UNIVERSITY of MARYLAND
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THE INSTITUTE FOR INNOVATION AND IMPLEMENTATION

Agreement between the State of West Virginia and the United States Department of Justice: Report By Subject Matter Expert

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Integrating Systems • Improving Outcomes

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Introduction

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

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

This report describes the State's progress since December 2020. Information reflected in this fourth SME report is derived from calls with State Leadership and team leads, including calls with topical workgroup leads, and a thorough review of documents, data, spreadsheets, policies, memoranda, logic models, and other information provided by the State (detailed in Appendices A and B). As with earlier reports, this report includes recommendations for the coming six months of work and beyond. The SME recommendations contained in this report, though grouped by services required under the Agreement, indicate when further cross workgroup coordination is recommended.

The State's Organizational Structures and Processes to Fulfill the Agreement

Our previous report issued December 2020 highlighted the need for the State to further address its structures, processes, communication, and decision-making strategies as it carried out its work for this Agreement; specifically: (1) the State's organization of tasks across workgroups to implement the Agreement and (2) the State's processes to identify and elevate operational decisions to Leadership that cross multiple workgroups.

The State has made strides in augmenting its workgroup decision-making processes per the prior SME recommendation to ensure that key decisions are made across workgroups. Previously, workgroups were focused on their topical area in a siloed fashion, leading to disparate decisions across workgroups and wasted effort as groups unintentionally worked at cross purposes or arrived at solutions which were incompatible. The State has proactively identified interdependencies across workgroups, and is bringing workgroups together when key issues need to be discussed or decided. For example, this coordination effort across workgroups has been demonstrated by the State's development of a draft document describing the pathway for access to services under the Agreement and how youth would be diverted from unnecessary residential placements. This document describes from a systems-level (e.g., bureau, provider, MCO/ASO, oversight) perspective how a child or youth would receive timely behavioral health screening, behavioral health assessment, access to home- and community-based services, and how referrals to residential interventions would be further assessed for appropriateness and the ability to divert. The pathway document itself is discussed in subsequent sections of this report. Additionally, the Department of Health and Human Resources (DHHR) has indicated plans to consolidate all service workgroups into one home and community-based workgroup to reflect the interconnectedness of the work across workgroups.

In reviewing the updated workplans for this fourth SME report, it appears that many unmet deadlines continued to be extended. Some of these were items that had been extended from the previous reporting cycle. As such, many items that were due to be completed by the third reporting period are now reflected to be completed in the fifth reporting period or beyond. Given the urgency of the COVID-19 pandemic and competing demands on limited staff time, it is fully expected that some activities would lag. It is also important to continue to recognize that no DHHR staff are fully assigned to the Agreement; all staff working on this Agreement also have other duties and responsibilities. It is important to continue to keep this staffing reality at the forefront as implementation of the Agreement continues. As COVID-19 demands change, it will be important for the State to re-evaluate if additional staffing resources can be re-assigned. In addition, as the work of state government continues and new initiatives must be undertaken as part of the work of government, it will be important to continue to protect and preserve the staffing resources assigned to this Agreement.

The SME notes that DHHR has recently divided the Bureau for Children and Families (BCF) into the Bureau for Social Services (BSS) and the Bureau for Family Assistance (BFA). The Bureau for Social Services (BSS) now oversees the child welfare system. The acronym BSS had been used in previous SME reports to reference behavioral support services. Moving forward the SME reports will use the following terminology:

1. BSS will refer to the Bureau of Social Services
2. Behavioral support services, with no acronym, will reference the behavioral support service requirements in the Agreement.
3. Positive Behavior Supports (PBS) and Positive Behavioral Interventions and Supports (PBIS) will reference specific research-based approaches being used for behavioral support services.

Workforce

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

Activities

As highlighted in a prior SME report, the State has initiated a Workforce workgroup to identify and address healthcare resource and provider needs to fulfill the Agreement. The State and SME have engaged in a discussion regarding the status of the workgroup's efforts. The State has identified its challenge in clearly articulating an actionable scope for this workgroup, given the multiple issues impacting workforce, the array of services West Virginia is implementing, and the Bureau staff's limited bandwidth.

In reviewing the service specific work plans, and based on review of materials submitted to the SME for this report, the State has begun work in one of the three requirements for workforce-related requirements, which is preparedness of providers to deliver services. The State has initiated training and coaching contracts for Children's Mobile Crisis Response (CMCR), Wraparound, and Behavioral Support Services; it continues its prior requirements for training for existing services incorporated under the Agreement such as Assertive Community Treatment (ACT), screening, and Child Assessment of Needs and Strengths (CANS) assessment. For example, the State has developed an agreement with Marshall University to implement a workforce training center named the West Virginia Behavioral Health Workforce and Health Equity Training Center. The initial contract with Marshall University, more fully described in the Wraparound section of this report, focuses on Wraparound and CMCR, with future activities focused on additional training and coaching topics. The State has continued its contract with WVU Center West Virginia University (WVU) Center for Excellence in Disabilities (CED) Positive Behavior Support (PBS) Program and has entered into an agreement with Concord University to also support the development of behavioral support services-related training and certification. DHHR has indicated plans to address training for other DOJ services, such as TFC and residential interventions, once the models for how DHHR wants to deliver those services is decided.

Recommendations

1. The SME recognizes the important work that DHHR has undertaken to provide infrastructure to train providers and looks forward to receiving the State's plans for training that are expected during the next several months. The other two aspects of workforce—ensuring availability of sufficient providers and implementing strategies to address shortages—require data. As such, the SME recommends that the State's Workforce Workgroup be reconvened with a focus on data, both data needed and data available to inform availability of sufficient providers. A plan for availability of sufficient providers builds upon current data available and projects future need based on estimated patterns. It would include the following components:

- a current list of available providers that is unduplicated by service and by county
- current utilization by provider by service and by county to understand provider volume/where children are receiving services in the State, including Medicaid claims/encounters and BBH and BSS funding
- projected need for services modeled from a national source, such as the Administration for Children & Families NSCAW Baseline report[1] or the Center for Health Care Strategies Faces of Medicaid: Children series[2]
- data to understand how current utilization reflects actual need versus system challenges, such as access, wait times, and lengths of stay
- comparison of actual utilization by service to expected utilization
  - For example, comparing a best practice approach to delivering Wraparound based on NWI with lengths of stay between 12–18 months, 1:10 care manager to family ratios, and multiple contacts per month to West Virginia data, for these indicators will help the State understand any gaps to providers delivering each service as intended.
- qualifications of the staff required by service
- training and coaching required by service

2. This plan should address how the State will work across bureaus and agencies and with its MCOs and other vendors. Additionally, the State should partner with universities, educational institutions, and workforce development centers to create a pipeline for a prepared workforce. Specifically, the State could add requirements for the MCOs, such as the creation of a specific hiring or contracting plan that identifies by county the number of staff needed and their credentials. The State could partner with universities and workforce development centers to ensure that educational content is developed that supports knowledge and skill development for home- and community-based services, such as Wraparound, CMCR and other services, in order to facilitate prospective interest in and preparedness for providing these services.

3. Given the broad scope of such an effort described in the two recommendations above, the SME recommends that the State begin with a sector-specific approach, such as focusing on workforce needed to deliver Wraparound, from which it can further build a behavioral health system-wide workforce plan described in recommendation two. The SME understands firsthand that workforce efforts are inter-related and inter-dependent, and the SME does not want to reinforce a siloed approach to the work. However, an initial narrow scope from which the State builds would facilitate progress on this important issue. Additionally, many aspects of workforce development specific to Wraparound are already being discussed by the State, so it would appear this is an area of the plan that could be more rapidly developed and implemented. Further, given the important role that

[1] https://www.acf.hhs.gov/opre/report/nscaw-ii-baseline-report-introduction-nscaw-ii-final-report
[2] https://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/

Wraparound will play in supporting DHHR to meet its goals, ensuring that the workforce is ready and able to provide Wraparound is essential.

Target Population

Agreement Requirements

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

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

Activities

While the Agreement describes the target population definition, and the population captured by provision a(i) is clear, the State needs to translate the population defined in provision a(ii) into operational parameters for data reporting and compliance oversight. The State has proposed operational parameters to translate this definition analytically in order to pull, analyze, and report data from DHHR's various data systems, and conduct the evaluation. DHHR has indicated that this analytic translation of the target population definition will only be used to pull data for reporting and would not be used to determine service eligibility or medical necessity criteria for services defined in the Agreement.

While section a(i) of the definition, *children who are placed in a Residential Mental Health Treatment Facility,* is identifiable from an administrative or claims data set, section a(ii), specific to children, *who reasonably may be expected to be placed in a Residential Mental Health Treatment Facility in the near future*, poses a challenge to quantify from an administrative or claims data set. As such, DHHR has proposed the following definition (see Figure 1) for youth at-risk of residential interventions.

Figure 1: Proposed Operational Definition to Define Youth At-Risk of Residential Interventions from Data Sources

<table>
<tr><th colspan="3">Proposed Operational Definition to Define Youth At-Risk of Residential from Claims or Administrative Data Sources</th></tr>
<tr><td>Children under 21 with an SED and a CAFAS/PECFAS score greater than or equal to 90 (≥90), and at least one of the following:
• Mobile Crisis Response incidence
• CPS involvement (e.g., foster care)
• YS involvement
AND expected to need a residential intervention in the next 30 days or less.</td><td>OR</td><td>Children under 21 with an SED and one of the following in the past 90 days:
• Incidence of acute psychiatric care hospital stay
• Incidence of ED visit for psychiatric episode
AND expected to need a residential intervention in the next 30 days or less.</td></tr>
<tr><td colspan="3">Definition for Serious Emotional Disturbance (SED): Children with ICD-10 F Diagnosis Codes, excluding the following standalone diagnoses.
• F90 series (ADHD)
• F10 – F19, F55 (SUD)
• F71 and F80 series (neurodevelopmental disorders)
• G25.6, G25.7 (medication-induced movement disorders)
• Z55-65 (health hazards related to socioeconomic and psychosocial circumstances)
• Z69-Z76 (Persons encountering health services in other circumstances)</td></tr>
</table>

As outlined in Figure 1, the State's draft operational definition would be based on inclusion/exclusion of certain diagnostic codes, utilization of certain services, or certain state agency involvement, and a score from an assessment tool called the Child & Adolescent Functional Assessment Scale (CAFAS) for ages 7–20, or the Preschool and Early Childhood Functional Assessment Scale (PECFAS) for ages 3–6. The CAFAS/PECFAS is a separate tool from the Child Assessment of Needs and Strengths (CANS) that is used throughout the behavioral health system as part of a behavioral health assessment. Currently in the West Virginia behavioral health system, the CAFAS/PECFAS is only used as part of the CSED Waiver eligibility determination process. The State intends to have any youth presenting with possible SED or seeking certain services such as Wraparound referred to the CSED Waiver eligibility determination process. Further, the State has proposed that children determined to be part of the target population must have a score of 90 or above on the CAFAS/PECFAS, an eligible SED diagnosis, and demonstrated use of certain services within an unspecified timeframe or have an eligible diagnosis and use of a different set of services within a 90-day time period from when the State runs the data, and data on those children would be pulled and reported on for compliance under the Agreement. In addition to the operational definition to identify at-risk children, DHHR has confirmed that any child who accesses any DOJ Agreement service would be included in any data set even if that child did not meet these at-risk criteria. This is important as is expected that children will need access CMCR, behavioral support services, and other Agreement services and would not meet these criteria.

The SME wishes to acknowledge the challenging task of translating the target population definition into a draft operational analytic definition in order to pull data for reporting and the evaluation and recognizes DHHR's considerable and thoughtful efforts to do so. Further, at time of this report, DOJ has expressed concerns that the State's proposed approach to defining the target population and the operational implementation of the planned approach may not meet terms of the Agreement. The State, DOJ, and the SME are still actively discussing the State's proposed approach to defining the target population for data reports and the evaluation. As discussions continue, the State plans to proceed with testing the definition. The SME supports the State's plan to enter a testing phase of its proposal and understands that before testing occurs, DHHR will develop and submit to DOJ and the SME for discussion a written plan for how it will test its operational definition of the target population.

Recommendations

As these discussions continue, the SME raises the following recommendations:

1. The identification of the at-risk population includes demonstrated access to certain services and supports. DHHR has acknowledged that access to certain services and supports is a challenge, particularly in certain areas of their State. The SME is concerned that a definition requires demonstrated access to a service that a child may not be able to access. The SME recommends that the testing of this proposed definition include a methodology to assess whether access issues to these required services reduce the number of types of children who would be identified as at-risk. This could include a look-back period of children who did and did not access these required services.

2. The identification of the target population is dependent upon timely access to a provider who is approved by DHHR to conduct an assessment that includes a CAFAS/PECFAS. Currently, only Independent Evaluator Network (IEN) providers who are approved to conduct CSED Waiver determinations by the Bureau of Medical Services (BMS) are funded to use the CAFAS/PECFAS as part of a behavioral health assessment. It will be critical for DHHR to ensure that this pathway is accessible to families and that timely access to assessments for the waiver can occur. Specifically, if families find the pathway too cumbersome to access, or wait times for assessments too long, they will not seek an assessment that includes the CAFAS/PECFAS and will never be found to be eligible for the target population. Thereby, DHHR's numbers of children in the target population would decrease, not due to behavioral health need, but due only to a bureaucratic hurdle. As such, DHHR will need to establish and implement a clear monitoring plan. The SME recommends that DHHR provide written clarity on oversight of this function to include the following:

    a. DHHR intends to have its ASO, KEPRO, receive referrals for the CSED Waiver and initiate a CAFAS/PECFAS via phone with the family in order to determine if the youth should continue to be referred to an independent evaluator for the CSED Waiver assessment. From a compliance perspective, DHHR will need to establish clear written expectations for KEPRO's role, including required timelines. DHHR will need to establish plans to monitor KEPRO's timely provision of this activity and the training and quality oversight of its CAFAS/PECFAS scoring beyond just instituting contract language for its vendor to follow.

b. Currently, there is a limited pool of IENs approved by BMS, with BMS intending to expand that number as demand grows. Since determination of who is in the class is dependent upon access to a specific assessment tool by a limited pool of providers, the State will need to need to ensure sufficient capacity for the IENs to conduct timely assessments. Given its intent to serve up to 1,000 children this year and 2,000 next year through the waiver, capacity will need to grow quickly beyond the current approved number of independent evaluators. From a compliance perspective, this means that comprehensive data points will need to be monitored, such as time between referral; initiation of vendor's telephonic screening, including the CAFAS/PECFAS; receipt of the actual assessment through the IEN; the vendor's receipt of the IEN's report and recommendation; approval/denial of the recommendation; notice to families; and initiation of services. The SME notes in the Wraparound section of this report that KEPRO does already gather some of this information via an Excel spreadsheet. As noted in that section of the report, the SME recommends formal reporting of this data in a consolidated way, alongside other CSED Waiver data in order to report a comprehensive picture of CSED Waiver utilization and activity.

c. The State should monitor utilization of non-CSED Waiver behavioral health services. If, for example, high numbers of youth continue to access BBH-funded Wraparound services or other Medicaid state plan services, while low numbers access the CSED Waiver, this *may* be a flag that access to the waiver, rather than presence of behavioral health need, is a factor. As such, DHHR will need to be prepared to examine data from those systems to determine if the populations served overlap with the intended target population.

d. The State should monitor families who decline to participate in the CSED Waiver eligibility process at time of referral to the CSED Waiver eligibility determination process. Families' reasons for declining will be important, particularly if those families pursue similar services through other funding mechanisms.

2. Testing of the target population definition will need to be sufficient in scope to demonstrate that all of the proposed criteria are consistent with the intended target population.

a. Regarding children with a CAFAS/PECFAS score of 90 or above, the State has thoughtfully approached its application of the CAFAS/PECFAS scores to the target population definition, and reviewed the developer's scoring scales for this tool. DHHR has decided to align its' cut-off score of 90 or above at a point in the CAFAS developer's stratification[3] below 100 as the developer indicated a score of 100 or above indicated a need for the most intensive services. The State will need to confirm that its intent is a score at 90 or above, as in one or two places language reads "above 90" while most documents read "at or above" a score of 90.

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

b. Regarding children with scores below 90, the methodology will need to demonstrate that youth with scores below 90 do not result in risk for residential interventions and a need for intensive home- and community-based services that indicate risk, such as frequent CMCR services, repeated inpatient placements, or other out-of-home placements.
c. Regarding the provision of "in the next 30 days or less," the methodology will need to clarify how this is determined. For example, will it be solely assumed based on a CAFAS/PECFAS score at or above 90, will it be a checkbox that an independent evaluator indicates based on criteria defined by the State, or will it be derived from a recommendation from an existing child and family team or multidisciplinary team (MDT). Most states use CAFAS/PECFAS scores as a proxy for determining immediacy of need, and thereby, a proxy for timeline. The SME recommends that West Virginia adopt this approach versus adding additional criteria to be tracked in a data set. If West Virginia plans to use something other than the CAFAS/PECFAS score as its proxy, additional criteria will need to be defined and accompanied by a clear process for how that information will be gathered, how providers will be trained, and how the State will provide quality oversight.
d. The draft operational definition does not propose a look-back time period for mobile crisis response incidents, youth services involvement, or child welfare involvement. The SME recommends that the State propose a time frame (i.e., similar to the 90 days proposed for an acute inpatient admission or ED utilization). Additionally, the SME recommends that a testing methodology include a look-back period that is greater than 90 days in order to ensure that the broadest group of children is studied in this testing phase. That way, DHHR can also test what look-back period captures the right children (e.g., 95 days, 100 days, 180 days, etc.).
e. Because the operational definition requires diagnosis of certain allowable conditions to establish the presence of an SED, DHHR will need to confirm how it will gather this information, i.e., whether it will be limited to the IEN's diagnosis, or whether diagnoses from services indicated in the definition, including mobile crisis response, inpatient hospitalization, emergency department visits, state agency sources, or other real-time data sources, will be included. The SME recommends that diagnosis from any of these sources be included for its testing phase.
f. The SME notes that a standalone ADHD diagnosis is eliminated for inclusion in the SED definition. The SME understands DHHR's position that large numbers of children are diagnosed with ADHD and that ADHD typically presents as a mild behavioral health need. The SME recommends that DHHR include ADHD for four reasons:
    i. SAMHSA's definition for serious emotional disturbance does not expressly eliminate it[4];
    ii. SAMHSA's 2014 expert panel[5] recommends that ADHD should be clarified as included in the definition of SED;

[4] https://www.samhsa.gov/find-help/disorders
[5] https://www.samhsa.gov/data/sites/default/files/SED%20Expert%20Panels%20Summary%20Report.pdf

iii. SAMHSA requires state mental health authorities to report data on SED as part of block grant funding. The most recent data available indicates that ADHD is the most frequent diagnosis of children with SED, representing 25% of youth served in 2017.

iv. Findings from a national study examining Medicaid claims show high numbers of Medicaid children in residential placements with a primary diagnosis of ADHD.[6]

v. Given that DHHR's draft operational definition includes other criteria in addition to diagnosis that indicate SED, such as CAFAS/PECFAS scores and utilization of other services, it seems that these other criteria would flag children intended for the target population.

g. Regarding changes over time, DHHR will need to propose if a child remains in the target population data set indefinitely, or if DHHR is proposing to refresh data based on an annual re-determination process. This decision will also have an impact on the evaluation and outcomes that can be understood over time.

3. The State will need to determine if it will propose a prospective test period for the operational definition of the target population, a retrospective look back based on available data, or some combination of both approaches when testing its draft operational definition. The SME recommends the following be included in its considerations:

a. If using a prospective approach, because the draft operational definition includes the utilization of certain services such as mobile crisis response, inpatient hospitalization, or emergency department visit for psychiatric reasons, DHHR will need to ensure that its processes to identify utilization of those services is timely. Given the 12-month claims lag that can occur, identification may need to rely on a real-time data source, such as authorizations or other real-time reporting sources specific to those services. Additionally, the State will need to consider coordinating its testing of the target population definition with its monitoring of potential operational barriers to the assessment pathway to ensure that the absence of a score for a child is not the result of a bureaucratic or operational barrier. This would also need to extend to oversight of access to behavioral health services, especially those services that are required to be present in the definition; specifically, children's mobile crisis response, acute inpatient, and ED visit for psychiatric reasons. Oversight of these potential operational barriers is a recommendation highlighted in the screening and assessment sections of the report in order that DHHR monitor its system to ensure that bureaucratic barriers do not prevent children from receiving CAFAS/PECFAS.

b. If using a retrospective approach, testing may be able to be achieved through a sampling of youth screened by primary care clinicians (PCCs) with both positive and negative results, past years' referrals to and utilization to the CSED Waiver, Medicaid claims data, BBH and BSS administrative data, data on families' decision to accept or decline an independent evaluation,

[6] https://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/

data from the 2019 SME ad hoc data report showing pre- and post-service utilizations for youth who had received residential interventions, CANS scores, out-of-home placements, inpatient admissions, and use of CMCR services.

c. The SME recognizes that the testing of the operational definition may need to occur in phases given the availability of data.

d. Regarding the timeline for a testing phase, DHHR will need to propose a reasonable timeframe in which to test its operational definition while expediting a final operational definition to align with the WVU evaluation timeline.

4. The State will need to decide how it will address the likely scenario that some families will decline to pursue the CSED eligibility determination process. Specifically, will the State propose an alternate pathway for identification in the class, such as use of a CANS score or service utilization patterns, such as inpatient admissions; or will it propose that if a family declines to participate in the CSED Waiver process, the family's decision precludes them from identification for the target population.

5. The SME notes that a primary diagnosis of SUD excludes a youth from the proposed at-risk target population definition. SAMHSAs definition of SED[7][8] also excludes substance use disorders but recommends co-occurring mental health and substance use conditions be included. As such, the SME recommends that the testing of this definition include a methodology that will capture any co-occurring substance use conditions. Specifically, that the presence of a primary diagnosis of SUD would not exclude a child from the target population if that child also had a mental health diagnosis from a different provider.

6. The State's approved amendment with Centers for Medicare and Medicaid Services (CMS) lists a CAFAS/PECFAS score OVER 90 as eligible for services; other materials presented 90 OR above. The State will need to clarify its intended scoring, and ensure all documents are consistent in language.

CSED Waiver

Activities

Initially, West Virginia's Children with Serious Emotional Disorder 1915(c) (CSED) Waiver was approved by CMS on December 19, 2019 and became effective March 1, 2020 for three years. Based on initial implementation, and in response to the work to implement the Agreement, the State sought an amendment to its original proposal in March 2021 and received approval from CMS on June 8, 2021. The State released its CSED Waiver policy manual for public comment reflecting changes in the approved amendment. Public comment on the manual was open until July 2, 2021. BMS plans to finalize the CSED Waiver policy manual by the end of the summer.

[7] https://www.samhsa.gov/find-help/disorders

[8] https://www.samhsa.gov/data/sites/default/files/SED%20Expert%20Panels%20Summary%20Report.pdf

The purpose of the amendment is to (1) expand the pool of evaluators for initial eligibility assessment to include WV Licensed Social Workers (LICSW), WV Licensed Professional Counselors (LPC), and WV supervised psychologists and change the name from Independent Psychologist Network to Independent Evaluator Network; (2) define that Electronic Visit Verification requirements are only for employees who go into a member's home to provide services; (3) change the name of the Case Manager to Wraparound Facilitator; (4) change the name and frequency of review of Person-Centered Service Plan to Plan of Care, though some instances of person-centered service planning language remain within the application, to align foundational training requirements for staffing for this waiver with other waivers; (5) remove some performance measures that were not necessary; (6) change the eligibility to reflect the statewide referral system, which conducts some screening and evaluations before the applicant is fully evaluated by the Independent Evaluator Network; (7) include rate increases for Wraparound Facilitation, In-home Family Support, Independent Living Skills and Peer Support effective 1/1/2021; (8) include rate increases for Mobile Crisis effective 7/1/2021; (9) include unit increases for Specialized Therapy and Assistive Equipment effective 7/1/2021; (10) change the Wraparound Facilitator case load from 1:20 to 1:15; (11) add the requirement for the Wraparound Facilitator to always be certified in the Children and Adolescent Needs (CANS) Assessment; (12) remove AMAP requirement as in-home CSEDW staff shall not administer medications; (13) change the language for the seven-day meeting and the 30-day meetings to be within 30 days of referral instead of intake; and (14) remove mention of the Statewide Settings Transition Plan (STP) since settings are not included as a service under the waiver.

As noted previously, the CSED Waiver includes an extensive list of services including Wraparound (called "case management" in the waiver), therapeutic services, independent living/skill-building, supported employment, job development, in- and out-of-home respite care, children's mobile crisis response (CMCR), non-medical transportation, parent peer support, in-home family therapy, in-home family support, assistive equipment, community transition, and other specialized therapies for children ages 3-17 with serious emotional disturbance and youth and young adults ages 18–21 with serious mental illness. The waiver continues to specify the unduplicated number of participants as 500 in year one, 1,000 in year two, and 2,000 in year three.

Medicaid waiver amendments are a time-consuming process. The SME notes the considerable work conducted by BMS, in partnership with other bureaus within DHHR, to address recommendations to improve waiver access, timelines, and services; negotiate these changes with federal CMS; and engage stakeholders in a public comment period.

Recommendations

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

1. In reviewing the draft CSED Waiver policy manual available for public comment, the SME notes some minor inconsistencies with the newly approved waiver amendment. These appear to reflect areas that were not updated from the first version of the manual. For example, page 40 of the manual continues

to state that Wraparound Facilitators' caseloads are capped at 1:20, while the approved amendment states 1:15, with DHHR previously indicating in verbal discussions that provider expectations would clearly message the NWI standard of 1:10. The SME supports that DHHR sought CMS approval for a ratio higher than NWI's to ensure that any unplanned overages would not result in a federal audit; however, the SME recommends that all provider expectations align with DHHR's commitment to NWI standards. Overall, the draft CSED Waiver policy manual reflects the changes in the amendment, but a few areas remain unchanged that are important expectations for providers. The SME recommends careful cross-walking and updating before the manual is finalized and released.

2. The CSED Waiver entertains service limits that have not yet been reached per the data available to date. The SME requests to review the standard operating procedure regarding how BMS is monitoring utilization. Specifically, BMS has indicated that additional units will be granted if determined medically necessary. The SME requests to review BMS's standard operating procedures for, e.g., how it communicates to providers that additional units beyond the caps can be sought, information required by the provider to be submitted for review, and how the State reviews these requests, along with the number of such requests received annually. Additionally, the CSED Waiver manual does not appear to address that providers can seek additional units beyond the stated caps or the process for doing so. This information may exist in another place and/or may be discussed in meetings with providers. The SME recommends that if this is the policy of BMS that it be reflected in the provider manual.

3. BMS has indicated "*Units will also be monitored closely for high utilization by the MCO who will report to BMS to best determine if the current services, provider and level of care are being provided efficiently and effectively.*"[9] The SME requests the SOP for how the MCO monitors the service utilization. Additionally, language indicates that BMS has asked its vendor to monitor overutilization. Given the needs of the population, and the limited available data, which indicates potential underutilization of services, the SME recommends that the MCO be tasked by BMS to monitor underutilization of Medicaid services for these children given their degree of complexity, the historical patterns of access challenges, and the reality that families eligible for/enrolled in the CSED Waiver may need extra support and extra engagement efforts to access services.

4. A previous SME recommendation indicated the need for BMS and its vendor to monitor youths' individual care plans to ensure individuation, as the initial services authorized appeared to be the same for most of the enrolled youth. Specifically, as more fully described in the Wraparound section, this remains a recommendation. The SME recommends that DHHR and its vendor develop an SOP to monitor that services are individualized to meet the needs of the youth and not a standard, one-size-fits-all approach. Additionally, the SME recommends that DHHR indicate in an SOP or other document how it monitors and provides oversight to these tasks that it may require of its vendor.

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[9]Retrieved from: https://dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx

Implementation of Services Required by the Agreement

Screening and Assessment

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

Screening Activities

Regarding screening, DHHR is implementing screening specific to each bureau (BSS, BMS with OMCHF, DCR, DOE), with each bureau using a different standardized screening tool and standard operating procedure. Additionally, BMS requires its managed care plans to perform certain screening-related activities.

BSS requires its workers to use the FAST, the Family Advocacy and Support Tool, which is the family version of the Child & Adolescent Needs and Strengths (CANS) tool also used by DHHR. BSS requires its workers to complete the FAST within 15 days for court-involved youth and 30 days for non-court involved youth per its youth services policy manual.

In addition, Youth Services, which is responsible for providing support services to youth and families referred by the court following juvenile offenses, amended its *Family Guide* to add a mental health statement, including clear notice about families' right to access mental health screening. DHHR and its vendor Aetna plan to disseminate the *Family Guide* this summer.

The Division of Corrections and Rehabilitation (DCR) requires use of the MAYSI-II. The newly formed DCR has not yet created formal policies specific to juvenile services at this time; DCR staff continue to follow former DJS policies that require the MAYSI-II to be completed on all youth within 72 hours of admission. The work plan notes that Probation has not yet finalized its mental health screening questions.

DHHR indicates that DOE follows requirements established for Health Check.

The Bureau of Medical Services has several requirements of its managed care organizations (MCOs) in its contract, including annual notification of screening due dates; outreach and education to providers, parents, and custodians; requirements that providers perform the screenings according to the State-determined periodicity schedule; referrals for treatment as determined by screenings immediately, with follow-up contact to ensure the enrollee receives a complete, appropriate evaluation; and referral and treatment tracking to ensure that screenings are completed for members and that members with identified needs through the screening are linked to medically necessary services.

BMS receives monthly reports from the MCOs on EPSDT screens. These reports are not specific to mental health (also include lead, dental) but do include categories for mental health screenings requested, mental health services approvals, and mental health services denials. These reporting categories are defined in the Bureau for Medical Services manual for Mountain Health Trust (MHT)

and Mountain Health Promise (MHP) titled *HealthCheck Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Quarterly Report Guide (April 2021).*

Only one of the four health plans is currently populating these mental health fields on the report, and the other MCOs have indicated challenges in collecting this data from providers. BMS is engaged in a CMS Learning Collaborative to improve its EPSDT screening rates; it plans to convene a meeting with the MCOs to discuss the challenges, learn from the approach used by the one MCO that is reporting the data, and determine action steps to ensure that all MCOs comply with this contract requirement. Additionally, consistent with a prior SME recommendation to attach a behavioral health modifier to existing screening claim codes in order to automate availability of behavioral health screening data, BMS and the Office of Maternal, Child, and Family Health (OMCHF) are assessing the ability to add modifiers within MMIS to indicate a positive or negative screen, and the timeline and actions steps needed. BMS indicates it will determine the viability of using modifiers in the fall.

OMCFH is conducting record reviews of the EPSDT behavioral health screening rates among primary care clinicians for Medicaid-eligible youth to monitor compliance in meeting HealthCheck requirements. OMCHF completed a detailed analysis of the behavioral health screening rates among primary care clinicians and developed a report named *Mental Health Screening in EPSDT: A Retrospective Analysis of Medical Records Linked to Administrative Claims December 31, 2020. (Note: This final report was not available for inclusion in the SME December 2020 report.)* OMCFH is employing a hybrid quality auditing process using claims data and clinical data from individual medical records to produce measures necessary to determine compliance with the Agreement. OMCFH used this sample to determine if psychosocial/behavioral screenings were delivered through (1) use of the PCL-C trauma screening questions on the HealthCheck form; (2) completion of both PHQ-2 depression screening questions on the HealthCheck form; and/or (3) addressing two or more psychosocial/social determinants of health during the encounter. A total of 713 records were analyzed; the results indicate that 82.3% of Medicaid members, ages 6-18 years, received a mental health screening at their EPSDT exam completed in calendar year 2019.

Based on this first review, OMCHF has initiated development of a quality improvement plan to improve its screening rates and address themes in the data, such as regional variations in screening rates. OMCHF indicates a final plan will be informed by discussions with primary care providers, stakeholders, and the Pediatric Medical Advisory Board (PMAB), a 28-member workgroup that advises OMCHF on HealthCheck matters. OMCHF also indicates that in addition to suggestions from primary care providers, stakeholders and the PMAB, quality improvement activities will include HealthCheck Program Specialists meeting with primary care providers about their own provider-specific data; sharing primary care blinded comparison data; and developing heat maps, new standard operating procedures (SOPs), and information packets about EPSDT and referral sources.

As described in this report, DHHR has proposed an assessment pathway to describe how children will be screened, assessed, and connected to DOJ Agreement and other services, with an emphasis to redirect from residential interventions and access home- and community-based services. Because the assessment pathway is currently designed to support children with complex needs, DHHR wanted to

develop a process to support primary care providers in differentiating likely high needs children from children with less behavioral health complexity, in order that PCCs would refer to one of two places—children with likely high needs would be referred to the assessment pathway and children with less complex needs would be referred to outpatient or other services. OMCHF drafted changes to its HealthCheck form to include additional behavioral health questions in an effort to support this differentiation. These new questions are an effort by DHHR to anticipate and prevent access issues; if every child with a positive behavioral health screen is directed to the newly planned assessment pathway, which is designed to access the CSED Waiver and other DOJ Agreement services, the referrals could exceed capacity, potentially resulting in children under the Agreement unable to receive care in a timely manner. The State wants to ensure that the target population with positive screens is identified and prioritized first. These additional questions were drawn from the CAFAS/PECFAS and would be used for persons ages 7- 20. These questions were also presented to and supported by the PMAB. OMCHF intends to develop and present to the PMAB for approval similar questions from the PECFAS for children ages 3-7.

Figure 2: HealthCheck form — Enhanced Indicators of Serious Disturbance, Ages 5–21 (adapted from CAFAS)

HealthCheck Enhanced Indicators of Serious Disturbance, Ages 5–21
Talks or repeatedly thinks about harming self, killing self, or wanting to die
Frequently mean to other people or animals
Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)
Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)
Frequent use of profane, vulgar, or curse words to household members
Deliberate damage to home
Frequently truant (i.e., approx. once every 2 weeks or for several consecutive days)
Marked changes in moods that are generally intense and abrupt
Friendships change to mostly substance users
Preoccupying cognitions or fantasies with bizarre, odd, or gross themes
Currently at risk of confinement because of frequent or serious violations of law
Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

Screening Recommendations

1. DHHR bureaus have selected their respective screening tools, and most bureaus have established written policies regarding the use of these tools. The SME recommends that DHHR develop a written plan and implement a process to monitor DHHR staff compliance with these bureau policies, including what data will be collected and what action steps DHHR will take based on the data to improve quality and compliance as needed.

   a. The SME recognizes that some practices are underway to monitor compliance, such as a random review of staff with documentation maintained on an Excel spreadsheet for some bureaus; the SME recommends scaling these types of efforts across all bureaus and with coordination in approach and consistency in data collected and timelines.
   b. The SME recommends that DCR formally update its policies from DJS now that it is part of DCR.
2. The SME recommends:

   a. A consistent set of data be collected across all bureaus, vendors, primary care clinicians, schools, and any other behavioral health screening entities/professionals, to ensure a comprehensive understanding of behavioral health screening rates in West Virginia. Specifically, the State should ensure that data are collected, how they are defined, timelines for collection, and the plan to identify and implement action steps to address data trends are consistent. The SME recognizes that the MCOs may collect more data than the bureaus, given their role, and that certain bureaus may collect additional data.

   b. A consistent set of data, methodologies, quality oversight and improvement approaches, and timelines across all bureaus and vendors in order that DHHR is able to provide a single, comprehensive presentation of behavioral health screening.

   c. Data across all bureaus, vendors, primary care clinicians, schools, and other behavioral health screening entities be consolidated into a single count of behavioral health screenings conducted, number of youth expected to be screened (e.g., number of youth in child welfare, number of youth with primary care visits, etc.), percent screened, number of positive screens, percent of positive screens, and number referred for behavioral health services and supports, percent referred for behavioral health services and supports, and, where possible, outcome of the referral (e.g., use of a behavioral health service).

   d. As part of the quality plan, report on areas for quality improvement and actions steps planned on an ongoing and regularly scheduled (versus ad hoc) basis.

   e. The State work with the SME to develop a mock-up of a screening data report.

3. OMCFH produced a valuable report from its record reviews of behavioral health screening rates. It addresses key policy and implementation issues, and provides a strong foundation for the State as it works to improve screening rates and quality of screenings. The SME acknowledges that OMCHF has not yet completed its quality improvement plan based on the report findings but has initiated activities to do so, indicating action is forthcoming this summer/fall. The SME commends OMCHF for committing to the development of a written quality improvement plan based on its findings, engaging in a transparent process with the PMAB to review and discuss the findings, as well as its plan to engage providers and other stakeholders similarly. A focused effort to use data, and transparency in engaging stakeholders to inform the data findings and action steps serves as a best practice approach for DHHR to model in other areas of the Agreement. The SME recommends that DHHR adopt a framework to guide quality improvement activities that is

similarly grounded in the gathering of information, analysis of qualitative and quantitative data, synthesis of policy implications, transparent engagement with stakeholders, and use of a quality improvement planning process with delineated action steps.

4. The SME acknowledges OCMHF's plans to conduct similar record reviews for populations ages 0-5 and 18–21. The SME recommends that DHHR provide its plan describing the timeline for completion of those reviews and any changes to the approach or methodology.

5. The SME notes OCMFH's thoughtful efforts to update the HealthCheck form to include additional screening questions from the CAFAS/PECFAS in an effort to help providers know where to refer a child (i.e., to the assessment pathway or to a behavioral health provider). Given that the questions added to HealthCheck were adapted questions taken from a standardized tool, the questions, used in this format and for this purpose, have not been tested. It will be important for DHHR to monitor whether the new HealthCheck questions support or hinder primary care providers to identify more complex behavioral health needs of youth and understand where to refer. The SME recommends DHHR propose its plan for assessing if these added questions help DHHR further identify the target population.

6. The SME recognizes the considerable work by the DHHR team to develop a Pathway to Care detailing the pathway from screening to assessment. The SME recognizes that the State has decided to maintain separate infrastructure and pathways for referrals for children who may have SED and for referrals for children with less complex behavioral health needs. The SME is concerned that this bifurcated approach may make tracking of children, and ensuring that they can access what they need, more difficult for DHHR to report and monitor. From a primary care provider perspective, it will be two different processes and approaches to getting access to behavioral health services that the provider will need to understand, remember, and establish in-house processes to track. Additionally, DHHR will need to ensure that the ease of using one of the pathways, particularly the ease of accessing a local behavioral health provider versus the assessment pathway, does not create a bureaucratic barrier to referring children from busy, under-resourced primary care clinicians. DHHR does not want to create a situation in which primary care defaults to referring to a local behavioral health provider with an assumption that the behavioral health provider will be better able to differentiate if the youth has a SED, as this process could unnecessarily delay access to needed services. When jurisdictions bifurcate their child behavioral health systems across SED and non-SED populations, monitoring of both the SED and non-SED population data AND referral pathways must occur to ensure that children are getting referred correctly and their behavioral health needs met. The SME recommends that the State's quality oversight plan address what data it will use and its approach to monitoring data for both the non-SED children and SED children, and their respective pathways.

7. The SME received a draft standard operating procedure document regarding EPSDT Referrals to the CSED Waiver. This SOP details how PCCs and others can refer children to the CSED Waiver. Consistent with the recommendation immediately preceding, the SME flags that this emphasis on children with SED and referrals to the CSED Waiver may inadvertently confuse primary care

providers on the process to refer children for behavioral health needs. The SME thinks it is necessary to develop a single SOP detailing how primary care referrals are made for behavioral health assessments and services with the planned details for how different referrals are handled. A single communication regarding referrals generally, with necessary details regarding different processes and locations that may receive these referrals (e.g., for children with likely SED, the Crisis line and for children with no SED indicators, the MCO or other source), will facilitate DHHR's aim to better support PCCs and ensure that children get access to needed behavioral health assessments as quickly as possible.

8. As OMCHF develops its quality improvement plan, the SME recommends the following items be included:
   a. The report indicates that, of 126 children/youth who did not receive a documented mental health screening at their EPSDT exam, 11 were already receiving mental health services. It will be important for the State to develop a policy and action steps to remedy in a timely way children who did not receive required screens and to determine if there are any trends in who is not screened, including by which providers or by regions of the state. For children who may be engaged in mental health services already, the State should clarify its policy on how the behavioral health screening requirement further informs any services those children are receiving.
   b. It will be important for the State to examine which populations of children are not seen by primary care, and therefore would not be captured by this data set. Efforts to identify populations of children not receiving behavioral screens is an important activity to reflect in the plan, as well as development of a plan to identify, quantify, and track this population. Specifically, the State will need to work with schools, consistent with recommendation two, to ensure it reaches populations of children covered under the Agreement who may not present to primary care.
   c. The State should address variations in screening rates by age of youth, noting that older adolescents receive fewer behavioral health screens than younger children.
   d. The State should address regional differences in screening rates, as well as any differences by type of provider (e.g., providers with larger panels or across different primary care disciplines).
   e. The State should track that children with positive screens accessed care.

9. Given the need for data from its MCOs, the SME recommends that the State move forward with adding modifiers to its EPSDT reporting system to capture this data. It will take considerable time to build the data source infrastructure to capture that data. As themed throughout this report, it is essential that DHHR implement more real-time data to report on and monitor its compliance with the Agreement.

Assessment Agreement Requirements: The Agreement requires the State to use the CANS tool (or a similar tool approved by both parties) to assist child and family teams (CFTs) in the development of ISPs for each child who has been identified as needing HCBS. It further requires a qualified individual to conduct an assessment of the child's needs and strengths with the CANS (or agreed upon tool) and

for the State to report on changes in functional ability of children in the population of focus, both statewide and by region, including data from the CANS assessment.

Assessment Activities

As part of the assessment pathway, DHHR has decided to use an additional standardized assessment tool, in addition to the CANS. The CAFAS, Child and Adolescent Functional Assessment Scale for children ages 7-20, and the PECFAS, Preschool and Early Childhood Functional Assessment Scale, for youth aged 3–6, will be collected as part of the CSED Waiver eligibility determination. Referrals for the CSED Waiver are made to KEPRO, who will conduct the CAFAS/PECFAS telephonically with families to determine if a child should be further referred to a CSED Waiver independent evaluator. If a child receives a score of 90 or above, KEPRO will assist the family to schedule an appointment with an independent evaluator. If the child scores below 90, KEPRO will assist the family to find other services. Additionally, DHHR has proposed use of the scores from the CAFAS/PECFAS to determine if a child meets the defined class of children under the DOJ Agreement target population definition. Please see the Target Population section on page 7 for additional information regarding target population definition.

Assessment Recommendations

1. With DHHR's decision to use the CAFAS/PECFAS assessment tool in addition to the CANS, the SME recommends that the State provide written clarity to its bureaus, vendors, and providers regarding the relationship between these two instruments, the purpose for each tool, and how information from each will be incorporated into the use of the other instrument, and how any conflicting information will be resolved between the two instruments.

2. The SME recommends that all assessment Agreement requirements be required of the CAFAS/PECFAS; specifically, the SME recommends that DHHR establish requirements in its contracts, operating procedures, and other documents standards for the CAFAS/PECFAS on par with the CANS, including provider qualifications, training requirements for qualified individuals and its quality oversight; and that the State report on the number of youth receiving CAFAS/PECFAS initially, and through any re-determination process, as well as the functional scores derived from the CAFAS/PECFAS consistent with the data planned for the CANS.

3. The SME recommends that caregiver and youth self-report measures that allow a youth and caregiver to directly report their needs (i.e., SDQ, Ohio Scales, or CIS) be included in the assessment process, particularly for Wraparound. Self- and caregiver-report measures provide a second indicator of need; these would allow DHHR to quantify and communicate needs identified by families, and further ensure decision-making process and services align with the family's identified needs.

4. Consistent with a prior report's recommendations, the SME recommends that this workgroup partner with Marshall University as it continues to support use of CANS as part of behavioral health assessments, including efforts for consistent training and coaching to ensure CANS is delivered by a qualified assessor.

5. The SME recommends that the work plan be updated to reflect the considerable tasks specific to the assessment pathway that are not yet captured in the work plan, including timelines, owners, and interdependencies with other workgroup activities.

6. The SME recommends that DHHR begin reporting CANS data, including the number of assessments using the CANS and changes in functioning ability noted in subsequent re-administrations, per requirements in the Agreement.

Wraparound Facilitation

Agreement Requirements: The Agreement requires the State to ensure statewide access for each child identified as needing in-home and community-based mental health services, with a child and family team (CFT) managing the care of each child. Further, the Agreement requires that each CFT operate with high fidelity to the National Wraparound Initiative's (NWI) model and use the Child and Adolescent Needs and Strengths (CANS) assessment or other assessment tool to develop an individualized service plan (ISP). Additionally, for any child who has a multidisciplinary treatment team (MDT), the screening and assessment and ISP must be made available to the MDT.

Activities

Presently, Wraparound is offered by three separate programs operated by each bureau—the Bureau of Social Services (BSS) operates Safe at Home (SAH), the Bureau for Behavioral Health (BBH) operates Children's Mental Health Wraparound, and the Bureau for Medical Services (BMS) operates the CSED Waiver in which Wraparound (called "case management" in the waiver) is provided. Historically, each bureau's programs have operated separately and have evolved differences in service definition, provider expectations, provider networks, tasks, required timelines, data, and reporting. As summarized in the December 2020 SME report, DHHR indicated plans to combine CSED Waiver Wraparound and BBH Wraparound into a single unified approach called West Virginia Wraparound. West Virginia Wraparound would provide Wraparound to children with SED per the Agreement or children needing Wraparound that were not Medicaid-eligible; the SAH program would be specific to BSS's family stabilizations services and work with child-welfare involved youth who did not have SED. DHHR has conveyed updates in meetings with the SME about efforts to draft common language for provider manuals, plans for shared training and joint technical assistance to providers, and intent to require a common provider network; no documented progress has been shared with the SME at time of this report.

Regarding the Agreement requirement ensuring statewide access to a child and family team and use of a standard assessment tool, as noted on page 17, DHHR engaged in considerable activities to develop an assessment pathway for youth to access DOJ Agreement services, support redirection from residential placements, and ensure use of standardized behavioral health assessment tools. The assessment pathway describes how the system will carry out certain decision points to determine a child's needs, and continue "moving" them through a path of other decision points until service needs, funding availability, and family/youth choice are determined. Development of the assessment pathway, and engagement with the SME for SME feedback coincided with the timing of this report; as

such, significant items remain to be clarified for the SME regarding how the assessment pathway will facilitate compliance with the Agreement, including use of the CAFAS/PECFAS, how the CAFAS/PECFAS coordinates with CANS, the use of a bifurcated approach to the role of KEPRO and BBH, use of interim services while CSED waiver eligibility occurs, and ensuring that any interim services initiated do not result in a change in provider once CSED Waiver eligibility is determined.

DHHR has developed its assessment pathway in a way that would allow the State to initiate services funded by BBH while the family completes the approximately three-week CSED Waiver eligibility determination process. These *interim services* would include Wraparound, parent peer support, in-home therapy and other services. At time of this report, DHHR was still working through the scope and role for interim services and operational challenges, such as how to provide interim services while ensuring minimal disruptions to the youth and family so that a family would not need to change providers following the CSED Waiver eligibility decision, as well as how to ensure that families could realistically engage in both an assessment process with an IEN for the waiver and similar assessment activities with an interim services provider at the same time. Additionally, as noted on pages 12–13, DHHR completed considerable activities to revise certain policies and procedures and amend the CSED Waiver with federal CMS.

The following paragraphs present data supplied by the State to the SME. The reader will note that the data differs depending on the data source cited, resulting in an inability to connect the findings across the data tables. The SME presents the data as provided by DHHR with citations as to its source and provides recommendations for development of a coordinated data approach in the future.

Regarding applications for the waiver, according to data provided in an email to the SME on July 16th, the State had received 609 total applications for the 1915(c) CSED Waiver through June 30, 2021, of which 38 were resubmissions. Data provided in an email on July 16th from DHHR is summarized in Table 1.

Table 1: CSED Waiver Applications by Age March 2020–June 2021

Age	Applications	Re-applications	Percentage by age^
3	3	0	0.5%
4	8	0	1.3%
5	11	0	1.8%
6	17	0	2.8%
7	10	1	1.6%
8	21	0	3.4%
9	32	5	5.3%
10	31	2	5.1%
11	43	11	7.1%
12	43	4	7.1%
13	49	1	8.0%
14	57	3	9.4%
15	74	4	12.2%
16	70	2	11.5%
17	74	5	12.2%
18	46	0	7.6%
19	14	0	2.3%
20	2	0	0.3%
21	4	0	0.7%
TOTAL	609	38	100%

^Percentages total greater than 100% due to rounding.

Table 2 below summarizes data provided in an email on July 6th and indicates that of the 609 applications, 109 were denied CSED Waiver eligibility with the following reasons indicated:

Table 2: CSED Waiver Denials from March 1, 2020–July 2, 2021

CSED Waiver Denial Categories	Number	Percent
No eligible diagnosis	26	23.9%
Score on BASC did not meet criteria	20	18.3%
Score on PECFAS/CAFAS did not meet criteria	28	25.7%
Score on both the BASC and CAFS/PECFAS did not meet criteria	28	25.7%
Primary Diagnosis was Intellectual Disability or Autism Spectrum Disorder	5	4.6%
Evaluation process was not completed by the family	2*	1.8%
TOTAL	**109**	**100%**

*Both youth re-applied and were approved

Regarding youth approved for the waiver, the SME received an Excel document titled *CSED Waiver Claims Data through June 30, 2021* with a tab for a separate spreadsheet titled *Roster by Age group* indicating that 190 youth are enrolled.

Data on service authorizations provided through June 2021 in an Excel spreadsheet titled *Aetna CSED Waiver Services Review through June 30, 2021* indicate that 116 children have services authorized. The Excel spreadsheet provides text fields with redacted data listing services requested and services authorized by redacted member by age.

Data from an Excel spreadsheet titled *CSED Waiver Participant Trend*, with data available for April and May 2021, indicates that 160 applications were closed, with 65 still in the evaluation stage, 9 still selecting a provider, 42 members services on hold, and 28 discharged.

Regarding waiver providers, the number of approved providers in June 2021 remains the same as it was in July 2020, with 23 providers approved to provide CSED services, and with utilization data indicating only 12 providers are providing services.

Current data on the utilization of Wraparound through the CSED Waiver, as well as utilization of other CSED Waiver services, are summarized below. Table 3 below summarizes the paid claims from March 2020 through April 2021. For the 13-month period, a total of 3,433 units of service equaling nearly 845 hours was provided to 190 youth.

Table 3: CSED Paid Claims by Age Group and CPT Code from March 1, 2020–June 30, 2021

	Ages 3–5	Ages 6–9	Ages 10–14	Ages 15–18	Ages >18	Total units	Total hours of service
Member Count (Total = 190)	11	38	85	54	2	—	—
A0160-HA: Non-Medical Transportation^	1	33	12	—	—	**46**	^
H0004-HA: In-Home Family Support	42	161	354	142	14	**713**	**178.25**
H0004-HO-HA: In-Home Family Therapy	74	368	675	318	63	**1498**	**374.5**
H0038-HA Peer Parent Support	15	23	60	13	—	**111**	**27.75**
H2017-HA: Mobile Response	—	8	24	15	—	**47**	**11.75**
T1016-HA: Case Management/Wraparound Facilitation	92	214	424	214	5	**949**	**237.25**
T2038-HA: Community Transition*	—	—	—	3	—	**3**	*
T1005-HA-HE: Respite Care – Out-of-Home	—	17	2	—	—	**19**	**4.75**
T2035-HA: Assistive Equipment*	1	—	2	2	—	**5**	*
T1005-HA: Respite Care – In-Home	—	29	11	—	—	**40**	**10**
G0176-HA: Specialized Therapy	1	—	—	—	—	**1**	*
T2019-HA: Supported Employment, Individual	—	—	1**	—	—	**1**	**0.25**
TOTAL	**226**	**853**	**1,565**	**707**	**82**	**3433**	**844.5**

Please note: Providers have twelve months from date of service to submit a claim. All services listed above are paid in 15-minute increments unless otherwise noted.
^Billed in units of one mile.
*Billed in units of $1.00.
**According to the CSED Waiver Provider manual, this service is authorized for youth aged 18 or older.

In addition to CSED Waiver-funded services, including Wraparound, as discussed above, Table 4 below summarizes BBH-funded Wraparound services. Data below were provided in a Word document from BBH titled *CMHW Application Data June 2020–June 2021.*

Table 4: CMHW Application Data (BBH) June 2020–June 2021

Age Range	Applications	Approved	Denied	Discharged/ Withdrew	Graduated
0–5	11	8	3	0	0
6–12	167	112	55	10	0
13–17	165	113	52	21	3
18–21	17	6	3	1	1
TOTAL	**360**	**239**	**113**	**32**	**4**

Data indicate that youth and/or families withdrew for a myriad of reasons, including out-of-home placement, seeking other services, or other reasons not captured in the data set. Interestingly, the data indicate that only one BBH Wraparound youth was enrolled in the CSED Waiver. This might be because BBH Wraparound is serving a different population of youth, or that BBH providers may not also be CSED Waiver providers, or that data collection and reporting systems are not flagging this item consistently.

Regarding the Agreement requirement to ensure fidelity of Wraparound to NWI, DHHR via BBH contracted with Marshall University, from June 1, 2021–September 29, 2021, to develop a West Virginia Behavioral Health Workforce and Disparities Training Center with the following goals:

- Develop and implement a comprehensive training and technical assistance system for Wraparound and Mobile Response service administrators and providers.
- In collaboration with the University of Maryland Institute for Innovation & Implementation and WVDHHR, develop and implement certification processes and fidelity tools to ensure Wraparound and Mobile Response providers are skilled and performing services with fidelity to national models and standards.
- Collect and analyze data to evaluate the effectiveness of the training system.
- Build in-state capacity to sustain and improve the comprehensive training system, which may expand to include training and fidelity measures for other community-based behavioral health services.

This initial contract period with Marshall University through September coincides with available federal funding. DHHR intends to continue its contract with Marshall University post-September with no interruptions in contract periods via other funding sources. At time of this report, the center was identifying its training needs, selecting potential trainers, and initiating contracts for future training.

Recommendations

1. The SME recommends that the State monitor applications and enrollment by age groups (see Table 4 as an example) to both ensure that eligible groups ages 3-21 are represented, but also to ensure that the CSED Waiver enrollment aligns with the age trends seen in the residential

placement data and for youth deemed at risk to ensure that waiver is diverting those youth and supporting their success in the community.

2. DHHR shared an Excel spreadsheet titled *CSED Waiver Participation Trend*. DHHR appears to be tracking some important elements to the CSED Waiver process, as indicated by rows in this spreadsheet. The SME recommends that this data, along with other data, be presented on a consistent basis to the SME and DOJ. The SME notes that DHHR has been regularly reporting certain data points, such as applications received, numbers enrolled, and numbers discharged; a coordinated, comprehensive view based on the other available data points provides actionable information to inform DHHR's priorities and provides a clearer picture of CSED Waiver activity. For example, the SME notes that denial reasons are gathered in this Excel spreadsheet. The SME recommends that ongoing monitoring of the denial reasons may help inform the target population operational definition test period (discussed on pages 11–12, shape training and education to independent evaluators, inform possible changes to the CSED Waiver process or requirements, and serve as an important oversight activity for DHHR as it strives to ensure quality and access).

3. As the SME reviewed the various CSED Waiver data provided by DHHR, the SME noted that data comes from multiple sources and is housed in different ways. The SME understands that this is due to different data coming from different processes, such as some things reported by KEPRO and other items gathered by BMS. DHHR is gathering useful data that can assist with oversight. But because the data are in various formats, managed by various people, and not consolidated in one location, the ability of DHHR to analyze and synthesize the data in a comprehensive way and to communicate the data trends to support the work of other workgroups that could benefit from understanding this data is impeded. Additionally, several of the reports provided were for different time periods, making it difficult to draw conclusions from the data. Given the various Excel spreadsheets, data points, and timelines, DHHR is hindered in drawing comprehensive conclusions about what is happening, making its efforts to ensure quality and access more difficult. The SME recommends that DHHR develop a coordinated suite of reports that are routinely analyzed and synthesized for oversight and decision-making. The SME is available to provide technical assistance as DHHR develops a coordinated suite of reports, a plan with a clear timeline, mock-ups of the reports needed, and its strategies for using the data to support DHHR's oversight.

4. The SME recommends that this comprehensive suite of reports be shared across the DOJ Agreement workgroups, as these data trends inform key issues that other workgroups are addressing, such as the assessment pathway, how services meet the needs of children, residential models of care and how residential interventions are part of the home and community-based service array, training of providers, and access to other needed behavioral health and social services.

5. The SME reviewed an Excel spreadsheet titled *Aetna CSEDW Service Review Through June 30th*, which is a redacted report showing services requested and services authorized. Gathering this type of information is an important quality oversight practice, and the SME understands that Aetna

reviews this information as part of its ASO quality oversight role. Given the narrative fields, the SME notes that it is difficult to draw conclusions for the population served, as comparisons across what was requested versus what is received can't be easily concluded. It is also challenging to understand in the current format how services are individualized to each child. The SME recommends that DHHR build from this foundation to create a report allowing for more quantifiable data that can be analyzed and reportable on an ongoing basis. Given DHHR's plan to review individual care plans as part of its quality oversight and Wraparound fidelity reviews to ensure NWI standards, which includes individuation of each plan of care for each child, this type of data would be used to support fidelity efforts to ensure that services are individualized to the youth and family. Additionally, data stratified by providers will support DHHR's quality oversight, inform an understanding of system strengths, and identify challenges that require training, support, or policy revisions.

6. Recognizing that West Virginia is still in the process of creating one common approach to Wraparound, the data provided by BBH regarding its BBH-funded Wraparound provide a helpful snapshot of other Wraparound service provision, in addition to the reported CSED Waiver data. Consistent with other data recommendations made throughout this report, the SME recommends that DHHR report this data in a combined way, across CSED Waiver and BBH-funded Wraparound, to facilitate an understanding of what is happening specific to Wraparound for enrolled children and consistent with its intent to create a single unified Wraparound approach. The SME recognizes that the extensiveness of the CSED Waiver data points may not be available to report for BBH-funded Wraparound services, which is undergoing plans to move to an electronic data system, but the SME recommends that DHHR coordinate its reporting on Wraparound across its different funding sources for certain categories that align with its assessment pathway, such as requests for services, recipients of services, and discharges. In addition to examining BBH data alongside CSED Waiver Wraparound data, the SME recommends that this combined data also be shared across workgroups to inform related tasks.

7. As DHHR considers offering interim services to children via BBH while a child completes the CSED Waiver eligibility process, the SME recommends that DHHR consider consolidating its approach to minimizing the bifurcated approach across BBH and KEPRO, that DHHR clarify what will be offered periodically in order to avoid a change in provider or services offered once CSED Waiver eligibility is known. Since KEPRO is completing the CAFAS/PECFAS immediately upon referral to the CSED Waiver, it would appear BBH could incorporate that CAFAS/PECFAS score into its planning. Alternatively, KEPRO could be charged with initiating an interim service plan on behalf of BBH.

8. As BBH serves a broader population that may fall outside the DOJ Agreement target population, further analysis is needed to understand how youth receiving BBH-funded Wraparound fit with the DOJ Agreement target population. Interestingly, the data indicated that only one BBH Wraparound youth was enrolled in the CSED Waiver. Some of the youth served by BBH Wraparound may not be Medicaid-eligible, BBH providers may not also be CSED Waiver providers so those youth and families are continuing to be served by providers they already have a relationship with, or data collection and reporting systems are not flagging this item. It will be

important for DHHR to understand if this data indicate that a number of BBH-funded providers cannot become Medicaid providers, or decline to do so, as that understanding will inform capacity assessment and workforce-related activities. If this data indicate that BBH is serving a population that is different from the waiver population, then that will inform system-wide capacity building efforts, as DHHR will need to ensure sufficient provider capacity and access for the DOJ Agreement population, while ensuring that it continues to provide needed services to all West Virginia youth. DHHR will need to ensure that its ongoing assessment of its provider capacity is consistent with the demand for services for both the Agreement population and the broader population of West Virginia youth it serves.

9. The SME notes receipt of a report titled *CSED Waiver Member Count by County* with data through March. These are helpful data, and the SME is pleased to see DHHR's development of a count by county. Consistent with prior recommendations above, the SME recommends that this type of data be reported as part of a coordinated suite of data with similar methodologies and timelines in order to provide a comprehensive understanding of Wraparound's reach in the communities across West Virginia.

10. The DOJ Agreement requires availability of in-home therapy services (provision 37.c). Discussions between the parties have occurred regarding the scope of that provision. The SME notes that the CSED Waiver data reflect more units of this service (in-home therapy) provided than for any other service. This is consistent with other states' data regarding service utilization. This may be the result of youth's identified needs, service availability for in-home family therapy being more extensively available than Wraparound prior to the CSED Waiver's start, more providers available to deliver in-home therapy services, or reimbursement rates and differential costs to provide those services. Given the amount of this service that is occurring, and the importance of intensive in-home family therapy approaches to support children in the community, the SME recommends further analysis including:

    a. An understanding of the needs of youth receiving in-home family therapy and in-home family support;

    b. Clarity on the approaches or models providers are using to meet those needs, including if models are consistent with intensive in-home family therapy models or more consistent with individual therapy with the child that happens to be occurring in the home; and

    c. Identification of opportunities for DHHR to strengthen provision of this important service, including clarifying what it does/does not want to purchase, training approaches to support its desired best practices, and ensuring that reimbursement rates and policies support effective delivery of this service.

Intensive in-home family therapy models are highly effective interventions to support improved outcomes for children. Given DHHR's history of deferring to providers on what providers want to offer versus consistently articulating what it wants to buy, this is an opportunity for DHHR to

define these important approaches, ensure children have access to the most effective services, and further support its goals.

11. As DHHR develops its suite of reports, the SME recommends inclusion of other state plan services, such as outpatient therapy and inpatient, in order to understand how Wraparound is activating all services available to youth and the scope of service provision happening. Regardless of data source, the SME recommends that DHHR track and report on lengths of stay, readmissions, age, and concurrent service utilization of all children receiving Wraparound. The SME recommends, as with other reports, that this be a coordinated report across payers with consistency in how data are reported from those two bureaus.

12. CSED Waiver data indicate that the State's planned enrollment in the CSED Waiver of 500 youth in year one and 1,000 youth in year two has not been reached. Current CSED data show paid claims but does not include the numbers of youth associated with claims. Additionally, service mix (the types of services being used by youth) is difficult to determine. Monitoring of what is happening requires real-time data. It will be important to determine if ongoing monitoring of data can continue to rely exclusively on claims data, or whether the State will need to use other sources, such as authorizations or the development of provider reporting requirements. While providers have up to 12 months to submit claims, understanding the claims completion rate within one month or three months can help inform data sources that will need to be used. Regardless of source—whether claims, authorizations, provider reported data, or some combination—the SME recommends that the DHHR engage in further development of data to understand the service intensity and service mix. Additionally, Plan of Care (POC) reviews or some method to track informal and community supports are helpful to capture the totality of what families find helpful to address their needs. Developing a way to track and monitor inclusion of those strategies on a POC can aid systems in building meaningful service arrays inclusive of non-traditional supports. The SME is available to provide technical assistance to support DHHR's efforts.

13. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks.

Children's Mobile Crisis Response

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

Activities

The State has begun implementation of this Agreement service in two ways: through BBH's AFA for Children's Mobile Crisis Response and Stabilization that will service Medicaid and non-Medicaid populations and through BMS's CSED Waiver for Medicaid children who are waiver-enrolled.

Regarding CMCR services, the SME received a Word document from BBH *titled Mobile Crisis Charts January to May 2021* summarizing crisis calls received by each regions' CMCR provider, CMCR services provided by telephone and CMCR services provided in person. Table 5 details that a total of 1,168 calls were received by CMCR providers, 510 CMCR services provided by phone, 666 provided in person, and 19 included law enforcement.

Table 5: BBH-Reported CMCR Services from January Through May 2021

Region	Total number crisis calls	CMCR services provided by phone*	CMCR services provided in person	Total by law enforcement
Region 1	36	25^	19	0
Region 2	4	4	0	0
Region 3	13	5	8	2
Region 4	587	136	461	12
Region 5	375	197	145	2
Region 6	153	143	33	3
Total	**1,168**	**510**	**666**	**19**

^Includes six calls for region 2.

*These data reflect all calls to the mobile crisis provider and includes multiple calls by same individual. Data were tallied only through May as June reports are not due until June 25, and some but not all agencies have reported monthly data.

In addition, the State is implementing mobile crisis services through BMS's CSED Waiver. As noted in the previous section on page 23, 47 units of CMCR were provided via the waiver (See Table 3).

The SME received an Excel spreadsheet titled *CMCR Referral Line Monthly Vendor Report* with separate tabs for months January–May 2021. The vendor for the call center, First Choice, operates multiple call lines for the State. The data provided to the SME are a subset of its larger report and are based on calls related to behavioral health for persons under age 21. Given that the Children's Crisis and Referral Line provides a single, coordinated number for multiple needs, including connection to CMCR services, and information regarding behavioral health, the information in this spreadsheet is varied and broad. For each month, there are upwards of 200 entries, showing multiple counts indicating a total of 1,500 calls related to behavioral health for persons under 21 with various text fields indicating need, age, and referral.

In addition to operating the call center, the Children's Crisis and Referral Line is charged with outreach to the community to increase awareness of the Children's Crisis and Referral Line. A PowerPoint was shared with the SME titled *FirstChoice CMCR Marketing and Outreach*, which shows a thorough approach to increasing awareness and use of the line. Additionally, an email was shared with the SME, indicating that the vendor reached out to 17 different organizations during this reporting period per their outreach and education plan.

BBH also supplied the SME with meeting minutes detailing its monthly meetings with CMCR providers to provide technical assistance, identify challenges, and promote shared learning. Additionally, as the Region 2 provider is now in place, BBH has engaged in specific technical assistance and peer-to-peer learning for this new provider in an effort to help the provider with administrative and service delivery practices.

As part of materials submitted to the SME in June for this report, BBH provided a draft CMCR provider manual describing expectations, policies, data indicators, and required reporting. In addition, the State's BBH is actively engaged in ongoing training and technical assistance discussions with providers through regular meetings with providers.

Finally, the State has worked to differentiate the functions of TFC agencies from CMCR providers with an initial draft TFC model indicating when a CMCR provider would be contacted to support a child and TFC parent when a child is experiencing a behavioral health crisis. While the State has reached its decision that youth and families involved with TFC will also have access to CMCR services, the SME looks forward to reviewing both the CMCR provider manual and the TFC program manual regarding how this decision is operationalized.

Finally, as indicated in the Wraparound service section, through Marshall University, DHHR is contracting for the provision of training to support the CMCR service including the following goals:

- Develop and implement a comprehensive training and technical assistance system for Wraparound and Mobile Response service administrators and providers.
- In collaboration with the University of Maryland Institute for Innovation & Implementation's National Wraparound Implementation Center and DHHR, develop and implement certification processes and fidelity tools to ensure Wraparound and Mobile Response providers are skilled and performing services with fidelity to national models and standards.
- Collect and analyze data to evaluate the effectiveness of the training system.
- Build in-state capacity to sustain and improve the comprehensive training system, which may expand to include training and fidelity measures for other community-based behavioral health services.

Recommendations

1. Consistent with recommendations for Wraparound, the SME recommends that a single, coordinated CMCR service be available in West Virginia instead of two separately operated and contracted services for different populations. Recognizing that the funding source may differ for certain populations, a single coordinated approach can still be achieved while leveraging different funding sources for different populations.

2. Consistent with data recommendations listed in the Wraparound section, the SME has similar recommendations specific to CMCR. Because CMCR is funded by different agencies, with different types of information available, it is difficult to have a comprehensive understanding of CMCR services happening. The SME recommends that DHHR coordinate its reporting to have a comprehensive picture of what is happening in West Virginia. The SME is available to provide technical assistance to support DHHR's development of CMCR reports that include CMCR utilization by region, length of CMCR engagement, and presenting needs, with additional stratification by age and other factors. The SME recommends that DHHR work with SME to develop a mock-up of reports.

3. The SME notes that the FirstChoice call center Excel spreadsheet provides a lot of useful data about the scope of calls received, the needs indicated during the calls, and the services children and families are connected to, including CMCR and other services. This type of information can be enormously helpful, and the SME is pleased to see the effort in trying to gather it. Because this information is in text fields with myriad choices, some that could likely be collapsed into fewer options, it is difficult to analyze this data, draw conclusions, and determine actions steps. The SME recommends that DHHR build from this foundation and create a quantifiable report that can provide a clearer understanding of the number of calls received, the type of need, which services were connected to (especially CMCR and Wraparound), how the call was resolved, and if follow-up to an initial call occurred.

4. The SME notes the efforts by First Choice to conduct outreach and trainings about the Children's Crisis and Referral Line and its continued planned approach for ongoing engagement with community providers and stakeholders. The SME recommends that this data be incorporated into a coordinated suite of reports specific to CMCR, consistent with other data recommendations in this report. It is also recommended that DHHR ensure that the First Choice activities and priorities include both a statewide and regional focus and that their outreach and education activities are informed by the data. For example, region 4 had higher rates of engagement with law enforcement, and all regions except 1 and 2 reporting some law enforcement involvement. Outreach and education materials submitted to the SME for this report did not indicate law enforcement as a recipient of outreach.

5. Review of the BBH-reported CMCR data leads to questions about differences in activity for regions 1,2,3 that reported low CMCR activity compared with regions 4, 5, and 6 with much higher reported activity and the high use of CMCR services provided telephonically in some regions. Specific to regional variation, in addition to the roll-out issues described in region 1, regions 2 and 3 also show

low utilization. A data synthesis from DHHR is needed to understand the reasons for the regional variation, and DHHR quality oversight activities. Specific to telephonic services, the SME recognizes that these data reflect COVID-19 safety measures, which resulted in an increase in telehealth for all services. The SME recommends further analysis and monitoring to determine if numbers provided telephonically were in response to COVID-19, or are reflective of, for example, differences across providers in their practice of CMCR, capacity issues and inability to travel onsite within 60 minutes, families' requests/choice, or are scheduled follow-up check-in calls from previous in-person CMCR services. This analysis could inform training needs, challenges to meeting performance expectations, access issues, and best practices.

6. DHRR submitted a draft CMCR Provider Manual to the SME on June 30th that details its expectations for delivering the CMCR service. Because the draft manual was submitted June 30th, and has not yet been discussed between the SME and DHHR, the SME acknowledges receipt and recommends that next steps include review and comment by the SME, and discussions between the SME and DHH about its manual.

7. The SME notes DHHR's plan through Marshall University to develop a training and coaching approach for CMCR. The SME looks forward to receiving the deliverables for review, including the training plan, proposed timeline, approach, and training content. The SME recommends CMCR training include an overview of all DOJ Agreement services and all other behavioral health services funded by DHHR; how CMCR services work with other services, schools, BSS caseworkers, MCOs/ASO, and the FirstChoice crisis and referral line; use of any standardized tools such as the CANS, CAFAS/PECFAS, the Crisis Assessment Tool (CAT), etc; expected outreach and education efforts; and required quality, outcomes, and data reporting.

8. In addition to the statewide, standardized training for CMCR that will be provided through Marshall University, current scopes of work require each CMCR provider agency to offer its own training on related topics. If there are training content requirements that DHHR has for agencies above and beyond a provider's completion of the statewide Marshall University training, and DHHR is not providing the standardized curriculum for those trainings, the SME recommends that the State review and approve the training content(s) offered by each provider agency. Although this step would add to the administrative burden for State staff, it would ensure consistency in training elements across the State and expedite the introduction of new materials or competencies that the State deems necessary.

9. Consistent with other data recommendations in this report, the SME recommends that the State incorporate CMCR data into its other workgroups to inform interconnected tasks and decision points, such as the assessment pathway work, redirection from residential interventions, and coordination with Wraparound.

10. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks.

Behavioral Support Services

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

Activities

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

BBH has engaged two different contractors to support the work of BBS. As mentioned in prior SME reports, the State has contracted with West Virginia University (WVU) Center for Excellence in Disabilities (CED) Positive Behavior Support (PBS) Program to:

- provide PBS services directly to children; and
- provide consultations to providers of other services on how to incorporate a behavioral support plan into their services (e.g., outpatient, wraparound, CMCR).

As described in CED's contract with BBH, the CED PBS Program focuses on providing prevention and intervention supports for individuals who are demonstrating significant maladaptive behaviors; at risk of out-of-home placement or involuntary commitment at a psychiatric hospital or psychiatric residential treatment facility (PRTF); or ready to return to the community from an out-of-home placement.

Initially the CED PBS Program was also providing some limited workforce capacity training. BBH has expanded the breadth of training by contracting with Concord University to develop the Collaborative Center for Positive Behavioral Support Education Program to provide comprehensive workforce training and coaching on PBS approaches, and coordination of certification for providers. BBH entered into a contract with Concord University effective July 1, 2021.

In addition to these training-related activities, BMS is in the process of identifying modifiers to attach to existing billing codes in order to differentiate behavioral support services from other similar services already available in the State plan. BMS is in the process of drafting related changes to its provider billing guide.

BBH provided the SME with five Excel spreadsheets, for months January–May, titled *PBS Report 2021.* Each month had two tabs, one tracking client services and the second tab tracking technical assistance and training. Based on this data, the SME prepared Table 6 below indicating an average of 32 clients each month receiving services by CED and an average of 39 consultations related to the needs of other youth reaching approximately 103 professionals per month.

Table 6: PBS Service Provision and Consultation

	CED Direct Services to Youth^ Number of youth who received direct services through the PBS program	**CED Consultation to Providers** Individual family/youth consultations to facilitate success in home and community settings
Jan 2021	30 youth	103 professionals/38 youth
Feb 2021	27 youth	57 professionals/24 youth
Mar 2021	25 youth	163 professionals/57 youth
April 2021	38 youth	122 professionals/46 youth
May 2021	42 youth	69 professionals/29 youth

^Note: These figures were compiled from raw data provided by the WVU Center for Excellence.

Recommendations

1. The SME commends DHHR for expansion of its behavioral support services efforts, with a clear focus on leveraging local expertise available through WVU to provide direct behavioral support services and to support other services providers to use behavioral support services plans; and the leveraging of Concord University expertise to build, centralize, and coordinate efforts for statewide training and endorsement (certification). The SME looks forward to receiving the deliverables for review including the training plan, proposed timeline, approach, and training content.

2. Given how behavioral support services can support success in home- and community-based settings, the pathway to access behavioral support services must be clear. The SME recommends that the assessment pathway clarify connection to behavioral support services, particularly for youth who may and those who may not meet CSED Waiver eligibility in order to ensure timely access, including how families, schools, behavioral health providers, courts/judges, and staff from all three bureaus can access the service.

3. The SME requests a draft of the behavioral support services' specific changes to the provider billing manual to allow for discussion and incorporation of any SME comments before it is finalized.

4. The Excel spreadsheet received by the SME titled *PBS Report 2021* for each of the five months contains very useful information. The SME understands that BBH reviews these reports monthly and notes issues and trends. However, much like other Excel spreadsheets received, it contains redacted information for each youth that contains varied text fields. Consistent with other data-related recommendations in this report, SME recommends that a quantitative report be developed that allows for synthesis and action planning that allows for behavioral support services-related data to be used by other workgroups to inform interconnected tasks and decision points such as the assessment pathway work, redirection from residential interventions, and coordination with Wraparound.

5. The SME notes that this Excel spreadsheet contained a field called Risk of Out of Home Placement with rankings for each redacted child from 0–10. In the follow-up query to DHHR, it is a question

posed to families in which they self-identify their perceived risk. The SME would like to discuss this further with DHHR to understand how the State plans to use this information, if at all, to support the identification of the target population. Specifically, the SME seeks to understand how this information will be used, how it will relate to the use of the CAFAS/PECFAS, and criteria for CSED Waiver eligibility.

6. As indicated in a prior report, given that Marshall University's West Virginia Wraparound Review report noted that 51% of referrals were from schools, it is critical that the assessment pathway clearly describe access to behavioral support services and how providers use a standardized assessment tool to ensure children are appropriately referred to services and supports, including Wraparound.
7. As indicated in the prior SME report, it is important for the State to clarify how data for recipients receiving behavioral support services will be included in the "at-risk" population planned for the target population and for the second phase of the evaluation. This is an opportunity for the QAPI and behavioral support services workgroups to coordinate related tasks.
8. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks.

Therapeutic Foster Care (TFC)

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

Activities

West Virginia is in the process of identifying its proposed model for TFC and identifying how it will secure providers to deliver TFC services.

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

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

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

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

Per a Word document titled *2021 TFC Capacity Review*, the State has been working to develop TFC homes, utilizing data analysis to determine areas of greatest need and priority. In late winter 2020, there were 79 Tier III TFC beds. This was a decrease from 2019 numbers indicating TFC capacity at 110. BSS indicated the significant loss of TFC homes is attributed the high number of adoptions of children by these families as well as lower recruitment numbers. BSS reported TFC capacity by county as summarized in Table 7 below. Recently, BSS selected new child protective agencies. Of these new agencies, six elected to provide TFC, which is expected to create an additional 69 TFC homes. BSS has indicated an approximate total of 150 TFC homes will be available through a phased-in approach in 2022.

Table 7: Tier III Bed Capacity by County, Winter 2020

Number of TFC Beds in the County	Number of Counties	Total TFC Beds
0	31	0
1	9	9
2	5	10
3	4	12
4	2	8
5	1	5
6	0	0
7	2	14
8	0	0
9	1	9
10	0	0
11	0	0
12	1	12
TOTAL	**55**	**79**

The State has issued a draft TFC Model Proposal. This model defines eligible TFC participants as meeting all of the following criteria:

- Age 4–21

- CSED Waiver enrollee
- Child cannot be safely maintained in their own home for behavioral health reasons
- Not a danger to others or self, or a habitual flight risk which cannot be safely addressed through a safety plan/flight risk plan

Additionally, children who are in a residential facility are also candidates for TFC if they meet the above criteria prior to residential placement and continue to meet these criteria and need an out-of-home setting.

BSS is striving to distinguish traditional foster homes more clearly from TFC homes and from homes serving children with medical complexity. The proposed TFC model includes a series of documents and assessments that are reviewed to determine eligibility for TFC, including behavioral health assessments, use of the CANS and CAFAS, psychosocial summary, educational documentation, service and treatment plans, and more. Additionally, the model includes draft performance measures and clarification of roles and expectations for TFC providers.

As indicated in a review conducted by BSS March 2021, most children currently in TFC meet the criteria for traditional foster homes, not TFC. The State's analysis showed that almost 70% of youth in a TFC Tier II placement moved to a Tier I placement after the first 30 days. In the March 2021 analysis, only 48 (8.6%) of children that entered a TFC placement met the new criteria for TFC. From this analysis, the State applied this factor to its residential placements by county and projected the number of additional TFC homes needed.

The State has engaged in four meetings with TFC Providers in June and July 2021 to present the State's planned approach to TFC, its interface with the CSED Waiver, details of its draft TFC model, and its plans to phase in the new model beginning October 1, 2021. Meeting minutes detail engagement by DHHR to solicit input from TFC providers about the planned approach.

Recommendations

1. Per prior SME Reports, the SME recognizes that the State and DOJ are discussing differences in the interpretation of which children are required to be provided TFC services under terms of the Agreement: whether it is all children in the target population or a subset who are in foster care. The SME has recommended that children, regardless of foster care status, can benefit from therapeutic foster care, especially as an alternative to other out-of-home placement settings.

2. The SME looks forward to seeing the revisions to the model proposal and eligibility criteria based on the written edits and suggestions from the SME, its meetings with providers, and input from families and youth. As the model is in drafting stage, the SME has indicated additional clarifications including functions and roles of TFC vis-à-vis other coordination and service activities, including:

a. The role of Children's Mobile Crisis Response, CPAs, and treatment foster homes when a child experiences a behavioral health crisis;
b. The role of Wraparound, CPAs, and the MCO regarding coordination of care functions;
c. Ensuring that children in TFC receive all Medicaid and other state-funded behavioral health services for which they are eligible. It is critical that youth receive the full Medicaid benefit and that the State employ all necessary strategies to enhance its provider base to ensure access; work with its providers to determine if any existing CPAs can become Medicaid-eligible providers for some services; and work with its providers to refer and coordinate with other providers when a child needs a Medicaid service that they do not provide.
d. How the State plans to respond to suggestions raised during discussions with Providers about perceived duplication between TFC services and CSED Waiver services and to the suggestion to offer CSED Waiver services following TFC enrollment versus concurrently.

3. The SME recommends that the State further differentiate TFC from traditional foster care homes and homes for children with medical complexity.

    a. This will be of particular importance in the process of phasing in the new model, as many TFC providers are serving children who do not meet the eligibility criteria. It will be important to differentiate between the needs of the children served in foster care versus TFC as well as the specific activities the providers and caregivers engage in when a child is in a TFC-level of service.
    b. The SME recommends the State expect it to be challenging for TFC caregivers to have a child leave their care when they no longer meet that level of need for TFC; this is an area where support should be given, and CPAs should ensure they are recruiting new homes with the understanding that this is a treatment intervention and not a long-term living arrangement. This may prove helpful in some recruitment activities, as it may engage individuals in the community who are more interested in providing a short-term support and partnering with birth families or kin (legal or fictive) to support permanency.
    c. Some children with complex medical needs may require additional behavioral support from the providers while others do not. The SME recommends the State explore how different homes for children with medical complexity may look, the requirements and expectations of those providers, and when a child can be served in which environment. The length of stay of the child may also vary, depending on whether the child's admission into that specialized home is driven by medical needs, behavioral needs, or a combination.

4. The SME recommends that the State continue to develop a clear implementation plan for the phasing in of the new TFC model.

    a. The SME recommends that this plan prioritize minimizing disruptions to children who currently are in TFC homes but may not meet the criteria under the new TFC model. It may cause more trauma and harm to children to change living arrangements suddenly than to create a thoughtful approach to transitioning that is focused on implementation of the child's permanency plan. Specifically, a phasing plan will need to assess and monitor

capacity, with an accounting of currently placed children's planned length of stay so the State will understand when existing capacity could be available and the timing of new TFC homes that may be available.

b. Providers will need to be supported during this transition plan to avoid providers feeling undervalued or that their efforts are not adequate or meaningful. The SME recommends the State work closely with the provider community and identify key champions that will assist with the direct messaging to CPAs and, most importantly, to the TFC families. It will be critical to emphasize that the TFC families have been doing what was asked of them, and more, and it is the *State* that is revising and clarifying its expectations and requirements in order to ensure that children are in the least restrictive setting as possible while receiving treatment interventions.

c. Providers will need to understand when rates will change and what it will mean in terms of expectations and roles. The SME encourages the State to engage the providers in sharing their expertise and knowledge about what has worked and where challenges exist, both in initial and ongoing implementation.

5. The SME encourages the State to meaningfully engage families and youth in this model development, refinement, and ongoing implementation.

    a. Families and youth should share their experiences and what it looks like when TFC families and agencies are partnering and helpful. They should share recommendations for what can be harmful or result in challenges to engagement and partnership. The SME recommends identifying some families and youth involved with foster care and some TFC parents to co-develop tip sheets about what works and what does not work.

    b. The SME recommends the State utilize resources from the HHS Children's Bureau's National Quality Improvement Center on Family-Centered Reunification (https://qicfamilyreunification.org/), including its best practices guide, to help identify strategies to support effective treatment and reunification.

    c. The SME encourages the State to identify families with lived experience, youth or young adults currently or formerly involved with foster care, and TFC parents to provide input on the model and its implementation, both initially and ongoingly. The SME encourages the State to compensate the families and youth financially.

6. The SME appreciates the work that the State has done to detail the roles and functions across BSS, CPAs, TFC parents, the ASO, and behavioral health providers, but more remains to be done.

    a. The SME notes that the providers gave feedback to the State that indicated a different experience in the services they provide and the purpose and availability of community-based providers. The State should continue to listen to providers to find out the existing barriers to integrating services and issues with role clarification and develop an intentional training and technical assistance approach to address this, including clear, written expectations and review protocols.

    b. The SME recommends the State engage in a transparent and ongoing process to obtain feedback on the proposed TFC approach. This will enable the State to make adjustments to both the approach and the associated training and ongoing technical assistance provided.

7. The SME recommends that the State review all assessment pathway materials to ensure that TFC is included as an option and further supports redirection from residential interventions during the phase-in process and in the future.

    a. The SME notes that the State previously thought that 100 children required TFC because that was the current capacity. However, there are more than 100 children in residential care. The SME recommends that the State reviews the children in residential care to determine how many may meet eligibility for TFC and determine a pathway to TFC out of residential care whenever possible.
    b. The SME notes that there may be children in TFC that do not meet eligibility and recommends that the State track capacity as these children reunify with families, otherwise achieve permanency, or leave these homes.

8. The SME acknowledges the work that the State has done to-date on outlining performance and outcome measures. However, the SME recommends the State create a detailed plan for how it will collect, review, analyze, and report on timely access to TFC, per the terms of the Agreement, as well as other prioritized performance and outcomes measures.

    a. The SME encourage the State to align this monitoring and reporting process with the other processes under the Agreement, as well as with reporting necessary for Family First Prevention Services Act implementation. The SME encourages the State to watch for any concerning trends with regard to psychiatric emergency room use and hospitalizations, residential interventions, re-entry into foster care, and entry into the juvenile justice system.

9. The SME recommends that the State revise its training and coaching for TFC parents. The SME understands that under the State's current model, Tier III TFC parents serve children who are medically fragile, infants who are drug exposed, and children with SED. TFC parents who serve children with SED must acquire and retain skills that are different than skills required to support other Tier III populations. The State and its contracted TFC agencies must create a robust training and coaching program that specifically addresses children with SED. In addition, the SME recommends that the State incorporate an evaluation methodology to assess whether its training is effective in assisting TFC parents in acquiring, retaining, and utilizing the skills necessary to maintain children in their initial TFC placement. Such skills typically include trauma-informed care, behavior management and positive behavioral reinforcement techniques, crisis management, de-escalation techniques, and stress management/self-care for TFC parents.

10. In developing this plan, the SME recommends that the State conduct a needs assessment that includes agency and organizational factors that may bolster or hinder training and coaching, such

as staffing needed for training and supervision; the recruitment and retention of foster parents willing to meet training standards; the infrastructure needs to maintain training and coaching, including whether such a program would be State-led or if the State would rely on an outside purveyor to develop training materials; and development of a monitoring and evaluation plan.

11. The role, functions, and expectations of the DHHR's ASO, KEPRO, who contractually provides oversight for TFC, may need further refinements based on the final model determined, clarifications of functions and roles, oversight expectations, and data collection and reporting. The SME recommends that DHHR provide written guidance to its ASO on all functions and expectation it expects it to perform on behalf of the State. It is not sufficient to assume that the ASO will monitor these youth; it is necessary for DHHR to be clear on how it wants KEPRO to monitor youth and the reports it wants to receive.

12. The SME recognizes that progress on this DOJ Agreement service was slowed because this service is inextricably linked to its broader procurement for its foster care system. With the foster care procurement completed, the SME recommends that DHHR develop a clear, consistent workplan with measurable and actionable goals, each with a clear owner, and firm deadlines in order to begin implementation of the intended TFC service. Further, several tasks from previous workplans remain uncompleted and will need to be revised to reflect decisions, including the targeted recruitment and evaluation activities related to TFC.

13. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks.

Assertive Community Treatment

Agreement Requirements: The Agreement requires the State to ensure that Assertive Community Treatment (ACT) is available statewide to members of the target population aged 18–20. The Agreement permits ACT teams to substitute for CFTs, provided they develop an ISP and ensure access to HCBS, as appropriate.

Activities

ACT is provided through the BMS as a Medicaid state plan service to eligible members ages 18 and up. The State provided the SME with Medicaid claims data in June 2021 for service year 2020. Table 8 below summarizes the data provided for youth aged 18–20.

Table 8: Count of ACT Recipients and Utilization for Individuals Ages 18–20 During the 2020 Calendar Year

	FFS	MCO	Total
Young adults	5	15	**18***
Initial count of units paid	619	3,184	**3,803**
Final count of units paid	617	3,230	**3,847**
Average LOS			211 days

*Young adult row total reflects an unduplicated count as two individuals were discharged and re-enrolled during the calendar year. Note: An ACT unit of service equals 15 minutes.

Data provided by BMS indicates that a total of 18 unduplicated youth received ACT, with total of 3,847 units paid, equaling 962 hours of service with a combined (across FFs and MCO) average length of stay of 211 days.

In our previous report, the SME recommended that the State clarify how youth eligible for ACT and Wraparound would be offered choice of the two services and referred to the selected service. A coordinated effort across workgroups has occurred to develop a single, common pathway for access to all services. In this draft pathway document, the team has focused attention to how youth would be determined to meet eligibility for either service, and how a youth eligible for both, would be offered choice and referred to ACT or Wraparound. While documents such as standard operating procedures, policies, guidance to providers, and expectations for Medicaid MCOs and ASO are not yet developed, the State indicated such documents will be developed and submitted in the coming months. The State has confirmed that the pathway will include offering youth a choice between ACT and Wraparound when eligible for both.

DHHR (both BMS and BBH) continued efforts to secure a provider for Region 2, the Eastern Panhandle, one area of the state without an ACT provider. A provider has agreed to serve that region but will not begin services until 2022 due to expected recruitment, hiring timeline, and necessary training of the hired Team in the ACT model before enrollment of youth and service provision can occur. BBH sought and received approval from SAMHSA to use block grant dollars to provide start-up funding for that provider. DHHR indicates that a specific start date will be determined by the end of summer. Additionally, since the selected provider already provides ACT services in another area of the State, BMS has granted a waiver allowing the provider to enroll up to 50 youth immediately, depending on their staffing levels versus new ACT providers who are only allowed to enroll 20 clients. DHHR has asked other providers to conduct outreach and refer to other appropriate services and is gathering a list of potential list to refer to the service when it is available. The SME notes DHHR's efforts to secure a provider for Region 2, an area of the State in which it is difficult to attract providers, the coordination across BMS and BBH to coordinate training, secure start-up funding for the provider, and proactively provide a waiver to increase the numbers of youth that the provider can serve once they begin services.

Under contract with the State, the State's ASO, KEPRO, conducts fidelity reviews of the ACT service annually. Reviews are conducted in a rolling fashion across an 18-month cycle from initiation to completion of the reports. Fidelity monitoring tools used by KEPRO were provided to the SME including the ACT Review Tool, a mock-up of a summary report of all ACT providers reviewed listing their scores for each element from the review tool, and a redacted ACT provider-specific report summarizing KEPRO's findings from its review of that provider, including recommendations to improve quality.

BMS indicated plans for provider workshops twice per year to meet with providers across the State, such as inpatient facilities, residential programs, and community mental health providers, to explain ACT service and support referrals to the service with virtual meetings being used during the pandemic. The SME understands that the State is developing a policy document for residential providers, which will include information about accessing ACT for older youth transitioning back to the community.

Recommendations

1. The SME notes the quality review process in place to monitor fidelity to the ACT model, and provider-specific reports that note strengths and areas for improvement. This type of monitoring is critical for all of the DOJ Agreement services and can serve as a model for similar approaches to other services.
2. Regarding which youth are referred to ACT or Wraparound, once the assessment pathway work is complete, DHHR will need to finalize a SOP describing how a member will be offered choice between ACT and Wraparound and to develop an oversight plan, including data that will be collected and describing how DHHR will monitor that choice is being provided to youth.
3. Regarding data, consistent with other data-related recommendations, the SME recommends that ACT data be shared on an ongoing basis; that utilization and lengths of stay are reported by Medicaid FFS or Medicaid MCO; and that data are shared with other workgroups, particularly Wraparound, to support monitoring of choice.
    a. The SME notes length of stay was reported as a combined figure across FFS and MCOs. This could be because of the small numbers served via FFS, or that length of stay data are similar across FFS or MCO. The SME flags it for BMS in the event that lengths of stay are significantly different across Medicaid FFS and MCO; thereby, potentially leading to observable differences in the data for youth in the target population. Additionally, if differences across FFS and MCO are observable here, it likely could impact utilization of other services that youth are also receiving.
4. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks.

Reductions in Placement

Agreement Requirements: The Agreement requires the State to reduce the unnecessary use of residential mental health treatment facilities (RMHTFs) for children relative to the number of children living there on June 1, 2015. The expected goal by December 31, 2022, is a 25% reduction from the number of children living in residential mental health treatment facilities as of June 1, 2015, with additional benchmarks to be established and met over time.[10]

Activities

Per the terms of the Agreement, DHHR has committed to reducing the number of children receiving residential interventions. Table 9 below summarizes the June 2015 *Foster Care Placement Report* and calculates the 25% reduction that the State must achieve by December 31, 2022.

Table 9: Foster Care Placement Report June 2015[11]

Facility Type	Youth in an In-State Facility	Youth in an Out-of-State Facility	Total Youth in Any Residential Placement
Group Care	678	174	852
Psychiatric Facility (short-term)	63	86	149
Psychiatric Facility (long-term)	28	1	29
Parentally-placed in a psychiatric facility**			66[12]
2015 Totals	769	261	1096
Youth Receiving Residential Interventions With a 25% Reduction by December 31, 2022			**822***
Youth Receiving Residential Interventions With a 35% Reduction by December 21, 2024[13]			**712***

*Rounded to the nearest whole child.

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

For this report, DHHR provided the SME with the following data reports containing information specific to youth receiving a residential service:

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

[11] https://dhhr.wv.gov/bcf/Reports/Documents/2015%20June%20Legislative%20Foster%20Care%20Report.pdf

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

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

- *Foster Care Placement Report* — a monthly report to the legislature that details by month the number of youth in-state, out-of-state, total, and percent out-of-state across fourteen different foster care placement types.
- *Foster Care Age Gender Type Breakout Report Year to Date* — built from the data source for the legislative report, tallying youth by residential type, age, and gender.
- *In-State Child Placement Report* — built from the data source for the legislative report for a subset of data specific to youth receiving in-state residential interventions.
- *Weekly Count of Children in Residential Placement* — provides a total number of children receiving residential interventions for in-state or out-of-state PRTF, and in-state or out-of-state group residential care.

In addition to these existing reports, DHHR provided an Excel table January–August 2021 with numbers for "parentally-placed" children, children whose parents sought residential interventions for their children. These data are tracked separately by the MCOs. Table 10 below summarizes the data provided by DHHR.

As Table 10 below summarizes, as of June 2021, a total of 827 youth received a residential intervention, with approximately 32% of those youth in an out-of-state location.

Table 10: Number of Youth Receiving Residential Interventions In-State and Out-of-State by Provider Type, January–June 2021*

	Youth In-state	Youth Out-of-State	Total Youth	Percentage Out-of-State
January 2021				
Group residential care	470	210	680	30.9%
Psychiatric facility (long-term)	46	56	102	54.9%
Psychiatric hospital (short-term)	19	0	19	0.0%
JANUARY TOTAL	**535**	**266**	**801**	**33.2%**
February 2021				
Group residential care	489	209	698	29.9%
Psychiatric facility (long-term)	50	57	107	53.3%
Psychiatric hospital (short-term)	12	0	12	0.0%
FEBRUARY TOTAL	**551**	**266**	**817**	**32.6%**
March 2021				
Group residential care	487	211	698	30.2%
Psychiatric facility (long-term)	51	53	104	51.0%
Psychiatric hospital (short-term)	16	0	16	0.0%
MARCH TOTAL	**554**	**264**	**818**	**32.3%**
April 2021				
Group residential care	498	211	709	29.8%
Psychiatric facility (long-term)	54	51	105	48.6%
Psychiatric hospital (short-term)	11	0	11	0.0%
APRIL TOTAL	**563**	**262**	**825**	**31.8%**
May 2021				
Group residential care	512	214	726	29.5%
Psychiatric facility (long-term)	49	51	100	51.0%
Psychiatric hospital (short-term)	7	2	9	22.2%
MAY TOTAL	**568**	**267**	**835**	**32.0%**
June 2021				
Group residential care	497	216	713	30.3%
Psychiatric facility (long-term)	45	49	94	52.1%
Psychiatric hospital (short-term)	19	1	20	5.0%
JUNE TOTAL	**561**	**266**	**827**	**32.2%**

Data source: Monthly Legislative Reports Jan–June 2021
*Data in Table 10 does not include youth placed by their parents in residential facilities.

Figure 3: WV Foster Care Placements, June 2020–June 2021, In-State and Out-of-State*

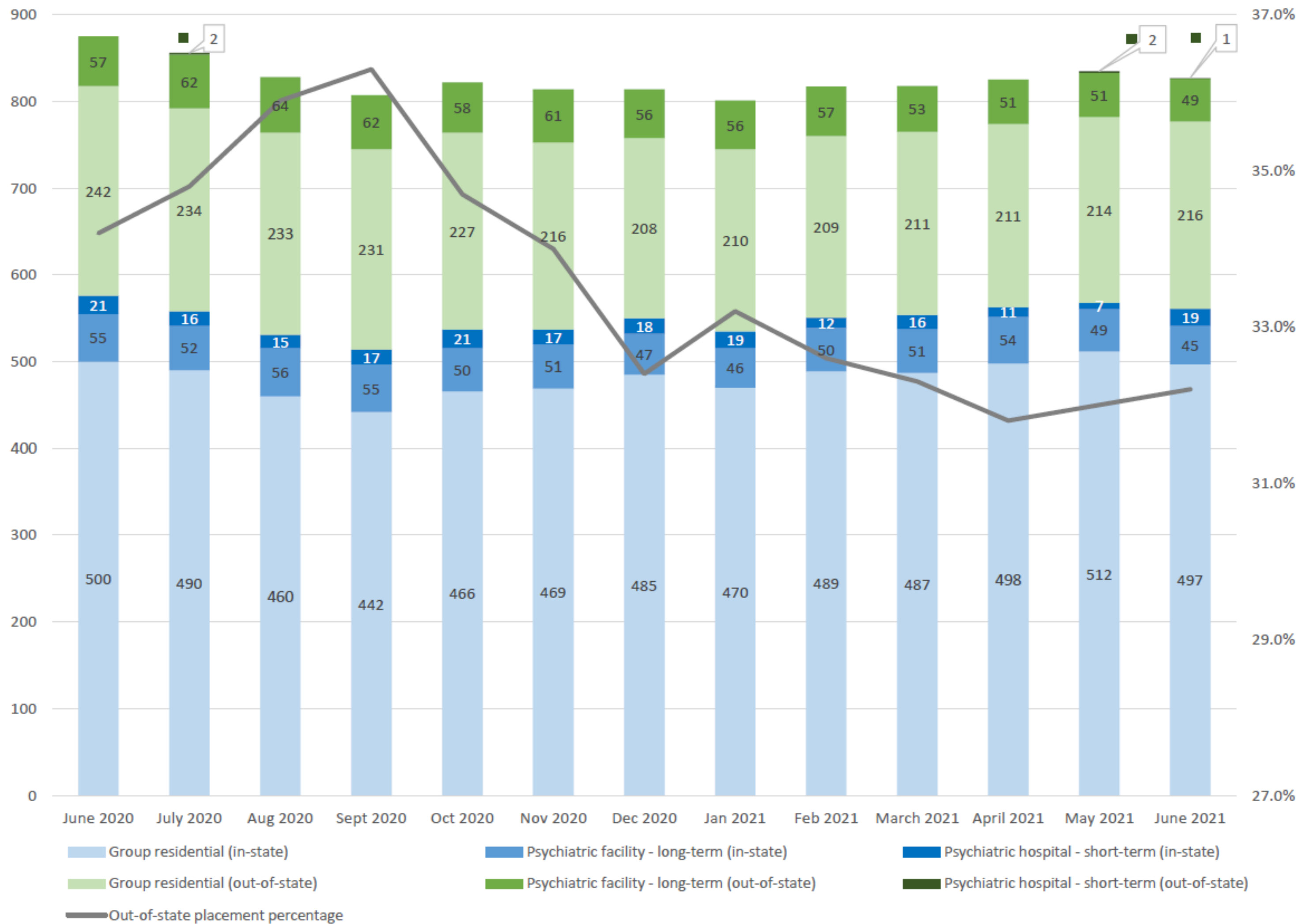

Figure 3 above provides data over a one-year period, from June 2020 through June 2021, for youth by placement type (group, short-term psychiatric, long-term psychiatric facility) and by in- or out-of-state placements, with a trend line indicating percent in an out-of-state facility. Note that these data do not include youth placed by their parents in residential facilities. This figure provides an opportunity to view residential placement numbers and the out-of-state placement trend over a longer period of time, showing the relative stability of the placement data across months, with little seasonal variation trends, differences across provider type, or in-state or out-of-state facility use.

Regarding available data for parentally-placed youth, Table 11 below summarizes data provided by DHHR from their MCOs for children receiving in-state residential interventions and out-of-state residential interventions. This set of data is a duplicate count across months.

Table 11: Number of Youth Receiving Residential Interventions In-State and Out-of-State by Provider Type*, January–June 2021

Parental Placements 2021							
	Managed Care Organization (MCO)						
	Anthem Unicare		The Health Plan		Aetna		
	In-State	Out-of-State	In-State	Out-of-State	In-State	Out-of-State	Total
January	1	0	1	1	1	3	7
February	1	1	1	0	1	3	7
March	1	1	2	1	3	5	13
April	2	2	2	1	2	5	14
May	3	1	2	1	0	3	10
June	1	2	3	1	0	3	10
July	1	0	2	3	2	3	11
August	1	0	0	2	3	1	7

In addition to the ongoing data reports described above, DHHR completed two ad hoc data analyses to inform reductions in use of residential interventions. First, DHHR partnered with Marshall University's Center of Excellence for Recovery and Dr. John Lyons from the University of Kentucky's Center of Innovation in Population Health, to identify the behavioral health needs of youth currently receiving residential interventions through a latent class analysis approach. The purpose was to understand the treatment needs of these youth in order to inform what community-based services can be utilized to keep the youth in a home-like setting and what new services may need to be developed. The State completed the initial analysis; presented initial findings to DOJ and the SME; and indicated its plans to complete its synthesis, decide policy action steps resulting from its analysis, and revise its work plan to reflect this new information.

Second, DHHR's Bureau of Children and Families released a survey to residential providers in January 2021 with responses due February, with a summary report issued by the DHHR in May 2021. A total of 24 individuals representing 21 organizations began the survey, with 22 individuals completing the

survey. Input on 34 items was sought on a range of critical issues, including the types of evidence-informed practices used as a part of an organization's residential interventions, provision of aftercare services once a child returns to a community setting, length of stay, family engagement, use of mental health assessment tools, and challenges and opportunities.

The State met with providers of residential services to present the results of the provider survey and discuss opportunities to enhance residential providers' capacity to provide home- and community-based services.

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

In the December 2020 SME Report, the SME indicated that the State shared documents for a new process outlining a policy for the review of out-of-state residential placements and requirements for Commissioner-level signoff on out-of-state placements. For this report, the SME received an internal policy from Aetna and related redacted log sheets of children reviewed by Aetna. The policy described a protocol for a Deep Dive workgroup to "*assess the cause of youth spending extended periods of time in a residential (type) environment, explore all alternatives, make recommendations, and follow through as needed to ensure the least restrictive, family-like environment is utilized.*" The redacted Excel spreadsheet indicated that about 70 youth were reviewed with columns tracked for member name (redacted), current facility, date of admission, DHHR worker, County/Region, Disposition (status).

In coordination with the Outreach and Education workgroup, the R3 workgroup has identified the need to address the perception among certain stakeholders that residential placement is the better or safest solution for most children with forthcoming materials to educate stakeholders about the negative outcomes that congregate care settings can have on children.

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

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

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

Recommendations

1. Regarding recommended action steps from review of available residential placement data, the SME recommends:
    a. The data reports for residential services are extrapolated from a subset of categories reported in the monthly legislative report. The SME recommends that DHHR identify the key questions it is trying to answer and then coordinate a suite of reports, specific to understanding residential interventions for this Agreement. In addition to tracking the required reduction in the number of youth, other data relevant to quality need to be analyzed, including lengths of stay, repeated admissions or changes in admission facility type during a single episode of care. These data should be stratified by provider, age, race/ethnicity, gender, LGBTQ+, and county of origin. The SME is available to provide technical assistance as DHHR develops these reports.
    b. As part of this suite of reports, the SME also recommends that the State collect data on which system children are entering residential interventions from and the decision source of the child's residential placement. DHHR has indicated that a sizeable number of children are ordered by a judge/court to a specific placement type, often without a formal behavioral health assessment indicating need for that placement. Additionally, given the role of BSS's MDTs to determine and secure needed services, including residential interventions, an understanding of the number of youth recommended for residential from the MDTs and the rationale for why home- and community-based services cannot meet the child's needs would also be important to collect and analyze. The goal should be a reform of the entire children's system of care and overall utilization of residential interventions, regardless of the system referring to or paying for the residential placement. Ultimately, these data could inform specific strategies with judges/courts, DHHR personnel, MDTs, and external stakeholders. It is incumbent upon DHHR to have a clearer picture of which children actually need residential interventions. This is critical to not only understand the formal *policies* under which a child may be referred to a RMHTF, but also to discern the informal *practices* through which a child may accrue to an RMHTF. Both policy and practice will need to be addressed, and modified or corrected, if the State is to successfully address the "front door" through which children are first referred to and secondarily authorized for residential care, including out-of-state placements. Once the State has a thorough understanding of the various entry points, and which children tend to follow those pathways, it can be clearer on what it wants and needs to purchase and begin reforming both policy and practice to align with these realities.
    c. The SME recommends that DHHR further explore data to identify disproportionalities in the number of children who are Black, Indigenous, or People of Color in the numbers served in group residential interventions and PRTFs, both in-state and out-of-state. This is further discussed in recommendations stemming from DHHR's cluster analysis below.

d. Data for parentally-placed children are ad-hoc reports from each MCO. The SME recommends that DHHR receive data that allows it to understand an unduplicated count of children and each child's length of stay on a monthly basis. While the numbers of parentally-placed youth appear much lower than in 2015, this is a population of children receiving residential services approved and managed by DHHR MCOs, and, therefore, should be incorporated into the recommended suite of reports and quality oversight activities.

2. The SME acknowledges the documents received indicating a policy for BSS Commissioner-level signoff for out-of-state placements, a policy for Aetna's "deep dive" reviews of children in in-state residential placements, and its accompanying redacted Excel spreadsheets tracking those reviews. It is clear that staff across DHHR bureaus, providers, and Aetna are meeting to review the status of youth recommended for review by this deep dive review team. BSS indicates that Commissioner-level signoffs are occurring, but does not yet have data available to understand the number of youth reviewed, the issues that result in the need for these out-of-state approvals, or if any out-of-state requests are being diverted. It appears that this process is in a nascent stage and would benefit from data to inform what is working and what needs to change. The SME recommends:
    a. A formal written policy and procedure regarding Commissioner-level sign-off be instituted.
    b. Data be reviewed from Aetna's deep dive process and from the Commissioner-level reviews to understand what impact the reviews are having, what action steps are resulting in positive change in placement for a youth, what actions are not resulting in any change, differences across placement, and youth needs. Given that out-of-state residential placements and TFC placements managed by KEPRO could also benefit from similar processes, an understanding of what is/is not working for the in-state process could support use of effective strategies across all out-of-home placements.

3. The SME commends the State for its focus on gathering and analyzing new data to guide its policy decisions through the two ad hoc reports it initiated, the cluster analysis and the provider survey. The SME understands from discussions with DHHR, and as reflected in their work plans, that the State continues to synthesize results from these two ad hoc analyses in order to determine its policy action steps. Given that the data were analyzed in the spring and early summer, this data synthesis and determination of policy decisions and action steps need to be completed more quickly. The SME recommends that the State conclude with its synthesis, policy planning, and decision-making about action steps, so it can present and share these findings with providers, families and youth, stakeholders, DHHR caseworkers, and other relevant personnel to solicit input and recommendations. Further, the SME recommends that DHHR determine its planned actions steps based on what DHHR learned from the cluster analysis, provider survey, and discussions with stakeholders and incorporate these into its plan to redirect youth from residential interventions.

4. As DHHR considers next steps resulting from the cluster analysis, the SME recommends the following:

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

d. It appears that children across all classes, but notably classes one and two, are Youth Service-involved, with smaller numbers involved with CPS or foster care. As such, factors specific to the Youth Services system and the role of judges and courts in deciding treatment locations needs to be addressed. The SME recommends that DHHR develop a strategy and written plan to actively engage the judicial system in committing to a reduction in residential placements. While this plan will need to be informed by the data recommended above, a plan can be initiated while data are gathered that considers the following:

   i. a priority on only considering congregate care settings when there is a clear demonstration of why a child *cannot* be treated in the community with home- and community-based services (i.e., treated HCBS as the default approach);
   ii. the role of evidence-based residential interventions as a behavioral health intervention versus a placement;
   iii. regular and ongoing meetings with judges regarding DHHR's commitment and their perspective, including presentation and discussion of the latent class analysis showing that these children do not have clinical reasons for being in these placements, the service needs of youth in their courts, their concerns about ensuring children or communities are safe, identification of HCBS champions within the judiciary—both within West Virginia and nationally—that can provide examples of the positive impact of engaging home- and community-based options for youth in their courts; and
   iv. support to parents and youth to advocate for HCBS services instead of placement.

   Additionally, since residential placement numbers have not changed since the Agreement was signed, DHHR may gain traction on this issue by seeking judges to commit to a "pilot" approach, thereby building new/renewed connections to home- and community-based services between judges, families, caseworkers, and behavioral health providers.

e. Further review of class two—described as youth with legal issues, substance use, and anger control issues—is needed. This appears to be a grouping of children who may be receiving residential interventions for reasons similar to class one, where presentation to other systems led to a decision for residential as a placement versus as a treatment need. It also appears that a sizable number of youth in this class have substance use needs. While the SME recognizes that the DOJ Agreement is specific to mental health, national prevalence data indicate that estimated rates of co-occurring mental illness among adolescents with substance use disorders range from 60–75 percent.[14] Therefore, the SME recommends that youth with substance use be carefully assessed to determine concomitant mental health needs. Finally, for any child in class two, this review provides an opportunity to determine if services are adequately available to meet these needs and

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

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

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

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

services ranked as a less of an issue than these others. This speaks to the need for the State to not assume that its focus on building services will result in reduced residential placements. Rather, working with the courts and within the BSS bureau to support caseworkers, increase foster care homes, and strengthen MDT's focus on community services and discharge planning are instrumental to achieving these goals. The SME recommends that the State develop and implement a specific plan to address these factors.

f. Residential providers noted difficulties in obtaining previous assessment data on youth in a timely way. Reducing lengths of stay for youth receiving residential interventions is predicated on a continuity of information on the whole child versus snapshots of a child while receiving residential interventions or a snapshot of a child while in community services. A coordinated single plan of care built upon a standardized assessment must provide the foundation for understanding and intervening for any behavioral health need. If DHHR continues to have siloed assessments and siloed treatment plans, children will not be redirected from residential interventions, and residential interventions will not become part of a continuum of home- and community-based approach. The SME recommends that DHHR develop a specific policy on this issue and monitor the data to ensure that all DHHR assessment information across providers and bureaus be shared with residential providers. Additionally, it is important that exchanges of information are not limited to assessments at the start of residential interventions, but are treated as regular touchpoints during treatment and transition planning.

g. Several residential programs indicated that children were not discharged because program levels were not completed. This may point to the issue that residential providers perceive residential interventions as needing to address *all* behavioral health needs versus the State's intended use of residential interventions to stabilize a child, initiate treatment, and then continue high intensity services in the community. The SME recommends that the DHHR clarify with providers what it means to complete a level. It seems this approach could be at odds with what the State wants to pursue under a new system. Additionally, a growing body of neuroscience research, along with both clinical and lived experience, demonstrates that prescriptive point and level systems applied universally to a group do not typically result in enduring behavior change for the 10–20% of youth with serious behavior challenges [15]. It will be important for DHHR to understand the extent of use of point system approaches by providers of residential interventions, as it will inform its efforts to identify and adopt evidence-based practices, and training and coaching to personnel.

h. One program noted that there were no shelters available to discharge a child to after nine months. The SME would not expect a child that had received a residential intervention for nine months to move anywhere other than a family-based or

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

independent living setting. No child known to DHHR or its providers for nine months should be stepped down to a shelter, which by its design is a temporary setting. That step unnecessarily elongates temporary settings for a child that has already been in one for a considerable time. This is an area that the SME recommends be monitored via data to ensure that it does not occur.

   i. There appears to be a disconnect between what residential providers do for discharge planning and the expectations of BSS staff. It would seem that residential providers should play a larger role in transition planning, particularly QRTPs, since this type of planning is required in the FFPSA for these programs.

6. The SME recognizes that DHHR is implementing its Family First Prevention Services Act (FFPSA) Prevention Plan[16], which includes several strategies and opportunities for alignment across West Virginia, particularly among families likely to engage with multiple child- and family-serving agencies.
   a. The SME recommends that DHHR update its Foster Care Policy[17] (last revised October 1, 2019) to align eligibility information and referral criteria with updated FFPSA opportunities and residential criteria as soon as they are finalized to ensure consistency across the state. These updates should be integrated into any pre-service and continuing education and training of the child welfare workforce.
   b. The SME recommends that the service pathway include how families may receive referrals to FFPSA services, particularly for youth experiencing behavioral health needs who may be appropriate to receive Functional Family Therapy (FFT) services.[18] A referral to determine eligibility for FFPSA could be in addition to or instead of a referral for Wraparound services, depending on the needs of the child and family.
   c. The SME recommends aligning performance and outcomes data collection and reporting activities with those being implemented for FFPSA, including the approach that is being designed to align with the federal Child and Family Services Review and the data being collected by KEPRO, including for socially necessary services (see p. 38–39 of the Prevention Plan).[19]

7. To support more rapid discharge, the SME recommends that the State presume that all children ready for discharge from residential interventions would benefit from Wraparound. The SME recognizes, based on the cluster analysis, that not all children would meet CSED

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[16]https://childwelfare.wv.gov/Documents/20200914_Family_First-5_Year_Prevention_Plan-Final%20Approved_by_ACF.pdf
[17]https://dhhr.wv.gov/bcf/policy/Documents/Foster%20Care%20Policy%20.pdf
[18]Defined in the Prevention Plan as "11 to 18-year-old youth who experience behavioral or emotional problems that bring them into contact with the juvenile justice system and meet the criteria to be defined as a foster care candidate" (p.22).
[19] https://childwelfare.wv.gov/Documents/20200914_Family_First-5_Year_Prevention_Plan-Final%20Approved_by_ACF.pdf

Waiver eligibility. But given the lengths of stay for youth in residential settings, the detrimental impact of long lengths of stay on children and the challenge in developing aftercare plans for children, Wraparound providers would be uniquely qualified to assess the whole child, engage the family, establish a plan, and support successful transition to community. This could operate much the same way as the planned "interim services" operate at the beginning of the assessment pathway. Similarly, as noted above, families may benefit from a referral to Family First Prevention Services Act (FFPSA) services. In particular, families with young children may benefit from the home visiting services available, while families with children 11–18 may benefit from FFT and other services.

8. As noted in prior SME recommendations, the SME has recommended that the State develop a pathway that redirects children from residential care. The State has engaged in considerable work to develop one. Efforts to date have focused on important issues, such as access to assessment and services like Wraparound. The SME recommends that future work expand on its assessment pathway to orient the pathway to demonstrating why a child cannot be treated in the community. The pathway will also need to demonstrate its interface with MDT processes and incorporate use of system flags for referral to the pathway when residential decisions by caseworkers, judges, and providers are made to demonstrate why a child cannot be treated in the community. This work may need to center on aspects of the pathway not yet developed, such as establishment of a coordinated process across certain providers—including CMCR, in-home family therapy, Wraparound, and BSS providers—who can proactively create a plan of care for a child to remain in the community.
9. The SME noted in the DHHR's R3 work plan that a review of the Mountain Health Promise continuum of services diversion model was going to occur. Given the importance of MHP's role to redirect from residential interventions and ensure a continuum of HCBS, the SME recommends this review occur.
10. The SME recommends that DHHR update its work plan to reflect revised dates and new and amended tasks.

Outreach and Education

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

Activities

During the reporting period, the Outreach and Education workgroup advanced several tasks to implement the requirements of the Agreement. In February, the workgroup identified two key problem statements to guide its work. These are:

1) Case workers, health care providers, and judges currently refer to the highest level of care.
2) Assessments and evaluations currently occur at each potential program level.

From these problem statements, the workgroup chose a communications strategy of focusing on immediate services and strategies (e.g., mental health screening, interim services such as CMCR) to address the first problem statement while engaging with the assessment workgroup to align outreach efforts with the revised assessment pathway to address the second.

One major accomplishment was the creation of two memos regarding practices for the State's outreach and education efforts. The first memo is directed to DOJ workgroup leads and outlines the "mechanics" of producing and releasing communication materials that are related to the DOJ Agreement. Specifically, it requires public-facing materials that are DOJ-related to undergo an additional level of review by a specific individual with appropriate subject matter expertise based on the content. It also emphasizes that DHHR employees are an important audience for these messages and encourages all internal communications to be brought to the Workgroup Leads meeting to ensure that internal messaging is consistent and aligned across the initiative.

The second memo is addressed to DHHR senior leadership and outlines outreach and education expectations across the department in order to align with the work of the Agreement implementation team. The memo lists key eight key messages for outreach and education and requests that senior leadership approve or propose alternatives to the stated messages. These memos are aligned with the SME's previous recommendations that the State ensure that topical subject matter experts are involved in the review of communications and that the State formally document its communication processes for creating, reviewing, and distributing materials.

In collaboration with the Screening and Assessment workgroup, the State developed a draft heat map to track the percentage of EPSDT exams that include mental health screenings for each region. The State hopes to use this map as a communication tool with providers and regional leadership to identify opportunities for improvement. See the Screening section on page 15 for more details.

The State also released its implementation plan for public comment and received one comment: the comment encouraged the meaningful integration of youth and families' perspectives within evaluations and assessments of the Agreement's key programs.

The State held its Child Welfare Collaborative meeting virtually on April 20, 2021; notes from the meeting are published on the Collaborative website. The next Child Welfare Collaborative meeting is scheduled for August 24, 2021.[20]

Recommendations

1. The two problem statements identified by the workgroup reflect thoughtful consideration of dynamics underlying the work of the Agreement and a promising opportunity to employ outreach and education tactics to address them. Based on a review of the master project plan, it appears the workgroup has not fully incorporated the newly identified strategy into its work plan. The SME encourages the workgroup to revise its work plan to reflect the new focus related to these problem statements, including outlining specific activities, establishing timelines for these activities, and clarifying which tasks will require joint efforts with other workgroups. For example, the work plan indicates that the workgroup has received content from the CMCR workgroup, but still doesn't have the content regarding MHST.

2. As the State develops materials to address its two priority problem statements, the SME recommends that as DHHR addresses the perception among certain stakeholders that residential placement is the better or safest solution for most children, that its strategy emphasize the shift to home- and community-based services, and not wholly on the ills of residential interventions. By focusing on residential best practices, discussions are redirected to future-oriented action steps, in which the expertise of residential providers can take shape. Otherwise, only focusing on the ills of residential placements and their negative outcomes could alienate or disenfranchise providers who have been serving youth and families in good faith based on their contracts with the State.

3. The SME is encouraged that the MCO contract language includes several requirements related to outreach and education. In the coming months, the SME recommends that the State prioritize coordinating with the MCO to develop a plan regarding targeted mental health education for its members. According to the master project plan, this work is only partially complete, despite a target completion date of April 2021. Outreach data provided by the MCO indicate that approximately 12 percent of children in the MHP program have received educational mailings since July 1, 2020; it is unclear whether this number indicates a strategic population of focus or an opportunity to expand outreach via these mailings further. It also appears there are 27,447 children in the MHP program, whereas only 23,729 members are receiving case manager outreach at one of the three tiers. It is unclear whether this discrepancy is due to differences in the time periods in which the data were captured or whether some members are not assigned to an appropriate tier.

    a. In addition, this targeted education plan should include a clear process for the State to monitor the MCO's activities in an ongoing way to ensure the plan is achieving its goals once this targeted outreach plan is established.

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[20]Due to the demands of the legislative session in early 2021, the parties agreed to schedule three quarterly meetings for 2021 rather than four.

4. The SME continues to encourage the State to identify strategies for gathering ongoing feedback from children, youth, and families directly, in addition to seeking feedback through affinity groups or formal organizations.

    a. For example, the CQI plan presentation mentions the importance of stakeholder involvement, but it does not specify families and youth as critical stakeholder groups. The State should specifically list families and youth as stakeholders whenever possible to ensure that these groups are integrated into the work.
    b. The State might explore opportunities to involve families and/or youth to participate in particular workgroups, which was suggested by a family member at the April Child Welfare Collaborative meeting.
    c. Another opportunity to collect information from families and youth was mentioned in the public comment on the implementation plan, i.e., ensuring that each program's evaluations and assessments include "real and robust" opportunities for individuals who are or could be served by these programs to give their feedback and input. This recommendation should be frequently revisited, particularly as WVU begins implementation of its evaluation plan.
    d. The majority of the outreach education activities mentioned in the workgroup grid document (e.g., family newsletter, press release, media campaign, update to family guide) are one-way communication tools that do not easily elicit family and/or youth feedback. Most other tactics that involve two-way communication do not have a specified timeline or frequency. The workgroup could focus on expanding outreach tools to families that allow for two-way communication and/or confirm details for the MCO-led focus groups and advisory councils mentioned.

5. As the State begins to expand its outreach efforts to a broader group of stakeholders, the SME encourages the State to tailor all communications materials to the intended audience, including in tone, language, and medium. The table included in the DHHR communications memo is a good example of this awareness that different audiences require different messages around the same topic or program. The State should also consider the method of communication (e.g., email and online resources, physical mail, in-person conversations, mass media) and the differences in how each audiences will engage with these methods.
    a. The master project plan indicates that the State has done some work to gather input from stakeholders regarding the "best way they receive information" (see task 1.1.4.5.7). Revisiting this information could be useful in ensuring the State's strategies are a good fit with stakeholder's needs and preferences.

6. The SME encourages the workgroup to seek out and consider additional national and West Virginia examples regarding messaging on topics such as redirection from residential interventions and children's behavioral health generally. While the State can always tailor messages to local circumstances, these "lessons learned" can serve as a foundation for the State's communication efforts.

7. During this reporting period, the State released its draft implementation plan for review and public comment. The plan received only one comment. (By comparison, the CSED Waiver received 31 comments during the public comment period.) The SME encourages the State to consider opportunities to improve response rates and gather additional comments on future iterations of the implementation plan.

8. The SME notes that a training for judges was tentatively scheduled for early May 2021; DHHR did not share any documentation about this training. The SME requests an update on this training and/or any other work to engage this important stakeholder group. Judges are an especially important audience for outreach and engagement given the workgroup's first problem statement.

9. The SME recommends that the State detail how it plans to involve WVDE and DHS in its communication plan. The addition of this task to the master project plan is a first step (see task 1.1.4.9), but there appears to have been no progress made in this area. The involvement of these agencies in the communications process was an alternative solution to modifying the governance structure to involve all three agencies, so the SME hopes to see more substantial coordination among these entities in future outreach and education work.

Quality Assurance and Program Improvement (QAPI)

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

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

(1) an analysis across child-serving agencies of the quality of mental health services funded by the State, measured by both improved positive outcomes, including remaining with or returning to the family home, and decreased negative outcomes, including failure of foster home placement, institutionalization, and arrest or involvement with law enforcement and the juvenile or criminal courts;

(2) an analysis of the implementation of the Agreement across and between all child-serving agencies, along with any barriers to effective coordination between these agencies and the steps taken to remedy these barriers;

(3) data to be collected and analyzed to assess the impact of the Agreement on children in the target population, including the types and amount of services they are receiving; dates of screening; dates of service engagement dates; admission and length of stay in residential placements; arrests, detentions, and commitment to the custody of the State; suspension or expulsion from school; prescription of three or more anti-psychotic medications; changes in functional ability (statewide and by region)

based on the CANS assessment and the quality sampling review process; fidelity of CFTs to the NWI model; and data from the CMCR team regarding encounters on the timelines of response and data on connection to services; and

(4) annual quality sampling of a statistically valid sample of children in the target population to identify strengths and areas for improvement for policies and practices, as well as the steps taken to improve services in response to the quality sampling review. The Agreement requires the State to take remedial actions to address problems identified through its analysis of data.

Activities

The State is engaged in partnerships with BerryDunn, WVU, ICF, and Marshall University to support various aspects of the QAPI, data dashboard, and evaluation work.

DHHR has presented to DOJ and the SME two components of their planned approach to the QAPI Agreement requirements: an evaluation to be conducted by WVU and the development of a data dashboard, including the dashboard indicators and a mock-up of the dashboard visualization.

Additionally, the SME and DHHR have engaged in several discussions about the need for DHHR to develop and implement a quality improvement plan that details how DHHR will establish operating procedures that require the use of data to monitor service provision, and how it will identify areas for improvement, and implement changes. DHHR submitted a draft plan to the SME.

Regarding the evaluation conducted by WVU, WVU expects to engage in the following activities by December 31, 2021:

- Refine data collection procedures related to participant recruitment and retention, incentives, and follow-up procedures for the Caregiver and Youth Surveys.
- Provide research support, literature scans of existing tools, and reference lists with question matrices.
- Draft new qualitative data collection tools for the Caregiver Interview, the Case Series interview, the Provider Focus Groups, and the Organization Interview.
- Commence provider and organization surveys, interviews, and focus groups for Summer/Fall 2021.
- Initiate data collection (surveys and interviews) with the residential population for Fall/Winter 2021 and for the at-risk population in Winter/Spring 2022.

Additionally, WVU will commence with annual quality sampling in the Fall/Winter 2021 with plans to select approximately ten youth and their families for in-depth interviews.

Regarding the data dashboard, DHHR has defined the scope of dashboard activities as *"a visual display of critical data points and statistics that provide a snapshot and offer evidence of progress towards achieving the DOJ Agreement role of reducing the reliance on mental health treatment facilities to treat children with serious emotional disturbance."*

DHHR is initiating work on the dashboard in two phases. Phase one will report on six indictors specific to children residing in mental health treatment facilities beginning February 2022; and phase two will report on six (different) indicators specific to children who may be reasonable expected to enter a

RMHTF in the near future by the end of 2022. Data will be drawn from the Medicaid Management Information System (MMIS) and the BSS Family and Children Tracking System (FACTS) system. Phase one data will include children in short- and long-term psychiatric facilities and group residential care. Phase two indicators will include children approved for and receiving services through the CSED Waiver.

Phase 1 indicators:

1. Unduplicated monthly head count for children placed in RMHTFs as of May 14, 2019 and beyond
2. The average number of children in beds per day during the month
3. Average Length of Stay* (ALoS) for children
4. RMHTF number of monthly new admissions
5. RMHTF number of prior placements* in an RMHTF
6. RMHTF number of exits from RMHTF by exit reason and outcome

Phase 2 indicators:

1. CSED active unduplicated head count
2. CSED utilization by service category 1
3. CSED average length of continuous service episode
4. CSED new enrollments
5. CSED roster with any RMHTF stay prior to CSED new enrollment 2; and as data become available, prior episodes of ACT, BBH Wraparound, or TFC
6. CSED roster with a post-service RMHTF admission; as data become available, subsequent episodes of ACT, BBH Wraparound, or TFC to be tracked

One related item to note is the West Virginia State Legislature passed House Concurrent Resolution 35 requiring DHHR to establish a continuous quality improvement system that measures outcomes for children and families in the child welfare system and outcomes for children with serious emotional disturbance served by any DHHR bureaus. DHHR is to submit a first report July 2022.

Recommendations

1. The Agreement requires reporting of data consistent with section 48, 49, and 50 within eighteen months of the Agreement, which is November 2020. The State has not met this timeline. The State has indicated that some required data elements will be available via the Data Dashboard with Phase One measures available February 2022 and Phase Two measures December 2022. The SME recommends that the State provide a written plan when reporting of the other measures in 48, 49, and 50 will occur. For example, the WVU evaluation documents provide ample details on when activities will commence but no details on when data analysis, synthesis, and findings reports will be completed.

2. House Concurrent Resolution 35 creates a considerable opportunity for DHHR to address needed infrastructure that currently challenges DHHR to access, analyze, and synthesize its data; and its ability

to rapidly initiate quality improvement strategies. The SME recommends that development of this office's scope be grounded in policy and not solely viewed as an office of analytics. One of the challenges raised by the SME in this report, and in previous reports, is that even in instances when data are available, DHHR struggles to understand the opportunities evident from the data in a timely manner and connect them to policy or practice changes. A scope that it is grounded in pertinent policy issues, and an understanding of implementation science, is necessary in order to effectively leverage and direct what analytics can provide.

3. DHRR submitted a draft CQI plan to the SME on June 30th that details how it will monitor service provision, use data to identify areas for improvement, and implement needed changes. Because the draft plan was submitted June 30th and was not discussed between the SME and DHHR prior to this written report, the SME acknowledges receipt and recommends that next steps include discussions with the SME about DHHR's planned approach. The SME commends DHHR for dedicating time and resources to initiating development of this critical step to supporting its compliance with the Agreement. Further, the SME notes the opportunity to align this work with Resolution 35 to establish an Office for Continuous Quality Improvement for children and families in the child welfare system and for children with serious emotional disorders.

4. Regarding the dashboard, it appears phase two measures report on CSED Waiver services only. The SME understands that DHHR is planning additional phases beyond phase two. For phase two, or subsequent phases, the SME recommends that DHHR also report on data from BBH or BSS related to the Agreement services. Consistent with data recommendations in this report, there is a need for consolidated data to provide an overall understanding of services received by youth. Additionally, the SME recommends that other behavioral health service received, such as outpatient therapy be included, and that data not be limited to certain services in the DOJ Agreement. In this way, a comprehensive picture of services received by youth in the target population can be understood.

5. The SME also notes overlap in membership, and potentially scope, between the Data Dashboard governance body, the Commission to Study Residential Placement, and the new House Resolution 35. The SME recommends DHHR give attention to clarifying the role of these various groups, how they connect, and how each can be leveraged to support a common goal and coordination of activities.

6. Some DOJ Agreement services, such as CMCR, Wraparound (via BBH), and Behavioral Support Services, will be provided to children who are not in the target population. While Agreement requirements are specific to data reporting of children in the target population, it will be necessary for the State, DOJ, and the SME to understand certain aspects of behavioral health service utilization for that broader population of youth receiving behavioral health services. For example, utilization of certain services by non-target population youth will inform whether the reported target population is accurate. Additionally, as the DHHR reports its provider capacity and availability, the SME will want to understand how that available capacity may be shared across the target population and non-target population. Finally, if access issues for certain services occur, an understanding of the utilization of those services by non-target population members can help inform strategies to support access for all youth, and mitigate pressures to redirect access to only the target population. The SME recommends

this is an area for discussion to include the identification of specific data points, opportunities to align with the new Office for Quality Assurance for Children, and opportunities to draw upon existing data that may already be available (e.g., Medicaid MCOs).

7. The SME notes that the workplan does not update the listed tasks and timelines. Additionally, because aspects of Agreement requirement 49 are embedded across various workgroups' tasks or being carried out by WVU as part of the evaluation, cross-walking these various documents to section 49 to have a comprehensive understanding of its status is difficult. The SME recommends that DHHR provide a written update on the status of each of these provisions.

Conclusion

Since the last SME report, the State has continued work in all areas of the Agreement. DHHR has made important inroads in several areas, including plans for training and coaching of the workforce; the development of a draft assessment pathway; planned improvements to its CSED Waiver eligibility process; planned enhancements to primary care screening and a quality review of the behavioral health-related HealthCheck requirements performed by primary care; and analysis of certain data including primary care screenings for behavioral health, cluster analysis of children in residential care, and a survey of residential providers. Additionally, there are several areas of DHHR's workplan that appear on track for completion in the coming six months, including an initial data dashboard, roll-out of training, and initial reports from the WVU-led evaluation.

One area of work that has realized little change in this past 6 months is reductions in residential interventions. The SME recognizes the effort DHHR made during these last 6 months to design the assessment pathway, institute deep dive reviews and a commissioner-level sign-off policy for out-of-state placements, analyze residential data, and survey residential providers. These are critical strategies that can impact residential placements, and this is vital work that must continue. However, these activities, while important strategies, have not yet had impact, and children remain unnecessarily in residential placements today. DHHR's goal of a 25% reduction in residential placements to a total of no more than 822 youth is 18 months away. The SME recommends that DHHR prioritize its resources to address the recommendations for reducing reliance on residential interventions, culminating in a clear, written plan for reductions.

Appendices

Appendix A — Reviewed Documents Received During the Report Period

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

General Organizing Documents

20210323_WV DHHR DOJ MOU_Project Plan
20210630_Full_List_Of_Deliverables FINAL
20210706_Additional_Progress_Report_Documents
20210630_Progress_Report_Cross_Walk
Anticipated data points and sources for June 2021 report 20210721
Anticipated_Data_Points_Sources_June_2021_Report_Response
Master Project Plan updated 20210630
20210419_DOJ Target Population FINAL
SME outstanding items and questions from June 30 docs update 20210715
SME outstanding items update 20210721
Anticipated_Data_Points_Sources_June_2021_Report_Response

Evaluation

CWE_caregiversurvey_04012021.pdf
CWE_DOJAgreementandEvalOutcomes_04012021.pdf
CWE_Organizationsurvey_04012021.pdf
CWE_providersurvey_04012021.pdf
CWE_Youthsurvey_04012021.pdf
WVU DOJ Evaluation Plan_20210408
WV DHHR Child Welfare Evaluation Plan_04022021

ACT

ACT Provider Scoring Example 20210624
ACT related clarifications for the report (Email from Annie Messinger, July 20, 2021 at 3:57 pm)
ACT Scoring Tool KEPRO
ACT utilization and length of service (LOS) data for 2020
ACT_Start-up_Contract_Mountaineer_Behavioral_Health_draft
Medicaid ACT Utilization for Ages 18-21 (AH 456)
Redacted ACT Review Overview Summary

Assessment

20210125 Assessment Entity Opps Challenges.pdf
Assessment Pathway V.1.5 approved 20210503
Assessment Work Flow
West_Virginia_FAST_Interview_Guide

West_Virginia_FAST_Manual
WVDHHR_Pathway_Series_Drafts

CMCR
Children's Mobile Crisis Response and Respite TA Call notes 5.12.2021
Children's Mobile Crisis Response Manual (draft)
CMCR Monthly TA Calls (Jan 2021-Apr 2021)
CMCR Referral Line Monthly Vendor Reports Jan to May 2021
CMCR Referral Line Vendor Outreach 2021 20210329
CMCR_Region_2_Mobile_Crisis_Launch_Support
FirstChoice CMCR marketing and outreach
FirstChoice_Contract
Mobile Crisis Charts_Jan to May 2021

CSED Waiver
2021_Draft_Edits_CSEDW_Public_Comment-Log 3 30 21
Aetna CSEDW Service Review Through 6.30.21
Anticipated_Data_Points_Sources_June_2021_Report_Response
Approval Letter for CSED Waiver Amendment
Chapter 502 CSEDW-DRAFT FOR PUBLIC COMMENT THRU JULY 2021
CSED Waiver data
CSEDW Amendment Application 7.1.21
CSEDW Applications 20210716
CSEDW Claims Data for DOJ March 1 2020 thru April 30 2021
CSEDW Claims Data Mar 1 20 thru June 30 21 w age breakdown
CSEDW Denied Application Reasons
CSEDW MCO Data Report Apr-May 20210603
CSEDW Member County Breakdown March 1 2020 thru April 30 2021
CSEDW Provider Detail for Providers Chosen for Services Mar 1 20 thru Apr 30 21
CSEDW Provider List 20210625

Outreach and Education
Children's Media and Outreach Meeting Minutes 03.26.21
DHHR_Communications_for_DOJ_Outreach_and_Education_Procedure_Memo
DHHR_List_Stakeholder_Engagement
ESC Outreach PPT slides shared at 2-22 meeting
MCO_Outreach_and_Education_Report
Memo_to_DHHR_Senior_Leadership
Outreach and Education Grid 20210622_v3
Sample_DHHR_Email_Blast_Communication_Draft
WVDHHR_Implementation_Plan_Public_Comments_Year_2

PBS
Concord University SOW (draft)
Concord_University_Proposal
FY22 WVU Research Corp PBS SOW.docx
PBS Report April 2021
PBS February 2021
PBS January 2021
PBS Report March 2021
PBS Report May 2021
PBS_State_Plan_Medicaid_Modifier_Draft
WV PBS Proposal Final.doc
WVU_CED_SOW_Draft

QAPI
20210130 QAPI Phase 1a Indicators Arbiter Discussion
20210308 ESC QAPI Presentation
Continuous Quality Improvement planning presentation
HOUSE CONCURRENT RESOLUTION 35
Phase_I_Indicator_Physical_Data_Specifications_FACTS
QAPI Phase 1a Indicators 20210304
QAPI_Phase_1a_Indicators_Draft
QAPI_Phase_2_Indicators_Requirements_Data_Sources_DRAFT
SampleDraftVizforDOJ20210406 (002)

R3
DD List for Dep Commissioner
Deep Dive 4.21.21
Deep Dive Guidelines
Foster care age gender type breakout report-7-26-21
In State Child Placement Report-7-26-21
June 2021 Deep Dive Special Review Report
Monthly_Legislative_Report_May_2021
R3 Categories of Stakeholders rev 20210611
R3_Provider_Survey_Summaries_20210221
R3_Provider_Survey_SurveyMonkey_FINAL
R3_Stakeholder_Notes_Cluster_Analysis
RMHTF_Provider_Survey_Results_DRAFT
WVDHHR_Pathway_Series_Drafts
WVDHHR_Weekly_Count_Residential_Placements_Utilization_Trend

Cluster Analysis
20210426 Long-Term Capacity Goal Graph DOJ
WV Youth in Group Residential and Psychiatric Residential Treatment Facilities-final-02-22-2021
WV Youth in Group Residential and Psychiatric Residential Treatment Facilities-Supp-Draft-03-18-2021
WVDHHR Latent Class Analysis slide Deck DOJ 20210426

R3 Educational Materials
R3 Assessment Role to Guide Appropriate Placement Slide Deck
R3 BBF Family Finding Training Plan Schedule Apr 2021
R3 Did You Know – Normalcy
R3 Informational Brief on Continuum of Care
R3 Informational Brief on Negative Effects
R3 Knowledge Action Power Email
R3 Service Array Blackboard Course Flyer

Screening
05-28-2021 Pediatric Medical Advisory Board Meeting Minutes
BMS_Reporting_MCO_EPSDT_1.4 Guide
Enhanced EPSDT Indicators of Serious Emotional Disturbance
Mental_Health_Screening_Infographic
MH Screening BJS Notes SME 20201203
MH Screening Chart Review Algorithm SME 20201201
MH Screening MAYSI Protocol for Rehabilitation Centers
MH_Screening_Tool_Job_Aid
New_MCO_Contract_Language_effective July 1, 2021
OMCFH DOJ Report w Executive Summary – FINAL
PCP_Referral_Assessment_Pathway_Draft_SOP
RE_Screening Related Items to Confirm (Email from Annie Messinger, July 14, 2021 at 1:49 pm)
Revised_EPSDT_Health_Screening_Forms
West_Virginis_FAST_Interview_Guide
West_Virginia_FAST_Manual
Youth Services January 2021
Youth_Services_Revised_Family_Guide

EPSDT MCO Data Reports
BMS_Reporting_MCO_MHP_ESDT_20210514_1.2
BMS_Reporting_MCO_MHT_ESDT_20210514_1.2
BMS_Reporting_THP_EPSDT_05172021
BMS_Reporting_UC_EPSDT_Q1_20210517
NavigantB_0511_BMS1800000002_01-Lewin

TFC
2021_TFC_Capacity_Review
20210607_Notes_TFC_Stakeholder_Meetings
20210623_Notes_TFC_Stakeholder_Meetings
20210630_Notes_TFC_Stakeholder_Meetings
20210707_Notes_TFC_Stakeholder_Meetings
Anticipated_Data_Points_Sources_June_2021_Report_Response
New_CPA_Contract (draft)
TFC_Proposal_20210325_mgj SF
TFC_Proposal_20210325_mgJ SME final 4-12-21_WV response1
TFC_Proposal_20210526_post SME meeting DRAFT
TFC_Proposal_DRAFT_20210630

Wraparound
Anticipated_Data_Points_Sources_June_2021_Report_Response
CMHW Application Data June 2020 through June 2021
DHHR SOW with Marshall University for Wraparound Facilitator Training and Fidelity Evaluation (draft)
Marshall University SOW with UMB for NWI Fidelity Training
Wraparound_Facilitator_Training_Materials_June_2021
WV Wraparound Manual Draft

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

Meetings	Dates
Department of Justice	Jan. 5, 2021; Feb. 3, 2021; Feb. 4, 2021; March 2, 2021; April 6, 2021; April 7, 2021; April 28, 2021; May 5, 2021; June 2, 2021; June 9, 2021; June 16, 2021
WV Implementation Team/Leadership	Jan. 4, 2021; Jan. 25, 2021; May 25, 2021
Child Welfare Collaborative	April 20, 2021
Calls with C. Chapman	Jan. 6, 2021; Jan. 13, 2021; Jan. 20, 2021; Jan. 27, 2021; Feb. 3, 2021; Feb. 10, 2021; Feb. 17, 2021; Feb. 25, 2021; March 10, 2021; March 17, 2021; March 25, 2021; April 7, 2021; April 26, 2021; May 5, 2021; May 12, 2021; May 19, 2021; May 26, 2021; June 9, 2021; June 16, 2021; June 23, 2021; June 30, 2021
Stakeholders	June 7, 2021
CMCR	Feb. 26, 2021; March 9, 2021; April 7, 2021
Wraparound	Jan. 22, 2021; March 9, 2021
TFC	March 30, 2021; June 7, 2021
Screening	March 1, 2021; May 3, 2021; June 16, 2021
Assessment	Jan. 12, 2021; Jan. 15, 2021; Jan. 20, 2021; March 29, 2021; May 5, 2021; June 15, 2021; June 16, 2021
PBS	March 9, 2021; June 2, 2021
Outreach and Education	March 3, 2021; June 24, 2021
CSED Waiver	—
Data and QAPI	Feb. 26, 2021; March 9, 2021; June 9, 2021
R3	Feb. 24, 2021; June 10, 2021
ACT	March 9, 2021; June 22, 2021

Appendix C — Summary of Recommendations and Information Sought

	Workforce	
	Recommendation	*Status Updates*
1	Reconvene the State's Workforce Workgroup with a focus on data, both data needed and data available, to inform availability of sufficient providers. See page 5 for a list of recommended components of this plan to ensure provider availability.	
2	Ensure that the workforce plan addresses how the State will work across bureaus and agencies and with its MCOs and other vendors (e.g., include MCO requirements regarding specific hiring or contracting plans, coordinate with universities regarding knowledge and skill development for HCBS).	
3	Given challenges with initiating workforce plan, begin with a sector-specific approach, such as focusing on workforce needed to deliver Wraparound, from which to further build a behavioral health system-wide workforce plan described in recommendation two. Wraparound is a promising starting point because of the important role this service will play in supporting DHHR to meet its goals and because the State is already discussing Wraparound workforce development.	
	Target Population	
	Recommendation	*Status Updates*
1	In testing the proposed target population, include a methodology to assess whether access issues to certain required services result in a reduced number of types of children who would be identified as at-risk.	
2	Establish and implement a clear monitoring plan to ensure that families can access the pathway and assessments for the waiver in a timely way, particularly given the limited types of providers that are approved to conduct CSED Waiver determinations.	
	Provide written clarity on oversight of the target population monitoring function. See pages 10–12 for a list of specific recommended items to include.	
3	Ensure that the testing of the target population is sufficient in scope to demonstrate that the proposed criteria are consistent with the intended	

	target population, including but not limited to the recommendations below.	
	Confirm consistent language across documents regarding a cut score of "at 90 or above" (versus "above 90").	
	Demonstrate that youth with scores below 90 do not result in risk for residential interventions and a need for intensive home- and community-based services that indicate risk (e.g., frequent CMCR services, repeated inpatient placements, other out-of-home placements).	
	Clarify in the methodology how a risk of RMHTF placement "in the next 30 days or less" is determined. Specifically, the SME recommends that the State use CAFAS/PECFAS scores as a proxy for immediacy of need and therefore timeline. If the State chooses another approach, the SME recommends additional steps to define criteria, train providers, provide quality oversight, etc. (See page 11 for details.)	
	Include a standalone ADHD diagnosis within the SED definition.	
	Clarify whether a child will remain in the target population data set indefinitely or whether the data will be refreshed based on an annual re-determination process.	
4	Determine what method(s) will be used in testing the draft operational definition (e.g., prospective test period, retrospective look-back, a combination). (See pages 12–13 for recommendations specific to each method.)	
	Propose a reasonable timeframe for testing the operational definition that will align with the WVU evaluation timeline. The testing may need to occur in phases given the availability of data.	
5	Decide how to address (for the purposes of target population identification) families that decline to pursue the CSED eligibility determination process.	
6	In testing the definition, include a methodology to capture co-occurring substance use conditions to ensure that a primary diagnosis of SUD does not exclude a child from the target population if they also have a mental health diagnosis from a different provider.	

CSED Waiver		
Note: The recommendations in this section are specific to the CSED Waiver process, operations, or materials. Additional recommendations specific to services approved in the CSED Waiver are addressed in the service sections that follow.		
	Recommendation	*Status Updates*
1	Carefully crosswalk the CSED Waiver policy manual with the newly-approved waiver amendment to ensure consistency and clarity, given slight language differences across documents, particularly for areas that include important expectations for providers.	
	Align provider expectations with DHHR's commitment to NWI standards. For example, the manual states that Wraparound Facilitators' caseloads are capped at 1:20 while DHHR has previously indicated that it would message to providers the expectation of a 1:10 caseload ratio.	
2	Allow the SME to review the standard operating procedure regarding how BMS is monitoring utilization of waiver services.	
	Allow the SME to review BMS's standard operating procedures, e.g., how it communicates to providers that additional units beyond the caps can be sought, information required by the provider to be submitted for review, and how the state reviews these requests, along with the number of such requests received annually.	
	Incorporate information into the provider manual about providers' ability to seek additional units beyond the stated caps and the process for doing so.	
3	Provide the SME with the standard operating procedure for how the MCO monitors service utilization.	
	Task the MCO with monitoring underutilization of Medicaid services for this population of children and families, in addition to overutilization.	
4	In partnership with the vendor, develop an SOP to monitor that services are individualized to meet the needs of the youth (compared to a standard, one-size-fits-all approach).	
	Indicate in a standard operating procedure (or other document) how DHHR monitors quality and provides oversight to these tasks that it may require of its vendor as part of its own DHHR quality oversight plan.	
Screening and Assessment		
	Recommendation	*Status Updates*
S1	Develop a written plan and implement a process to monitor DHHR staff compliance with the	

	respective bureaus' policies regarding the screening tools, including what data will be collected and action steps DHHR will take based on the data to improve quality and compliance as needed.	
	Scale efforts to monitor compliance (e.g., random reviews of staff with documentation in Excel for some bureaus) across all bureaus with coordination in approach and consistency in data collected and timelines.	
	Formally update DJS policies now that it is part of DCR.	
S2	Use a consistent set of data across all bureaus, vendors, primary care clinicians, schools, and any other behavioral health screening entities/professionals to ensure a comprehensive understanding of behavioral health screening rates. This recommendation includes ensuring consistency in data collected, how they are defined, timelines for collection, and plans to identify and implement action steps to address data trends.	
	Implement a consistent set of data, methodologies, quality oversight and improvement approaches, and timelines across all bureaus and vendors that DHHR provides in a single, comprehensive presentation of behavioral health screening.	
	Collect data from all bureaus, vendors, and primary care clinicians, schools, and other behavioral health screening entities/professionals: • a single count of behavioral health screenings conducted • number of youth expected to be screened (e.g., number of youth in child welfare, number of youth with primary care visits, etc.) • percent screened • number of positive screens • percent of positive screens • number referred for behavioral health services and supports • percent referred for behavioral health services and supports • where possible, outcome of the referral (e.g., use of a behavioral health service)	

	As part of the quality plan, report on areas for quality improvement and actions steps planned on an ongoing and regularly scheduled (versus ad hoc) basis.	
	Develop a mock-up of a screening data report.	
S3	Adopt a quality improvement framework that, like OMCFH's record review report, is grounded in the gathering of information, analysis of qualitative and quantitative data, synthesis of policy implications, transparent engagement with stakeholders, and use of a quality improvement planning process with delineated action steps.	
S4	Provide the plan for completing the record reviews for populations ages 0-5 and 18–21, including the timeline and any changes to the approach or methodology.	
S5	Propose a plan for assessing if the questions added to the HealthCheck form help DHHR further identify the target population.	
S6	Address in the quality oversight plan what data and approach the State will use to monitor both non-SED children and SED children and their respective pathways.	
S7	Develop a single standard operating procedure detailing how primary care referrals are made for behavioral health assessments and services with the planned details for how different referrals are handled in order to avoid confusion for primary care providers and ensure that children get access to needed behavioral health assessments as quickly as possible.	
S8	In developing the OMCHF quality improvement plan, develop a policy and action steps to remedy in a timely way any children who did not receive required screens and to determine if there are any trends in who is not screened, including by which providers or by regions of the state.	
	In developing the OMCHF quality improvement plan, clarify the policy on how the behavioral health screening requirement further informs any services that children already engaged in mental health services are receiving.	
	In developing the OMCHF quality improvement plan, examine which populations of children are not seen by primary care (and therefore would not be captured by this data set). In general, the plan should include activities to identify, quantify, and track the population of children who are not receiving behavioral screens. Working with	

	schools to reach these children will be an important aspect of this work.	
	In developing the OMCHF quality improvement plan, address variations in screening rates by age of youth, noting that older adolescents receive fewer behavioral health screens than younger children.	
	In developing the OMCHF quality improvement plan, address regional differences in screening rates, as well as any differences by type of provider (e.g., providers with larger panels or across different primary care disciplines).	
	In developing the OMCHF quality improvement plan, track whether children with positive screens accessed care.	
S9	Move forward with adding modifiers to the EPSDT reporting system in order to capture this data from the MCOs.	
A1	Provide written clarity to bureaus, vendors, and providers regarding the relationship between the CAFAS/PECFAS and the CANS, the purpose for each tool, how information from each will be incorporated into the use of the other instrument, and how any conflicting information will be resolved between the two instruments.	
A2	Require all assessment Agreement requirements apply to the CAFAS/PECFAS. Specifically, DHHR should establish in its contracts, operating procedures, and other documents standards for the CAFAS/PECFAS on par with the CANS, including provider qualifications, training requirements for qualified individuals, and quality oversight.	
	Report on the number of youth receiving CAFAS/PECFAS initially and through any re-determination process, as well as the functional scores derived from the CAFAS/PECFAS consistent with the data planned for the CANS.	
A3	Include in the assessment process caregiver and youth self-report measures that allow a youth and caregiver to directly report their needs (i.e., SDQ, Ohio Scales, or CIS), particularly for Wraparound.	
A4	Partner with Marshall University as it continues to support use of CANS as part of behavioral health assessments, including efforts for consistent training and coaching to ensure CANS is delivered by a qualified assessor.	

A5	Update the work plan to reflect the considerable tasks specific to the assessment pathway that are not yet captured in the work plan, including timelines, owners, and interdependencies with other workgroup activities.	
A6	Begin reporting CANS data, including the number of assessments using the CANS and changes in functioning ability noted in subsequent re-administrations, per requirements in the Agreement.	
Wraparound Facilitation		
Recommendation		*Status Updates*
1	Monitor applications and enrollment by age groups (see Table 4 on page 28 as an example) to ensure that eligible groups ages 3–21 are represented, that the CSED Waiver enrollment aligns with the age trends seen in the residential placement data, and, for youth deemed at-risk, that the waiver is diverting those youth and supporting their success in the community.	
2	Present data related to the CSED Waiver process (including data points DHHE has already been reporting) on a consistent basis to the SME and DOJ. A coordinated, comprehensive view based on the other available data points provides actionable information to inform DHHR's priorities and provides a clearer picture of CSED Waiver activity.	
	Engage in ongoing monitoring of waiver denial reasons to inform the target population operational definition test period, shape training and education to independent evaluators, inform possible changes to the CSED Waiver process or requirements, and serve as an important oversight activity for DHHR as it strives to ensure quality and access.	
3	Develop a coordinated suite of reports that are routinely analyzed and synthesized for oversight and decision-making. The SME is available to provide technical assistance as DHHR develops this suite of reports, a plan with a clear timeline, mock-ups of the reports needed, and its strategies for using the data to support DHHR's oversight.	
4	Share the comprehensive suite of reports across the DOJ Agreement workgroups, so that the workgroups can understand the data trends that inform the key issues they are addressing.	

5	Building from the redacted Aetna CSEDW Service Review, create a report that allows for more quantifiable data that can be analyzed and reportable on an ongoing basis. This type of data could also be used to support fidelity efforts to ensure that services are individualized to the youth and family and to stratify data by provider to support DHHRs quality oversight; inform an understanding of system strengths; and identify challenges that require training, support, or policy revisions.	
6	Consistent with the intent to create a single unified Wraparound approach, report data across CSED Waiver and BBH-funded Wraparound in a combined way to facilitate an understanding of what is happening specific to Wraparound for enrolled children.	
	Coordinate reporting on Wraparound across the different funding sources for certain categories that align with its assessment pathway, such as requests for services, recipients of services, and discharges, even if BBH-funded Wraparound services cannot collect the same extensiveness of data as for the CSED Waiver services.	
	Share the combined data across workgroups to inform related tasks.	
7	Consolidate the assessment pathway approach to minimize the bifurcated approach across BBH and KEPRO.	
	Clarify what services will be offered interimly while CSED waiver eligibility occurs in order to avoid change in provider or services offered once CSED Waiver eligibility is known.	
8	Engage in further analysis to understand how youth receiving BBH-funded Wraparound fit with the DOJ Agreement target population.	
	Ensure that the ongoing assessment of provider capacity is consistent with the demand for services for both the Agreement population and the broader population of West Virginia youth.	
9	Report CSED Waiver Member Count by County data as part of a coordinated suite of data with similar methodologies and timelines in order to provide a comprehensive understanding of Wraparound's reach in the communities across West Virginia.	
10	Engage in further analysis regarding in-home therapy services including:	

	• an assessment of the needs of youth receiving in-home family therapy and in-home family support • clarity on the approaches or models providers are using to meet those needs, including if models are consistent with intensive in-home family therapy models or more consistent with individual therapy with the child that happens to be occurring in the home • opportunities for DHHR to strengthen provision of this important service, including clarifying what it does/does not want to purchase, training approaches to support its desired best practices, and ensuring that reimbursement rates and policies support effective delivery of this service	
11	In developing the suite of reports, include other state plan services, such as outpatient therapy and inpatient, in order to understand how Wraparound is activating all services available to youth and the scope of service provision happening.	
	Track and report on lengths of stay, readmissions, age, and concurrent service utilization of all children receiving Wraparound. This report should be coordinated across payers with consistency in how data is reported from those two bureaus.	
12	Engage in further development of data to understand the service intensity and service mix. Monitoring of what is happening requires real-time data; data sources may include claims data, authorizations, provider-reported data, or some combination.	
	Develop a way to track and monitor inclusion of Plan of Care reviews (and/or informal and community supports) to capture the totality of what families find helpful to address their needs in order to build meaningful service arrays inclusive of non-traditional supports.	
13	Update the work plan to reflect revised dates and new and amended tasks.	
Children's Mobile Crisis Response		
	Recommendation	*Status Updates*
1	Offer a single, coordinated CMCR service in West Virginia instead of two separately operated and contracted services for different populations; a	

	single coordinated approach can still be achieved while leveraging different funding sources for different populations.	
2	Coordinate data reporting across the different funding sources to have a comprehensive picture of what is happening in West Virginia. The SME recommends that DHHR work with SME to develop a mock-up of the reports.	
3	Build from the foundation of the FirstChoice call center Excel spreadsheet to create a quantifiable report that can provide a clearer understanding of the number of calls received, the type of need, which services were connected to (especially CMCR and Wraparound), how the call was resolved, and if follow-up to an initial call occurred.	
4	Incorporate training and outreach data into a coordinated suite of reports specific to CMCR, consistent with other data recommendations in this report.	
	Ensure that First Choice activities and priorities include both a statewide and regional focus and that its outreach and education activities are informed by the data.	
5	Synthesize data to understand the reasons for the regional variation in CMCR activity and identify the DHHR quality oversight activities it plans to address the variation.	
	Specific to telephonic services, engage in further analysis and monitoring to determine if services provided telephonically were in response to COVID-19, or are reflective of, for example, differences across providers in their practice of CMCR, capacity issues and inability to travel onsite within 60 minutes, families' requests/choice, or are scheduled follow-up check-in calls from previous in-person CMCR services.	
6	Prepare for SME review of and comment about the draft CMCR Provider Manual and participate in discussions with the SME about the manual.	
7	Include in the CMCR training an overview of all DOJ Agreement services and all other behavioral health services funded by DHHR and how CMCR services work with other services; schools, BSS caseworkers, MCOs/ASO, and the FirstChoice crisis and referral line; use of any standardized tools such as the CANS, CAFAS/PECFAS, the Crisis Assessment Tool (CAT), etc.; expected outreach	

	and education efforts; and required quality, outcomes, and data reporting.	
	Share deliverables, including the training plan, proposed timeline, approach, and training content, with the SME for review.	
8	If DHHR has training content requirements for agencies above and beyond a provider's completion of the statewide Marshall University training, and DHHR is not providing the standardized curriculum for those trainings, review and approve the training content offered by each provider agency to ensure consistency in training elements across the state.	
9	Incorporate CMCR data into other workgroups to inform interconnected tasks and decision points, such as the assessment pathway work, redirection from residential interventions, and coordination with Wraparound.	
10	Update the work plan to reflect revised dates and new and amended tasks.	
Behavioral Support Services		
	Recommendation	*Status Updates*
1	Upon completion, provide the SME the deliverables for review, including the training plan, proposed timeline, approach, and training content.	
2	In the assessment pathway, clarify the connection to behavioral support services—particularly for youth who may and those who may not meet CSED Waiver eligibility—in order to ensure timely access including how families, schools, behavioral health providers, courts/judges, and staff from all three bureaus can access the service.	
3	Provide the SME with a draft of the behavioral support services specific changes to the provider billing manual to allow for discussion and incorporation of any SME comments before it is finalized.	
4	Develop a quantitative report that allows for synthesis and action planning and that allows behavioral support services-related data to be used by other workgroups to inform interconnected tasks and decision points, such as the assessment pathway work, redirection from residential interventions, and coordination with Wraparound.	

5	Discuss the "Risk of Out-of-Home Placement" field in a provided Excel spreadsheet so the SME can understand how the state plans to use this information, if at all, to support the identification of the target population. Specifically, the SME seeks to understand how this information will be used and how it will relate to the use of the CAFAS/PECFAS and criteria for CSED Waiver eligibility.	
6	Given the high volume of referrals from schools, in the assessment pathway clearly describe access to behavioral support services and how providers will use a standardized assessment tool to ensure children are appropriately referred to services and supports, including Wraparound.	
7	Clarify how recipients receiving behavioral support services will be included in the "at-risk" population planned for the target population and for the second phase of the evaluation. This is an opportunity for the QAPI and behavioral support services workgroups to coordinate related tasks.	
8	Update the work plan to reflect revised dates and new and amended tasks.	
Therapeutic Foster Care (TFC)		
Recommendation		*Status Updates*
1	As the parties discuss interpretation of the Agreement, consider the SME recommendation that children, regardless of foster care status, can benefit from therapeutic foster care, especially as an alternative to other out-of-home placement settings.	
2	While the model is in drafting stage, clarify functions and roles of TFC vis-à-vis other coordination and service activities, including: • The role of Children's Mobile Crisis Response, CPAs and treatment foster homes when a child experiences a behavioral health crisis • The role of Wraparound, CPAs, and the MCO regarding coordination of care functions • Ensuring that children in TFC receive all Medicaid and other state-funded behavioral health services for which they are eligible • How the State plans to respond to suggestions raised during discussions with providers about perceived duplication between TFC services and CSED Waiver services, and the suggestion to offer CSED	

	Waiver services following TFC enrollment versus concurrently	
3	Further differentiate TFC from traditional foster care homes and homes for children with medical complexity. This will be of particular importance in the process of phasing in the new model, as many TFC providers are serving children who do not meet the eligibility criteria.	
	Plan for the likelihood that it will be challenging for TFC caregivers to have a child leave their care when they no longer meet that level of need for TFC; this is an area where support should be given, and CPAs should ensure they are recruiting new homes with the understanding that this is a treatment intervention and not a long-term living arrangement.	
	Explore how different homes for children with medical complexity may look, the requirements and expectations of those providers, and when a child can be served in which environment. The length of stay of the child may also vary, depending on whether the child's admission into that specialized home is driven by medical needs, behavioral needs, or a combination.	
4	Continue to develop a clear implementation plan for the phasing in of the new TFC model.	
	In the plan, prioritize minimizing disruptions to children who currently are in FC homes but may not meet the criteria under the new TFC model. Specifically, a phasing plan will need to assess and monitor capacity, with an accounting of currently placed children's planned length of stay so the state will understand when existing capacity could be available, and the timing of new TFC homes that may be available.	
	Support providers during this transition plan to avoid providers feeling undervalued or that their efforts are not adequate or meaningful. Work closely with the provider community and identify key champions that will assist with the direct messaging to CPAs and, most importantly, to the TFC families.	
	Engage the providers in sharing their expertise and knowledge about what has worked and where challenges exist, both in initial and ongoing implementation.	
5	Meaningfully engage families and youth in model development, refinement, and ongoing implementation.	

	Identifying some families and youth involved with foster care and some TFC parents to co-develop tip sheets about what works and what does not work.	
	Utilize resources from the HHS Children's Bureau's National Quality Improvement Center on Family-Centered Reunification (https://qicfamilyreunification.org/), including its best practices guide, to help identify strategies to support effective treatment and reunification.	
	Identify families with lived experience, youth or young adults currently or formerly involved with foster care, and TFC parents to provide input on the model and its implementation, both initially and in an ongoing way. The SME encourages the State to compensate the families and youth financially.	
6	Continue to listen to providers to find out the existing barriers to integrating services and issues with role clarification and develop an intentional training and technical assistance approach to address this, including clear, written expectations and review protocols.	
	Engage in a transparent and ongoing process to obtain feedback on the proposed TFC approach. This will enable the State to make adjustments to both the approach and the associated training and ongoing technical assistance provided.	
7	Review all assessment pathway materials to ensure that TFC is included as an option and further supports redirection from residential interventions during the phase-in process and in the future.	
	Review the children in residential care to determine how many may meet eligibility for TFC and determine a pathway to TFC out of residential care whenever possible.	
	For children in TFC who do not meet eligibility, track capacity as these children reunify with families, otherwise achieve permanency, or leave these homes.	
8	Create a detailed plan for collecting, reviewing, analyzing, and reporting on timely access to TFC, per the terms of the Agreement, as well as other prioritized performance and outcomes measures.	
	Consider aligning this monitoring and reporting process with the other processes under the Agreement, as well as with reporting necessary	

	for Family First Prevention Services Act implementation.	
	Consider monitoring for any concerning trends with regard to psychiatric emergency room use and hospitalizations, residential interventions, re-entry into foster care, and entry into the juvenile justice system.	
9	Revise the training and coaching for TFC parents. The State and its contracted TFC agencies must create a robust training and coaching program that specifically addresses children with SED.	
	Incorporate an evaluation methodology to assess whether the training is effective in assisting TFC parents in acquiring, retaining, and utilizing the skills necessary to maintain children in their initial TFC placement. Such skills typically include trauma-informed care, behavior management and positive behavioral reinforcement techniques, crisis management, de-escalation techniques, and stress management/self-care for TFC parents.	
10	Conduct a needs assessment that includes: • agency and organizational factors that may bolster or hinder training and coaching, such as staffing needed for training and supervision • the recruitment and retention of foster parents willing to meet training standards • the infrastructure needed to maintain training and coaching, including whether such a program would be State-led or rely on an outside purveyor to develop training materials • development of a monitoring and evaluation plan	
11	Provide written guidance to the ASO on all functions and expectations it is expected to perform on behalf of the State, clearly explaining how the State wants KEPRO to monitor youth and the reports the State wants to receive.	
12	With the foster care procurement completed, develop a clear, consistent work plan with measurable and actionable goals, each with a clear owner, and firm deadlines in order to begin implementation of the intended TFC service.	
	Revise tasks from previous workplans to reflect decisions, including the targeted recruitment and evaluation activities related to TFC.	

13	Update the work plan to reflect revised dates and new and amended tasks.	
Assertive Community Treatment		
Recommendation		*Status Updates*
1	Use the quality review process in place to monitor fidelity to the ACT model and provider-specific reports as a model for similar approaches to other DOJ Agreement services.	
2	Once the assessment pathway work is complete, finalize a standard operating procedure describing how a member will be offered choice between ACT and Wraparound.	
	Develop an oversight plan that includes data that will be collected and a description on how DHHR will monitor that choice is being provided to youth.	
3	Regarding data: • Share ACT data on an ongoing basis • Report utilization and lengths of stay by Medicaid FFS or Medicaid MCO • Share data with other workgroups, particularly Wraparound, to support monitoring of choice.	
4	Update the work plan to reflect revised dates and new and amended tasks.	
Reductions in Placement		
1	Identify key questions and then coordinate a suite of reports, specific to understanding residential interventions for this Agreement. In addition to tracking the required reduction in the number of youth, other data relevant to quality need to be analyzed, including lengths of stay, repeated admissions, or changes in admission facility type during a single episode of care. This data should be stratified by provider, age, race/ethnicity, gender, LGBTQ+, and county of origin.	
	Collect and analyze data on which systems children are entering residential interventions from and the decision source of the child's residential placement (e.g., judges/courts, MDTs). Both policy and practice will need to be addressed and modified or corrected if the State is to successfully address the "front door" through which children are first referred to and secondarily authorized for residential care, including out-of-state placements.	

	Further explore data to identify disproportionalities in the number of children who are Black, Indigenous, or People of Color in the numbers served in group care and PRTFs, both in-state and out-of-state.	
	Receive data that allows the State to understand an unduplicated count of children and each child's length of stay on a monthly basis (compared to an ad hoc report from each MCO).	
2	Institute a formal written policy and procedure regarding Commissioner-level sign-off.	
	Review data from Aetna's deep dive process and from the Commissioner-level reviews to understand what impact the reviews are having, what action steps are resulting in positive change in placement for a youth, what actions are not resulting in any change, differences across placement, and youth needs.	
3	Conclude with the data synthesis, policy planning, and decision-making about action steps, so DHHR can present and share these findings with providers, families and youth, stakeholders, and DHHR caseworkers and other relevant personnel, to solicit input and recommendations.	
	Determine planned actions steps based on what DHHR learned from the cluster analysis, provider survey, and discussions with stakeholders and incorporate it into its plan to redirect youth from residential interventions.	
4	Include in the action plan resulting from the cluster analysis the distinction between the behavior health needs of youth and the levels of intervention needed (i.e., decoupling the intensity of intervention from a placement location).	
	As this shift occurs, ensure that emergency shelter placements are not used as a substitute for other residential placements and are accessed solely when it is in the best interest of the child and is the least restrictive, most community-based setting available.	
	Given the numbers of youth in all classes that are wards of the state, adjudicated, or deemed status offenders, develop a plan to work across bureaus and departments to develop individualized plans specific to each.	
	Create a population overlap on top of the county and judicial districts to help determine differences	

	in philosophy and approach versus service gaps which may drive decision-making.	
	Carefully review and discuss the population labeled as class one, including how this population (particularly for the youth out-of-state) found its way to residential interventions. This review will inform which pathways need to be redirected, including engagement with caseworkers, judges, and other systems that may perceive residential interventions as an appropriate placement location versus a behavioral health intervention.	
	Develop a plan to discharge youth in class one to the most appropriate home setting and connect them to treatment needs. This step is particularly important for those youth in out-of-state locations for whom connection to in-state services prior to discharge will not be possible.	
	Based on the number of youth involved in the Youth Service system, develop a strategy and written plan to actively engage the judicial system in committing to a reduction in residential placements. A plan can be initiated while data are still being gathered; see pages 56–58 for specific recommendations for what should be considered in this plan.	
	Explore the opportunity for judges to commit to a "pilot" approach, thereby building new/renewed connections to home- and community-based services between judges, families, caseworkers, and behavioral health providers.	
	Further review class two, many of whom may be in residential as a placement versus as a treatment need. For example, carefully assess youth with substance use to determine concomitant mental health needs. In addition, determine if services are adequately available to meet this population's needs, what additional services may need to be developed, and/or if behavioral health clinicians need additional training and support to work with these populations effectively.	
	Carefully review the data on the youth included in class two, particularly for disproportionality and overrepresentation of youth who are Black in residential care. Examine data to identify action steps, including examining policies across DHHR and courts for implicit bias; training for behavioral health professionals, judges/court personnel, and	

	DHHR personnel; and engaging families and Youth of Color in identification of challenges and opportunities for improvement.	
	Stratifying length of stay data by class to help delineate additional factors that may be maintaining residential interventions. This process will help DHHR identify specific factors to address in order to inform engagement strategies with key stakeholders, inform policy and procedure changes, develop or modify training and coaching to support improved practice, and inform system-level indicators to monitor the system.	
	Implement a specialized working group, with additional outside consultation if needed, to review the data specific to youth with an autism spectrum disorder or a developmental disability, assess current and additional service needs, and develop recommendations specific to meeting the needs of this group of youth.	
	Facilitate specific training and coaching for residential providers to ensure that treatment and supports are trauma-responsive and recognize chronic, community, and inter-generational trauma and their impacts on goal-setting, engagement, treatment planning, and outcomes.	
5	Determine actions steps resulting from the analysis of responses to the DHHR survey of residential providers. Include these actions steps in the coordinated reductions in residential plan.	
	Further explore the specific services that residential providers currently offer to support children transitioning from residential interventions. It is also necessary to understand the remaining group of residential providers (approximately half) who indicated that they did not provide aftercare or transitional services when a child returns home; increasing providers' capacity to deliver these services is essential.	
	Include rate analysis and an assessment and action plan to determine how to include residential providers as Medicaid providers. This step is particularly important given the dearth of aftercare services provided and the need to evolve residential providers to utilize and/or expand their capacity to provide services in home and community settings.	

	Ensure the efforts regarding workforce and training are connected to the R3 workgroup, including opportunities for providers to share additional feedback on the changes and resources needed to address workforce issues that are impacting the quality of residential care.	
	Given some providers' concern about a lack of infrastructure or a single coordinating entity to whom referrals for socially necessary services or behavioral health services could be made, seek clarity on this issue to determine if it is confusion among a few providers or a larger issue for many providers.	
	As DHHR finalizes its assessment pathway, clarify how the assessment pathway can facilitate access to both behavioral health services and other socially necessary services.	
	Develop and implement a specific plan to address these factors that influence long lengths of stay other than a lack of community services. Such a plan should include working with the courts, working within the BSS bureau to support caseworkers, increasing foster care homes, and strengthening MDT's focus on community services and discharge planning.	
	Develop a specific policy on the issue of providers' timely access to assessment data. Monitor the data to ensure that all DHHR assessment information across providers and bureaus be shared with residential providers. Such a policy should ensure that exchanges of information are not limited to assessments at the start of residential interventions but are treated as regular touchpoints during treatment and transition planning.	
	For providers with program levels, clarify with providers what it means to complete a level, as this approach could be at odds with what the state wants to pursue under a new system. It will be important for DHHR to understand the extent of use of point system approaches by residential providers, as it will inform its efforts to identify and adopt evidence-based practices for residential interventions, and training and coaching to residential personnel.	
	Monitor data to ensure that children discharged from residential interventions are only transitioned to family-based settings or an	

	independent living setting (i.e., not another temporary setting).	
	There appears to be a disconnect between what residential providers do for discharge planning and the expectations of BSS staff. It would seem that residential providers should play a larger role in transition planning, particularly QRTPs, since this type of planning is required in the FFPSA for these programs. The SME recommends that DHHR document in the SOP, provider manual, and other appropriate locations, clear guidance on discharge planning for residential providers.	
6	Update the Foster Care Policy (last revised October 1, 2019) to align eligibility information and referral criteria with updated FFPSA opportunities and residential criteria as soon as they are finalized to ensure consistency across the state.	
	Integrate updates to the Foster Care Policy into any pre-service and continuing education and training of the child welfare workforce.	
	Include in the service pathway how families may receive referrals to FFPSA services, particularly for youth experiencing behavioral health needs who may be appropriate to receive Functional Family Therapy (FFT) services. This referral could be in addition to or instead of a referral for Wraparound services, depending on the needs of the child and family.	
	Align performance and outcomes data collection and reporting activities with those being implemented for FFPSA, including the approach that is being designed to align with the federal Child and Family Services Review and the data being collected by Kepro, including for socially necessary services (see p. 38–39 of the Prevention Plan).	
7	Presume that all children ready for discharge from residential could benefit from Wraparound. Given the lengths of stay for youth in residential settings, the detrimental impact of long lengths of stay on children, and the challenges in developing aftercare plans for children, Wraparound providers would be uniquely qualified to assess the whole child, engage the family, establish a plan, and support successful transition to the community.	
	Because families may benefit from a referral to Family First Prevention Services Act (FFPSA)	

	services, consider how these services could support youth upon discharge. In particular, families with young children may benefit from the home visiting services available, while families with children 11–18 may benefit from FFT and other services.	
8	Expand on the assessment pathway to orient the pathway to demonstrating why a child cannot be treated in the community. This work may need to center on aspects of the pathway not yet developed, such as establishment of a coordinated process across certain providers—including CMCR, in-home family therapy, Wraparound, and BSS providers—who can proactively create a plan of care for a child to remain in the community.	
9	Review the Mountain Health Promise continuum of services diversion model as indicated in the work plan.	
10	Update the work plan to reflect revised dates and new and amended tasks.	
Outreach and Education		
1	Revise the work plan—including outlining specific activities, establishing timelines for these activities, and clarifying which tasks will require joint efforts with other workgroups—to reflect the new focus on the two identified problem statements.	
2	In developing materials, emphasize the shift to home and community-based services, rather than focusing on the ills of residential interventions. Focusing on residential best practices redirects discussions to future-oriented action steps, in which the expertise of residential providers can take shape.	
3	In the coming months, prioritize coordination with the MCO to develop a plan regarding targeted mental health education for its members.	
	Include in this targeted education plan a clear process for the State to monitor the MCO's activities in an ongoing way to ensure the plan is achieving its goals.	
4	Identify strategies for gathering ongoing feedback from children, youth, and families directly, in addition to seeking feedback through affinity groups or formal organizations. For example:	

	• specifically list families and youth as stakeholders whenever possible to ensure that these groups are integrated into the work • explore opportunities to involve families and/or youth to participate in particular workgroups • frequently revisit the recommendation offered in public comment on the implementation plan to ensure that each program's evaluations and assessments include "real and robust" opportunities for individuals who are or could be served by these programs to give their feedback and input • expand outreach tools to families that allow for two-way communication • confirm details for the MCO-led focus groups and advisory councils mentioned	
5	Tailor all communications materials to the intended audience, including in tone, language, and medium. In particular, consider the method of communication (e.g., email and online resources, physical mail, in-person conversations, mass media) and the differences in how each audience will engage with these methods.	
	Revisit input from stakeholders regarding the "best way they receive information" (see task 1.1.4.5.7) to ensure the state's strategies are a good fit with stakeholders' needs and preferences.	
6	Seek out and consider additional national and West Virginia examples regarding messaging on topics such as redirection from residential interventions and children's behavioral health generally.	
7	Consider opportunities to improve response rates and gather additional comments on future iterations of the implementation plan.	
8	Provide an update on the judges' training (tentatively scheduled for May 2021) and/or any other work to engage this important stakeholder group.	
9	Detail plans to involve WVDE and DHS in the communication plan to facilitate more substantial coordination among these entities in future outreach and education work.	

Quality Assurance and Program Improvement (QAPI)		
1	Provide a written plan regarding when reporting of the measures in sections 48, 49, and 50 will occur (e.g., timeline for activities such as data analysis, synthesis, and creation of findings reports related to the WVU evaluation).	
2	Develop the scope of the Office for Quality Assurance for Children to be grounded in policy, rather than solely viewed as an office of analytics. A scope that it is grounded in pertinent policy issues, and an understanding of implementation science, is necessary in order to effectively leverage and direct what analytics can provide.	
3	Plan discussions with the SME about DHHR's planned approach as outlined in the draft CQI plan.	
4	For phase two and subsequent phases of the dashboard, report on data from BBH or BSS related to the Agreement services.	
	In this data report, include other behavioral health services, such as outpatient therapy, and avoid limiting data to that of certain services in the DOJ Agreement in order to understand the comprehensive picture of services received by youth in the target population.	
5	Given the overlap between the Data Dashboard governance body, the Commission to Study Residential Placement, and the new House Resolution 35, clarify the role of these various groups, how they connect, and how each can be leveraged to support a common goal and coordination of activities.	
6	Consider for future discussion the identification of specific data points, opportunities to align with the new Office for Quality Assurance for Children, and opportunities to draw upon existing data that may already be available (e.g., Medicaid MCOs) to better understand certain aspects of behavioral health service utilization for the broader population of youth receiving behavioral health services.	
7	Provide a written update on the status of each of these provisions detailed in Agreement requirement 49.	