any age to phone in, the dedicated CCRL offers the added benefit of referral services for children in crisis and their families.

In addition to the implementation of the CCRL during the previous reporting period, CQI processes allowed identification of additional data needs. Beginning in May 2021, BBH implemented more detailed data collection related to referrals, which has been included in this report. CCRL data are reviewed at least quarterly to assess call and referral quality and determine need for adjustment or improved outreach efforts.

## 14.2 Review Summary

At least one individual from 38 of the state's 55 counties called the CCRL during the reporting period. Given the CCRL is still in its beginning stages as a resource for families, changes are expected as further outreach and knowledge of the line are expanded. The Quality Committee reviewed county-level coverage to assess opportunities for outreach; however, the map was excluded from this report due to the low rate of calls when viewing the information at the county level.

Figure 49 shows the number of calls by month. Monthly values from July 2020 – June 2021 have also been included to compare with monthly values from the current reporting period. During July – December 2021, there were 187 total calls, an average of 31 calls per month—an increase from the previous reporting period, which averaged 27 calls per month. The increase in January 2021 calls coincides with the December 2020 press release highlighting the availability of the dedicated CCRL. Additionally, changes in methodology (reduced age to 0 – 21) and reporting finalization updates resulted in differences in number of calls compared to data reported previously.

**Figure 49: CCRL Calls by Month, July 2020 - December 2021**

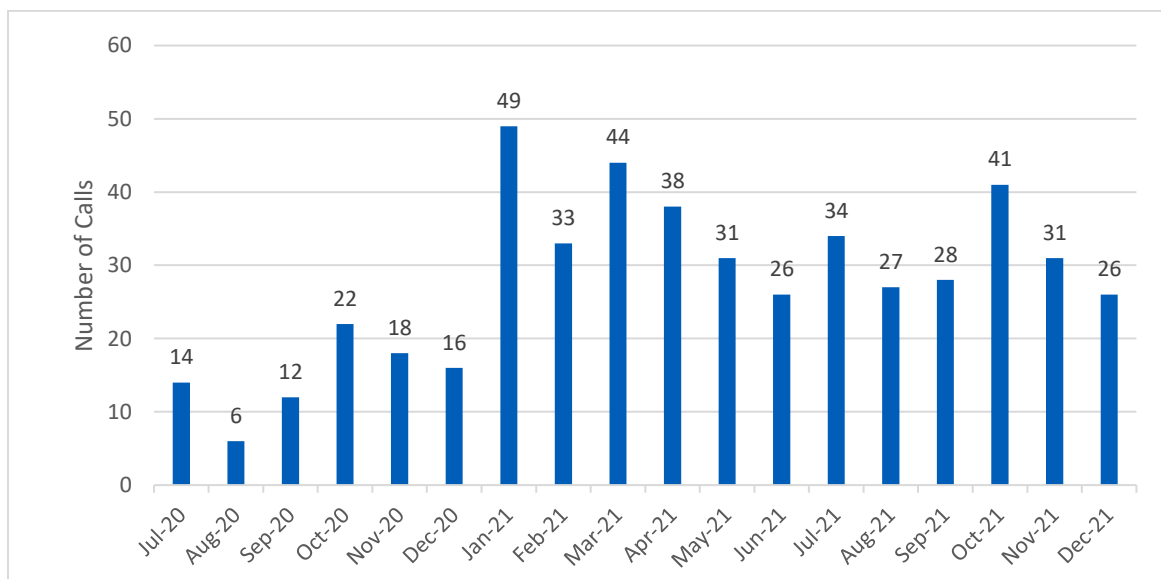
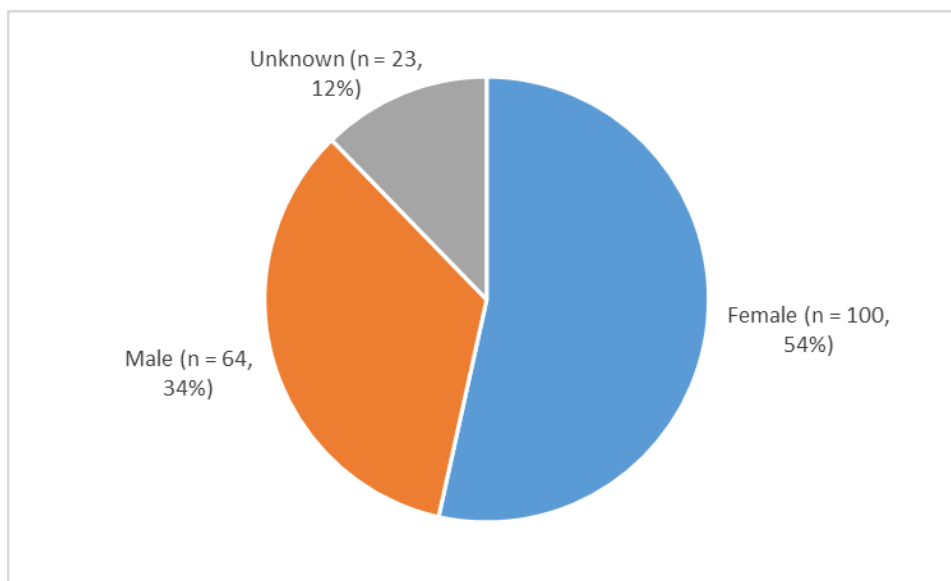


Figure 50 displays the breakdown of calls by gender. While the line is still relatively new, initial data has consistently shown that, generally, slightly more calls may occur for females than males.

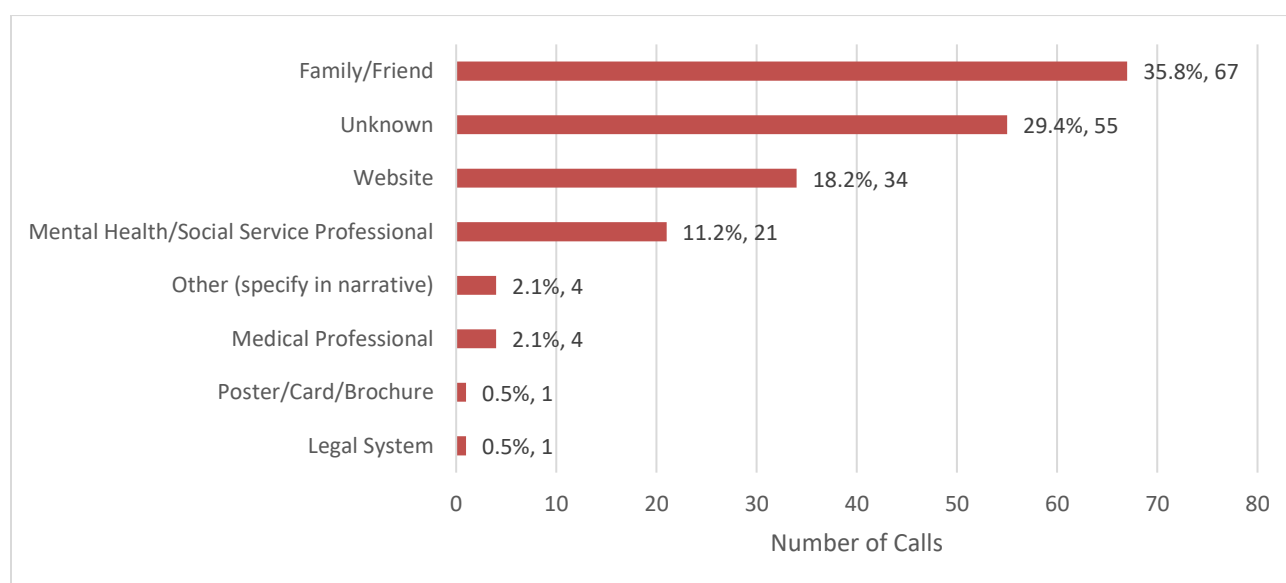
**Figure 50: CCRL by Gender, July – December 2021**



Data regarding race were missing in 83% of call reports, thus race data were not deemed reliable for reporting.

The referral source for call is depicted in Figure 51. Family/Friend or the Help4WV website was the most common way individuals found out about the call line (54% of reported referral sources). Of calls, 11.2% were the result of referral from mental health/social service professionals. Nearly 30% of calls had an unknown referral source, compared to 19% for the previous reporting period.

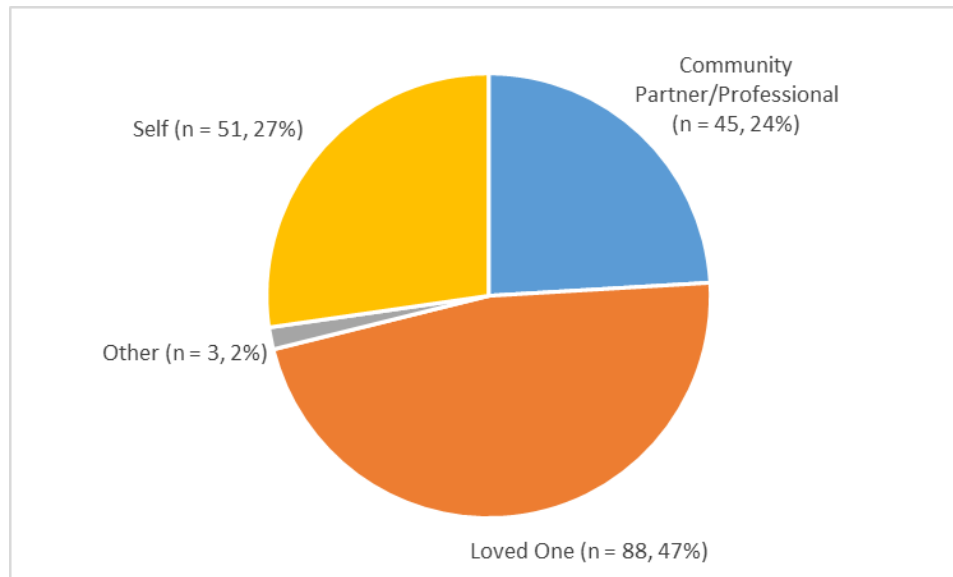
**Figure 51: Referral Source for Call, July – December 2021**



The caller's relation to the individual in need is displayed in Figure 52. Out of all calls for the CCRL, 47% came from a loved one, while 27% were the child themselves making the call. Note that "loved one"

includes parent, grandparent, other family, guardian, friend, significant other, and/or spouse. Compared with the previous reporting period, caller relation listed as self was reduced from 34% of calls to 27%, while community partner/professional calling increased from 16% to 24%. This might be due to the implementation of the Assessment Pathway and expansion of knowledge for school counselors and primary care providers to use the CCRL as a resource.

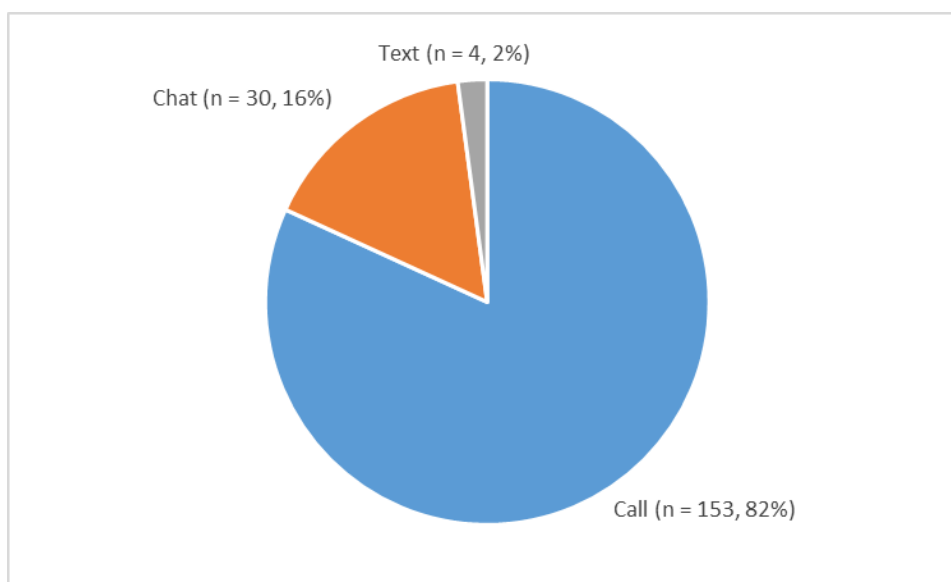
**Figure 52: Caller Relation to Individual in Need, July – December 2021**



As displayed in Figure 53, 82%<sup>11</sup> of contacts in July – December 2021 came via traditional call, compared to 18% of contacts that came from text and chat features. Use of text and chat increased from 8% in the previous period. The increased utilization of chat or text highlights the importance of this alternative feature for children and families in need who may not feel comfortable reaching out verbally. Although this feature presents an opportunity for families in need, it also presents additional challenges for capturing call-related data with the limitations of the chat/text format.

<sup>11</sup> Note: An error was identified with this indicator for the January 2021 report. When data was recoded for analysis, results were inversed, inadvertently. Calls are more prevalent compared to chat/text.

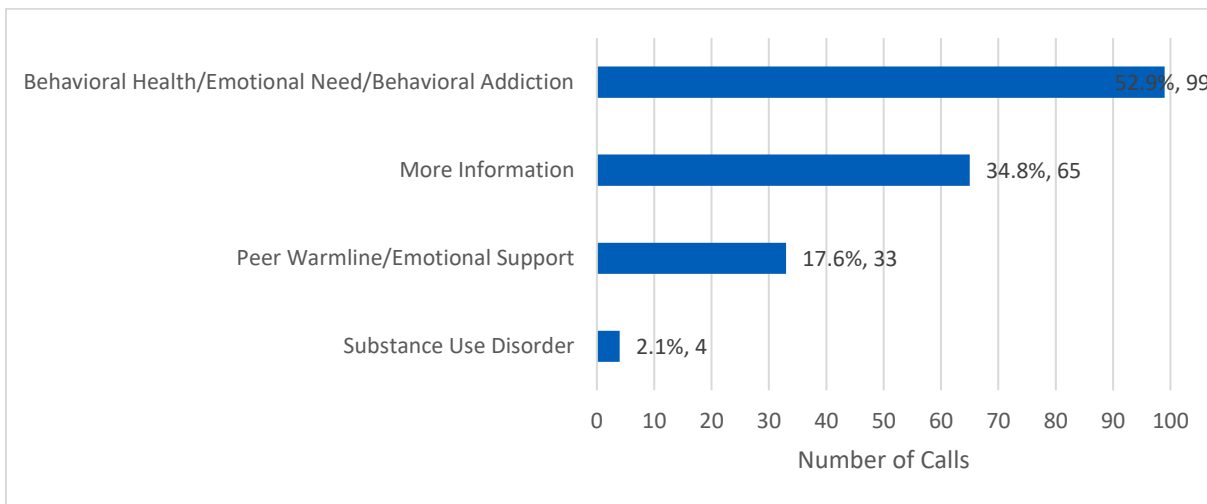
**Figure 53: Type of Call, July – December 2021**



Individuals reached out to the CCRL for various reasons. In order of descending frequency, the needs of these individuals were the following: behavioral health or emotional need (52.9%), acquire more information (34.8%), seek connection with Peer Warmline<sup>12</sup>/Emotional Support (17.6%), and substance use disorder (2.1%). Note that individuals may have reported more than one need, making the total add up to greater than 100%. 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.

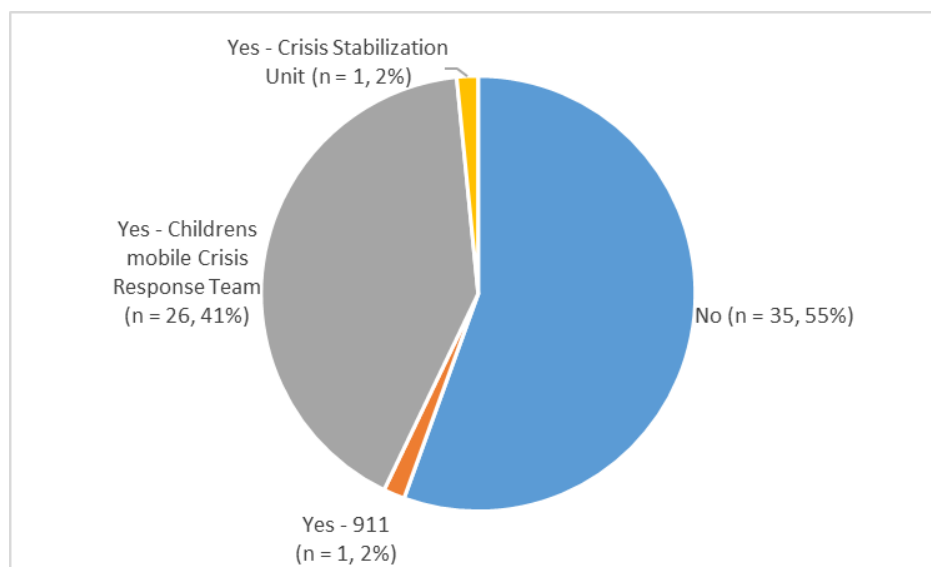
<sup>12</sup> Warmline is a line that offers a personal connection; it can be to offer emotional support, help problem solve, or just listen; it can also help connect people to services.

**Figure 54: Presenting Need, July - December 2021**



Of individuals for whom the call was reported as an "emergency/crisis/urgent" and had a response listed for referral, 41% were reported as being directly transferred to a mobile crisis response team via "warm transfer."<sup>13</sup> BBH is in the process of working with the vendor to further understand their processes regarding interpretation of this data and to identify any changes needed. More information will be gathered to determine if these results reflect appropriate action by the CCRL and if additional training should be provided to call specialists.

**Figure 55: Warm Transfer, Attempted or Completed, of Calls Reported as "Emergency/Crisis/Urgent" and had a Response Listed for Referral, July – December 2021 (n = 63)**

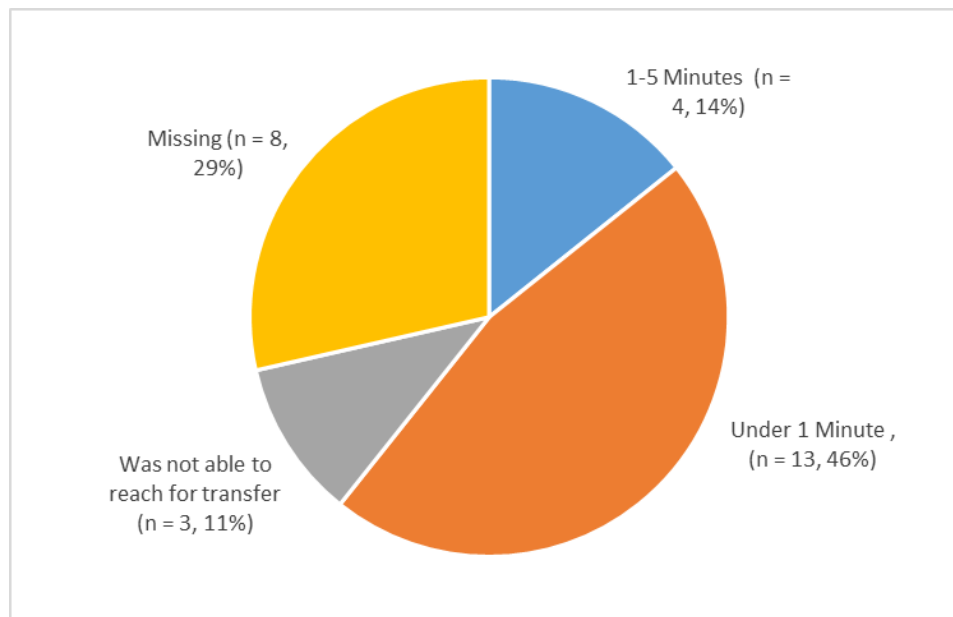


<sup>13</sup> Warm transfer is when the crisis line staff stays on the line with the caller until the connection to the mobile crisis team is made and introductions are completed. The decision to attempt a warm transfer is made in conjunction with the family and their needs and willingness to accept assistance at the time of the call.



Timeliness measures for warm transfer from the CCRL to a mobile crisis response team were added in May 2021. Of calls with a reported warm transfer attempt to mobile crisis services, 60% were connected in five minutes or less, with 46% connected in under a minute. Twenty-nine percent of timeliness data was missing/unknown, identifying an opportunity for training for Help Line staff. Three call records listed that the Help Line specialist was unable to reach the mobile crisis agency for transfer. Further analysis and review is necessary to identify opportunities for training and to assess further needs to be addressed with both the crisis line and mobile crisis team.

**Figure 56: Timeliness of Warm Transfer Attempt to Mobile Crisis and Stabilization Team, of Calls Reported as "Emergency/Crisis/Urgent" with Transfer Attempt, July – December 2021 (n = 28)**



### 14.3 Provider Capacity/Statewide Coverage

The implementation of the Assessment Pathway as well as media campaigns and other outreach campaigns are anticipated to increase the number of services and awareness of the CCRL. CQI processes have permitted timely changes to training strategies and data indicators. First Choice services, the provider that runs the CCRL, monitors call loads and weekly or seasonal trends to ensure adequate coverage to meet family and child needs.

**Figure 57: CCRL Capacity**

	Current Personnel	Budgeted Personnel	Occupancy Rate
Help Line Specialists	16	16.5	97%
Crisis Counselors	2	2	100%
Shift Leads (shared with other call lines)	3	3	100%

## 14.4 Strengths, Opportunities, Barriers, and Next Steps

Successful crisis response procedures require a focus on quick rapport building and needs assessment, which can result in barriers to complete data collection. This referral line is still early in its implementation to reach children and their families. BBH and the call line vendor have worked consistently over the past year to improve data collection and be able to more completely tell the story of call outcomes, whether that caller needs a listening ear, additional information, or immediate services with a warm transfer. Crisis line staff help individuals connect with behavioral health services faster and divert inappropriate use of emergency rooms and 911 calls.

In addition to helping families in crises, 35% of calls were requesting information from the referral line, indicating individuals are using the CCRL as a valuable resource for information and connection to/awareness of services. It is important the CCRL continues to be aware of these various services statewide with access to efficient connections; continued communication and training is essential to continuing this important function.

Next steps:

- Continue to work with the call center provider to help ensure that processes are in place to capture complete data when feasible and to capture missing data on follow-up calls.
  - The Quality Review Committee recommended identification of prioritized data entry fields to be completed during each call if feasible.
- Expand outreach and continue to encourage calls to the central line rather than local provider lines when possible.
- Continue to review call line data routinely to identify opportunities for further outreach to families across the state and provide technical assistance for the call line staff and the teams they refer to as needed to improve call and referral quality, including review of calls unable to be transferred in a timely manner.
- Given the nature of crisis line calls and difficulty with data completion, racial disparities might be examined first in mobile crisis data. The CCRL will continue to work on fully populating requested data inputs when feasible.
- Further outreach continued to medical offices and schools as part of expanded screening efforts.
  - These partners have been directed to utilize the CCRL for youth and families in need.
  - Continue outreach to identified access points such as to emergency departments, medical offices, schools, etc., with special focus in rural areas and areas with no calls to the CCRL.
- Work with providers and partners to identify opportunities to collect information on direct referrals from schools to better assess reach and need for outreach via schools.

## 15.0 Children’s Mobile Crisis Response and Stabilization (CMCR)

The CCRL can connect youth experiencing a behavioral health crisis and their families to regional CMCR Services, which have been statewide since May 2021, through a warm transfer to the regional CMCR team nearest them. A “crisis” is determined by the family. The CMCR team will speak with the youth or family member and respond in-person in the home, school, or community based on the youth’s or family’s preference. The crisis specialist is expected, on average, to provide on-site support within one hour of the request.

After de-escalating the crisis, the CMCR team completes a crisis plan and links the youth or family to appropriate community-based services, including the Assessment Pathway and WV Wraparound, to help them stay in their homes and communities. In addition to calling the CCRL, which has been available since October 1, 2020, youth and families may call the regional CMCR teams directly, but promotion has shifted to calling the CCRL since its implementation.

In addition to services provided by CMCR, BMS also offers mobile response services through the CSED Waiver. However, these services were reviewed and noted in Quality Committee reviews that utilization had primarily shifted to calls to the CCRL and thus CMCR; therefore, only CMCR data was included for review purposes in this report. BMS CSED Waiver mobile response will continue to be monitored routinely for any changes in utilization.

### 15.1 Review Period, Data Sources and Limitations, Population Measured

**Figure 58: CMCR Data Overview**

Data Review Period	Data Source	Limitations	Population Measured
Jul 2021 – Sept 2021 Oct 2021 – Dec 2021	BBH CMCR and Stabilization Grant Reporting BBH System of Care Epi Info Interface	Prior to October 1, 2021, reporting was a combination of de-identified and aggregated data, which prohibited the ability to report unique numbers served across programs. Therefore, when patterns across quarters are similar, only the most recent quarter is reported.  At the time of this report, indicators regarding timely provision of services and referral to additional services were unavailable. Indicators have been added to the new reporting system set to be updated by October 2022 and will be reviewed in future assessments.	Children served directly through the BBH program.  Services are provided to individuals and families with children ages 0 – 21 experiencing an emotional or behavioral crisis initially through BBH's CCRL or connected through a local CMCR line.

As stated above, the change in data collection mechanism is expected to improve ability to review service level interactions. It is expected that the number of children and families served over time will

increase as these new providers grow in rapport and awareness within their communities.

## 15.2 Review Summary

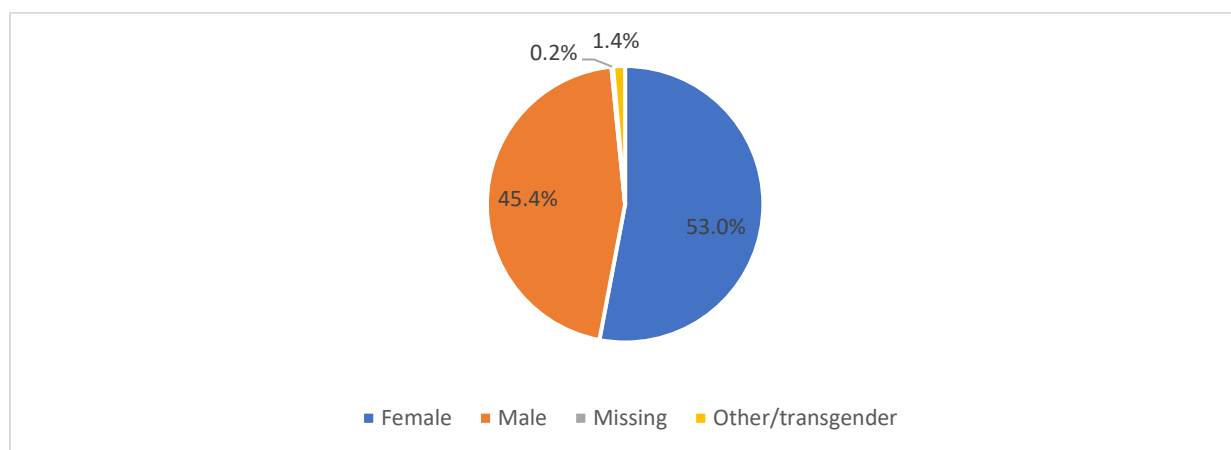
For the review period (July 2021 to December 2021), the System of Care Epi Info Interface went live in October 2021. Seven providers served 397 children across six regions in July – September 2021. The same providers served 502 youth from October to December 2021, representing a 26% increase in usage from the prior quarter. This significant increase is a positive indicator of the increased awareness of these services as well as children and families embracing these services to assist with keeping children at home.

**Figure 59: Children Served**

Review Period Available	Unduplicated Children Served
July – September 2021	397
October – December 2021	502

More females than males sought mobile crisis services in the last quarter of 2021 (Figure 60). Similarly, slightly more females called the CCRL, which may signify a difference in pathways into services by gender, with a higher proportion of crisis services being accessed by females compared to other services such as Wraparound, Behavioral Support Services, and RMHTFs. As enhanced data collection and upgrade to systems are implemented to allow interconnectivity of data sets across child-serving entities for record-level data, it is expected more information will be able to be gleaned from patterns in entry points for different subpopulations.

**Figure 60: Gender, October 2021 – December 2021**

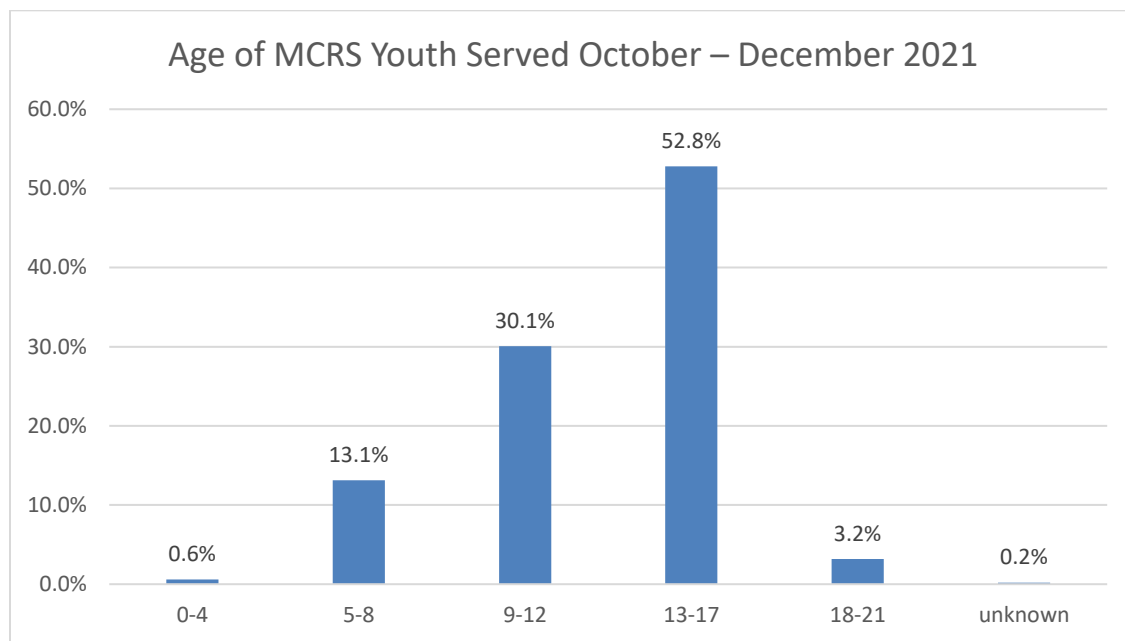


Fifty-three percent of individuals served were ages 13 – 17, which is also the largest age group served by the RMHTFs. This may indicate further opportunity to provide preventative and stabilization services to children at a critical age. The quality committee recommended continued consideration be given to how to reach these families before they are in crisis when possible, shifting the ages served slightly younger for other intervention programs. In response to this, additional focus will be placed on ensuring

screening, education, and referral through primary care providers to address needs when possible before families are in crisis.

It should be noted that it is possible an individual in crisis is a parent or caregiver with a small child. In these cases, the child would also be enrolled in the program to help provide services for the family as a whole. Some of these instances may make up the less than 1% of children ages 0 – 4.

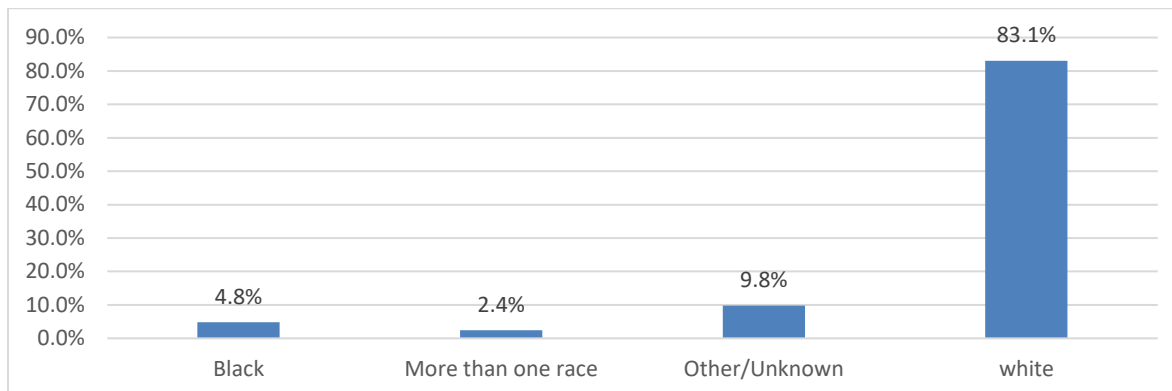
**Figure 61: Children Served by Age Grouping, October 2021 – December 2021**



CMCR and stabilization teams strive to reach vulnerable and marginalized populations such as children who are adopted from foster care, or children who identify as BIPOC or LGBTQ+. Data from the new interface had a larger percentage of missing information for adoptive status and identifying as LGBTQ+ compared to previous data collection indicating an opportunity for data completion improvement to better assess family and youth needs and utilization.

Race and ethnicity data were similar to WV's population less than 21 years of age, with individuals of more than one race having slightly lower representation. Nevertheless, the amount of unknown data related to race increased with the transition to the new data system, identifying an opportunity to improve data quality and completion to further monitor that this service is reaching individuals who may need it.

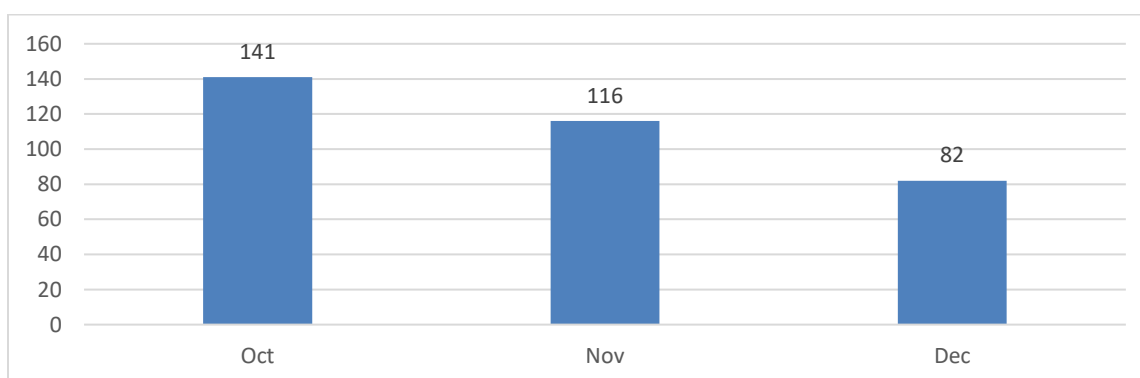
**Figure 62: Percentage of Children Served by Race Compared to WV Population Under Age 21, October – December 2021**



CMCR services provide a key opportunity for individuals who need to be connected to preventative and supportive services, such as Wraparound services. While CMCR services are designed to provide short-term support, the connections and planning developed are meant to provide the family longer-term stability when possible.

Children engaging in CMCR services for the first time, increased in September (92) and October (141) 2021 from only 47 in August 2021, likely due to the stress associated with return to school and referrals and connection through school and community professionals. It was noted as typical for calls to decrease around the holidays (November and December 2021). As data are monitored over time, DHHR will seek to understand any seasonal trends associated with mobile response. More information on referral source is being collected in the new data system and will be included in future reports to further assess how children and families are being connected with services and where further awareness of these services may be needed.

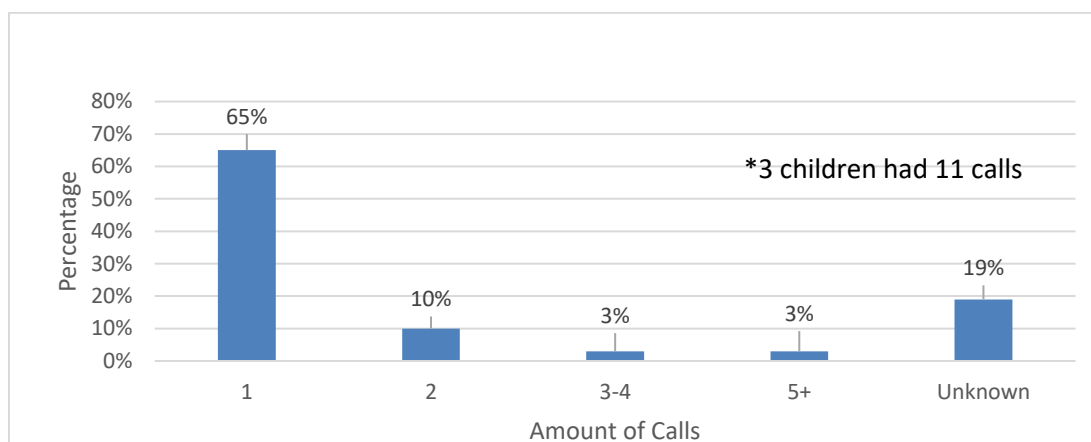
**Figure 63: New CMCR Youth Served by Month October – December 2021**



Repeat callers were assessed for quarter 3, July – September 2021. Data was not yet available for quarter 4 but will be in future reports. For 65% of youth served (Figure 64), crisis need appeared to be met and stabilized within one call. For 16% of children, additional needs were met through multiple interactions. During review of the data, BBH program staff indicated they would like to look at outliers in the future to seek to understand the characteristics and circumstances of individuals accessing crisis

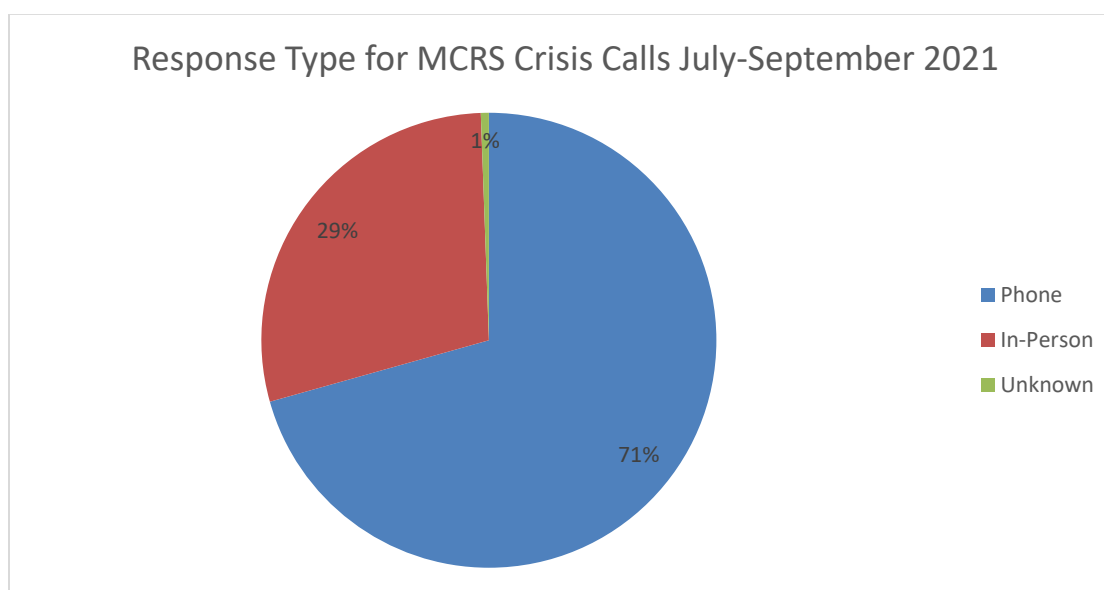
response repeatedly (e.g., three children had 11 calls over the period). The program team agreed this information could help identify possible unmet needs or gaps in available services. Additionally, 19% of children had missing information related to crisis call interactions, an opportunity for improvement in data quality.

**Figure 64: Number of CMCR Crisis Calls Reported Per Youth Served July – September 2021**



For total calls, 528 came in for CMCR services in quarter 3; 71% were indicated as completed and stabilized over the phone, while 29% required in-person intervention and stabilization services. Quarter 4 data was not available at the time of the report. However, additional data for timeliness and detail of services is currently being aligned to allow aggregation in future reports. This will allow equivalent services provided by different payor sources to be represented at the full utilization level. Training is developed through Marshall University for both Wraparound and Mobile Response/Crisis services to provide consistent training and curriculums.

**Figure 65: Response Type for CMCR Crisis Calls July – September 2021, n= 528 total calls (for 397 individuals)**



## 15.3 Provider Capacity/Statewide Coverage

CMCR services are available statewide as of May 2021. In addition, the CCRL is transitioning to being the primary source to route individuals in crisis to the appropriate mobile crisis team. Individuals may also be connected to mobile crisis services through the Assessment Pathway.

Providers have indicated challenges still exist in providing response within one hour due to the rurality and geography of the state. Data are not yet available regarding timely response but are being refined to ensure national standards are being met and to support CQI reviews in the future. Since BMS only accounts for a small number of response services, capacity was not included here. It should also be noted that children enrolled in CSED are referred to the CCRL and thus CMCR services as a primary mobile response service option.

Marshall University is contracted to assist with development of training and curriculum programs for both CMCR and WV Wraparound. Currently BBH, BMS, and BSS staff meet with Marshall University weekly as part of the continuing planning efforts.

As indicated in Figure 66, BBH CMCR providers are currently undergoing staffing shortages, with only 64% of positions throughout the state filled. It was recommended by the Quality Committee that DHHR continue to work with providers to offer technical assistance for improving workforce capacity.

**Figure 66: BBH CMCR Provider Capacity**

	Current Personnel	Budgeted Personnel	Occupancy Rate
Region 1	3	4	75%
Region 2	3	5	60%
Region 3	3	5	60%
Region 4	4	7	57%
Region 5	4	7	57%
Region 6	4	5	80%
Total	21	33	64%

## 15.4 Strengths, Opportunities, Barriers, and Next Steps

Statewide CMCR coverage creates opportunities to offer crisis relief and plans for stability to support families and children in need. As noted in data presented by quarter and month, the number of individuals utilizing these services has increased over time, demonstrating increased awareness and embracing of these critical services. The implementation of an interconnected network with the CCRL, Wraparound services, Assessment Pathway, and warm transfer to mobile crisis and stabilization teams allows multiple entryways and connections to longer-term services for children and families with different levels of need.



#### Next Steps:

- Specific focus should be placed on diverse communities and BIPOC, children identifying as LGBTQ+, and adoptees with assistance from 988 and TTI funding efforts as previously described.
- As data become available on timeliness of response, additional assessment should focus on regional needs and technical assistance.
- Additional training and technical assistance should be provided to improve data quality and completion. BBH has already begun to develop detailed reports to highlight missing data, which can be addressed with providers.
- Continue to conduct outreach for crisis services based on findings across the state and in key access points, as with CCRL services, with identification and outreach for areas of focus with low utilization of crisis services and/or high RMHTF placements.
- Connect families and/or children diagnosed with SED/SMI exiting foster care who are aging out or achieving permanency through adoption with appropriate mental health services such as mobile crisis. This can be done in collaboration with BSS in outreach to recent adoptees or by increasing two-way communication about service accessibility to all families.
- DHHR will work with BBH CMCR providers to offer technical assistance to improve workforce occupancy.
- As with CCRL, provide additional outreach to identified access points such as emergency departments, medical offices, schools, etc., with special focus in rural areas.

## 16.0 Residential Mental Health Treatment Facility (RMHTF) Services

The overarching goal to improve outcomes for children is to reduce the reliance on RMHTFs and to increase home and community-based services available to children with SED. In addition to increasing availability of community-based services, DHHR is focused on RMHTF models of care to help ensure children placed in care are served in the least-restrictive setting and for a length of time that meets their needs.

Reducing the overall census in RMHTFs is a primary focus for DHHR. DHHR has a goal of reducing census to 822 by December 31, 2022, and 712 by December 31, 2024. The point-in-time census in RMHTFs has declined from 1,096 as of June 1, 2015, to 814 as of July 15, 2022. An overall decline has been observed; however, some fluctuation in census throughout the period was noted. Following the lifting of pandemic restrictions in February 2022, an increase in overall RMHTF census was observed, followed by a decline when schools released for the summer. The Quality Review Committee and program teams are continuing to monitor census, admissions, and discharges over time to better understand seasonal trends associated with holidays and school being in and out of session. Additionally, the committee discussed the possibility of trending CPS and YS new cases opened against residential placements by county.

In addition to overall census reductions, other areas of focus include:

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

### 16.1 Review Period, Data Sources and Limitations, Population Measured

**Figure 67: Overview of RMHTF Data**

Data Review Period	Data Source	Limitations	Population Measured
July 1, 2021 – December 31, 2021	BSS FACTS Data System BMS DW/DSS	DW/DSS claims are the data source for parental placements to PRTFs. Owing to claim payment lag and data warehouse update cycles, parental placement data for the later part of the study period may be incomplete. However, as noted, claims data account for less than 1% of RMHTF data. Claims data reported here include payments through March 2022.	RMHTF enrollment and utilization data for children in state custody are sourced from FACTS. Parental placements of children into PRTFs make up less than 1% of overall placements and are sourced from the DW/DSS.

Data Review Period	Data Source	Limitations	Population Measured
		FACTS data may show a brief lag, as field workers may not be able to update the system immediately, but analysis shows FACTS data are very stable after one to two months. Therefore, FACTS data for the study period, based on analyses completed in May 2022 including FACTS data updated through April 2022, can be considered complete.	
January – April 2022	The MCO RMHTF Monthly Report spreadsheet	The data was updated on 05/13/2022. All date calculations (e.g., age) are done using 04/31/2022 as a reference date for the period. In instances where children had multiple entries and thus multiple CAFAS/PECFAS scores, the record with the most recent score date was kept.	Children included in this report related to discharge planning have a CAFAS/PECFAS score less than or equal to 80 (i.e., less than 90). These children are in a RMHTF.

## 16.2 Review Summary

### 16.2(a) Qualified Independent Assessment

Effective May 1, 2022, DHHR expanded its contract with Kepro, the ASO, to perform a qualified independent assessment of children who are at risk of residential placement or referred to residential placement or shelter care, as a part of the Assessment Pathway process. A CAFAS/PECFAS and CANS assessment will be utilized in the development of the qualified independent assessment. The assessment will identify the child's needs and provide a recommendation on the appropriate level of intervention and least-restrictive service setting to meet those needs.

Currently, DHHR is working with the ASO and MCO to develop the qualified independent assessment process, data collection, communication, and monitoring. A phased implementation is expected to begin in August and continue through the second half of 2022. Throughout the phased implementation, data will be reviewed, and adjustments made to the phased approach as relevant.

Additionally, DHHR is collaborating with Marshall University and the Praed Foundation to finalize a decision support model predicated on the CANS assessment tool. The proposed model consists of five levels of placement need with Level 1 being the lowest level of intervention or need and consisting of traditional foster or kinship care, and Level 5 being the highest level of residential placement, a PRTF. The decision support model will assist with making level-of-care recommendations that are based on treatment need and complexity.

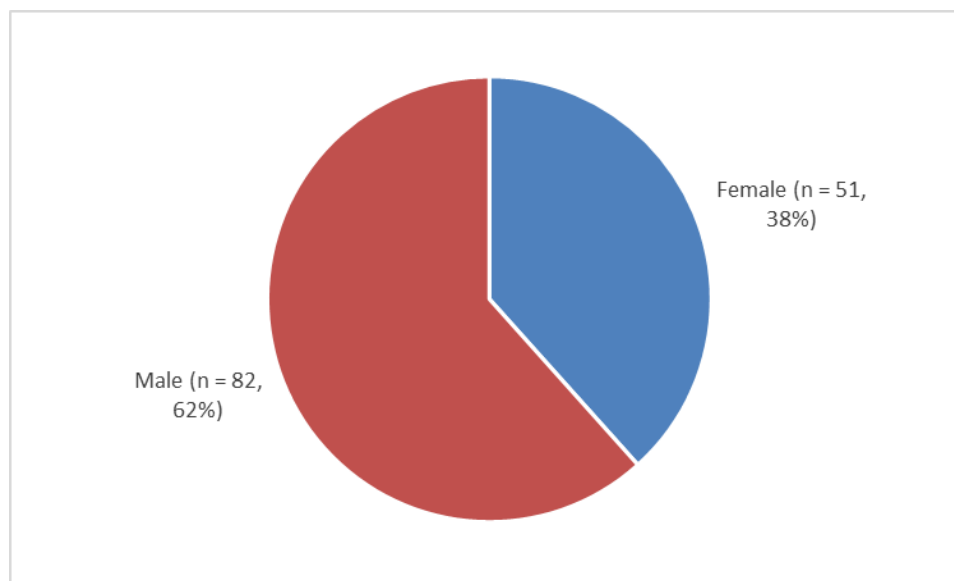
The qualified independent assessment process is a key component of ensuring children are placed in the

least-restrictive setting while best addressing their needs and will assist with diverting children from unnecessary residential placement.

## 16.2(b) Prioritized Discharge Planning

DHHR is actively collaborating with the MCO, Aetna Mountain Health Promise, to prioritize discharge planning for children currently placed in residential settings with a CAFAS/PECFAS score less than 90<sup>14</sup>. To assist with this effort, collection of data elements associated with discharge planning was initiated in January 2022. A discharge planning report is published monthly for use by the BSS field staff, supervisors, and managers as well as the Aetna Mountain Health Promise care managers. For the period January – April 2022, 133 children were in residential settings with a CAFAS/PECFAS score less than 90. Of these individuals, 62% were male showing a similar proportion to all individuals in RMHTF settings as shown in Figure 68.

**Figure 68: Gender of Children with CAFAS/PECFAS <90**

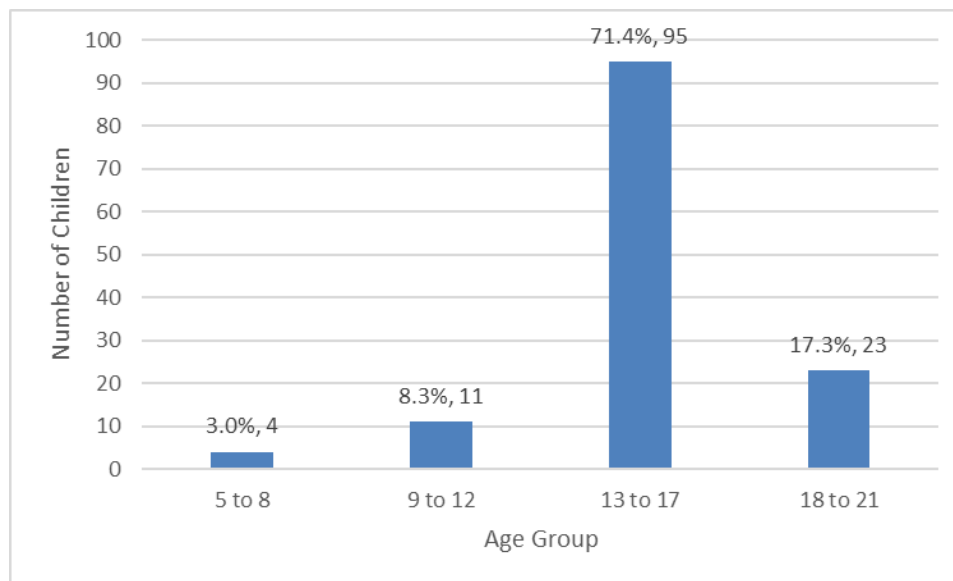


Similarly, 71% of individuals fell into the 13 – 17 age category (reference Figure 69) compared to 80% of all individuals in RMHTFs. This points toward similarities in populations for the broader RMHTF population and those with scores below 90; however, this will need to be considered further as more data become available, as there were some identified differences in the 9 – 12 age category and a larger difference in individuals 18 – 21. Approximately 17% of individuals with a CAFAS/PECFAS <90 were ages 18 – 21 compared to 1.5% in the broader residential population. CAFAS/PECFAS scores at admission were not available for most individuals; therefore, functional improvement during residential treatment could not be accurately assessed for purposes of this report. Based on preliminary review, many of

<sup>14</sup> A CAFAS/PECFAS is completed every 90 days for children in residential placement. A child's most recent CAFAS/PECFAS score is being utilized for purposes of this report and may not be reflective of the child's initial needs or score at entry to the RMHTF.

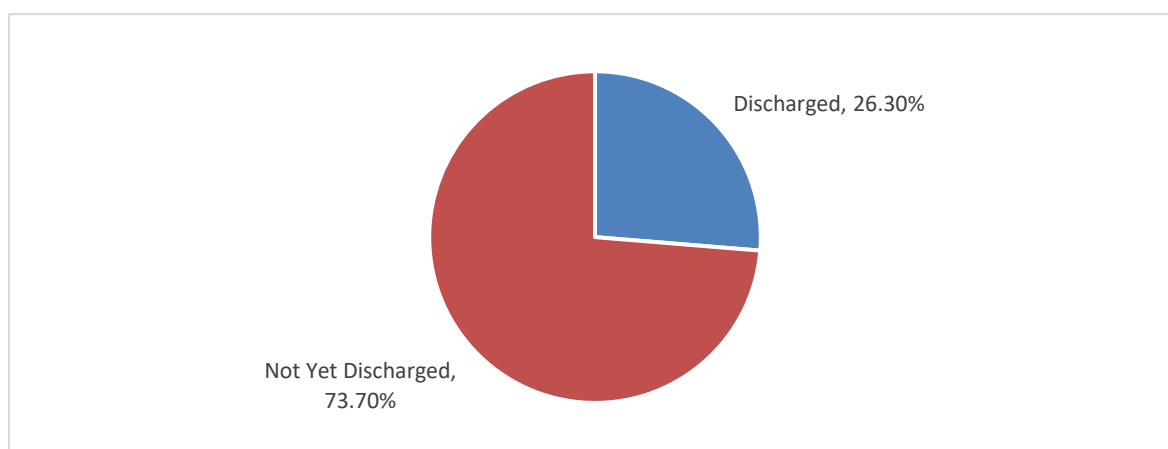
these individuals have made progress during residential intervention as evidenced by transitioning to lower levels of care, including transitional and independent living settings with some participating in college or vocational programs. Some of these individuals have requested to remain in a residential setting where they receive housing and educational, and staff support as they do not have family available and do not want to be placed in foster care. The 18 – 21 age group representing a greater proportion for those with an identified CAFAS/PECFAS <90 could be an artifact of longer time in care—time to stabilize the individual—or could be indicative of a need for alternative community-based placement options to meet the unique needs of transitioning youth. More time and data are needed to better understand these considerations.

**Figure 69: Age of Children with CAFAS/PECFAS <90**



From January to April 2022, a little over one quarter (26.3%, n=35) of the children were discharged to community-based settings who may not have otherwise been discharged without this new prioritized discharge planning process in place.

**Figure 70: Children with CAFAS/PECFAS < 90 Discharged to Community Settings**



Effective June 2022, BSS and the MCO, Aetna Mountain Health Promise, are meeting twice each month to review the status of children prioritized for discharge and address any identified discharge barriers.

Discharge barrier was collected for 68 of the 133 children. Based on review of the initial data, the top three discharge barriers identified were:

- An appropriate and viable discharge plan is not in place
- No foster family is available when the child does not have family to discharge to
- Parent/family is not ready to have the child return but is making progress toward that goal

To address the primary discharge barriers for children and families, effective January 2022, the MCO, Aetna Mountain Health Promise, developed and initiated discharge planning training for Aetna Mountain Health Promise care managers, BSS staff, and residential providers covering the definition and purpose of discharge planning as well as the roles and responsibilities of those involved. Through June 2022, 17 trainings have been completed with 620 participants. DHHR and Aetna Mountain Health Promise are exploring the possibility of offering this training on a recurring cycle in the future.

To help facilitate transitions to lower levels of care and community placements, in February 2022, Aetna Mountain Health Promise implemented monthly Faces to Cases meetings with providers to provide more individualized information for children needing placement. Each level of care has a set monthly review meeting in which information on children is presented. Through this process, individualized information on three to four children is shared with specific providers based on possible fit. To date, 18 Faces to Cases meetings have been held with 60 children reviewed. While this process is still new, the initial outcomes represent an improvement over what DHHR has observed historically as there is better coordination among providers working together to find community placements. Positive outcomes through June include six children finding foster homes, six children assigned to Mission WV to find adoptive families, and three children moving to a lower level of residential care.

In addition, since March 2021, Aetna Mountain Health Promise has continued to hold specialized reviews for children experiencing a crisis or placement disruption. Any member of the child's multidisciplinary treatment team can request the review. Once requested, the review is typically held within 24 hours, and all multidisciplinary treatment team members are invited. From March to December 2021, 116 reviews were completed. From January to June 2022, over 100 reviews have been completed. The Quality Review Committee recommends BSS work with Aetna Mountain Health Promise to enhance data collection and reporting associated with specialized reviews in order to better understand the outcomes of these reviews.

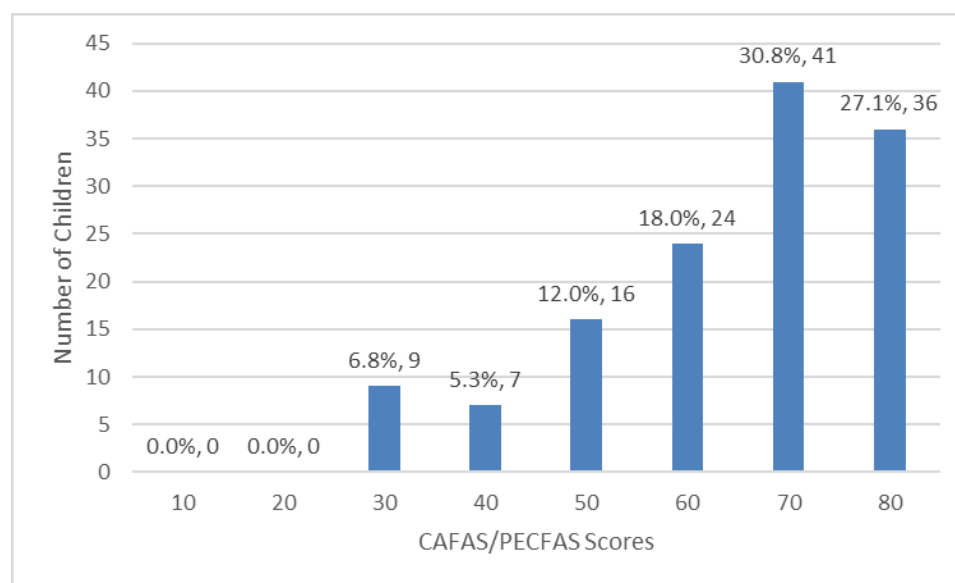
To help address the lack of available foster families, the MCO is facilitating monthly Family Finding orientation sessions. Since the beginning of 2022, 255 MCO, BSS, and residential provider staff have participated in this orientation. In follow-up to the orientation, Aetna Mountain Health Promise offers a three-day intensive Family Finding Boot Camp, which is done in collaboration with Family Finding authors Kevin Campbell and Liz Wendal. Year to date, two of the three-day intensive Family Finding Boot Camps were completed with 146 staff attending. Going forward, to support efforts to find community-

based homes for children transitioning out of residential placements, the Boot Camp will be offered on a quarterly basis.

The Quality Review Committee and BSS program teams will continue to monitor discharge barriers over time, including an analysis of barriers by age category, to better understand and address any considerations preventing timely discharge of children to community-based settings.

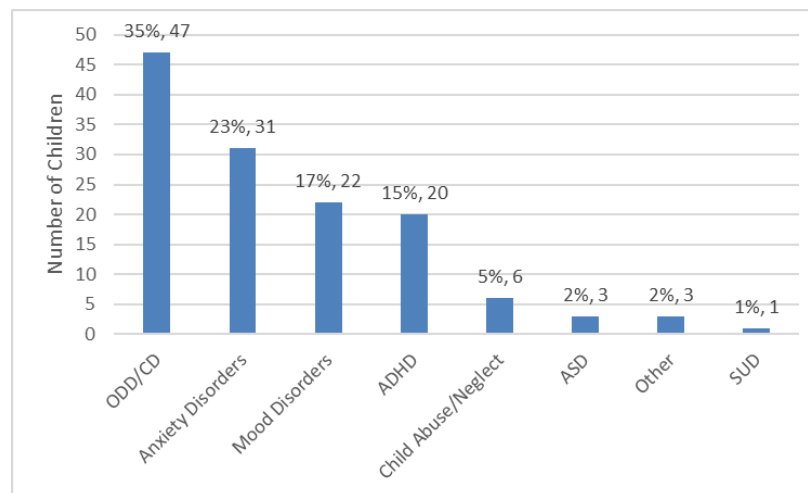
CAFAS/PECFAS scores for children in in-state residential placement prioritized for discharge are shown in Figure 71 below with nearly three-fifths of scores indicated as 70-80. Sixteen children (12.1%) had a score below 50. Based on review of this data, the Quality Review Committee discussed consideration be given to requiring out-of-state providers to implement, track, and report CAFAS/PECFAS scores for children in out-of-state residential placements. The group also suggested additional analysis based on length of stay, age of the child, and/or “barrier to discharge” to allow further assessment for opportunities to support children and frameworks in providing a transition to community-based services.

**Figure 71: CAFAS/PECFAS Scores <90 for Children in Residential Placement, January – April 2022**



Primary diagnosis related to authorization for residential services was also considered in this review, with the most common primary diagnosis for authorization being conduct disorders or oppositional defiance disorder representing 35%. Note while children may have had co-occurring or coexisting diagnoses, only the primary diagnosis related to authorization was reported here. BSS program staff note that based on historical experience, foster families are less willing to accept a child diagnosed with oppositional or conduct disorders. The Quality Review Committee indicated an interest in further understanding the population served with ASD as a potential co-occurring condition with other mental health diagnoses. Although 2% of individuals received authorization through a primary diagnosis of ASD, this may not be indicative of the prevalence of ASD among this group of children. Additional time and data are needed to better understand the considerations associated with diagnosis and barriers with community placements.

**Figure 72: Primary Diagnosis for Authorization for Children with CAFAS/PECFAS < 90 in In-State Residential Placement, January – April 2022**



As a next step in determining how to best serve these children, DHHR is planning a meeting with stakeholders in July 2022 to share the above-summarized data and information and brainstorm how to better serve these individuals whose needs do not quality for residential level of care.

### 16.2(c) Residential Services

Information reflected in the following figures represent children in state custody placed in residential settings and parentally placed children in PRTFs.

The census trend data are provided for an expanded period outside the typical review period for this report. The May 2019 through May 2022 data show census has declined from 1,019 to 836, with a more recent update showing a census of 814 as of July 15, 2022. The long-term goal through December 2024 is to reduce the number of children in RMHTF to 712 or fewer. For the period of review specifically, July – December 2021, the RMHTF census decreased from 820 to 785. Although the census has increased in recent months, these changes may be expected due to seasonal effects and changes in bed utilization due to easing of restrictions associated with the pandemic.

For purposes of quality improvement and identifying where to focus efforts, DHHR has begun tracking residential placement rates by county. Reference Figure 73 below. The greatest rates of RMHTF utilization were represented by some of the most rural counties in the state, with Randolph County having the highest rate at 9.2 per 1,000 children with a population of less than 6,000 children under age 20. In contrast, Jefferson County, an urban county, had the lowest rate at 1.1 per 1,000 children, with nearly 14,000 children living in the county.

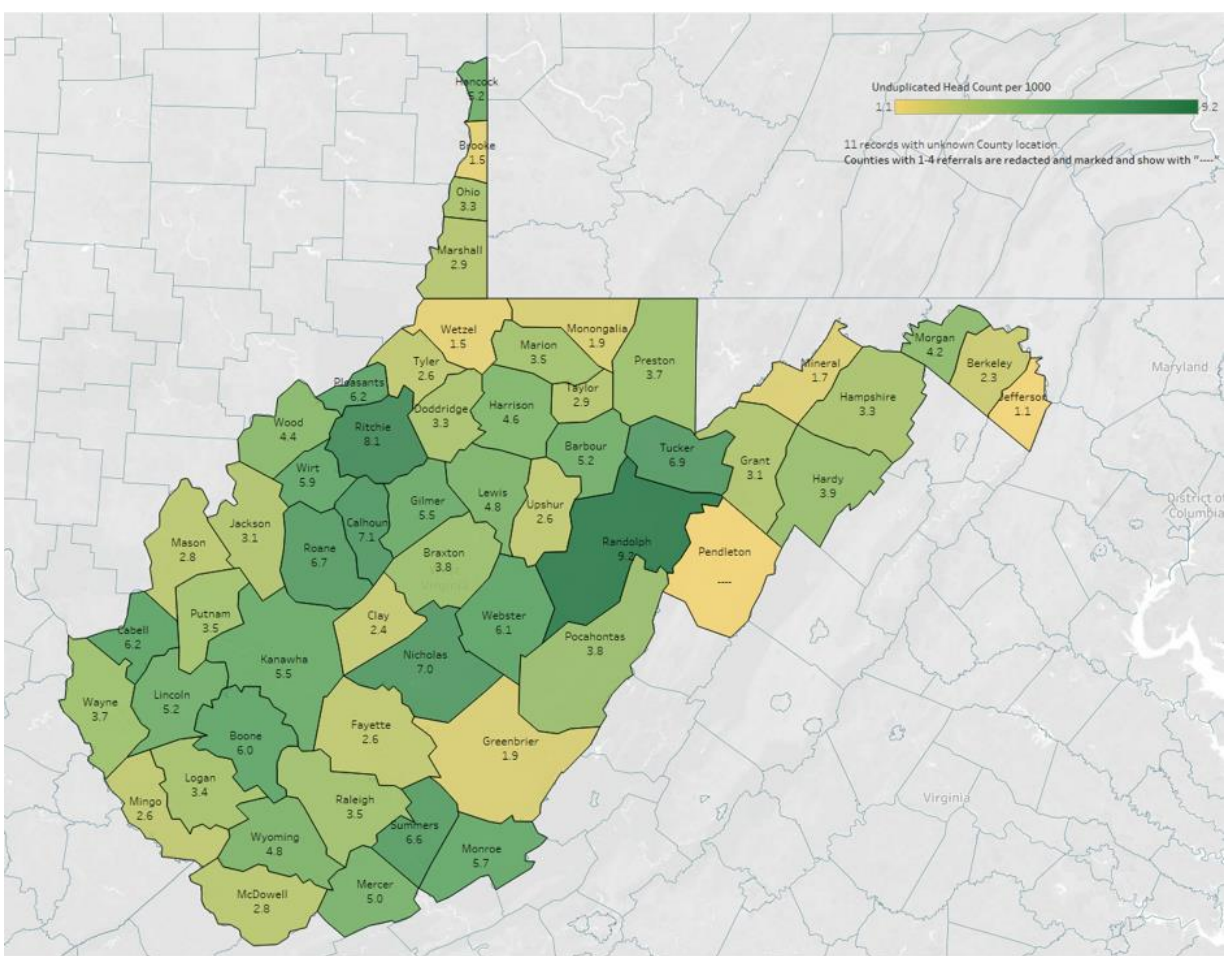
According to findings from WVU's Children's Community-Based Services Evaluation, providers responding from some of the most rural areas of the state indicated barriers for youth and families, including challenges with transportation and an overall lack of medical, school-based, and community-based providers to address mental health needs. Although telehealth services have expanded due to COVID-19 pandemic precautions as a replacement for group therapy or in-home visits, responses



suggest that telehealth is not as successful as in-person services, as many families struggle with unstable internet connections and prefer in-person over virtual interactions.

Counties with a high number of admissions are also being identified, as they will have a greater impact on decreasing RMHTF census. These counties can also be used to bring a regional focus to outreach, education, and service provision, which could make some of the largest impacts to WV's overall number of placements. Counties such as Kanawha and Cabell, among the most populous areas in the state, were expected to have higher numbers of admissions, with an average admission, respectively, of 12 and 9 children monthly in 2021. However, Wood and Mercer counties, each with populations less than 20,000, had approximately the same average monthly admissions (four) as Berkeley County with a population of over 30,000 children. To consider reductions in overall census it is important to continue to look at the number of placements by removal county to identify state needs—just because a county is more populous does not mean the number of placements will necessarily be higher.

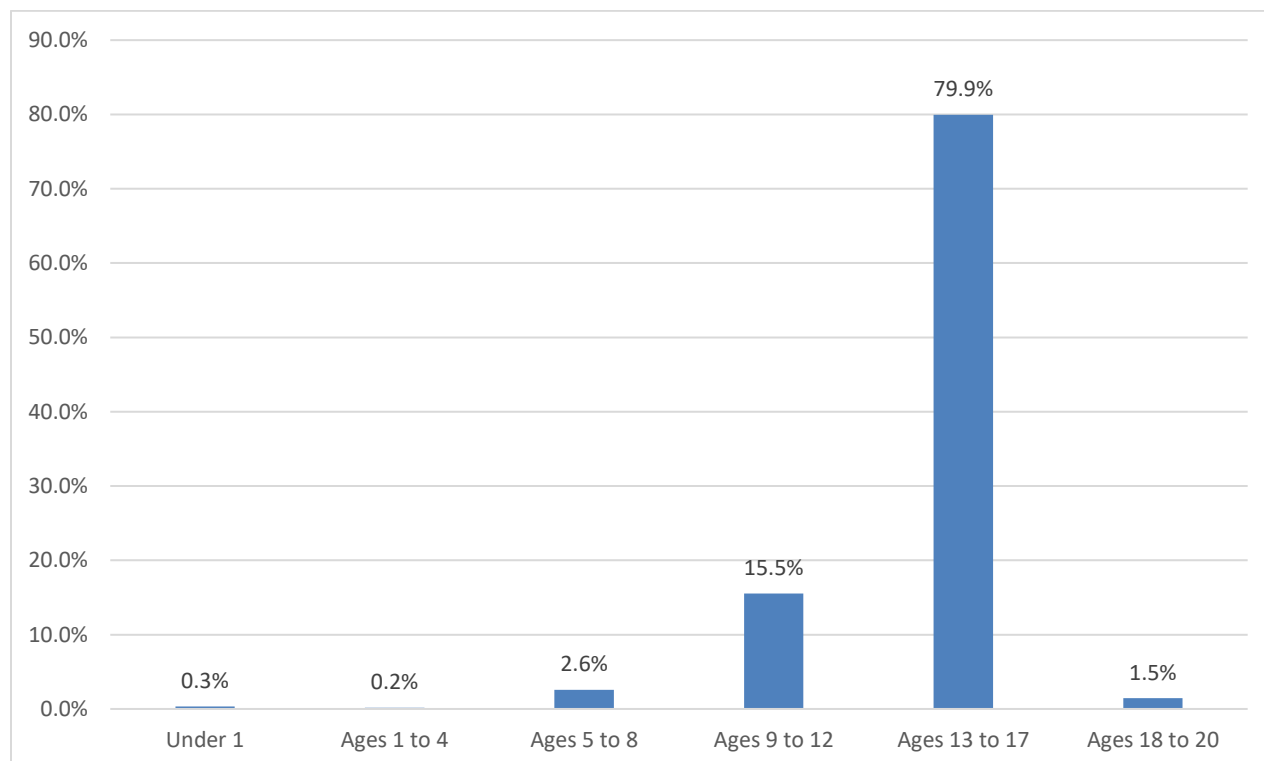
**Figure 73: 2021 RMHTF Unduplicated Head Count per 1,000 Children Under 20 by County of Origin**



Most of the children served were between 9 and 17 years of age. For the July – December 2021 period, the majority of children in RMHTFs were ages 13 – 17 (80%) followed by children ages 9 – 12 (15.5%). The age data are consistent with the July 2020 – June 2021 reporting period. This age group aligns with

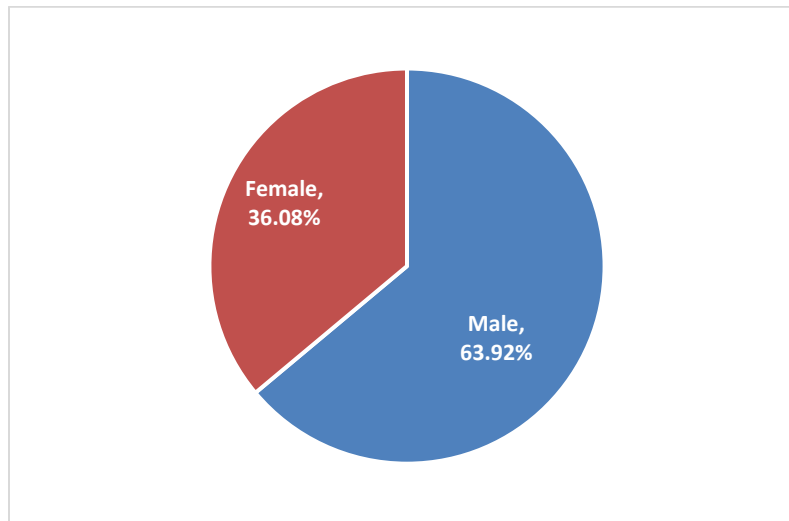
the data seen in many other behavioral health service utilization data, which show the largest proportion of children are between 9 and 17 years of age. Increased focus on home and community-based services for the younger children may be warranted to provide intervention to younger children to reduce the risk of residential placement as children age.

**Figure 74: RMHTF Admissions by Age Group at Admission, July – December 2021**



More male children are utilizing RMHTFs for treatment intervention compared to female children. This aligns with observed trends for high-intensity behavioral health service utilization data where the majority of children are male.

**Figure 75: RMHTF Admissions by Gender at Admission, July – December 2021**



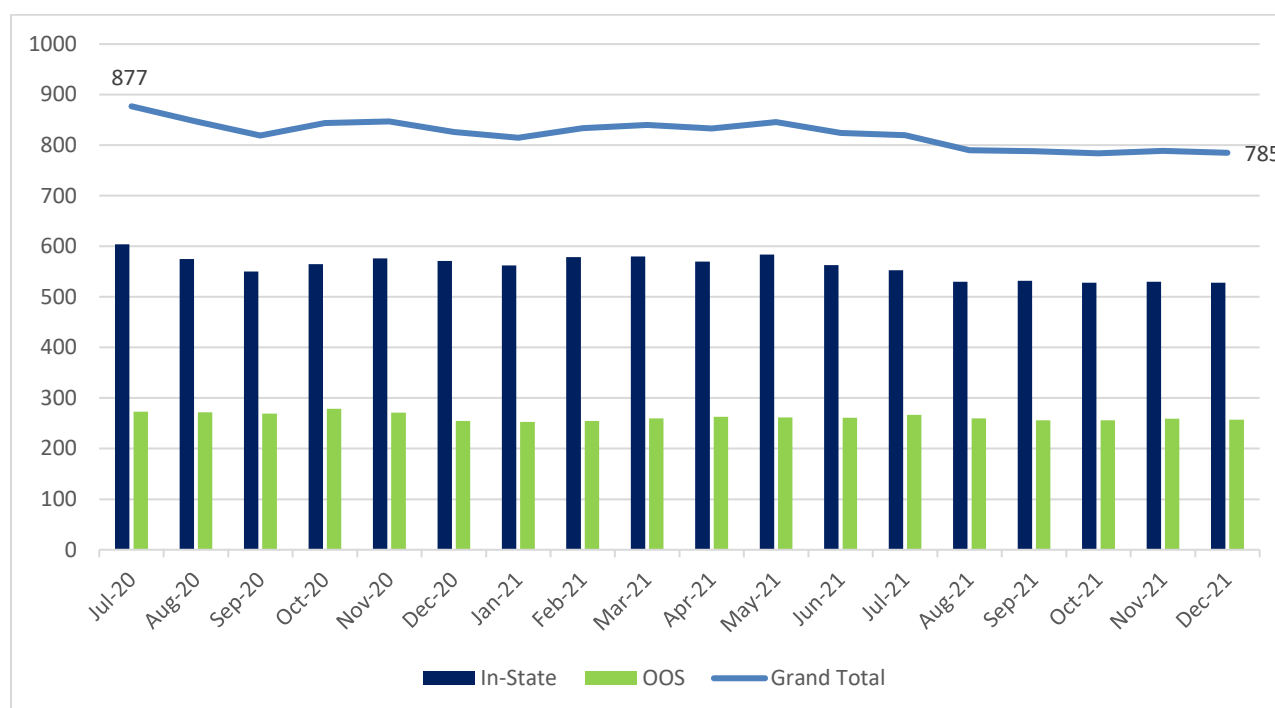
A 6% reduction in census occurred between the July 2020 and December 2020 period compared to July – December 2021. Figure 76 shows a 10% reduction in bed utilization from July 2020 to December 2021, although variations are expected due to seasonal factors and COVID-19 precautions, census is generally trending down. Much of this decrease is attributed to in-state census reductions, as much of DHHR’s focus has been on in-state facilities.

DHHR is taking steps to impact out-of-state placements. Effective March 2022, the out-of-state placement request and review process was enhanced to require that any out-of-state placement request first be reviewed with the Program Manager or Child Welfare Consultant and include involvement of the MCO case manager. The Program Manager is required to ensure all other options have been exhausted before approving and forwarding the request to the BSS Commissioner for final approval. The Quality Review Committee recommended data collection be established for the out-of-state placement review and approval process, so DHHR can determine the impact of this updated process on out-of-state placements.

DHHR is further analyzing the needs of the children being sent out of state, to better understand their unique needs resulting in in-state providers being unwilling to serve them. Based on the unique needs identified, DHHR intends to seek out providers willing to adapt their service model to meet the needs of these individuals so they can be served in state, keeping them closer to home to assist with maintaining family involvement and improve chances of reunification.

DHHR expects to see additional declines in bed utilization as the Assessment Pathway—including the qualified independent assessment for level of care process, prioritized discharge planning, and specialized review processes—are more fully established.

**Figure 76: Average Monthly RMHTF Bed Utilization, May 2019 – March 2022**



Average annual length of stay for placements (i.e., change in facility of residence or discharge) by facility type for children in state custody is shown in Figure 77 below. For calendar year 2021, average length of stay for short-term acute psychiatric was 37 days. While children may be stabilized within a matter of days or weeks, the lack of a community placement option may result in the child remaining in the short-term acute facility until a placement can be found. This phenomenon represents an opportunity for DHHR to continue efforts to expand community-based placement options.

**Figure 77: Average Length of Stay by Facility Type – 2018 – 2021**

Facility Type	2018	2019	2020	2021
Group Residential	204	223	223	218
PRTF	276	257	275	267
Short-Term Acute Psychiatric Hospitalization	35	40	34	37

\*Includes only state-custody individuals; ongoing stays were excluded from this analysis.

Figure 78 displays the rolling 12-month average length of stay for continuous RMHTF stays<sup>15</sup> by in-state or out-of-state provider type at discharge for children in RMHTF in-state custody. The rolling average smooths variation and trend sensitivity to outliers by including 12 months' worth of discharges in each data point. That is, the July 2020 data points include all discharges occurring in the months between August 2019 and July 2020, inclusive; the August 2020 data points include all discharges occurring in the months between September 2019 and August 2020, inclusive; and so on. The December 2021 data point includes all discharges occurring between January 2021 and December 2021, inclusive, and therefore represents the average length of stay over the 2021 calendar year.

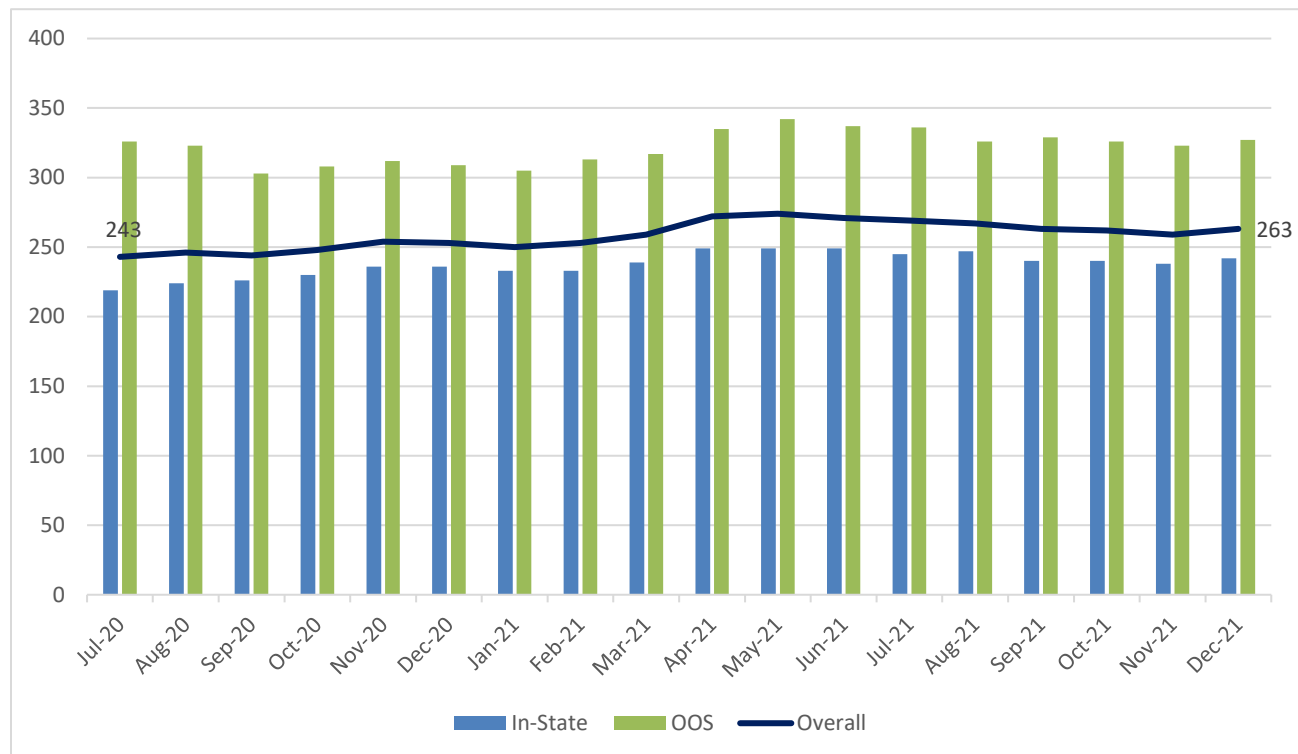
The average lengths of stay over the 18 month period reflected in Figure 78 show an increase occurring between the March 2021 and April 2021 data points, the point when the rolling 12 month periods begin to only include months during the public health emergency; during this period shifts in procedures for congregate care facilities were implemented to prevent outbreaks and surges in transmission. The overall rolling 12 month view shows a difference of about 20 days, from July 2020 to December 2021. Following the increase, length of stay has remained consistent. The recent implementation of prioritized discharge planning as described above as well as the upcoming implementation of monthly clinical reviews for each child in in-state residential placement are anticipated to result in decreased lengths of stay after fully operationalized over an extended period.

Based on the rolling average for discharges in 2021 in the last month shown in Figure 78, children placed in out-of-state facilities have a 35% longer average length of stay than children placed with in-state providers (327 days for out-of-state versus 242 days for in-state). DHHR is working to ensure children have options to stay closer to home, family, friends, schools, and communities for behavioral and mental health treatment intervention when residential placement is the most appropriate option. DHHR has identified model-of-care changes, such as small, specialized community-based group homes, to expand service offerings and ensure individualized high-quality care is available for children with significant needs.

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<sup>15</sup> A continuous RMHTF stay is defined as a period during which a child is placed in group residential care or PRTF with no gaps of 14 days or more between reported exit and entry dates, or in short-term acute psychiatric hospitalization with no gaps of 2 or more days between reported exit and entry dates *or* the exit reason from the stay is a permanent reason such as reunification. Please note the annual average length of stay data in Figure 77 above are *placement* level average lengths of stay.

**Figure 78: Rolling Average Length of Stay for In-State and Out-of-State: Average Length of Stay for a Rolling 12 Months of Discharges, July 2020 – December 2021, by In- or Out-of-State Provider Status at Discharge**



Children often experience multiple stays in RMHTF during their treatment. DHHR is focused on efforts with the Assessment Pathway to offer children and families home and community-based interventions to decrease the number of readmissions children experience.

Figure 79 below summarizes the number of prior RMHTF stays experienced per child by age group for children in RMHTF care during the study period. Please note these figures do not tally the number of changes in placement (e.g., change in facility of residence) a child might experience during a continuous stay<sup>16</sup> in the RMHTF level of care, but the number of prior continuous RMHTF stays each child experienced. For example, a child who resided in three different RMHTF facilities over the course of their first continuous RMHTF stay would be recorded in the “0” category.

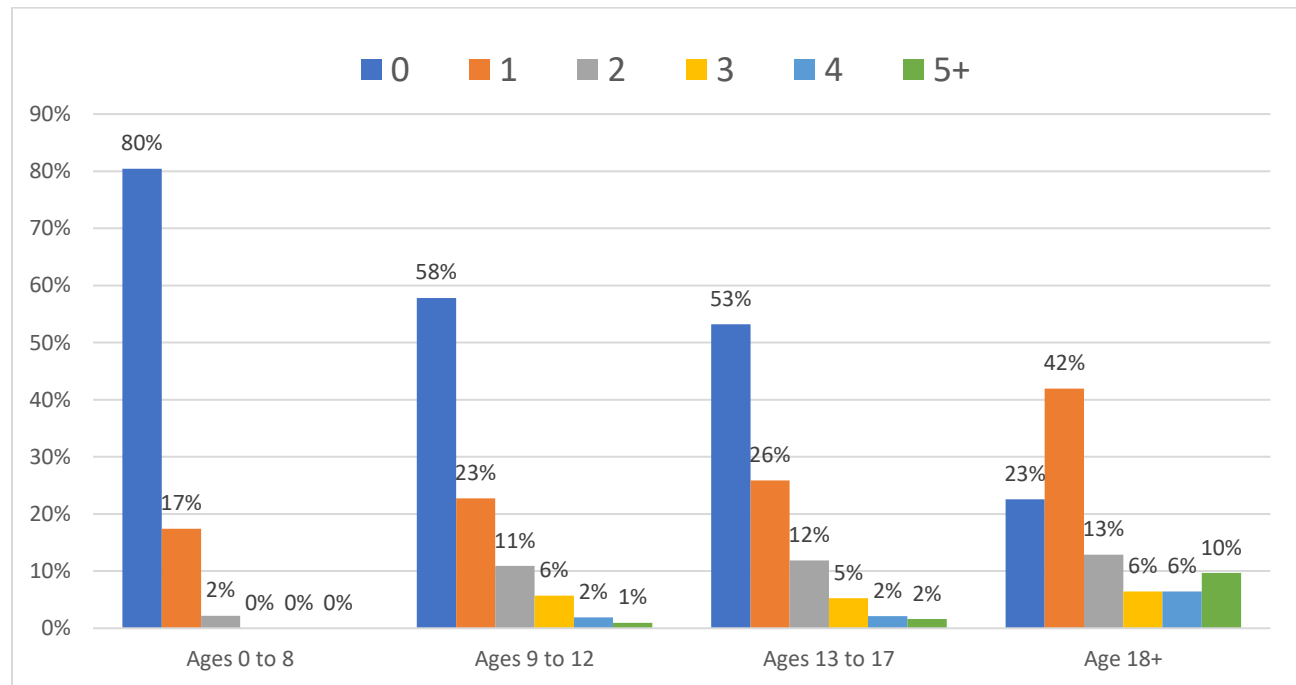
Admissions displayed in the light blue “0” color were the first reported state custody RMHTF admission for the child. The majority of admissions for children in all age groups except the 18+ age group are the first admission.

The increase in percentage of readmissions as a child ages may be attributed to many factors including a

<sup>16</sup> A continuous RMHTF stay is defined as a period during which a child is placed in group residential care or PRTF with no gaps of 14 days or more between reported exit and entry dates, or in short-term acute psychiatric hospitalization with no gaps of 2 or more days between reported exit and entry dates, or the exit reason from the stay is a permanent reason such as reunification.

longer period of interaction with the Child Welfare System, unique service needs, housing issues, or other considerations. While there is no national data available for comparison with the number of readmissions for WV's children in residential placement, the Quality Review Committee recommended BSS further analyze those children in residential placement with a high number of failed placements, beginning with those children with five or more failed placements to attempt to understand the unique characteristics and circumstances for these children that may be driving repeat placements.

**Figure 79: Admissions During the Period July 2020 – December 2021 in Each Displayed Age Group With 0, 1, 2, 3, 4, and 5 or More Prior RMHTF Stays**

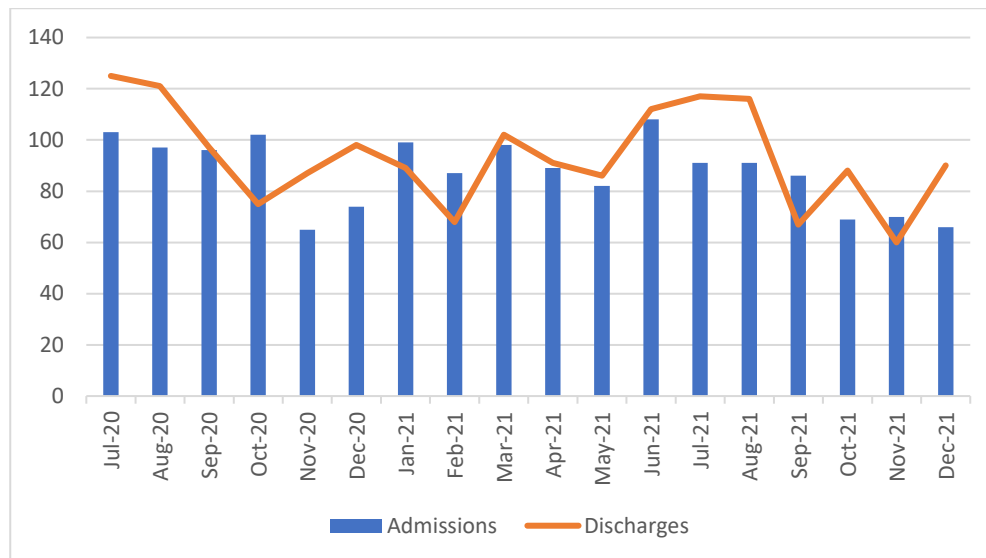


DHHR is actively focused on reducing admissions through implementation of the Assessment Pathway, including the qualified independent assessment process for determining level of care, and prioritized discharge planning and specialized reviews to help ensure children who are currently in an RMHTF are transitioned, where appropriate, to a less-restrictive level of care or discharge to community settings.

Figure 80 reflects admissions versus discharges for the 18 month period of July 2020 to December 2021. The Quality Review Committee discussed possible trends related to the holiday season (November and December) as well as late spring/early summer months (May – July). Specific patterns or trends in this data are still being established with review necessary over a longer period, post pandemic, to better understand seasonal fluctuations associated with school, holidays, etc. Preliminary review resulted in hypotheses related to increased discharges associated with school breaks, which may indicate an opportunity to address cultural norms around requiring a child to remain in a residential setting to finish out a term or related session before transitioning to the community.



**Figure 80: Total Admissions versus Discharges by Month for In-State and Out-of-State Placements, July 2020 – December 2021**



### 16.3 Provider Capacity/Statewide Coverage

The RMHTF provider capacity statewide is adequate to meet the needs for the number of children placed compared to the number of licensed bed capacity. However, the level and type of care offered by each in-state provider varies and, in some cases, may not meet the individual needs of the children needing residential intervention, as evidenced by children continuing to be sent out of state. The focus over the coming years will be to increase in-state provider capacity and training to serve children with high level of care needs who are now being served in out-of-state facilities.

DHHR is developing a service model for small community-based group homes that will serve children with specialized needs, such as significant physical aggression, moderate to severe self-harm, ASD, and intellectual and developmental disability/borderline intellectual and developmental disability. Children with these needs appear more likely to be declined by in-state residential providers due to severity of behaviors or need. DHHR completed outreach to multiple out-of-state providers and recently met with two providers to learn more about the services they provide in other states, including specialized group homes, respite, and behavioral health urgent care for children.

DHHR is also in process of expanding transitional living options and services for older youth. DHHR is seeking in-state providers willing to transform their current residential offerings to provide non-treatment residential services for these youth. Additionally, DHHR is planning to seek stakeholder feedback regarding types of services and supports needed to expand community-based transitional living services for older youth. If these older youth can be successfully served in lower levels of care, this might allow current in-state residential providers to accept and support children with higher-acuity needs.



## 16.4 Strengths, Opportunities, Barriers, and Next Steps

While overall residential census has trended down since May 2019, DHHR recognizes this decrease is partly impacted by pandemic-related holds in residential facilities. DHHR anticipates a potential increase in demand for out-of-home placements as a result of mental health impacts on children and families associated with the pandemic. For these reasons, DHHR continues to work aggressively to implement the following processes:

- The prioritized discharge planning process DHHR and the MCO implemented in early 2022 is expected to result in continued census reductions, as is the broader implementation of the specialized review process for children experiencing a placement disruption. The Quality Review Committee recommended the following associated with these processes:
  - Enhancements to the data collection and reporting for the specialized review process in order to better understand the outcomes of these reviews.
  - An analysis of barriers by age category to better understand and address any considerations preventing timely discharge of children to community-based settings.
- Implementation of the monthly clinical review process in August 2022 for children in in-state residential placement is expected to result in reduced lengths of stay and faster transition to lower levels of care and discharge to community placements. The Quality Review Committee recommended steps be taken to begin the process to require out-of-state providers to complete monthly clinical reviews and to complete and report CAFAS/PECFAS scores for children in out-of-state placements.
- Implementation of the qualified independent assessment process in the second half of 2022 is expected to increase the number of diversions from residential placement, resulting in decreased placements.

DHHR will continue to monitor trends in the quarterly Quality Review Committee reviews as these new processes are implemented to determine if expected results are achieved and make recommendations for adjustments as relevant. The results of county-level data will now be included as part of ongoing monitoring to be used to identify prioritized areas for outreach and education activities and to be used to identify the best strategy for phased implementation of the qualified independent assessment process.

Based on the identification of lack of an available foster home as one of the top three barriers to discharging children in residential placement to community settings, the Quality Review Committee recommended a process be considered for tracking foster care capacity and the process for making referrals to foster care providers be evaluated for possible improvements. Additional analysis of age and length of stay was also recommended to assist with prioritizing foster care needs for subgroups within the child population who may be more difficult to place as well as the possible need for other alternative community-based placement options to meet the unique needs of certain populations including transition-age youth.

Based on review of the prior placement data, the Quality Review Committee recommended BSS further analyze those children in residential placement who have a high number of failed placements, beginning with those children with five or more failed placements, to understand the unique characteristics and circumstances for these children that may be driving repeat placements.

Based on review of the existing data for residential services, the Quality Review Committee recommended additional elements be explored for analyses in future Quality Review Committee review meetings as more data over a longer period become available:

- Create trends of new open cases for CPS and YS against residential placements by county.
- Identify any seasonal trends for admissions and discharges based on school being in or out of session, holidays, etc.
- Begin tracking pre- and post-placement history of services for children in residential placements. The ability to track this level of information is not currently available but is noted as a long-term goal for DHHR.
- Begin capturing diagnosis for all children in residential placements, not just those with CAFAS/PECFAS <90, and evaluate feasibility of capturing co-occurring disorders, such as intellectual and developmental disabilities and more specifically ASD.
- Request reporting of CAFAS/PECFAS scores from the MCO and ASO for all children in residential placement, both in state and out of state.
- Incorporate the use of CANS results after CANS data at the child level becomes available.

To better assess the drivers of referrals for residential placement in order to further impact reductions in residential placements and enhancements to community-based services, DHHR is requesting the ASO track and report the following data elements associated with the qualified independent assessment process:

- Referral Source/Decision-Maker Requesting Placement – to assist with identifying cases where placement is in contradiction to the recommendation of the treatment team (i.e., court-ordered), as well as identify opportunities to further spread awareness and education to the judicial system and families on availability of community-based services when deemed the appropriate level of care.
- Reason the Individual Cannot Be Served in the Community – to assist DHHR with understanding why the decision-maker who is recommending placement is indicating the child cannot be served in the community. Understanding these reasons will assist DHHR with addressing potential gaps or barriers in community-based services, such as specialized care for an individual with ASD, highly aggressive behavior, etc.
- System the Individual is Coming From – to better understand the potential needs and barriers that may face that child and their family.

## 17.0 Outcomes

DHHR continues to establish data sources and systems for collecting outcomes data for children receiving services. During the May 2022 Quality Committee reviews, additional outcomes data and key indicators were discussed to identify potential metrics that could be obtained and utilized to verify positive change as processes are implemented. In order to effectively track outcomes, data collection at the child level will need to be available in the data store, which is still in the early stages of being built out. Below is an update on the potential data sources for each outcome:

- Arrests or detainments: DHHR has started discussions with the Division of Probation Services to establish reporting of juvenile petitions filed. The source for this data is still being determined.
- Commitment to the custody of BJS or DHHR: The data source for commitments to BJS has been identified as the Offender Information System. The data source for commitments to DHHR is FACTS. These data are anticipated to be included in future reports.
- Suspension or expulsion from school: DHHR is collaborating with the WV Department of Education to evaluate the possibility of collecting this data at the child level.
- Prescribed three or more antipsychotic medications: An initial polypharmacy analysis using pharmacy claims data did not identify significant numbers of children with three or more antipsychotic medications. BMS has policies and processes in place to flag any child for whom polypharmacy may be an issue and can intervene when needed.
- Changes in functional ability, statewide and by region, including data from the CANS assessment and the quality sampling review process: DHHR is partnering with Marshall University to complete quality sampling reviews. Further outcome methodology for the CANS assessment is being developed and tested and expected for future reports.

As data collection becomes more robust and the data store continues to grow, DHHR anticipates more outcome data will become available for consideration and reporting.

## 18.0 Conclusion

DHHR has made significant progress in designing, developing, and expanding mental and behavioral health services for children and families across the state of WV. In late 2021 and 2022, DHHR has placed a primary focus on implementing new processes and pathways associated with services and establishing data collection and reporting to allow continuous evaluation and improvement of services. Another key step forward included the appointment of the Director of the Office of Quality Assurance for Children's Programs in May 2022 to assist with driving these efforts and ensure alignment across DHHR bureaus and other child-serving entities.

Though implementation is still in early stages, the increase in mental health screenings conducted as part of early intervention, increased referrals to the Assessment Pathway for further evaluation and connection to services, and increased use of CCRL, mobile response, and CSED Waiver services are all positive signs. These positive trends demonstrate increased awareness and embracing by families and other stakeholders of the home and community-based options available to divert children from residential placements and are evidence that DHHR's efforts are having the intended effect. Implementation will continue in the months and years ahead.

DHHR's ongoing analysis of data associated with recently implemented CQI processes at both the program and cross-bureau level will assist with measuring implementation progress and identifying strengths and opportunities to continue to enhance the processes, programs, and pathways. As more data become available and can be aligned across systems via the data store, additional recommendations and next steps are expected to be brought to light. DHHR will continue to consider its opportunities while taking an incremental and sustainable approach to implementing change.

Key next steps:

- Continue to enhance quality infrastructure and processes within DHHR, to include phased build-out of the data store to allow synthesis of data across sources and systems, oversight and monitoring of DHHR staff and third-party contracts (e.g., vendors, MCOs), and data to provide feedback to providers and ensure accountability to performance outcomes.
- Develop a formal plan and timeline to capture, report, and monitor provider capacity, a critical next step given the increased demand evidenced by increasing referrals to the Assessment Pathway and CSED Waiver applications.
- Prioritize and address considerations and next steps noted throughout this report as well as findings captured in the WVU evaluation during the August 2022 cross-bureau Quality Committee reviews.
- Implement the qualified independent assessment process in the second half of 2022 to assist with diverting children from out-of-home placement and ensuring children are placed in the level of care appropriate for their needs.

DHHR is committed to continuing to transform children's mental and behavioral health programs

toward increased use of evidence-based practices and high-quality care that facilitates positive clinical outcomes, improved quality of life, and safety, permanency, and well-being for children and their families.

## Appendix A: Glossary of Acronyms and Abbreviations

**Figure 81: Glossary of Acronyms and Abbreviations**

Acronym/ Abbreviation	Description
ACT	Assertive Community Treatment
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
ASO	Administrative Service Organization
BASC	Basic Assessment System for Children
BBH	Bureau for Behavioral Health
BIPOC	Black, Indigenous, and People of Color
BJS	Division of Corrections and Rehabilitation-Bureau of Juvenile Services
BMS	Bureau for Medical Services
BPH	Bureau for Public Health
BSS	Bureau for Social Services (formerly Bureau for Children and Families)
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Needs and Strengths
CIP	Court Improvement Partnership
CMCR	Children's Mobile Crisis Response
CCRL	Children's Crisis and Referral Line
CSED	Children with Serious Emotional Disorder
SED	Serious Emotional Disorder
CPA	Child Placing Agency
CPS	Child Protective Services
CQI	Continuous Quality Improvement
DHHR	Department of Health and Human Resources
DW/DSS	Data Warehouse/Decision Support System

Acronym/ Abbreviation	Description
EDS	Enterprise Data Solution
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FACTS	Family and Children Tracking System
ICD	International Classification of Disease
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Questioning, and Others
MAYSI	Massachusetts Youth Screening Instrument
MCO	Managed Care Organization
NWI	National Wraparound Initiative
PATH	People's Access to Health
PBS	Positive Behavior Support
PECFAS	Preschool and Early Childhood Functional Assessment Scale
PRTF	Psychiatric Residential Treatment Facility
RMHTF	Residential Mental Health Treatment Facility
SMI	Serious Mental Illness
STAT	Stabilization and Treatment
TTI	Transformation Transfer Initiative
WV	West Virginia
WVCHIP	WV Children's Health Insurance Program
WVU	West Virginia University
YS	Youth Services