

# 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. The 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 and June 2020.

This report describes the State's progress since June 2020. Information reflected in this third SME report is derived from calls with State Leadership and team leads, including calls with topical workgroup leads, and a thorough review of documents, spreadsheets, policies, memoranda, logic models, and other information provided by the State (detailed in Appendices A and B). As the COVID-19 pandemic progressed and as the workgroups focused on developing logic models to guide their work, the SME had more limited interaction with team leads and staff. However, we wish to acknowledge the willingness of West Virginia to make staff available even as other responsibilities weighed upon the State.

As with earlier reports, this report includes recommendations for the coming six months of work and beyond. It differs in kind from the two previous reports; the first report primarily requested clarification and additional information to enable the SME to comprehend the current delivery system, while the second provided a lengthy list of recommendations to carry the work into initial data and implementation reporting by the State, as required by the Agreement. In this third report, the SME has focused only on the most critical and urgent issues for two reasons: first, to acknowledge that, as COVID-19 continues, staff capacity has been and will continue to be limited by the immediacy of the public health crisis for some time to come and second, to clearly enumerate activities necessary for achieving compliance with the Agreement.

## The State's Structures and Processes to Carry Out the Work

In addition to service specific recommendations, the SME and the State have been discussing their structures, processes, and approach to carrying out the work. Two central themes surfaced in the

SME's work with the State over the last six months: (1) the State's organization of tasks to implement the Agreement and (2) the State's processes to identify and elevate operational decisions to Leadership that cross multiple workgroups.

Regarding the State's organization of tasks, the SME recognizes as relative strength the State's organizational processes in forming topical workgroups—each charged with overseeing one or more components of the Agreement, from Assertive Community Treatment (ACT) to Wraparound. However, solely relying on workgroups to operate independently from one another creates challenges; each workgroup considers only the current programs, practices, policies, and data it deems relevant and, as such, reaches conclusions about the feasibility, effectiveness, and value of solutions largely in isolation. In their present configuration, each topical workgroup is largely unaware of what the other workgroups are considering and any related decision-making, leading to wasted effort as groups unintentionally work at cross purposes or arrive at solutions which are incompatible. As such, the SME recommends that key decisions be made *across* workgroups and the respective West Virginia Department of Health and Human Resources (WVDHHR) bureaus to which they belong, rather than in a siloed fashion. The SME recommendations contained in this report, though grouped by services required under the Agreement, indicate when further cross workgroup coordination is recommended.

Regarding the State's processes to identify and elevate to Leadership operational decisions that cross multiple workgroups, in reviewing the updated workplans for this third SME report, it appears that many unmet deadlines were simply extended. Given the urgency of the COVID-19 pandemic and competing demands on limited staff time, it was fully expected that some activities would lag. However, in speaking to each workgroup prior to the production of this report about tasks and timelines, the SME noted that some workgroups seemed stymied to move the work forward. They had reviewed their current system, articulated weaknesses and potential pathways for reform or refinement, but were unable to achieve consensus and/or lacked a clear process and timeline for elevating decisions to higher level management or State Leadership in order to complete the tasks. As such, the SME recommends that the State establish clear timelines and processes for decision-making, including when a consensus is needed or when differing points of view will be elevated to Leadership for decision-making and in what allowable timeframe. Further, by making key decisions across workgroups (see the first recommendation, above), it will become clearer which decision points need to be elevated to Leadership for their input.

In tandem with the SME's discussions with the State, the State independently engaged its contractor, BerryDunn, to produce a "lessons learned" report aimed at illuminating what worked well for West Virginia staff working on the Agreement, as well as what opportunities are present for future improvement as staff carry out tasks to fulfill the Agreement. BerryDunn's report was drawn from an online survey and multiple group interview sessions with staff designed to gather feedback from key participants. From the information gathered, BerryDunn made eight recommendations with which the SME concurs. The SME calls attention to the concurrence between several of their recommendations and the SME's, including:

- increase and improve communication amongst the topic-specific workgroups
- address the need to conduct an analysis to determine the drivers for Title II ADA Noncompliance
- engage in an organization change management process, and

- increase the emphasis on and resources available for the Quality Assurance and Program Improvement (QAPI) Data Reporting and Dashboard System required by Paragraph 48 of the Agreement.

The SME commends the State for proactively reviewing its organization of staffing and resources to implement the Agreement, and its processes to identify, elevate, and address operational decisions that cross multiple workgroups. Additionally, the SME commends the State for developing a Workforce Workgroup to identify and address healthcare resource and provider needs to fulfill the Agreement. The Agreement requires the State to take steps to address workforce preparedness to deliver services, availability of sufficient providers and any workforce shortages. Therefore, this coordinated effort will assist the State to proactively identify and plan for Workforce needs.

### Implications to the Agreement Timelines Resulting from the COVID-19 Pandemic

The SME wishes to recognize that this third report was produced in cooperation with the State under unprecedented circumstances. Governor Justice declared a state of emergency for all 55 counties on March 16, 2020 in response to the COVID-19 pandemic. As of this writing in early December 2020, the State has just under 55,000 confirmed<sup>1</sup> cases of COVID-19 and has experienced the loss of over 800 residents. These numbers reflect a sharp recent increase: the number of COVID-19 cases in West Virginia increased 91% from October 31, 2020 to November 30, 2020. Nearly half (49%) of West Virginia's total cases from the COVID-19 pandemic occurred in those 30 days.<sup>2</sup>

COVID-19 has created historic financial pressures for hospitals, health systems, and child- and family-serving agencies and organizations. Simultaneously, COVID-19 has led to job losses, increasing the number of uninsured and increasing those eligible for Medicaid. Amid these challenges, West Virginia has issued several memoranda expanding access to services via telehealth, and the Centers for Medicare & Medicaid Services (CMS) approved the State's application for [Appendix K](#) related to its 1915(c) waivers, including the relatively new Children with Serious Emotional Disorder Waiver, and a [Section 1135](#) Waiver to grant additional flexibility in administering its Medicaid program. These urgent changes to existing policies and programs demanded the time of staff and Leadership, who in turn paused some of the activities and work discussed in this report. The SME notes that these COVID-19-specific initiatives described are but a few of the activities carried out by West Virginia and should not be read as the complete array of activities that the State has and will continue to undertake to protect the public health and safety of its residents.

## Implementation: Community-Based Services

### Wraparound Facilitation

**Agreement Requirements:** The Agreement requires the West Virginia Department of Health and Human Resources (WVDHHR) to ensure statewide access for each child identified as needing in-home and community-based 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

<sup>1</sup> West Virginia Department of Health and Human Resources. Coronavirus Disease 2019 (COVID-19). <https://dhhr.wv.gov/COVID-19/Pages/default.aspx>

<sup>2</sup> <https://governor.wv.gov/News/press-releases/2020/Pages/COVID-19-UPDATE-Gov.-Justice-announces-free-in-home-COVID-19-testing-now-available-for-all-West-Virginians.aspx>



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—Bureau for Children and Families (BCF) 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 network, tasks, required timelines, data and reporting. The WVDHHR Bureaus—BCF, BBH and BMS—have been meeting in an effort to standardize the three separate Wraparound programs and to enhance each program to meet NWI standards. Each bureau reviewed and scored their Wraparound program using the Wraparound Implementation Standards - Program (WISP).

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 (3) years. The waiver provides Wraparound (called “case management” in the waiver), in-home family support and 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 and family support, assistive equipment, community transition, and other specialized therapies for children aged three (3) through 17 with serious emotional disturbance and youth and young adults aged 18 to 21 with serious mental illness.

The State contracted with Aetna Better Health to create Mountain Health Promise (MHP), a specialized managed care organization (MCO) to serve children and youth who are in foster care; individuals receiving adoption assistance (effective March 1, 2020); and children aged three (3) through 21 eligible for the CSED waiver and enrolled in the MCO, as waiver slots are available. The waiver specified the unduplicated number of participants as 500 in year one, 1,000 in year two, and 2,000 in year three.

As of December, the State had received 374 total applications for the 1915(c) CSED waiver, of which 34 were resubmissions. Applications had been processed for children and youth 3-19; to date, the State had not enrolled any individuals aged 20 or 21. Just over two-thirds of applicants were aged 12-17. Of the 103 children approved to date, approximately 45 were actively receiving services as of the writing of this report. Seventy-three (73) applications were denied; the most common reasons for rejection were ineligible Behavior Assessment for Children (BASC) scores (10, 13.7%), lacked an eligible diagnosis (12, 16.4%), ineligible BASC and CAFAS scores (17, 23.3%), and ineligible CAFAS scores (19, 26%).

The number of approved providers in December 2020 remains nearly the same as it was in July: 23 (an increase of one) providers have been approved to provide CSED services; however, only 12 are actively providing services due the COVID-19 and staffing challenges. A “Provider Readiness” spreadsheet dated Nov. 27, 2020 listed potential providers and contained several months of contact notes. Several providers indicated they declined to participate due to concerns about reimbursement rates and staffing requirements. To resolve some concerns related to reimbursement, the State has indicated they are raising reimbursement levels for some services, effective Jan. 1, 2021.

In addition to data, The SME received copies of provider workshop training materials; a CSED brochure; workgroup meeting minutes; CSED waiver forms including the initial application, initial person-centered care plan, certificate of trainings, service logs and progress notes, transfer discharge, request to continue services, freedom of choice, and COVID-19 response materials; a client pathways flow; and a workplan from the West Virginia Wraparound workgroup outlining its goals and enumerating specific tasks through 2022.

In 2020, Marshall University drafted a report “to determine the needs of the State in order to improve current services to families as well as maintain a strong workforce to deliver these services.” The report reviewed 50 records from Safe at Home and 10 records from West Virginia Children’s Mental Health Wraparound. Child records selected were randomly generated using a small list of criteria (e.g., at least one CANS assessment, case opened in 2019, etc.). Data was collected using online surveys, Wraparound plan and CANS reviews via Zoom, and the West Virginia CANS management system. The ages of the children reviewed were similar to those enrolled in the CSED waiver; 76% were 13-16. Notably, slightly more than half were referred for a school-related issue.

The SME also provided technical assistance and a national scan of how other States have designed to a rapid pathway to Wraparound, including timelines consistent with NWI and processes that expedite enrollment into Wraparound. This discussion highlighted how the State’s various Wraparound programs were performing, and elevated the need for re-examining the CSED waiver process including its timelines, the requirement that the independent psychological evaluator (IPE) used to determine eligibility for the waiver be conducted by a licensed psychologist vs. all licensed mental health professionals (e.g. LCSW, LCPC, etc.) recognized by the State, and a written requirement in the CSED Policy Manual to receive data and reports from schools and other systems to make a determination, which can unnecessarily delay eligibility determination depending on the responsiveness of those other systems to requests for information. Based on these discussions, the State is in the process of revising the 1915(c) CSED Waiver, including its timelines and process to access the waiver, and expanding the types of licensed mental health professionals (e.g., LCSWs, LCPCs) who will be able to perform eligibility determinations. Further, the State indicated that the reference to receipt of Individualized Education Plans as part of the waiver application process was an error, and it intended to remove that language from the CSED policy manual.

Recently, the State Leadership and SME engaged in several technical assistance discussions to address the challenges in standardizing three separate Wraparound programs and enhancing each separate program to meet NWI standards. The SME presented three possible scenarios at a meeting with Leadership on December 7, 2020 to address these challenges.

- Scenario 1 would largely leave the current bureau-specific approach intact, with separate programs operating via BBH, via BCF (operating as SAH), and the Bureau of Medicaid Services (operating as the CSED waiver) but would maximize entry to the CSED waiver to maximize the use of federal dollars.
- Scenario 2 would partially decouple population from service by consolidating BMS and BBH operated Wraparound into one program to meet the needs of all SED non-foster care children, while leaving BCF to continue to operate SAH for foster care children with serious emotional disturbance (SED). This would reduce to two the number of programs that had to be standardized.

- Scenario 3 would completely decouple the target population – children with SED – from bureau-specific service delivery, resulting in tiers of Wraparound. In this scenario, non-SED child welfare-involved youth would continue to receive safety and permanency services via BCF’s SAH program while all children with SED, including those in child welfare, would be served by a common Wraparound approach, with services driven by a common assessment tool.

In discussions with Leadership, the SME recommended the State elevate Wraparound from one of several home and community-based services to a service that drives access to both home and community and residential services. WVDHHR Leadership reached a decision on December 14, 2020 on the best scenario for their State, adopting scenario three described above with the addition that BBH and BMS would jointly design and manage the new Wraparound program, with the development of Wraparound to be the conduit for access to other home and community services and residential services. The State’s forthcoming revised implementation plan and work plans will provide detail about the State’s timeline and action steps.

### **Recommendations**

We commend the State for recognizing that its efforts to standardize three separately operated Wraparound programs would not result in a common approach across West Virginia and could hinder their efforts to meet the Agreement. While the State made efforts to identify commonalities, it recognized inserting common language into separate contracts, managed by separate bureaus, with historical differences in the functions of the programs (child welfare, behavioral health treatment), would not result in a standard service for all children in the target population. Further, the SME wants to acknowledge that the work to reorganize the delivery of Wraparound will be occurring while it also oversees and manages the service as it is delivered today.

- The State has engaged Marshall University and Dr. John Lyons in developing a CANS assessment algorithm to assist decision-making. After meeting with the Team, we recognize that this project is in its relatively early stages. We also understand that while it began specific to the SAH Wraparound program, the Team recognizes the broader utility and implications for all Wraparound programs and other services as well. As such, this work will need to be coordinated with both the Wraparound implementation plan and activities of the Screening & Assessment Workgroup.
- As the State designs and implements its revised approach to delivering Wraparound, we recommend the State use Wraparound to direct children to appropriate supports and services, both home- and community-based services (HCBS) and residential services. This would create a single plan of care that would drive *all* services instead of a program or bureau specific approach to the care offered.
- We recommend the State create a multi-agency workplan with granular action steps, each with a clear deadline and owner. We recommend the workplan include a clear pathway for entry with clear processes for establishing timely initial and continuing eligibility based on screening and standardized assessment. We also recommend that the implementation plan include coordination



with mobile crisis response, and screening and assessment, given these workgroups are discussing pathways to services.

- The SME raised concerns about the processes and timelines regarding access to the CSED waiver. We commend the State for acknowledging those issues and agreeing to review ways to revise those processes and timelines. The SME recognizes the State began and has continued significant mail and telephonic outreach to families with pending applications, even as they were burdened with responsibilities related to the COVID-19 pandemic. The State has recently indicated its intent to revise the waiver to expand the type of licensed mental health providers that are permitted to conduct assessments to determine waiver eligibility, and to shorten allowable timelines and expedite enrollment. The SME looks forward to providing continued technical assistance on this issue, including discussing and reviewing drafts of the State’s intended enhancements to its waiver.
  - As the state considers changes to its waiver, we recommend that this plan be informed by a review of the enrollment data. In November, The SME received data showing 358 total applications, of which 122 were listed as “closed.” We note that “closed” constitutes the largest single category – *fully one-third of the total*. These applications were closed after the State was unable to reach the family, because the family was unwilling or unable to provide complete documentation, and/or unable to schedule an appointment with an IPE. In conversations with the State, scheduling with an IPE was named as a common point of difficulty. This data can help inform other potential changes to the waiver.
  - Additionally, as the state considers changes to the waiver, we also recommend it strengthen and modify language to ensure that the case management service described in the waiver is consistent with NWI Wraparound.
  - Given the importance of the role of the State’s MCO to successfully support access to and quality of services delivered to children in the target population, we recommend the State share with the SME documents related to MCO case reviews for children pending accrual to the waiver; and information on (1) the specific contractual requirements of the MCO with regard to care management; (2) the required reports related to those contractual requirements (e.g., monthly or quarterly data sharing, narrative reports, etc.); (3) the State’s oversight and management plans related to contractual reporting by the MCO such as meeting minutes, corrective action plans, or related documents to support continuous quality improvement by the MCO.
- We recommend that findings from Marshall University’s fidelity review report be incorporated into the Wraparound implementation plan. This report raised several issues critical if the State is to meet NWI fidelity: long timeframes from referral to the first CFT meeting (77% did not meet the timeline of 14 days from referral); 55% of Wraparound facilitators are able to complete Phase I in 7-14 days, but only if Marshall eliminates the outliers of those that took over 35 days, which is the largest category (12/49) although they note “the over 35 days may be the result of poor data reporting or inability to contact family once referral was received”; fewer than half of reviewed cases had Phase III implementation attached; case files lacked crisis plans and only slightly more

than half of facilitators were familiar with mobile crisis; and inconsistency in CANS ratings, particularly “strengths often rated too high for these youth.” State staff did report on a call with the SME that they are in the planning stages for addressing the findings, including review with Local Coordinating Agencies’ leadership.

- In reviewing, a spreadsheet of listing active service counts, by age, for children participating in the CSED waiver through Nov. 23, 2020, the majority of children participating in the waiver had requested and been approved for a very similar array of services: case management, in-home family therapy, in-home family support, and mobile response. Only a small fraction of those approved for waiver services had been approved for or had a claim paid for parent peer support, specialized therapies, transportation, or community transitions. None had claims paid for respite care, independent living/skill building, or supported employment. A total list of claims, by age group, from March 1-November 30, 2020 is below in Table 2. As the State moves forward with its revised implementation for delivering Wraparound, it is essential that the State review this data and any companion data available via BBH, to include action steps for how it will monitor the service array and plans of care to ensure plans are appropriately individualized per the Agreement. We note that providers can submit claims up to one year from data of service so because of claim lag we would caution against drawing firm conclusions from the data. However, paid claims, coupled with authorization data, would be important for the State to review on an ongoing basis to ensure that plans are individualized, trends in provider practice inform provider training, and inform how the State may re-evaluate the services included in the waiver.

Table 1: CSED Waiver Claims

<b>Total Claims</b>	<b>Age Group</b>	<b>A0160-HA: Non-Medical Transportation</b>
1	6-9	
5	10-14	
<b>Total Claims</b>	<b>Age Group</b>	<b>H0004-HA: In-Home Family Support</b>
6	3-5	
21	6-9	
45	10-14	
11	15-18	
<b>Total Claims</b>	<b>Age Group</b>	<b>H0004-HO-HA: In-Home Family Therapy</b>
3	3-5	
42	6-9	
48	10-14	
30	15-18	
2	18+	
<b>Total Claims</b>	<b>Age Group</b>	<b>H0038-HA: Peer Parent Support</b>
3	10-14	
<b>Total Claims</b>	<b>Age Group</b>	<b>H2017-HA: Mobile Response</b>
1	6-9	
7	10-14	
9	15-18	
<b>Total Claims</b>	<b>Age Group</b>	<b>T1016-HA: Case Management</b>

19	3-5	
48	6-9	
82	10-14	
15	15-18	
1	18+	
<b>Total Claims</b>	<b>Age Group</b>	<b>T2038-HA: Community Transition</b>
3	15-18	

### 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 three ways: through BBH’s AFA for Children’s Mobile Crisis Response and Stabilization that will service Medicaid and non-Medicaid populations; through BMS’s CSED waiver for Medicaid children who are waiver-enrolled; and as a consideration to be provided by for BCF’s Therapeutic Foster Care agencies for children in foster care placed in TFC.

The State’s BBH released an [Announcement of Funding Availability](#) (AFA) for Children’s Mobile Crisis Response and Stabilization Teams to serve Region 1 (Hancock, Brooke, Ohio, Marshall, and Wetzel Counties) and Region 2 (Pendleton, Grant, Hardy, Mineral, Hampshire, Morgan, Jefferson, and Berkeley Counties) in December 2019. Unfortunately, the AFA did not attract a provider for the Eastern Panhandle (Region 2). Despite these difficulties, strong State leadership was able to overcome the workforce challenges compounded by the region’s proximity to Washington, D.C., Virginia, and Pennsylvania and execute a contract with University Health Care Physicians (UHCP, affiliated with West Virginia University) in mid-November to provide CMCR services for region 2; UHPC is scheduled to begin services in January. To ensure coverage in Region 2 until UHPC begins services, BBH activated existing providers from other regions to cover Region 2 on a rotating basis. The State’s BBH vendor, First Choice Services, is taking crisis calls by telephone (844HELP4WV or 844-435-7498) 24 hours a day, seven days a week and has also launched a website at <https://www.help4wv.com/ccl>. Since July 1, 2020 (FY21), the State’s BBH contracted providers have taken a collective 239 crisis calls, 99 of which were responded to in-person. (The remainder were responded to telephonically; zero calls required law enforcement response.) The SME notes that the ratio of in-person to telephonic responses is likely affected by the ongoing COVID-19 pandemic, as some families have been reluctant to meet face-to-face, while others have been hesitant to use virtual options.

In addition, the State’s BBH is actively engaged in ongoing training and problem-solving efforts through participating in weekly meetings, providing technical assistance via monthly trainings, and conducting mock calls using mock scenarios to BBH contracted providers. Since September 1, 2020,

First Choice Services has conducted nearly 20 presentations to myriad stakeholders, reaching an estimated 770 people across the State. It also purchased over 50 billboards statewide, launched targeted digital advertising, and created a [YouTube ad](#).

The State's BBH is planning to conduct additional, in-depth training in January 2021 for First Choice Services staff on community-based services, including Regional Youth Service Centers and Wraparound services. BBH also plans to train behavioral health providers on engaging law enforcement and first responders, with the assistance of the State Police and providers with successful strategies. State staff presented about mobile crisis at both the August and November West Virginia Child Welfare Collaborative meetings and are planning additional publicity in the coming months for the hotline. BBH staff are also in the early stages of developing a Memorandum of Understanding (MOU) between the two bureaus (BBH and BCF) to permit information and data sharing.

In addition, the State is implementing mobile crisis services through BMS's CSED waiver. As noted in the previous section, approximately 40 youth are actively receiving services through the BMS CSED waiver. BMS has contracted with 23 providers to provide waiver services overall. In a document "CSEDW Provider Readiness thru 11\_27\_2020" the State recorded 14 providers, of 26 total, who were planning to offer Mobile Crisis services.

Finally, the State is working to provide Mobile Crisis services for children in foster care placed in a Therapeutic Foster care (TFC) through the TFC agencies. Per their contracts, BCF's TFC agencies are required to provide 24/7 crisis response to therapeutic foster care children experiencing a crisis. Under this model, the TFC Agency would provide CMCR as part of a bundled service to TFC parents and children.

### **Recommendations:**

The SME commends the State for its progress on CMCR, especially amid the COVID-19 pandemic. These recommendations focus in two key areas: identification and resolution of any gaps in CMCR that could result in access or quality of care challenges due to the bureau-specific approach (i.e., three different ways) that CMCR is available in West Virginia; and monitoring of data to ensure access to care and to guide quality improvement.

- Regarding the first key area, identification and resolution of any gaps in its bureau-specific approach to providing CMCR services that could result in access or quality of care challenges for youth and families:
  - The SME notes that the State will face some similar challenges with mobile crisis as noted with Wraparound since it is also provided by three separate bureaus, BMS via the CSED waiver, BBH via CMCR and BCF via TFC agencies. Since each bureau maintains different mobile crisis providers; establishes separate contracts; and uses different service definitions, documentation, and billing/payment codes, the State needs to engage in a crosswalk of the differences in the three approaches to delivering mobile crisis to determine if any gaps in access or quality of care will result. In addition, the State needs to determine how it will be able to gather data across the three bureaus to demonstrate compliance with the Agreement. Several illustrative examples follow.

- Example 1: If a CSED waiver youth's family inadvertently calls the BBH mobile crisis provider instead of a CSED waiver provider, what written information exists to inform how that child's crisis needs will be met without delay?
  - Example 2: If a TFC placed youth presents in crisis, how will the State ensure that the TFC agency connects the child with any needed Medicaid behavioral health services that are not offered by the TFC agency (e.g., CSED waiver, Behavioral Support, Therapy)?
  - Example 3: Given that the three bureaus have different data systems and collect different data points from providers, what consistent data across all three bureaus will be available, and able to be combined, in order to demonstrate compliance with the Agreement?
- The State should make every effort to minimize the differences in mobile crisis response across the three bureaus in order to ensure a similar service that meets the Agreement requirements is offered by each bureau. The specific avenues to address any differences will be dependent upon the differences identified in the State's crosswalk of the programs. For example, if training varies greatly across the three mobile crisis programs, efforts to align training content, and expectations for how providers deliver services, will be important. The State can leverage its own strengths to achieve this aim. For example, BBH has completed extensive training for its CMCR providers that could be adopted by BMS and BCF to train its own providers. (The SME recognizes that some enhancements would be made to a base curriculum to address foster care specific issues). Additionally, the State could consider joint provider meetings in order to support the work of all providers, identify issues that cross systems, and provide a consistent level of technical assistance to all providers. BBH has initiated technical assistance calls with its providers to address how to improve their delivery of the service and identify system challenges, and support providers to practice more effectively. Joint calls with mobile crisis providers across bureaus could further support consistency in access, quality, and provider practice.
- At present, each CMCR provider agency that is contracted by the State constructs and offers its own training. Although the State monitors the trainings via monthly technical assistance calls, it does not review the content each provider agency is using; it only approves that training was conducted. As the CMCR matures, we recommend the State centralize core trainings, or review and approve the training(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.

The State should provide for the SMEs review clarification in writing (e.g., provider contract, policy, etc.) how BCF's TFC agencies will provide mobile crisis services consistent with the Agreement, including the data that will be tracked, how TFC providers will be trained, and how BCF will ensure that any TFC placed child receives access to the full array of Medicaid behavioral health services needed as a result of the mobile crisis intervention. Based on discussions and review of available materials, it appears that the TFC agencies 24/7 capacity has been geared towards supporting the foster family to respond to the child behavior and maintain the child in the TFC home. *This is an essential part of the TFC service but differs from a capacity to assess a child's behavioral health needs, provide a behavioral*



health treatment intervention to reduce or ameliorate the crisis, and identify additional services and supports, particularly those not offered by the TFC agency itself. It seems the current TFC requirement may be geared more to the child welfare mandates of safety from neglect and child abuse and permanency of the foster care placement, but not to intervene and treat behavioral health conditions, and expeditiously connect to other Medicaid behavioral health services. Clarifying these expectations to providers and health plan partners in written documents will be important.

- Regarding the second key area, monitoring of data to ensure access and guide quality improvement:
  - While the evaluation plan requires the development of a data dashboard, the evaluation design will not be finalized until sometime in 2021. The SME would like to review a draft of the data plan, including the data elements and mechanisms for gathering the data. We recommend the State establish ongoing cross-bureau processes to collect, review, and analyze data on the timeliness of access, the demographic characteristics and service utilization patterns of children and youth served, and their outcomes after engaging with crisis services. This final category of data should specifically show how the children were assessed and how that assessment created a referral pathway to HCBS, including Wraparound, and reduced the use of out-of-home placements.
  - We recommend the State incorporate CMCR data into its cross-agency Wraparound workgroup. This action will serve two main purposes: (1) raise the profile of CMCR services among non-BBH staff and the Wraparound programs they currently operate, an area of weakness identified by the Marshall University CANS report, and (2) as calls to the hotline increase, the State should expect to see some related increase in demand for HCBS if referral processes are operating as intended. Routinized examination of CMCR data could serve as a demand forecast for other bureaus and their respective programs and reinforce shared, cross-agency collaboration to meet the needs of all children in the target population.

## Behavioral Support Services

**Agreement Requirements:** The Agreement requires the State to implement statewide Behavioral Support Services (BSS), 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 BSS 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.

The State's BBH released an [Announcement of Funding Availability](#) (AFA) for the Positive Behavior Support (PBS) Program in October 2019 and entered into a grant agreement with the West Virginia University (WVU) Center for Excellence in Disabilities (CED) for activities that commenced on July 1,

2020. The purpose of this grant agreement is to build workforce capacity and to serve individual clients.

As part of its scope of work, the CED conducts trainings to providers, families, and systems on Positive Behavioral Services (PBS). The SME was provided with a document “Positive Behavior Support Program 2019-2020 Accomplishments”, which noted multiple trainings had occurred to large numbers of participants and included data on participant satisfaction. Data on numbers of trainings and participants are not reflected here pending review and validation of the data set to ensure data provided is specific to West Virginia only. Additionally, as part of its Scope of Work, the CED provided 692 interactions to 37 direct clients, of whom seven received Positive Behavior Support Plans. While the CED has limited data on individuals to demonstrate a decrease in “challenging behaviors”, CED plans to use a follow-up survey to assess these data and are re-evaluating their data collection measure and CANS assessments.

In addition to these CED activities, BMS is in the process of identifying new billing codes for these services and planning for certification and training of providers to deliver BSS services. BMS reviewed information provided by the SME regarding the Commonwealth of Virginia in order to better identify processes used in the certification and credentialing of service providers and develop standardized training to ensure fidelity. BMS also identified a potential provider to assist the state in establishing the accreditation process for implementation of behavioral support services.

The workgroup’s workplan lists several large tasks that will be completed in January 2021, including developing training materials and opportunities to educate families about PBS services, assessing the availability of PBS services, and developing an evaluation plan for PBS that ensures statewide quality services and training opportunities for agency providers and families who serve the target population. These actions are dependent on sub-tasks which were scheduled for the summer of 2020 but are delayed. As such, the SME expects the deliverable dates in the workplan to shift.

### **Recommendations**

These recommendations focus in three areas: ensuring access to BSS services by assessing provider capacity, commencing cross-bureau work to ensure connection of BSS services within the continuum of services of each bureau, and collecting data and metrics to ensure compliance with the Agreement.

Regarding assessment of access and provider capacity:

- The workplan notes that the State must assess the availability of PBS services to ensure statewide access and anticipated doing so by January 2020 with an updated due date of January 2021. The SME has received a list of Positive Behavioral Support Service Agencies or Certified Staff, by agency (BBH, BMS, and those providers offering Positive Behavioral Intervention Services (PBIS) for BBH’s Expanded School Mental Health Services (ESMHS)), but these items are only one component of a capacity analysis. The SME recommends that the State conduct an analysis of statewide and regional needs, provider capacity, and current utilization data; the State should also engage stakeholders in this process to identify real or perceived gaps. The initial analysis would likely be followed by development of a strategic plan to ameliorate the identified gaps, followed by implementation planning in coordination with the CED and other local and regional entities. This analysis would include four items:

1. an estimation of need based on prevalence data;
  2. an inventory of the total service providers available, disaggregated by county/region;
  3. a review of provider volume to identify where children are receiving services within the State and specific county/region; and
  4. utilization data (the number of consumers using services), via Medicaid claims as well as bureau-specific data. An analysis of utilization considers services at the child level, including which services are being delivered, and how service delivery changes over time.
- The Agreement notes that the BSS service is more than a service intervention and also includes assessments, service planning, and skill-building. The assessment must include indicators that regularly and consistently measure the referral, provision, and inclusion of these related services in the ISPs of children and youth in the target population. The SME recommends that the PBS/BSS workgroup ensure this requirement is realized, including related data collection, analysis, and reporting, which the CED noted was an area of improvement. The SME is available to provide technical assistance to help the State determine the best approach to analyzing utilization. The SME also recommends that the State identify a process and timeline by which the SME will receive drafts of the analysis, have an opportunity to review and provide comments, and discuss with the workgroup prior to finalization.
  - Given that Marshall University’s West Virginia Wraparound Review report noted that 51% of referrals were from schools, it is critical that PBIS, PBS, and BSS providers use a standardized assessment tool to ensure children are appropriately referred to services and supports, including Wraparound. At present, it is unclear how children with SED who receive BSS services and supports are connected to larger continuum of care, and how referrals are consistently tracked to avert and divert children from acute and residential care. This is an opportunity for the Wraparound, Screening & Assessment, and BSS workgroups to coordinate related tasks.

Regarding the use of data and developing an evaluation plan:

- West Virginia’s Implementation Plan to the DOJ Agreement reports that the State will develop an evaluation plan for PBS “that ensures statewide quality services and training opportunities for the agency providers and families who serve the target population” in January 2021 alongside the capacity assessment, which is due the same month. The SME recommends that the State perform the capacity assessment first, followed by developing an evaluation plan, rather than conducting both simultaneously. This sequencing is important because the State should first understand its current providers’ capacity to collect and report on data—a critical component of the capacity analysis—before designing an evaluation plan. The capacity analysis should include providers’ ability to report data to BMS and BBH, as it appears children could be receiving from both bureaus simultaneously (e.g., PBIS services as part of ESMH and BSS as a Medicaid service). Providers’ current ability to collect uniform data and/or the State’s ability to clean, store, and manage data related to desired outcomes must be well understood before the State settles on an evaluation methodology.
- It is also important for the State to clarify how recipients in BSS will be included in the “at risk” population planned for the second phase of the evaluation. This is an opportunity for the QAPI and BSS workgroups to coordinate related tasks.

Regarding cross-bureau collaboration:

- Given how BSS services must be connected to the work and services of all three bureaus, the SME recommends a cross-agency approach to both conducting the capacity assessment and developing the evaluation plan.
  - For example, BMS is moving forward, having identified billing codes, to plan for certification and training of new and existing staff to deliver services, but it remains exactly unclear how eligibility for services is assessed for children in BMS programs (i.e., State Plan services delivered via MCOs and the CSED waiver), as well as bureau-specific services (BCF's SAH program and BBH's Wraparound and ESMH programs).

### 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, BCF has a contract with KEPRO to authorize certain services, including TFC and out-of-state residential, 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 BCF after review of what is in the best interests of the child.

The SME has provided considerable technical assistance to the TFC workgroup including:

- a series of memos on defining a TFC model to guide how providers would deliver the service,
- how TFC is defined within the broader benefit array to ensure differentiation across services and levels of need/intensity, and
- selecting and defining a set of outcome and quality measures to understand the effect of the service on child and youth outcomes;
- a briefing document on how several states permit the use of Intensive Care Coordination using Wraparound (ICC/Wrap) for children in child welfare, including children in foster care and TFC, with example language used to differentiate the roles and responsibilities of the behavioral health, Medicaid, and child welfare agencies, as well as TFC parents; and
- facilitated discussions with current or former leadership from New Jersey and Oklahoma to discuss those states' respective planning and implementation processes for TFC services.

West Virginia's Implementation Plan to the DOJ Agreement reports that it has completed an assessment of current capacity to determine the number of TFC homes needed to ensure the least restrictive placement is available. BCF has communicated its intention to differentiate the numbers reported for and the requirements for TFC homes for children with SED needs from TFC homes used for children with medical needs.

Additionally, the State has decided for the time-being to operate TFC as a level of foster care in its foster care system, with plans to select future TFC providers in a phased approach, drawing from a pool of new foster care providers that will be selected from a planned Request for Information released late winter or early spring.

### **Recommendations**

- The SME recommends that the State reconsider and 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 in kind than those required to support the 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.
  - 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 the State would rely on an outside purveyor to develop training materials; and development of a monitoring and evaluation plan.
- The SME recognizes that the State and the 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 shared the 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. The SME recognizes the State's current limited capacity of therapeutic foster care homes, and the necessity to prioritize its' current use, while growing future capacity.
  - The State must develop a clear referral pathway for the service, including criteria for when TFC should be considered, to ensure that access to TFC is driven by a comprehensive assessment identifying the needs of the child and recommending services available within the continuum of care, including services available to the child through BMS and BBH.
  - The TFC service must address the following items: the role and function of the TFC parents and provider agencies; which services will be included or excluded from the TFC model;



data collection to support that decision; the roles and expectations for interactions with juvenile justice, schools, behavioral health service providers, CMCR, and case management, including data and oversight related to each; the pathway into and out of TFC, including the mean and median length of stay; provider eligibility; and the establishment of provider quality standards and ongoing monitoring.

- The State must also ensure that children in TFC receive all behavioral health services for which they are eligible, including CMCR and Wraparound services.
  - Specific to Wraparound, the State must decide if TFC enrolled children will access Wraparound as a separate service or if TFC agencies will continue to provide Wraparound services as part of a bundle of required service components defined for TFC. It is the SME's current view that the TFC agencies may have difficulty meeting NWI Wraparound standards and maintaining fidelity if Wraparound is part of a bundle of required TFC services. While not insurmountable, specific issues will need to be addressed.
  - Specifically, case ratios may be too low to manage the costs of the program depending on the numbers of children served by each TFC agency and the numbers of those children that meet criteria for Wraparound. It may also be difficult to meet the NWI requirement to have a dedicated Team delivering Wraparound if that same agency staff is also delivering other services. Having a TFC agency provide both Wraparound and other services also raises issues with regard to federal freedom of choice and conflict-free case management standards. If the State wishes to have TFC agencies provide Wraparound in accordance with NWI standards, it will need to conduct an analysis of its current TFC capacity and standards, crosswalk those to NWI standards, and determine the initial and ongoing financial and administrative feasibility of such an approach.
  - Currently, mobile crisis is included in the bundled payment rate to TFC agencies. The State must decide whether it plans to maintain that service as part of the bundled rate, if it is the TFC agency itself that must provide the service or if the TFC agency will be required to subcontract with CMCR providers under contract with BBH or BMS. In considering this decision, the State must take into account what is needed to ensure that children have ready access to CMCR, the TFC agencies' capacity to provide 24/7 response, and the TFC agencies' ability to meet rigorous standards for the population in crisis, including initial and ongoing data collection and analysis and timely referral to other behavioral health services. The State should consider the implications carefully, including competition for similar providers, management and oversight, and common quality metrics. Here again, the SME recommends that the State conduct a robust analysis to weigh the considerations of the form and function of CMCR within and external to TFC.
  
- The State has indicated its intent to specify its TFC capacity for specific populations of children to more clearly delineate its tiering of homes (as that level is currently used for children with SED, children who are medically frail, and infants who are drug exposed). The SME looks forward to reviewing the State's planned approach to this delineation, and how data will be collected and reported such as the use of modifiers to the claim code to differentiate populations, and/or differentiating licensing or credentialing requirements for TFC beds that serve children with SED.

- Following the State’s decisions, the State must develop clear, consistent workplans with measurable and actionable goals, each with a clear owner, and firm deadlines.
  - Several tasks from previous workplans remain uncompleted and will need to be revised to reflect decisions, including “assess current capacity and determine number of Therapeutic Foster Family Homes needed to ensure least restrictive placement is available”, “increase Therapeutic Foster Family Care home capacity by modifying existing contracts with child placing agencies or through a competitive procurement process”, “assess the child placing agencies’ performance with creating Therapeutic Foster Family Care capacity to ensure adherence to [State] goals”, and “modify capacity, as needed, based on data from the evaluation to ensure adherence to the [State] goals.”
  - A capacity analysis would include four items:
    1. an estimation of need based on prevalence, and would align with the work of the residential workgroup;
    2. an inventory of the total service providers available, disaggregated by county/region;
    3. a review of provider volume to identify where children are likely to receive services within the State and specific county/region; and
    4. utilization data (the number of consumers using services), via Medicaid claims as well as bureau-specific data. An analysis of utilization services at the child level, including which services are being delivered and how service delivery changes over time.
  - Additional tasks would include reviewing current agency contracts; developing standard training for current and new agencies and TFC families which align with the goals in the Agreement; and identifying current and future data collection processes.
  
- The SME notes that no additional analysis beyond the May 2020 white paper has been completed, including the promised deeper analysis of Tier III capacity and need. In addition, although the State’s previous work had anticipated increasing TFC capacity by modifying existing contracts with child placing agencies or by executing a competitive procurement process, the SME learned in a mid-November 2020 workgroup call that the State will use a Request for Information (RFI) process that is currently under development. Once the State has secured and entered into contracts with Child-Placing Agencies (CPAs) for traditional foster care, the State will conduct a separate selection process from the pool of CPAs specific to therapeutic foster care. The delay in this work has resulted in the delay of the State’s assessment of child placing agencies’ performance (planned for September 2020) and an evaluation to modify capacity, as needed (planned for October 2020). The SME is available to provide technical assistance regarding the determination of which agencies will provide TFC. The SME also recommends that it review the in-process RFI before its release and any related documents to provide technical assistance to the State prior to its release.
  
- The SME recommends that the State complete its analysis of TFC capacity, including Tier III beds. Paragraphs 24-26 of the Agreement require every child in the target population for whom community-based services are appropriate to have timely access to an array of HCBS, including TFC. To date, the SME has received only limited data regarding children placed in TFC. The white paper did not include a specific time period, making it difficult to compare to other State

documents and data or to consistently measure change over time. It is the SME's strong recommendation that any forthcoming analyses detail:

- the source(s) the data were drawn from (Medicaid authorization and claims, claims only, state-funded services, bed census, etc.);
  - the period(s) of time (calendar year, state fiscal year, federal fiscal year, etc.);
  - the children and youth included (in-state, out-of-state, all children in the target class, all Medicaid-eligible children, etc.); and
  - disaggregation of data by narrower age ranges (i.e., 0-5, 6-10, 11-12, 13-17, 18-21), as the largest share of children and youth in residential placement are 13 or older.
- The SME recommends aligning the work of the TFC workgroup with the work of the reducing residential workgroup in order to develop a pathway that includes TFC as a service to redirect from residential care or to step down children from residential care.
  - The SME requests information regarding the State's contractual relationship with KEPRO, including contractual obligations for KEPRO to produce regular or ad hoc data, narrative reports, performance measures, continuous quality improvement indicators, etc.

### 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 January 2020 for individuals aged 18-20 who accessed ACT, including their provider and primary diagnosis. The SME also received an updated ACT workplan and training slides ("Assertive Community Treatment (ACT) Overview," March 2020), and the State communicated that it had updated its website with information on ACT, which may be found here: <https://dhhr.wv.gov/bms/Public%20Notices/Pages/Assertive-Community-Treatment-information-on-services-is-now-available!-.aspx> (updated September 30, 2020). 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. The State has plans to use DACTS to conduct reviews of providers' fidelity to this evidence-based approach.

### Recommendations

These recommendations focus in three areas: clarification of who gets referred to ACT and how the process across bureaus and services occurs; data collection and evaluation; and efforts to address provider availability in one region.

Regarding who is referred to ACT:

- The SME recommends the State’s ACT workgroup work with the Wraparound workgroup to decide on a pathway for referral to each service. At present, youth in the target population who are aged 18-20 are eligible for either ACT or Wraparound. In deciding upon this referral pathway, the State should provide clarity to providers, staff, and youth and families regarding which service is to be considered for which youth based on clear defined medical need (e.g., decision tree), how an assessment informs which service is medically necessary, how youth choice will occur in the event that either service could be appropriate for a specific youth, and available providers, including their willingness to serve young adults and implications for provider recruitment and retention across the state, especially as CSED waiver services (which include Wraparound) are slated for a rate increase in January and ACT providers (which is a Medicaid State Plan service) are not.

Regarding data and evaluation:

- In addition to the evaluation data required in the Agreement, which encompass and assess the impact of the State’s efforts to reduce residential placement, there is a need for real-time or near real-time program-specific data. In particular, real-time management of continuity of care is critical to transition youth and young adults from pediatric systems to adult systems without requiring they “fail up” to access appropriate care.<sup>3</sup> The SME recommends that the two workgroups engage in a coordinated review of data, to more fully inform WVU’s evaluation and to ensure compliance with the Agreement.

Regarding provider capacity in one area of the State:

- The SME commends BMS’s efforts to secure a provider in the Eastern Panhandle in the face of significant difficulty attracting a provider in this region, much as BBH did for CMCR. The SME recommends that BMS consult with BBH to leverage any lessons learned from their own efforts to identify a provider for that same region for CMCR. In addition, the SME recommends that the State explore cross-state contracting. Cross-state contracting can prove difficult or impossible given issues such as of scope of practice/licensure, state-level regulations, eligibility, liability insurance, and so on. Nonetheless, if the State has not already done so, it may be worth exploring this option, given that Maryland’s Frederick and Washington counties are geographically proximate are have operating ACT teams.

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<sup>3</sup> Cf. Fernandes-Alcantara AL. (2018). Vulnerable Youth: Background and Policies. Congressional Research Report No. RL33975. Retrieved from <https://fas.org/sgp/crs/misc/RL33975.pdf>; Lindgren E, Söderberg S, Skär L. (2013). The gap in transition between child and adolescent psychiatry and general adult psychiatry. *J Child Adolesc Psychiatr Nurs* 26(2):103-109. Doi:10.1111/jcap.12027; Naert J, Roose R, Rapp RC, Vanderplasschen W. (2017). Continuity of care in youth services: A systematic review. *Children and Youth Services Review* 75: 116-126 Doi:10.1016/j.childyouth.2017.02.027; Munson, M.R., Lox, J.A. (2012). Clinical Social Work Practice with Former System Youth with Mental Health Needs: Perspective of Those in Need. *Clin Soc Work J* 40, 255–260. doi:10.1007/s10615-012-0381-6; Rachas A, Lefevre D, Meyer L, Faye A, Mahlaoui N, et al. (2016). Evaluating Continuity During Transfer to Adult Care: A Systematic Review. *Pediatrics* 138(1): e20160256; Doi: 10.1542/peds.2016-0256

## 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 WVDHHR 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.

**Assessment Agreement Requirements:** The Agreement requires the State to use the CANS tool (or a similar tool approved by both parties) to assist 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.

**Activities:** Regarding screening, the State is implementing two avenues. The first avenue is assessing the EPSDT behavioral health screening rates among primary care clinicians for Medicaid-eligible youth via an MOU with the Office of Maternal, Child, and Family Health (OMCFH). The second avenue is reviewing the policies/processes and available data regarding the behavioral health screening performed by the State, including the Division of Corrections and Rehabilitation (for juvenile services), BCF, and the Department of Education.

Regarding assessment, the SME notes that the State's implementation plan dated November 13<sup>th</sup> focuses on activities specific to screening, with limited information regarding assessment activities.

The State provided the SME with CMS Form 416, Annual ESPDT Participation Report, which details overall EPSDT screening rates for children within West Virginia. The data in this report capture all EPSDT screens and are not specific to behavioral health screening. The State is also in the process of identifying the psychosocial/behavioral gaps in the Healthcheck (EPSDT) screening process for children and youth who have Medicaid but are not in the Youth Services, child welfare, or juvenile system systems. To accomplish this step, 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. BMS provided OMCFH an ad hoc report containing Medicaid claims for EPSDT screening. To obtain a sample size with a 95% confidence level and 3% margin of error, the OMCFH selected a random sample of 1,049 children (855 of whom were enrolled in managed care). OMCFH is using 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; (3) and/or addressing two or more psychosocial/social determinants of health during the encounter.

Although the project was delayed due to COVID-19, by late November 2020, OMCFH had secured clinical data for 619 of the 1049 children/youth in the sample and nurses had reviewed 435 of the 619 records received. The State reports the target date for completion of this study and accompanying comprehensive evaluation is December 31, 2020.

The SME notes that this process is time-intensive and laborious; we commend the State's considerable time and attention to it, despite competing priorities. This methodology, developed in partnership



with the State’s epidemiologists and BMS, will produce a careful and accurate accounting of children who received a psychosocial/behavioral health screen as part of an initial or periodic EPSDT screen.

Regarding a review of the screening activities conducted by the bureaus, the SME received information from the Division of Corrections and Rehabilitation. Debi Gillespie, Director of Juvenile Programs, reported that every youth who enters any facility—whether it is detention, diagnostic, or commitment/rehabilitation—must have the MAYSI-II completed within 72 hours. Ms. Gillespie also noted that, in addition to the MAYSI-II, all committed youth receive a comprehensive mental health assessment unless they have a psychological evaluation that is six months old or less.

### **Recommendations Specific to Screening:**

- The SME recognizes the tremendous effort of the OMCFH and its partner bureaus in determining a retrospective mental health screening rate by primary care clinicians serving Medicaid-enrolled youth. The SME commends the state for developing and using a thorough methodology for this process, which will result in actionable information to improve screening rates and assessment rates for the target population. The SME notes that the process developed will need to be repeated annually or biannually in perpetuity if the State plans to monitor its behavioral health screening rates beyond the planned exit date of the Agreement. Given the time, staffing resources, and costs to conduct any type of retrospective review, the SME recommends that the State consider possible methods for automating all or some of this work, such as the addition of a HCPCS or CPT code modifier to identify a behavioral health EPSDT screening that includes one of the aforementioned screening tools. Automation would also result in more real-time information available, allowing the State to identify and address gaps or issues more quickly. Additionally, the State could review the contractual responsibilities of the managed care organization for wholly or partially reporting this data to the State and/or consider using its Medicaid External Quality Review (ERQ) vendor to perform some or all of this work. The SME notes that the State indicates discussions with Qlarant, the State’s EQRO, are underway to achieve this work. The SME looks forward to discussing further specifics about this potential scope of work.
- The current MCO contract requires submission of a report to BMS 45 calendar days after the end of each quarter identifying its performance regarding EPSDT outreach/enabling services, screening and referral rates, well-care child visit rates, dental visits, and immunization rates, but the contract does not specify how it reports on the mental health component of any screening. The SME recommends the State explore modifying this report in the current or future contract to specify behavioral health screens as it could reduce the scope of the OMCFH review to only those children not enrolled in managed care.
- OMCFH reported that beginning in January 2021, it will begin facilitating the dissemination of sampling results as a tool to increase awareness and engagement of mental health providers in utilizing mental health screening as part of a child’s continuum of care. The SME recommends that the OMCFH work in collaboration with the Outreach and Education workgroup to leverage their resources in reaching providers and other stakeholders.
- The State has completed its review of the policies and processes for all bureaus, indicating that policies and processes are in place for the screening of all children entering a bureau. The SME recommends that the State develop and implement a process to audit these policies and regularly

report data and any quality improvement activities to address any findings. The SME expects that the State may address this through its data dashboard, QAPI, and evaluation efforts.

#### **Recommendations Specific to Assessment:**

- The SME recommends that the State focus on assessment. In the review of the updated workplan, there were several tasks related to screening but far fewer related to assessment. While the workgroup listed several assessment-related tasks (“assess the current systems for referring ‘positive’ screens for CANS assessment, assess the gaps when referrals for assessments are not made, modify policy and practice based on the data”), they have neither an owner nor a due date listed. In keeping with the theme of decision-making, the SME recommends the State begin assigning these tasks to ensure compliance with the Agreement.
- Given the significance of assessment work as a pathway to all services, the SME recommends that workplan tasks be coordinated across workgroups to ensure that a single assessment drives all decisions for services and supports rather than a service specific assessment that only looks at services individually. Since children in the target population frequently need multiple services concurrently, one assessment should inform the need for all behavioral health services and supports.
- The SME recommends that this workgroup partner with Marshall University as it continues to evaluate the quality of CANS tool to support behavioral health assessment by BCF’s SAH and BBH’s Children’s Mental Health Wraparound programs, including their efforts around the need for consistent training and coaching to ensure CANS is delivered by a qualified assessor.
- The State has completed its review of the policies and processes for all bureaus, indicating that policies and processes are in place for the *assessment* of all children that have an indicated need for treatment, either via the bureaus screening or due to current engagement with treatment services. The SME recommends that the State develop and implement a process to audit these policies and regularly report data and any quality improvement activities to address any findings. The SME expects that the State may address this through its data dashboard, QAPI, and evaluation efforts.

### **Reductions in Placement**

**Agreement Requirements:** The Agreement requires the State to reduce the unnecessary use of residential mental health treatment facilities 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 (RMHTF) as of June 1, 2015, with additional benchmarks to be established and met over time.

**Activities:** The State’s activities focus on oversight of two different vendors, each with a role to authorize different types of residential services and development of a workgroup specific to residential services.

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.

Consistent with an SME recommendation, the State formed a workgroup, Reducing Reliance on Residential Placement (R3), “consisting of WVDHHR stakeholders with residential provider engagement and guidance from Casey Family Programs”<sup>4</sup> to coordinate this aspect of the Agreement. This workgroup is in the initial stages of formulating a workplan and has developed a logic model with input from a number of internal and external stakeholders. The State has commenced meeting with residential providers to discuss the State’s goals for reducing use of residential.

As previously mentioned, 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). Based on discussions with the State and review of meeting minutes, the State is meeting regularly with MHP to review all requests for in-state residential services. In addition, the SME reviewed documents outlining a policy for the review of out-of-state residential placements produced by BCF including: (1) a Memorandum on Placing Youth in Out-of-State Facilities, dated Dec. 2, 2020, which noted the Multidisciplinary Team Desk Guide is in the process of being revised and will be re-released; (2) the accompanying Standard Operating Procedure: Placing Youth in Residential Facilities, effective Dec. 1, 2020; and (3) the Request for Out-of-State Face Sheet.

Initial drafts of the State’s workplans anticipated providing a cluster analysis to determine gaps in the continuum of care, including those currently being filled by residential mental health treatment facilities. The production of that analysis is planned for January 2021.

### **Recommendations**

- The SME commends the State’s engagement of residential providers. It understands that the State has held several meetings with providers, individually and as a group to articulate the State’s vision for residential services, engage providers in a change process, and surface concerns from providers. The SME was invited to join one provider forum in which the State clearly articulated its vision to reduce reliance on residential *and* recognize the important role of residential as part of a home- and community-based system.
- As the State moves forward with engaging providers, data will be critical to change practice. Given the importance of this cluster analysis to both planning for Residential Workgroup tasks, and to inform the broader evaluation and QAPI plan which have tight timelines, the SME recommends that the State move quickly to complete the cluster analysis noted above, begin analysis of the data, and engage stakeholders in reviewing the data. It notes that the State had a plan in March 2020 regarding the data the State planned to collect and analyze. The State sent the SME an Excel spreadsheet with three tabs (Children in RHMTF, Children at Risk for RHMTF, and MH Provider Capacity) with a number of indicators represented on the X axis. The SME recognizes that both the pandemic and staffing resources have impacted timelines.

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<sup>4</sup> West Virginia’s Implementation Plan to the DOJ Agreement, rev. November 13, 2020.

- The SME recognizes that this workgroup is in the initial stages of forming and articulating a workplan. As such, the SME has had only one opportunity to discuss the scope with this newly formed workgroup. From that discussion, it appears that the workgroup is focused on activities specific to defining its residential levels of care and defining the medical need for residential. This is important work that needs to continue. However, the SME cautions that the workgroup cannot decide needed levels of and criteria for residential placement without both the data from the cluster analysis and from a re-review of the ad hoc residential data the SME requested last spring.
- Additionally, this workgroup needs to be charged with identifying and creating a pathway that redirects from residential care. A specific and actionable plan for redirection is needed. If the workgroup only focuses on reorganizing residential, it will not realize its goals. If, on the other hand, the workgroup focuses on establishing a pathway that requires providers to demonstrate why a child cannot be treated in the community, the State will facilitate faster and more appropriate reductions in these placements. This process will then allow the State to have a clearer picture of which children actually need residential and design a residential service to best meet those needs. These data are critical to understand not only 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 placement. 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.
- The SME recommends developing a cross-agency pathway for entry to, diversion from, and transition from residential. As described earlier, multiple bureaus and multiple vendors authorize and oversee different types of out-of-home/residential placements. Additionally, courts and judges have a critical role in the success or failure of diversion efforts. The State needs to develop cross-agency policies, processes, and data systems to oversee all residential placements that are occurring in the State. This approach can include either joint purchasing strategies and use of a shared vendor or, if multiple vendors and bureaus maintain separate roles, the alignment of contracting, data, and reporting requirements in order to provide a cogent snapshot of residential authorizations and quality of care in the State.
  - Cross-agency planning and implementation can address how the MDT analyzes information about the youth (e.g., CANS or CAFAS assessment data), how an MDT refers a youth to HCBS, which encompasses services delivered by BBH (e.g., state-funded Wraparound), BCF (e.g., SAH), and BMS (e.g., the CSED waiver); what role the CFT plays in recommending residential if the youth is already receiving Wraparound services; the role of courts and judges to support home and community-based options during decision-making by courts and judges; the data collection processes and evaluation of the processes within the flowchart; and the regulatory and oversight roles of State agencies with regard to facilities’ refusal to serve youth related to diagnosis, functional assessment, previous history, etc.

- The SME recommends that this cross cutting/cross-agency approach encompass the development of a common data set to ensure that the State is consistently collecting data on children in the target population referred for, admitted to, and discharged from RMHTFs. This task will enable the State to standardize data to demonstrate compliance with the Agreement in reducing accrual to RMHTFs.
  - The SME repeats its June 2020 recommendation that these data be disaggregated by demographic characteristics and geography to assist the State in determining if there are particular areas of challenge, such as for children of color, youth identified as LGBTQIA,<sup>5</sup> and older youth, as marginalized populations are often overrepresented within RMHTFs.<sup>6</sup>
- The SME recommends that the workgroup more clearly define its tasks and interdependencies with other workgroups. For example, the workplan includes the tasks “define assessment timeframes and medical necessity” and “research and recommend evidence-based assessment tools,” but does not include an owner or due date for each. In the “Notes” column, the workgroup considers whether these tasks should be under the purview of the Screening and Assessment Workgroup or a joint activity.
- In reviewing other State work, the SME encourages this workgroup to leverage the knowledge and past experience of the Commission to Study Residential Placement. In reviewing the Commission’s recent work, there is significant overlap in membership, not only with this specific workgroup, but across nearly all the workgroups. In June, the Commission received an update regarding the State’s work with the DOJ, but it does not appear that this workgroup or others are being similarly updated about the work of the Commission. The Commission includes several sub-groups or task teams, each of which appears to overlap to some degree: Education; System of Care; and Service Development and Delivery, which includes the Integrated Data Outcomes and Evaluation Task Team, the Transformation Collaborative Outcomes Management Task Team, and the Best Practice Task Team.

## 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; and (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.

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<sup>5</sup> Fish, J. N., Baams, L., Wojciak, A. S., & Russell, S. T. (2019). Are sexual minority youth overrepresented in foster care, child welfare, and out-of-home placement? Findings from nationally representative data. *Child Abuse & Neglect*, 89, 203–211. Doi:10.1016/j.chiabu.2019.01.005

<sup>6</sup> Howze, K.A. & McKeig A.K. (2019). The Greenbook and the Overrepresentation of African American, Hispanic, and Native American Families in the Child Welfare System. *Juvenile and Family Court Journal* 70(4): 103-118. Doi:10.1111/jfcj.12154 and Heaton, L.L. (2018). Race and ethnic differences in mental health need and services received in justice-involved youth. *Children and Youth Services Review*, 90:54-65. Doi.org/10.1016/j.childyouth.2018.04.043



**Activities:** The State has continued to use its established listserv ([CHILDWELFARE\\_WV-L@LISTSERV.WVNET.EDU](mailto:CHILDWELFARE_WV-L@LISTSERV.WVNET.EDU)) to announce upcoming meetings and related events and to publicize the State's children's crisis services and hotline (844-HELP4WV). Two virtual meetings of the Collaborative were held in August and November 2020.

The State provided documentation detailing the breakdown of those subscribed to the listserv by percentage (e.g., 10.46% of emails are affiliated with advocacy groups such as Disability Rights West Virginia, 5.88% are affiliated with the State's judicial branch, etc.) and completed additional analysis of its stakeholder survey with the Family Outreach Survey Report (June 2020). The State also completed its 2020-2024 Outreach and Education Plan and initial drafts of content that would be incorporated into an educational toolbox, which will be added to the Child Welfare Collaborative [website](#).

### **Recommendations**

- The SME commends the State for its efforts on outreach and education, even amid COVID-19, such as its efforts to compile an exhaustive list of active stakeholder groups, including those that are regional or local (i.e., focused on a particular county or counties with a geographic region of the State), as well as statewide groups, advocacy and provider organizations, and school-based and charitable groups. The SME recommends that the State add to this list as appropriate and consider its means of outreach and education to families whose native language is not English and LGBTQIA individuals.
- The State's 2020-2024 Outreach and Education Plan notes that WVDHHR's Office of Communications will review each item drafted by topical subject matter experts in order to include these items in the educational toolbox by Feb. 2021 and will prepare and send emails about programs for internal outreach by March 2021. The SME supports this centralization of communications but recommends that a topical subject matter expert(s) participate in the review of communications to ensure consistency about eligibility, programmatic functions, assessment and referral pathways, etc., and to encourage common language among WVDHHR's bureaus.
- The SME recommends that the State continue to use the multiple avenues it has developed to engage stakeholders including written materials, surveys, face-to-face meetings (given the pandemic, when such meetings are no longer a public health risk), and virtual platforms to augment its outreach and education even after the current public health crisis has passed. Virtual platforms facilitate participation by reducing the need for transportation and childcare. In addition, if properly configured (i.e., [508 compliant](#)), virtual spaces can facilitate the participation of individuals who require visual or auditory accommodation.
- The SME recommends that the State engage in strategies to engage youth and families directly, including surveys, focus groups, interviews, and related methods to actively engage in dialogue about the needs and challenges youth and families face in accessing services and their experiences with those services. As noted above, the use of virtual platforms can promote accessibility, particularly for youth and families with challenges regarding scheduling, transportation, childcare, etc.

## 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 the U.S. DOJ. 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. The State has begun mapping data needed and identifying potential data sources to meet the Agreement requirements.

The State produced ad hoc reports, including one in late June 2020, which recorded the services, by CPT or HCPCS code, that Medicaid-enrolled children received preceding or following discharge from a RMHTF. Those data showed:

1. about half of children entering a RMHTF had an associated claim for outpatient counseling services prior to entry and about one-third following discharge;
2. about 40% of children had an associated claim for case management before admission, but the percentage receiving the service declined following discharge; and
3. few children had a claim for therapeutic behavioral services, which are designed to address maladaptive behaviors either before or following admission.

The State also established a Data Dashboard Governance Structure to “provide oversight and support to the QAPI workgroup to ensure that deliverables are complete and adhere to the Implementation Plan target dates. The members will convene on [a] monthly, and as-needed basis.”

### **Recommendations**

- Based upon review of the State’s Implementation Plan and materials submitted to the SME regarding the past six months of activities, it appears the State may not meet its proposed timelines in this area. The SME understands that progress on the QAPI is dependent upon other workgroups completing key tasks (e.g., the Wraparound workgroup must define common programmatic elements and requirements). The SME also understands that the State’s data and IT expertise has been redirected to meet the demands of the State’s COVID response and that the State has mobilized partnerships with BerryDunn, WVU, ICF, and Marshall University to continue its focus on this work. The SME understands that WVDHHR Leadership is planning WVDHHR Leadership discussions in January to resolve this issue. As the State considers how to address the matter, the SME recommends that the State deploy additional State staff to this function.
- The SME recommends that existing workplans, data dashboards flows, and other documents be revised to reflect interdependencies across workgroups and to incorporate dates that the State expects can be met. Additionally, the SME recommends that the State documents reflect the need for initial and ongoing data collection and analysis capabilities; and that it reflect language contained in its own WVU Scope of Work (SOW) that requires collaboration in developing the logical model.
- The SME recommends that the criteria to define the population “at risk” as part of the Agreement’s target population match the eligibility criteria for its CSED waiver. Specifically, the State has selected criteria for functional impairment defined as either a CANS score of 40 or higher or a CAFAS score of 100 or higher. By comparison, the CSED waiver establishes eligibility with a CAFAS score of 90 or higher. This is just one example that shows the opportunities for further cross-workgroup coordination to ensure alignment of evaluation criteria with programmatic requirements. The SME wishes to explicitly connect the difficulty defining and collecting data related to the at-risk population to the bureau-specific approach for providing services discussed in the Wraparound section above. The siloed approach to delivering services to children has led to the creation of multiple data systems, likely not interoperable, which must be mined to collect relevant indicators and then cleaned and/or matched to ensure the State and its partners are comparing like to like. As the State decides on a final model to provide Wraparound and related services to children and youth in the target population, the SME recommends that Leadership consider the administrative and financial burden of continuing to maintain disparate systems as part of their decision-making process.
- The SME recommends that State Leadership decide on common reporting metrics to roll-up data for children in the target class to comply with the Agreement. The State must take care to ensure that each bureau is able to collect the necessary data points, and that providers serving children in the target class have been trained and are able to report data clearly, consistently, and timely. Such metrics typically include timeliness of screening, timeliness of assessment with a standardized tool following a positive, referral to initial services following intake, family

satisfaction, etc. Each of the sentinel indicators chosen must be able to be disaggregated by demographic group and geography, consistent with the requirements in the Agreement.

- The SME commends the State for establishing a Data Dashboard Governance Structure composed of leadership from WVDHHR, BBH, BCF, BMS, and the Bureau for Public Health.
  - The SME wishes to clarify whether the governance group has met in 2020, and if so, seeks to review copies of the agendas and minutes of those meetings to ensure a complete understanding of the current work, including opportunities and challenges posed by and to Leadership.
  - Given that schools represent a significant referral source for SAH and BBH's Wraparound programs (as per the Marshall University's West Virginia Wraparound Review), the SME wishes to clarify how the State will engage representatives from the West Virginia Department of Education and the Department of Military Affairs and Public Safety in accordance with the Agreement as the State has informed the SME that governance will remain within WVDHHR only.
  - The SME notes that the Data Dashboard Governance Structure does not appear in the State's QAPI workplan. In keeping with the recommendation theme of organization, the State should clarify whether the governance body will be responsible for ensuring the workplan tasks are completed and how tasks the governance body deems necessary will be communicated to the workgroup and reflected in future workplans.
- The SME also notes some overlap between members of the Data Dashboard governance body and the Commission to Study Residential Placement, as well as topical overlap between this body and the Commission's Integrated Data Outcomes and Evaluation Task Team. The SME wishes to clarify how these groups will interact to leverage available resources and expertise without duplicating effort.

## Conclusion

WVDHHR has continued to make strides towards meeting Agreement requirements despite the challenges of the pandemic, including the redeployment of staff and resources from this effort to address the public health crisis. The State is nearly one and a half years into Agreement implementation. As such, it is expected that the State would need to re-evaluate its progress and adjust its plans. As described in this third report, there are several areas where the State is well-positioned to meet the terms of the Agreement in the coming years. In other areas, the State needs to revise its plan. While revisions will result in extended timelines for some activities, these changes are necessary in order for the State to meet its obligations under the Agreement, and to ensure the success of the State's longer-term goals for West Virginia. The SME commends the State for its willingness to re-evaluate its planned approach to certain provisions of the Agreement and its commitment to expediting the development of an implementation plan for those provisions. The SME also recognizes the enormity of the task ahead for the State as it continues to provide services to children and families while revising and implementing a new approach to certain services required in the Agreement.

# Appendices

## Appendix A – Documents Reviewed

### General/Organizing Documents

Clarifying Linkages Report DRAFT 20200513 SME 20200515  
Department of Justice (DOJ) Agreement Project Lessons Learned Playbook, Memorandum, Oct. 5, 2020  
Initiative Level Logic Model Graphic  
Questions-SME for Semi-Annual Report due June 2020 clc 20200522  
SME [Subject Matter Expert] DOJ [Department of Justice] RTM 20200515  
SME DOJ RTM 20200526  
The Implementation Plan of the Memorandum of Understanding between the State of West Virginia and the United States Department of Justice, Nov. 13, 2020  
U.S. Department of Health and Human Services, Child and Family Services Reviews, Onsite Instrument and Instructions, Jan. 2016

### Data Sources

2017 Data, Supreme Court of Appeals of West Virginia, Published Feb. 2018  
Adoption From Foster Care, Child Trends, Federal Fiscal Year 2017  
Child Maltreatment, Child Trends, Federal Fiscal Year 2017  
Child Welfare Agency Spending in West Virginia, Child Trends, State Fiscal Year 2016  
December 2019 CPS Caseloads Report, Revised SME 20200601  
FCYS Caseload Report 2019 (staff numbers not current) SME 20200601  
Federal Fiscal Year 2019 Vacant and Allocated Positions Data  
Foster Care, Child Trends, Federal Fiscal Year 2017  
Kinship Caregiving, Child Trends, Federal Fiscal Year 2017  
Legislative Foster Care Placement Report, Sept. 2019  
Statewide Trends, 2010-2017, Supreme Court of Appeals of West Virginia, Published Feb. 2018

### Policies

Child Protective Services Policy, Feb. 2019 (BCF)  
New Provider Agreement for Socially Necessary Services Agencies Memorandum, June 29, 2019 (BBH)

### ACT

ACT [Assertive Community Treatment] Statement SME 20200515  
ACT Overview PPT 202003030 SME 20201130  
ACT Workflow 20200512 SME 20200515  
ACT Workplan SME 20201113  
Assertive Community Treatment Data Pull (Ad Hoc 330), Jan. 9, 2020

### CMCR

Announcement of Funding Availability, Children’s Mobile Crisis Response and Stabilization Teams, May 16, 2019  
Children’s Mobile Crisis Response and Stabilization, SFY 2020  
CMCR agenda 8.12.20.docx  
CMCR [Children’s Mobile Crisis Response] Children Service Flyer 20200421 SME 20200515



CMCR Mobile Crisis Fall Training SME 20200515  
 CMC Respite TA Call 11 13.asd.docx  
 CMCR and Stabilization AFA [Announcement of Funding Availability] SME 20200515  
 CMCR Training Sept 2019 SME 20201113  
 CMCR SOW [Scope of Work] 2020 SME 20200515  
 CMCR Workflow 20200514 SME 20200515  
 CMCR TA CALL 1 21 2020.docx  
 CMCR TA Call 6-17-20.docx  
 CMCR TA Call 10-13-20 (002).asd.docx  
 First Choice Trainings Outreach for Children's Crisis and Referral Line 12-4-20.docx  
 Mobile Crisis Response Workplan SME 20201113  
 Mobile Crisis TA Call (003).docx  
 Mobile Crisis TA Call April.docx  
 Mobile Crisis TA Call FEB.docx  
 Mobile Crisis TA Call March.docx  
 Mobile Crisis TA Call May.docx  
 Mobile Crisis - Added notes for SME 20201203.docx  
 Mobile Crisis and Crisis Line Outreach.pdf  
 Mobile Crisis and Crisis Line training materials.pdf  
 Mobile Crisis Charts FY 21 June through September.docx  
 Mobile Crisis COVID19\_Clarification\_LTR.pdf  
 Mobile Crisis Region 2 coverage schedule.pdf  
 Mobile Crisis Response Numbers FY 21.pdf  
 PP-Facilitation Overview FINAL 9 3 20.pptx  
 Regional Youth Service Center SOW SME 20200522  
 Regional Youth Service Centers (email from Annie Messinger to SME Team, Jan. 14, 2020)  
 RYSC DATA 20200529 SME 20200601

### **CSEDW**

Approved Aetna CSEDW Spring Provider Workshop Training.pptx  
 Approved CSEDW Incident Management Training.pptx  
 Chapter 502 CSEDW 1.28.2020.pdf  
 Children with Serious Emotional Disturbance 1915(c) Waiver  
 Closed Contacts for HC 11.30.2020\_.xlsx  
 CSED Brochure 11.2.2020 SME 20201123.pdf  
 CSEDW Active Services Count by Age thru 11\_23\_2020 SME 20201123 (1).xls  
 CSEDW Active Services Count by Age thru 11\_23\_2020 SME 20201123.xls  
 CSEDW Aetna October Discovery Remediation Report SME 20201123.xlsx  
 CSEDW CM Assignment Spreadsheet thru 9\_8\_2020 .xls  
 CSEDW Denial and Termination Letter 10.19.2020 SME 20201123.docx  
 CSEDW DHHR Worker OOS App Process 3\_9\_2020 SME 20201123.pdf  
 CSEDW DOJ SME Data from March 1 thru November 30.xlsx  
 CSEDW FAQ 9.24.2020 SME 20201123.docx  
 CSEDW Flowchart SME 20201123.xlsx  
 CSEDW Initial Application 5.25.2020 SME 20201123.docx  
 CSEDW Memo to SME 20201204.pdf  
 CSEDW Provider Readiness thru 11\_27\_2020 (3).xlsx  
 CSEDW Provider Readiness thru 11\_27\_2020.xlsx

CSEDW QA 4.29.2020 (1).xlsx  
 CSEDW QA 4.29.2020.xlsx  
 CSEDW SME DOJ meeting SME 20201123.docx  
 CSEDW Welcome Letter w Provider Information.docx  
 CSEDW [Children with Serious Emotional Disorder Waiver] Workflow 20200429 SME  
 20200515  
 DOJ SME Provider Detail for Providers Chosen for Service Delivery per FOC thru 11\_27\_2020  
 (1).xlsx  
 DOJ SME Provider Detail for Providers Chosen for Service Delivery per FOC thru  
 11\_27\_2020.xlsx  
 Medicaid 1915 (c) Waiver for Children with Serious Emotional Disorders-November 2020  
 Update  
 Model Purchase of Service Provider Agreement for Mountain Health Promise (v22)  
 Provider Manual, Chapter 502, Children with Serious Emotional Disorder Waiver, March 1,  
 2020  
 SED Update to SME 10.28.2020 SME 20201110  
 SED meeting minutes 6.4.2020.docx  
 SED meeting minutes 6.11.2020.docx  
 SED meeting minutes 6.18.2020.docx  
 SED meeting minutes 6.25.2020.docx  
 SED meeting minutes 7.2.2020 (2).docx  
 SED meeting minutes 7.2.2020.docx  
 SED meeting minutes 7.16.2020.docx  
 SED meeting minutes 8.13.2020.docx  
 SED meeting minutes 5.28.2020 (1).docx  
 SED meeting minutes 5.28.2020.docx  
 Targeted Case Management State Plan Amendment, 15-007  
 WV-BMS-CSED-01 Initial Application 5.25.2020.docx  
 WV-BMS-CSED-02 Freedom of Choice Form 1.15.2020 (4).docx  
 WV-BMS-CSED-02 Freedom of Choice Form 1.15.2020.docx  
 WV-BMS-CSED-03 HV Form 1.3.2020.doc  
 WV-BMS-CSED-03 HV Form Updated 3\_30\_2020 Due to COVID 19 Response.doc  
 WV-BMS-CSED-04\_Initial PCSP1.3.2020.doc  
 WV-BMS-CSED-05\_PCSP 12.2019.docx  
 WV-BMS-CSED-06 Certificate of Trainings 1.3.2020.doc  
 WV-BMS-CSED-07\_Service Log and Progress Notes 1.3.2020.doc  
 WV-BMS-CSED-08\_Specialized Therapy and Adaptive Equipment 1.3.2020.doc  
 WV-BMS-CSED-10\_Transfer Discharge Form 1.3.2020.doc  
 WV-BMS-CSED-11\_HCBS Notice of Death Form 1.3.2020.docx  
 WV-BMS-CSED-12\_Request to Continue Services 1.3.2020.docx

### **Data/QAPI**

COGNOS Catalog V-11 with Descriptions SME 20200526  
 Data Dashboard Roadmap SME 20201103  
 Foster Care Utilization Management Guidelines, March 20, 2017 (KEPRO)  
 FREDI Report List 11242019 SME 20200526  
 PM Workplan DHHR DOJ Eval\_finalv3\_042020 SME 20200522  
 QAPI Dash Dashboard Roadmap Plan v1 SME 20201201

QAPI System Workplan SME 20201113  
Workforce Workplan SME 20201113  
WVU Evaluation SOW FINAL SME 20200526  
WVU PPT 20200518 SME 20200522

### **Juvenile Justice**

Division of Children and Juvenile Services, Court Improvement Program Overview, Supreme Court of Appeals of West Virginia, Sept. 30, 2019  
West Virginia, Juvenile Justice Commission, 2017 Annual Report

### **Outreach and Education**

2020-2024 Outreach and Education Plan In Accordance with the Memorandum of Understanding between the State of West Virginia and the U.S. Department of Justice Children and Family Programs SME 20201113  
Community/Behavioral Health Groups, Annual Youth Stakeholder Focus Group Summary, 2018-2019  
CW [Child Welfare] Collaborative Notes 20200512 SME 20201201  
CW [Child Welfare] Participant List 20201116 SME 20201201  
CW [Child Welfare] Regional Meetings Response SME 20201202  
Family Outreach Survey Report June 2020 SME 20201110  
O&E [Outreach and Education] Crosswalk 20201201 SME memo 20201201  
OUT [Outreach] Family Stakeholders Initial List 20200102 SME 20200515  
OUT Family Survey Progress Report SME 20200515  
OUT Survey protocol email L\_Hunt SME 20200515  
OUT SurveyMonkey\_Family\_202004 SME 20200515  
Outreach and Education Workplan SME 20201113  
Program Overview for Families SME 20201113  
Program Overview for Stakeholders SME 20201113  
Toolbox Tips Stakeholder User Guide SME 20201113  
West Virginia Family Resource Networks  
    Annual Report, 2017-2018  
    Reference Manual, July 2018  
    Statement of Work (undated)

### **PBS**

Announcement of Funding Availability Positive Behavior Support (PBS) Program, Oct. 2, 2019  
CANS Overview PowerPoint PDF  
CED Programs Overview PowerPoint PDF  
Deescalation for First Responders.zip  
Endorsed PBS Professionals.pdf  
Foundations graduates list.xlsx  
PBS AFA [Announcement of Funding Availability] 20191010 SME 20200515  
PBS Crosswalk.xlsx  
PBS Family Outreach Survey flyer April 2020 SME 20200515  
PBS FY2021 SOW Final SME 20200515  
PBS Workplan SME 20201113

## Positive Behavior Support Program 2019-2020 Accomplishments

- 1- What are ACES - Releate to Toxic Stress.pdf
- 2- Understanding Child Trauma - NCTSI.pdf
- 3 - How Interventions Should Be Emphasized - Diagram.docx
- 4 - Clear Mini Map.pdf
- 5 - 10 Gratitude Exercises.docx
- 5- Mindfulness Exercises for Kids.pdf
- 6- Mindfulness Exercises and Resources.pdf
- 7- Positive Environment Checklist - KIPBS.pdf
- 8- Circles of Social Support (with definitions).docx
- 9- What is Calming for you Activity 3.2018.docx
- 10- 100 WAYS TO COPE WITH STRESS.doc
- 12- 5 Steps to FERBs that Work.docx
- 13- Social Story - Mad Magic.docx
- 14- Ways to Build Resilience from APA.docx
- 15- PBSP Template with Letters for TIPBS.docx
- 16- Virginia West - PBSP -10-23.docx
- 6.13.19 CED Overview Summ, Evals, SignIn NL
- 9.5.19 CANS Stonewall Summation, Evaluations, SignIn
- 9.25.19 CANS Glade Springs Summation, Evaluations, SignIn

## **R3**

- Children's Residential Services and PRTF Review, Aug. 19, 2019
- Children's Residential Services and PRTF Review, State Wards, Aug. 20, 2019
- FAST and Case Planning Reminder CAS-YS-4-20, June 26, 2020
- FFY2019 Residential Placements by Facility and Age
- Memorandum Placing Youth in OOS Facilities 12020202 SME 20201203
- Out of State Residential Facilities, Annual Youth Stakeholder Focus Group Summary, 2018-2019 (Source: KEPRO)
- R3 Workplan SME 20201113
- Request for Out of State Facesheet 12-02-2020 SME 20201203
- Residential Facilities, Annual Youth Stakeholder Focus Group Summary, 2018 (Source: KEPRO)
- SOP Placement 12-02-2020 SME 20201203
- State Wards and PRTF, 150-390 Day Episode Comparison

## **Screening & Assessment**

- Form CMS-416: Annual ESPDT Participation Report (2019)
- Form CMS-416: Annual EPSDT Participation Report (2018)
- Mental Health Screening Tools Workplan SME 20201113
- MH [Mental Health] Screening and Assessment Update SME 20201201
- MH [Mental Health] Screening Chart Review Algorithm SME 20201201
- MH [Mental Health] Screening BJS [Bureau of Juvenile Services] Notes SME 20201203
- MH [Mental Health] Screening MAYSI Protocol for Rehabilitation Centers
- MHS [Mental Health Screening] MCO [Managed Care Organization] Contract Language SME 20200515
- MHS Summary of Workflow DRAFT SME 20200515

- Table APC-CH. Percentage of Children and Adolescents Ages 1 to 17 who were on Two or More Concurrent Antipsychotic Medications for at Least 90 Consecutive Days, as Submitted by States for the FFY 2018 Child Core Set (CMMS)
- Table APP-CH. Percentage of Children and Adolescents Ages 1 to 17 who had a New Prescription for an Antipsychotic Medication and had Documentation of Psychosocial Care as First-Line Treatment, as Submitted by States for the FFY 2018 Child Core Set Report (CMMS)
- Table DEV-CH. Percentage of Children Screened for Risk of Developmental, Behavioral, and Social Delays Using a Standardized Screening Tool Preceding or on their First, Second, or Third Birthday, as Submitted by States for the FFY 2018 Child Core Set Report (Source: CMMS)
- Table FUH-CH. Percentage of Discharges for Children Ages 6 to 20 Hospitalized for Treatment of Mental Illness with a Follow-Up Visit with a Mental Health Practitioner within 7 and 30 Days After Discharge, as Submitted by States for the FFY 2018 Child Core Set Report (CMMS)

### **Substance Use Disorder (SUD)**

- West Virginia Governor's Advisory Council on Substance Abuse Report, 2016  
 West Virginia Office of Drug Control Policy, Semi-Annual Report, November 2019  
 Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders, Section 1115 Waiver, (Project Number: I I- W-00307/3) (BMS)

### **TFC**

- Children and Family Services Plan, 2015-2019  
 Socially Necessary Services (SNS) Code of Conduct (undated)  
 Socially Necessary Services Monthly Report Desk Guide, July 1, 2018  
 TFC [Treatment Foster Care] MCO role response SME 20200515  
 TFC White Paper 20200514 SME 20200515  
 TFC\_SME report question\_20200512 SME 20200515  
 Therapeutic FC Workplan SME 20201113

### **Wraparound**

- 2.27.19 Registration - MAPs for Wraparound  
 Agenda - 2.11.20 Morgantown Creative Facilitation Using the MAPs Process in Wraparound.docx  
 Agenda Wrap TA 8-7-20.docx  
 Agenda Wrap TA 9 14 20.docx  
 Agenda Wrap TA10 13 20.docx  
 BBH Childrens Mental Health Wraparound Overview 9-25-19.pdf  
 Children's Mental Health Wraparound Referral Form 2018  
 CMH [Children's Mental Health] Wraparound\_Process\_Final\_20200514\_SME\_20200515  
 Facilitation Overview Registration NAME LIST (cleaned) 9.2.2020.xlsx  
 Local Coordinating Agencies Wraparound Facilitation Agreement, April 2017  
 MAPS for WRAPS PPT PDF.pdf  
 Multidisciplinary Treatment (MDT)  
     Case Plan Report Template  
     Journey Observation Report  
     Case Profiles, Activities 1-3



Desk Guide, Revised April 6, 2015  
MDT [Multi Disciplinary] Teams, Bureau of Children and Families, Division of Training,  
June 2015 (Powerpoint)  
Multidisciplinary Team (MDT) Desk Guide SME 20201203  
Training Case Scenario  
Requirements for Case Plan  
Safe at Home Bench Card 20200826.pdf  
SAH CANS System Updates Guide - December 2020\_FINAL.pdf  
SAH LCA Monthly Meeting 20201006.pptx  
SAH LCA Webinar Update 20201118.pdf  
SAH Letter Redesign Sept 8 2020.doc  
SAH Monthly Meeting Agenda October 2020.docx  
SAH Quick Reference Guide 20200827.docx  
SAH Webinar for Districts 20201119.pdf  
SAH Webinar Questions and Answers 20200911.pdf  
SAH [Safe at Home] Workflow 20200507 SME 20200515  
Safe at Home West Virginia, West Virginia's Title IV-E Waiver Initiative (Source: BCF)  
Final Evaluation Report, Nov. 2019  
Semi-Annual Progress Report, October 1, 2018 – April 30, 2019  
West Virginia Wraparound Review 2020 (Draft from Marshall University)  
West Virginia Wraparound Workplan SME 20201113  
Wraparound TA 11 9 20  
Wraparound Review Team Decision Form, June 2018  
Wrap TA 2 10 20.docx  
Wrap TA 1 13 20.docx  
Wraparound counts FY 21.docx  
Wraparound counts.docx  
Wraparound Facilitator TA Call 3 2020.docx  
Wraparound Facilitator TA Call 6-8-20.docx  
Wraparound Facilitator TA Call 7-13-20.docx  
Wraparound Fidelity Review Report-Final-08-18-2020.docx

## Appendix B – Contacts with West Virginia and the Department of Justice

Meetings	Dates
Department of Justice	July 6, 2020; July 23, 2020; Aug. 4, 2020; Sept. 1, 2020; Sept. 29, 2020; Oct. 6, 2020; Nov. 4, 2020; Dec. 3, 2020
WV Implementation Team/Leadership	Sept. 21, 2020 (Re: Internal Logic Model); Nov. 30, 2020 (Quality Assurance and Performance Improvement); Dec. 4, 2020 (Leadership Strategy Planning Session); Dec. 7, 2020 (Leadership Strategy Session 1); Dec. 9, 2020 (Prep for Commissioner call); Dec. 11, 2020 (Follow up call with Commissioners re: Wraparound); Dec. 14, 2020 (Leadership Strategy Session 2), December 16, 2020 (Preview Report Findings)
Calls with C. Chapman	July 17, 2020; Aug. 11, 2020; Aug. 19, 2020; Aug. 26, 2020; Sept. 2, 2020; Sept. 9, 2020; Sept. 16, 2020; Sept. 23, 2020; Sept. 30, 2020; Oct. 7, 2020; Oct. 14, 2020; Oct. 20, 2020; Oct. 30, 2020; Nov. 4, 2020; Nov. 11, 2020; Nov. 24, 2020; Dec. 3, 2020
Wraparound	July 20, 2020; Nov. 5, 2020; Nov. 19, 2020; Dec. 10, 2020
Therapeutic Foster Care	July 17, 2020; Aug. 25, 2020; Sept. 9, 2020; Sept. 23, 2020; Oct. 13, 2020; Oct. 19, 2020; Oct. 21, 2020; Nov. 4, 2020; Nov. 9, 2020; Dec. 1, 2020
Children’s Mobile Crisis Response	Nov. 19, 2020
Positive Behavior Supports	Nov. 20, 2020
Assertive Community Treatment	Nov. 30, 2020
Screening and Assessment	Nov. 19, 2020; Dec. 9, 2020
Outreach and Education	Nov. 30, 2020
CSED	Nov. 23, 2020; Dec. 16, 2020
Data/ QAPI	Aug. 24, 2020; Nov. 30, 2020; Dec. 4, 2020
Reducing Residential	Oct. 27, 2020; Dec. 1, 2020
West Virginia Child Welfare Collaborative (virtual meeting)	Aug. 13, 2020; Nov. 16, 2020

## Appendix C – Summary of Recommendations

Wraparound Facilitation		
	Recommendation	Status Updates
1	Use Wraparound to direct children to appropriate supports and services, both home- and community-based services (HCBS) and residential services using a single plan of care to drive <i>all</i> services	
2	Create a multi-agency workplan in coordination with the screening and assessment and mobile crisis response workgroups with granular action steps, each with a clear deadline and owner,	
3	Create a clear pathway for entry with clear processes for establishing timely initial and continuing eligibility based on screening and standardized assessment	
4	Review enrollment and claims data related to the State’s 1915(c) waiver	
5	Strengthen and modify language in the 1915(c) waiver to ensure that the case management service is consistent with NWI Wraparound standards	
6	Share documents related to MCO case reviews for children pending accrual to the 1915(c) waiver; and information on (1) the specific contractual requirements of the MCO with regard to care management; (2) the required reports related to those contractual requirements (e.g., monthly or quarterly data sharing, narrative reports, etc.); (3) the State’s oversight and management plans related to contractual reporting by the MCO such as meeting minutes, corrective action plans, or related documents to support continuous quality improvement	
7	Incorporate findings from Marshall University’s fidelity review into the Wraparound implementation plan and workgroup’s workplan	
8	Review and monitor service array data and plans of care to ensure plans are appropriately individualized per the Agreement, trends in provider practice inform provider training, and inform how the State may re-evaluate the services included in the 1915(c) waiver	

### Children’s Mobile Crisis Response

<i>Recommendation</i>		<i>Status Updates</i>
1	Create a crosswalk of the differences in the three approaches to delivering mobile crisis (via BBH, BMS and TFC via BCF) to determine if any gaps in access or quality of care will result.	
2	Determine how it will gather data across BBH, BCF, and BMS to demonstrate compliance with the Agreement	
3	Minimize the differences in mobile crisis response across BBH, BCF, and BMS to ensure a similar service that meets the Agreement requirements is offered by each	
4	Consider joint provider meetings to support the work of all providers, identify issues that cross systems, and provide a consistent level of technical assistance to all providers	
5	Centralize core trainings, or review and approve the training(s) offered by each provider agency (BBH, BCF, BMS) to ensure consistency in training elements and expedite the introduction of new materials or competencies deemed necessary	
6	Provide written documentation (e.g., provider contract, policy, etc.) of how BCF's TFC agencies will provide mobile crisis services consistent with the Agreement, including the data that will be tracked, how TFC providers will be trained, and how BCF will ensure that any TFC- placed child receives access to the full array of Medicaid behavioral health services needed as a result of the mobile crisis intervention	
7	Establish ongoing cross-bureau processes to collect, review, and analyze data on the timeliness of access, the demographic characteristics and service utilization patterns of children and youth served, and their outcomes after engaging with crisis services to show how children were assessed and how that assessment created a referral pathway to HCBS, including Wraparound, and reduced the use of out-of-home placements	
8	Incorporate CMCR data into its cross-agency Wraparound workgroup to (1) raise the profile of CMCR services among non-BBH staff and the Wraparound programs they currently operate, an area of weakness identified by the Marshall University CANS report, and (2) track demand for HCBS as calls to the hotline increase	

<b>Behavioral Support Services (BSS)</b>		
<i>Recommendation</i>		<i>Status Updates</i>
1	Conduct an initial analysis of statewide and regional needs, provider capacity, current utilization data, and stakeholder's real or perceived gaps. The initial analysis would likely be followed by development of a strategic plan to ameliorate the identified gaps, followed by implementation planning in coordination with the CED and other local and regional entities	
2	Develop a strategic plan to ameliorate the identified gaps, followed by implementation planning in coordination with the CED and other local and regional entities	
3	Require PBIS, PBS, and BSS providers use a standardized assessment tool to ensure children are appropriately referred to services and supports, including Wraparound	
4	Perform a capacity assessment for PBS/BSS services prior to developing an evaluation plan, rather than conducting both simultaneously; the State should first understand its current providers' capacity to collect and report on data—a critical component of the capacity analysis—before designing an evaluation plan	
5	Develop a cross-agency approach to both conducting the capacity assessment and developing the evaluation plan	
<b>Therapeutic Foster Care</b>		
<i>Recommendation</i>		<i>Status Updates</i>
1	Reconsider and revise training and coaching for TFC parents to differentiate the training and coaching needs for children with SED from those with other health or social needs	
2	Incorporate an evaluation methodology in its revised training and coaching plan to assess whether training is effective in assisting TFC parents in acquiring, retaining, and utilizing the skills necessary to maintain children in their initial TFC placement	
3	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 the State would rely on an outside purveyor to develop training materials;	



	and development of a monitoring and evaluation plan	
4	Develop a clear referral pathway for the service, including criteria for when TFC should be considered, to ensure that access to TFC is driven by a comprehensive assessment identifying the needs of the child and recommending services available within the continuum of care, including services available to the child through BMS and BBH	
5	Ensure that children in TFC receive all behavioral health services for which they are eligible, including CMCR and Wraparound services	
6	Decide if TFC enrolled children will access Wraparound as a separate service or if TFC agencies will continue to provide Wraparound services as part of a bundle of required service components defined for TFC	
7	Conduct a robust analysis to weigh whether crisis services will be maintained as part of the bundled rate, if it is the TFC agency itself that must provide the service, or if the TFC agency will be required to subcontract with CMCR providers under contract with BBH or BMS	
8	Clearly delineate its tiering of homes (as that level is currently used for children with SED, children who are medically frail, and infants who are drug exposed) with details on how data will be collected and reported such as the use of modifiers to the claim code to differentiate populations, and/or differentiating licensing or credentialing requirements for TFC beds that serve children with SED	
8	Develop clear, consistent workplans with measurable and actionable goals, each with a clear owner, and firm deadlines	
9	Complete its analysis of TFC capacity, including Tier III beds	
10	Align the work of the TFC workgroup with the work of the reducing residential workgroup to develop a pathway that includes TFC as a service to redirect from residential care or to step down children from residential care	
11	Share information on the State's contractual relationship with KEPRO, including contractual obligations for KEPRO to produce regular or ad hoc data, narrative reports, performance measures, continuous quality improvement indicators	

Assertive Community Treatment (ACT)		
Recommendation		Status Updates
1	Collaborate with the Wraparound workgroup to decide on a pathway for referral to each service for older youth eligible for each	
2	Engage with the Wraparound workgroup to review data to more fully inform WVU's evaluation and to ensure compliance with the Agreement	
3	Consult with BBH to leverage any lessons learned from their own efforts to identify a provider for the Eastern Panhandle	
4	Explore cross-state contracting for the Eastern Panhandle (specifically, Washington and Frederick counties in Maryland)	
Screening and Assessment		
Recommendation		Status Updates
1	Consider possible methods for automating all or some of the work to determine the rate of behavioral health screening within EPSDT, such as the addition of a HCPCS or CPT code modifier to identify a behavioral health EPSDT screening	
2	Explore modifying the current MCO contract reporting requirements to specify data collection of behavioral health screening within EPSDT to reduce the scope of the OMCFH review to only those children not enrolled in managed care	
3	Collaborate with OMCFH and the OMCFH work in collaboration with the Outreach and Education workgroup to leverage their resources in reaching providers and other stakeholders as it disseminates its sampling report to increase and engagement of mental health providers in utilizing mental health screening as part of a child's continuum of care	
4	Develop and implement a process to audit the current <b>screening</b> policies and regularly report data and any quality improvement activities to address any findings	
5	Focus on assessment. While the workgroup listed several assessment-related tasks they have neither an owner nor a due date listed; we recommend the State begin assigning these tasks to ensure compliance with the Agreement	
6	Coordinate workplan tasks across workgroups to ensure that a single assessment drives all decisions for services and supports rather than a service specific assessment that only looks at services individually	
7	Partner with Marshall University as it continues to evaluate the quality of CANS tool to support	

	behavioral health assessment by BCF’s SAH and BBH’s Children’s Mental Health Wraparound programs, including their efforts around the need for consistent training and coaching to ensure CANS is delivered by a qualified assessor	
8	Develop and implement a process to audit the current <b>assessment</b> policies and regularly report data and any quality improvement activities to address any findings	
<b>Reductions in Residential Placement</b>		
<i>Recommendation</i>		<i>Status Updates</i>
1	Quickly complete the cluster analysis of children in residential care, begin data analysis, and engage stakeholders in reviewing the data	
2	Identify and develop cross-agency pathway for entry to, diversion from, and transition from residential; a specific and actionable plan for redirection is needed	
3	Develop a develop cross-agency policies, processes, and data systems to oversee all residential placements that are occurring in the State via joint purchasing strategies and use of a shared vendor or, if multiple vendors and bureaus maintain separate roles, the alignment of contracting, data, and reporting requirements in order to provide a cogent snapshot of residential authorizations and quality of care	
4	Develop a common data set to ensure that the State is consistently collecting data on children in the target population referred for, admitted to, and discharged from residential mental health treatment facility providers to standardize data to demonstrate compliance with the Agreement. We repeat our June 2020 recommendation that these data be disaggregated by demographic characteristics and geography to assist the State in determining if there are particular areas of challenge, such as for children of color, LGBTQIA youth, and older youth	
5	Clearly define this workgroups tasks and interdependencies with other workgroups in accomplishing tasks in its workplan. For example, the workplan includes the tasks “define assessment timeframes and medical necessity” and “research and recommend evidence-based assessment tools,” but does not include explicit coordination with the Screening and Assessment workgroup	
6	Leverage the knowledge and past experience of the Commission to Study Residential Placement given the significant overlap in membership	

<b>Outreach and Education</b>		
<i>Recommendation</i>		<i>Status Updates</i>
1	Include a topical subject matter expert in the centralized review by the WVDHHR Office of Communications to ensure consistency about eligibility, programmatic functions, assessment and referral pathways, etc., and to encourage common language among WVDHHR’s bureaus	
2	Continue to use the multiple avenues it has developed to engage stakeholders including written materials, surveys, face-to-face meetings (given the pandemic, when such meetings are no longer a public health risk), and virtual platforms to augment its outreach and education even after the current public health crisis has passed	
3	Explore strategies to engage youth and families directly, including surveys, focus groups, interviews, and related methods to actively engage in dialogue about the needs and challenges youth and families face in accessing services and their experiences with those service	
<b>Quality Assurance and Program Improvement (QAPI)</b>		
<i>Recommendation</i>		<i>Status Updates</i>
1	Revise existing workplans, data dashboards flows, and other documents to reflect interdependencies across workgroups and to incorporate dates that the State expects can be met	
2	Revise documents to reflect the need for initial and ongoing data collection and analysis capabilities	
3	Align criteria to define the population “at risk” as part of the Agreement’s target population to match the eligibility criteria for its CSED waive via cross-workgroup coordination to ensure alignment of evaluation criteria with programmatic requirements	
4	Consideration, by leadership, of the administrative and financial burden of continuing to maintain disparate systems as part of their decision-making process in determining a model to provide Wraparound and related services to children in the target population	
5	Decide on common reporting metrics to roll-up data for children in the target class to comply with the Agreement while ensuring each bureau is able to collect the necessary data points, and that providers serving children in the target class have been trained and are able to report data clearly, consistently, and timely, and that such data can be	

	disaggregated, consistent with the requirements of the Agreement	
6	Clarify if the Data Dashboard Governance Structure met in 2020, and if so, provide copies of the agendas and minutes of those meetings to ensure a complete understanding of the current work, including opportunities and challenges posed by and to leadership	
7	Clarify how the State will engage representatives from the West Virginia Department of Education and the Department of Military Affairs and Public Safety in accordance with the Agreement as the State has informed the SME that Data Dashboard Governance Structure will remain within WVDHHR only	
8	Include the Data Dashboard Governance Structure in the State's QAPI workplan and clarify whether the governance body will be responsible for ensuring the workplan tasks are completed and how tasks the governance body deems necessary will be communicated to the workgroup and reflected in future workplans	
9	Clarify how the Data Dashboard Governance Structure will interact with and leverage available resources and expertise from the Commission to Study Residential Placement without duplicating effort	