Continuous Quality Improvement Plan for Children's Programs

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Office of Quality Assurance for Children's Programs

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1.0 Introduction

Quality measurement, review, and evaluation are key factors in continuing to transform the child welfare system and child mental and behavioral health programs toward increased use of evidence-based practices and high-quality care that achieves good clinical outcomes, improves quality of life, and helps ensure safety, permanency, and well-being for children and their families.

The Continuous Quality Improvement (CQI) Plan for Children's Programs[1] describes the goals, objectives, tools, resources, and processes used by the West Virginia Department of Human Services (DoHS) to assess, manage, and improve the availability, accessibility, quality, and sustainability of mental and behavioral health services for children.

West Virginia's Office of Quality Assurance for Children's Programs (Office of QA) is responsible for driving the strategic vision, mission, and scope for quality improvement and data-driven practice across DoHS. The Office of QA operates within the office of the DoHS cabinet secretary. DoHS leadership and the Office of QA prioritize the alignment of quality improvement efforts across bureaus in tandem with ongoing cross-bureau collaboration to streamline programmatic work to provide a seamless system of care for children and families, in support of DoHS's strategic planning initiatives.

The CQI Plan builds upon existing quality assurance and improvement efforts in place across DoHS and continues to evolve in response to increased data availability, new information, experience, and best practices.

1.1 Mission of DoHS Children's Programs and Services

DoHS promotes a thriving and healthy West Virginia by providing access to critical healthcare, essential social services and benefits, and trusted information with a special emphasis on vulnerable populations. Programs will be conducted in an effective, efficient, and accountable manner, with respect for the rights and dignity of the employees and the public served.

1.2 Purpose of the CQI Plan

The purpose of the CQI Plan is to take a continuous and proactive approach to improving child welfare services and services for children with mental and behavioral health needs, including serious emotional disorders. Ongoing quality improvement will help ensure all eligible children, youth, and families are provided timely, effective, high-quality, and individualized care that is appropriate in scope, intensity, and duration to meet their needs.

[1] The CQI Plan was initiated as a result of House Concurrent Resolution 35, passed during the 2021 legislative session, requiring the implementation of a continuous improvement program with performance measures and outcomes for the child welfare system and for all children with serious emotional disorders served by the department to continue to evaluate and identify areas in need of improvement. To further support this effort, the Office of QA was established in May 2022.

Quality improvement activities will include two complementary approaches, as follows:

(1) Quality Assurance (QA) helps ensure programs and services comply with minimum regulatory and quality standards. QA activities are typically retrospective and, therefore, are more reactive in approach.

(2) CQI is the ongoing evaluation of systems and processes for the purpose of identifying problem areas and opportunities for improvement. This approach is proactive and data-driven. People at all levels across the service system (e.g., staff, youth, families, providers, etc.) are involved in planning and implementing ongoing proactive improvements. Everyone involved is encouraged to ask continuously, "How are we doing?" and "How can we do it better?"

1.3 CQI Guiding Principles

The following principles will guide West Virginia's quality improvement activities:

(1) CQI is prominent in DoHS's culture. DoHS recognizes that positive system change occurs when people at all levels are working together to improve the outcomes for children, youth, and families.

(2) CQI training, tools, and resources are provided with support from leadership to promote the involvement of staff at all levels.

(3) DoHS uses data to make policy and practice decisions and guide day-to-day work.

(4) DoHS focuses on systems and processes rather than individuals, emphasizing the identification of system gaps rather than blaming individuals.

(5) DoHS seeks input from employees and stakeholders at all levels within the organization and service delivery system.

(6) DoHS collaborates with stakeholders, including grantees and vendors, to incorporate these guiding principles into their practices as well.

(7) DoHS establishes key performance indicators (KPIs) with defined targets or benchmarks and measures progress toward performance goals.

(8) DoHS facilitates cross-bureau, cross-system collaboration to achieve positive outcomes for children, youth, and families.

(9) Transparency and accountability are essential to our stakeholders and to each other.

2.0 Scope

Quality improvement is integrated into the array of child welfare and mental and behavioral health services, including home- and community-based services and group, short-term, and long-term residential services. Home- and community-based services are prioritized to build and maintain success at home and in the community for children and their families/caretakers, and to minimize out-of-home placements. Home- and community-based services include, but are not limited to:

- Wraparound Facilitation

- Children with Serious Emotional Disorder (CSED) Waiver Enrollment and Services
- Mental Health Screening and Assessment
- Traditional and Therapeutic Foster Care Homes
- Behavioral Support Services
- Children's Crisis and Referral Line
- Mobile Crisis Response and Stabilization
- Assertive Community Treatment
- Other behavioral and mental health supports as agreed to during the continued evolution of the CQI Plan

Areas for evaluation to drive quality improvement and goal setting may include but are not limited to the list displayed in Table 1 below.

Table 1: Areas for evaluation

Evaluation of screening and intake processes	Timely access to services
Care management	Provider capacity
Assessment and individualized service planning	Workforce availability
Caseworker caseloads	Workforce training and certification
Availability and stability of placement options	Family and stakeholder engagement
Permanency	Outreach
Fidelity to evidence-based practices	Child/youth outcomes

3.0 Goals

The overarching goal across West Virginia's child welfare and mental and behavioral health services is to help children, youth, and families thrive in their homes, schools, and communities through a seamless system of care. To that end, the quality improvement framework and processes are guided by the following goals:

- Eligible children, youth, and families are screened, assessed, and provided timely access to appropriate services.
- Barriers are minimized for children, youth, and families, decreasing the burden on accessing treatment.
- Children, youth, and families receive services in their homes and communities when clinically appropriate and continue to be linked to services to maintain success over time.
- When out-of-home residential intervention is required to help ensure a child's safety, children are placed in or near their community of origin to keep the child connected to their family and support systems.
- Residential intervention is limited to the length of stay per episode of need.

- Residential interventions engage the family and community providers throughout care, to help ensure rapid reintegration into home and community settings.
- Care provided aligns with the strengths, needs, and goals of children, youth, and families.
- Children, youth, and families experience positive outcomes, including improved clinical and functional outcomes.
- Services are experienced as collaborative, engaging, effective, and of high quality.

4.0 Quality Governance, Leadership, and Infrastructure

The quality infrastructure outlined below provides the framework for carrying out CQI activities across the DoHS bureaus and programs providing child welfare and mental and behavioral health services for children, youth, and families.

4.1 Office of QA for Children's Programs

The Office of QA for Children's Programs is responsible for:

- Developing and maintaining the CQI Plan, including an annual review of the plan
- Involving executive leadership to help ensure resources and tools are available to support CQI processes and promote the involvement of staff at all levels in the quality improvement process
- Helping to ensure implementation of CQI-related mentoring, modeling, and support across DoHS, to include, but not limited to:
    - Data-driven decision-making
    - Identification of data and planning needs
    - Integration of key staff at the bureau level, which includes verification that appropriate program-level training and policy is monitored
    - Day-to-day multilevel involvement with bureaus and staff at all levels, including integration of data culture into processes at all levels
    - Involvement of vendors, contractors, and providers in supporting quality improvement activities
    - Tracking recommended action from Quality Committee reviews, including responsible parties, timelines, and status updates
- Partnering with DoHS leadership to promote a culture of ongoing quality improvement
- Communicating/supporting awareness of the CQI Plan throughout DoHS children's services including, but not limited to:
    - Sharing updates at DoHS recurring Quality Committee meetings, monthly workgroup leads, and routine bureau-level CQI meetings

    - Continuing involvement of bureau staff in development and updates of KPIs, visuals/dashboards, and associated reporting related to their work
    - Sharing themes and highlights of CQI activities and results/updates with stakeholders
    - Including CQI tracking as part of collaborative activities to establish clear responsibilities and timelines for prioritized tasks
    - Encouraging and providing guidance to program/bureau leadership on establishing expectations and holding vendors, contractors, and providers accountable for data collection, data quality, reporting, and quality improvement to support DoHS's overall quality improvement efforts
- Coordinating an overall data plan to include streamlining of data collection, development and maintenance of the data store and associated dashboards, and reporting to support CQI processes in partnership with respective bureaus and the information technology team
- Defining required data to be tracked, monitored, and reported to the Office of QA
- Providing guidance in defining performance benchmarks and targets
- Helping to ensure aggregation of data across DoHS programs and services for children, which includes data from DoHS's internal systems as well as from third-party systems (i.e., vendors, contractors, providers, and other child-serving entities)
- Assisting with both ongoing and ad hoc data analysis as requested by bureau-level leadership and quality functions
- Collaborating with bureau leadership and bureau-level quality functions to help ensure the formation and implementation of Quality Committees with interdisciplinary, cross-bureau membership, who meet on a routine basis to review and analyze data, outline findings to include strengths and opportunities for improvement, and document and follow up on recommended actions
- Prioritizing quality opportunities and chartering prioritized quality initiatives
- Outlining the format, frequency, and expectations for Quality Committee meetings to include associated report format, tracking of action, and planning

4.2 Bureau-Level Quality Functions

Bureau commissioners (or their designees) are responsible for the following:

- Helping to ensure implementation of the CQI Plan and guidance from the Office of QA within their respective bureaus
- Working to help ensure program-level quality reviews are carried out as outlined in Section 4.3 below, including ensuring relevant program managers are facilitating data review and discussion for their respective programs and services, following up on recommended actions, and monitoring for improvements
- Maintaining updates to program and policy manuals and contracts to communicate clearly the expectations and requirements for vendors and providers associated with data collection and reporting and quality improvement activities

- Overseeing and monitoring vendor contracts, including Managed Care Organizations (MCOs) and service providers, to help ensure expectations and accountability for required data collection and reporting, data quality, performance measures, quality standards, quality reviews and audits, customer satisfaction, and outreach to support DoHS's overall quality improvement efforts
- Helping to ensure implementation of quality sampling reviews, fidelity reviews, and other mechanisms for feedback which may include surveys, focus groups, or other methods
- Establishing a regular cadence of meetings with MCOs and/or providers as relevant to address performance and quality issues, data quality issues, systems issues, provider capacity, and workforce challenges
- Overseeing and monitoring bureau staff to help ensure fidelity to policies and processes
- Helping to ensure staff from a variety of levels within each bureau actively participate in Quality Committees
- Helping to ensure CQI is incorporated in bureau culture and mentorship is supported for new and tenured employees
- Facilitating ongoing partnership, collaboration, and communication with the Office of QA and interdepartmentally to assist with continued enhancements and streamlining of quality improvement data, reporting, and associated activities
- Ensuring data collection and reporting comply with all applicable laws, regulations, and standards relevant to bureau programs and services
- Establishing and maintaining bureau-level or program specific CQI processes, as needed, to meet more specific programmatic or bureau-level needs

Bureau-level quality units will continue their current quality and compliance functions to maintain compliance with all applicable laws, regulations, and standards associated with their children's programs and services in collaboration with the Office of QA.

4.3 Quality Committee Functions

Quality Committees may be implemented at various levels, including program and service level, bureau level, and department level. Quality Committees may be appointed by the cabinet secretary, deputy secretaries, bureau commissioners, or director of the Office of QA. DoHS will have two main types of Quality Committees with multiple levels of reviews. The first are standard Quality Committees which occur regularly (on average monthly at the bureau and workgroup lead levels; and on average quarterly at the department level). The second type of Quality Committee is considered a Prioritized Quality Initiative (PQI) Team. A PQI team is formed based on identified opportunities and needs from established data review processes, when additional prioritization and resources are necessary to understand and/or work through addressing identified needs. The PQI team members will work collaboratively to establish plans and expectations regarding when the PQI need can be resolved, and the team adjourned. Additional details on PQI teams are included in Section 6.2.

Quality Committee membership is expected to be cross-functional with the involvement of people at multiple levels with varying roles. Membership may include staff, providers, contracted vendors, other

child-serving entities, and children, youth, and families with familiarity with the subject matter (as appropriate). Additional requirements will be considered when building team membership based on relevant subject matter expertise.

Quality Committees are expected to meet on a formal, scheduled basis and have a responsibility to:

- Complete a documented review of data and information, both quantitative and qualitative, to evaluate performance
- Help ensure baselines are established and performance targets or benchmarks are defined as relevant
- Identify strengths, problem areas, and opportunities for improvements based on data review
- Capture Quality Committee review meeting notes
- Identify recommended actions and set goals for improvement, where appropriate, and document them in the Quality Committee review meeting notes
- Submit completed Quality Committee review meeting notes to the Office of QA following each review
- Monitor progress toward meeting goals, incorporating problem solving and making course corrections based on new information or lack of progress
- Communicate quality plans and progress updates to leadership to help ensure accountability
- Assist with identifying the relevant KPIs as the CQI processes continue to evolve, to help ensure meaningful measures are in place to track progress toward the goals for children's services
- Make recommendations for improvement to data collection and reporting as needed to facilitate quality improvement efforts
- Make recommendations for increased frequency of monitoring of any KPIs where focused need for improvement is identified

5.0 Feedback, Data Systems, and Monitoring

Data and information to evaluate and monitor services and outcomes are drawn from a variety of sources, including multiple data systems, quality sampling reviews, fidelity reviews, and feedback from staff, children/youth, families, providers, caregivers, and other stakeholders. The process for defining KPIs and the associated reports and dashboards utilized for monitoring are outlined below.

5.1 Data Collection/KPIs

KPIs to monitor progress toward DoHS's overall goals for child welfare and behavioral and mental health services are outlined in Appendix A. Individual bureaus, and programs within each bureau, may identify and adopt additional KPIs as relevant for their programs and services. Some KPIs are utilized for more detailed internal CQI processes, while others are included in public-facing reporting. At all levels, KPIs are anticipated to require flexibility to help ensure they remain actionable and informative as more data becomes available and as experience and understanding of data evolves. These KPIs will be reviewed at

least annually to help ensure the metrics are meaningful and capture the information needed to assess DoHS's progress toward the goals for children's programs and services.

5.2 Data Reporting and Dashboards

DoHS is developing a data store to house data from multiple sources across DoHS's child welfare and mental and behavioral health services systems, with the goal of aggregating data from all child-serving bureaus into a single, unified system. A large portion of this data store is already developed and in use. As part of a DoHS data migration strategy, DoHS is moving this data into the agency's Enterprise Data System which will serve as the single, unified system long-term. Data is collected from a variety of sources, including DoHS's internal systems, MCOs, providers, other contracted vendors, and other stakeholders. Data and information are gathered through a variety of methods such as quality sampling reviews, chart reviews, adverse event reporting, quality audits, surveys, and focus groups.

Each bureau is responsible for working to help ensure that data collection and reporting requirements associated with quality improvement efforts and agreed-upon KPIs are specified in vendor contracts and other agreements, including frequency and format of collection and reporting. Data is requested to be captured at the child- and encounter-level using unique child-level identifiers in order to allow data tracking and comparison across systems and programs. Bureau-level quality functions are responsible for oversight and monitoring of each contract to help ensure accountability. With guidance from the Office of QA, the bureaus are responsible for developing policies and procedures outlining formalized oversight and monitoring processes, including documentation and reporting of results. This process will be reflective of bureau-level time frames, but additional needs will be assessed at least annually.

A Quality Assessment and Performance Improvement (QAPI) dashboard was launched in September 2021 to assist Quality Committees and DoHS staff in assessing and monitoring children's services, systems, and outcomes. The QAPI dashboard utilizes data from the data store to facilitate and automate the creation of charts and graphs to assist with data analysis and identification of patterns or trends over time. The QAPI dashboard system continues to expand as more data and information is captured in the data store. Reports are also published on a recurring basis by analytical staff with consideration for identified Quality Committee needs and requests. This process will continue while the data store and the dashboard system are being further developed and expanded for future automated processes and reporting.

DoHS utilizes the expertise of community partners for support in quality initiatives, evaluation, and training.

- West Virginia University (WVU) is contracted to complete an ongoing evaluation of children's in-home and community-based services. WVU will provide routine reports of the evaluation to DoHS.

- Marshall University is contracted to complete an ongoing evaluation of service fidelity processes, including utilization of the Child and Adolescent Needs and Strengths (CANS) Assessment, to the National Wraparound Initiative standards. Marshall University will provide routine reports to DoHS.

Reports from these contracted vendors will be included in the Quality Committee review cycle for review and incorporation in quality improvement recommendations and associated action.

5.3 Quality Sampling Review

To further support quality improvement efforts, DoHS will conduct an annual quality sampling review of a random sample of children with mental health needs. The sample will include children in the community and those in RMHTFs. The review will include but is not limited to the services the children in the sample have received including information from case files and feedback gathered directly from the children in the sample, their families, caregivers, and providers as available. Results from the quality sampling review will be incorporated into DoHS's Quality Committee review cycles and used to identify strengths and areas for improvement to drive future action.

6.0 Systematic Analysis and Action

Consistent and collaborative review and analysis of data with associated action based on findings must take place across multiple levels of the system in order to improve quality continuously. This section outlines the expectations for a regular cadence of Quality Committee reviews and action based on the data and reports described above.

6.1 Data Analysis/Identification of Strengths and Opportunities for Improvement

Quality Committees are expected to meet per the agreed-upon schedule established by the Office of QA in collaboration with the bureau commissioners (or their designees). Follow-up action including owners and timelines will be documented and monitored with status updates occurring via workgroup leads and Quality Committee meetings and formal updates published in each annual report. Performance metrics may be reviewed on varying frequencies (i.e., weekly, monthly, quarterly, semiannually, and annually) as relevant to each metric and factoring in any lag time associated with the data. Metrics for programs and services that have reached stable and ongoing operations will be reviewed semiannually. Programs, services, and processes that are being implemented or need additional prioritization may be reviewed more frequently to support closer monitoring and timely improvements.

During each Quality Committee meeting, the following will be completed:

- Documented review and analysis of performance data against targets/benchmarks and recommendation of new targets, as relevant
- Review of progress on quality improvement activities in follow-up to action identified in prior review meetings, including review of data associated with specific prioritized focus areas for improvement identified by DoHS
- Identification of strengths and opportunities for improvement
- Prioritization of opportunities for improvement
- Identification of any new action(s) based on findings
- Identification of any issues, resources needed, recommendations for policy and/or practice changes that should be communicated to leadership, up to and including the Executive Steering Committee, which is made up of deputy secretaries, commissioners, and the chief information officer

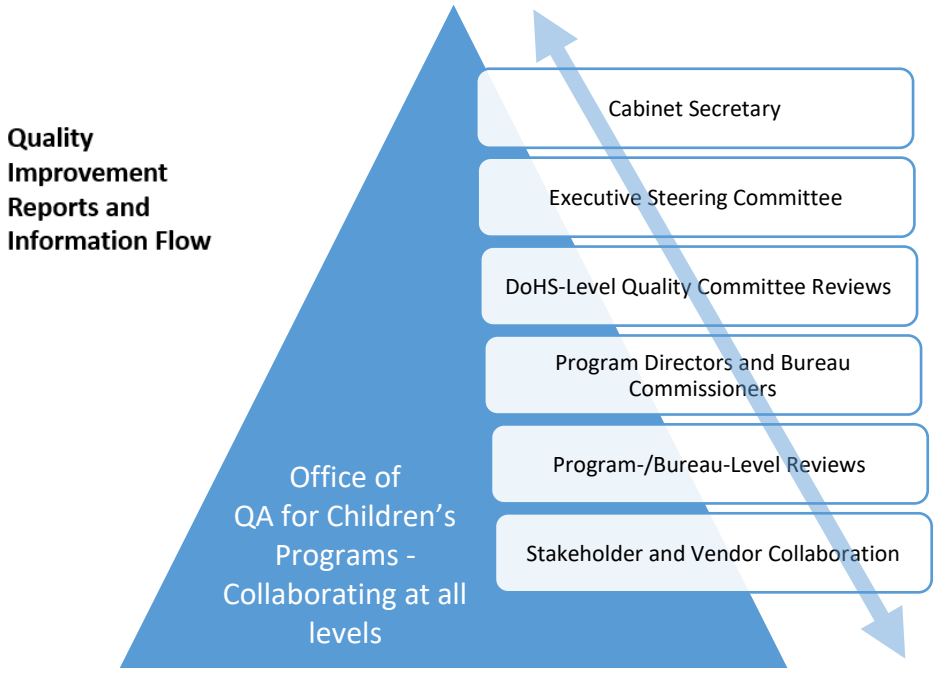
- Documentation and assignment of responsibility and next steps

During review processes, consideration should be given to differences, patterns, and/or trends associated with important child-level characteristics, including, but not limited to, diagnoses, demographics, region/county, service utilization profile, and service provider.

Within each bureau and at the program/service level, more frequent reviews may be warranted and may include regular review meetings with MCOs, Administrative Service Organizations (ASOs), provider groups, other contracted vendors, other child-serving agencies, and/or children, youth, and families. More frequent reviews may be determined as needed during early implementation periods, process changes, or when monitoring for Rapid Cycle Improvement. Documentation of the review meetings will be maintained and provided to the Office of QA upon request.

Figure 1 below depicts the expected flow of communication and reporting between the levels of the quality improvement infrastructure to help ensure recommended action, policy and practice changes, resource needs, etc., are considered and acted on.

Figure 1: Communication Flow Within the Quality Improvement Infrastructure



6.2 Prioritized Quality Initiative (PQI) Committees

A key purpose of the quality review process is to identify areas needing improvement and make recommendations for action to achieve those improvements. In some cases, a formal PQI team may need to be commissioned.

Based on reports and recommendations from Quality Committees, the bureau commissioners (or designees) in partnership with the Office of QA will prioritize any opportunities for improvement that warrant a formal PQI.

The PQI team is expected to have a leader identified along with interdisciplinary team members (i.e., representing each of the areas of expertise affected by the project) and may include other stakeholders such as youth, families, vendors, providers, etc.

PQI teams meet on a frequency agreed upon by the team, based on the activities to be completed and the associated timelines. PQI teams require development of action steps, timelines, and setting a time period for reassessment of the need for the PQI team. If key stakeholders or staff are unavailable, meetings are rescheduled to help ensure appropriate representation is available for discussions.

As part of the CQI process, additional data collection and analysis needs will be identified by the Quality Committee and/or PQI team, who will create a plan in conjunction with the Office of QA. Analytical staff (i.e., embedded analysts, epidemiologists) will help support mentoring and discussion of best analytical practices to understand data and needs further. Larger system and process changes may be identified for items with a high likelihood to impact outcomes or ability to access appropriate services. DoHS tracks findings, discussion, and action plans via program-, department-, and workgroup-lead-level meetings. This or similar approaches may also be tracked or expanded to a PQI team. Discussion, additional analysis, increased frequency of data collection/monitoring, and programmatic next steps should typically be driven by identifying vulnerabilities, determining action plans, sorting data for common themes, discussing results with leadership/stakeholders, and using results or themes to shape priorities for future action.

6.3 Measuring Success/Impact

A key function of the quality infrastructure is to set and attain meaningful performance goals collaboratively at all levels of the system. Quality Committees are responsible for making recommendations for performance benchmarks or targets for relevant KPIs with support from the Office of QA. Performance targets will be agreed upon by the Office of QA and relevant program staff. Targets should include consideration for baseline findings and a goal to improve or sustain indicator levels. In cases where a benchmark is not available or where a target is not appropriate—due to measures new to collection or not having an expected threshold yet due to unprecedented influences (e.g., COVID-19 pandemic) or implementation-related impacts—Quality Committees will monitor for changes in patterns or trends. The Office of QA will provide guidance to Quality Committees and bureau/program leadership in performance measurement, including assisting with establishing targets and benchmarks. Guidance and recommendations may be provided based on existing program or state policy as well as recent literature or statistics. The Office of QA is embedded in this work by participating in program-level reviews and relevant meetings. The Quality Committees and Executive Steering Committee may

influence guidance and support, and stakeholders also have opportunities to provide feedback in commission/collaborative meetings.

Required performance measures may be included in vendor contracts and may also include incentives or penalties related to performance outcomes. Additionally, where more resource intensive intervention is needed, PQI teams may be required in collaboration with vendors. As with the process described above, the Quality Committee and/or relevant program leads will determine when a PQI is needed related to vendor activities.

7.0 Communication of Results

DoHS aims to foster transparency and accountability through interdepartmental collaboration and enhanced communication with stakeholders, including children, youth, and families. To that end, the Office of QA, in partnership with bureau leadership, bureau-level quality functions, and DoHS's Office of Communications, collaborate to enhance CQI processes and associated reporting. Data sharing and feedback occur via routine meetings with stakeholders, evaluation activities, direct feedback to and from staff, and family and youth outreach. Communication of results includes meetings and data sharing with the following groups:

- DoHS Executive Steering Committee
- Internal DoHS staff at all levels
- External stakeholders, such as other child-serving entities, MCOs, providers, children, youth, and families
- Commission to Study Residential Placements of Children and Kids Thrive Collaborative Combined Meetings
- Partners at the West Virginia Department of Education, West Virginia Department of Homeland Security, and Supreme Court of Appeals of West Virginia
- Others as recommended by the Office of QA and Quality Committees

DoHS publishes a comprehensive report annually[2] in the fall of each year on the quality and outcomes for children's mental and behavioral health services for the prior calendar year. The annual quality and outcomes report summarizes data analyses, and includes identified strengths, opportunities for improvement, and planned action based on results. These reports are published on the West Virginia Kids Thrive Collaborative website under Plans and Reports. Additionally, indicators are published on the Kids Thrive Collaborative website and Child Welfare dashboard on a routine basis. Additional reporting may be provided as needed and as resources allow to support CQI efforts and transparency for the public and key stakeholders.

[2] Previously, DoHS published a quality and outcomes report on a semiannual basis. In 2024, DoHS decided to move toward annual reporting to allow adequate time for program changes to take effect as well as align with fiscal decision-making related to DoHS's annual budget.

8.0 Plan Review

The director of the Office of QA is responsible for ensuring the CQI Plan is reviewed annually, with updates considered when relevant. Any significant changes will be shared for feedback with the Executive Steering Committee. The plan will continue to evolve in response to increased data availability, new information, experience, and best practices as DoHS seeks to support the success of children, youth, and families across West Virginia.

Appendix A: KPIs

The list below outlines the KPIs associated with systems, processes, and outcomes for children's mental and behavioral health services. As DoHS has continued implementing CQI processes and learning from these processes, updates have been made to the KPIs. The KPIs can be expected to change and evolve for a variety of reasons, including but not limited to additional data and information becoming available; recognition that indicators are not providing meaningful and relevant information needed to measure progress toward goals as determined through regular Quality Committee reviews and feedback; and/or new learning that indicates the need for additional or modified KPIs. Additional indicators may be reviewed outside of this list to provide additional context to KPI results.

DoHS continues to partner with WVU to evolve and expand outcome measures associated with the DoHS Children's In-Home and Community-Based Services Improvement Project Evaluation Plan. DoHS also partners with Marshall University to capture an evaluation of Wraparound Fidelity. Recurring evaluation reports are provided by WVU and Marshall University and incorporated into DoHS's quality review processes.

Regular discussions between the Office of QA, program teams, and vendors/contractors clarify data needs, data sources, as well as format and process for submitting the data on a routine basis. Efforts continue to help ensure data is captured at the child- and encounter-level with unique child-level identifiers allowing data to be tracked and compared across programs and systems. Frequency of review, who is responsible for review, and guidance for review associated with the indicators are subject to change based on recommendations from the director of the Office of QA for Children's Programs, program-level Quality Committees, and DoHS's cross-functional, cross-bureau Quality Committees.

KPIs may be disaggregated by demographics and other characteristics such as diagnosis, county/region, and child-serving entity (i.e., provider). Any KPIs associated with "timeliness" will be evaluated against the timelines defined by policy or contract where applicable. Measures of timeliness of service engagement may include comparisons to screening dates, dates of mobile response encounters, referral dates, eligibility determination dates, etc.

Program teams, in partnership with the Office of QA, continue to evaluate which comparison populations may be most relevant for each data set. Comparison populations may include West Virginia's general child population, Medicaid-eligible children with SED, children considered at risk of residential placement, children referred to the Assessment Pathway, children who readmit to residential treatment facilities, children in DoHS custody, children in Bureau of Juvenile Services (BJS) custody, and children with Probation Services interactions, among others.

As CQI processes have evolved over time and availability of data in the data store has increased, trends and comparisons have been built into DoHS reporting for KPIs. These comparisons support leadership and program teams to better understand how policy and practice changes impact results.

Note: The highlighted (bold) KPIs are proposed indicators to assist with evaluating the impact of the programs and services on children and families and determining the efficacy of the programs and services. Some indicators and data sets are still in development and may not yet be available for evaluation until the data store is further developed and analysis prototyping is completed.

Mental Health Screening Indicators

- Number/proportion of screenings by screening entity (Youth Services, CPS, primary care physician, Probation Services, BJS)
- Number/proportion of positive screens
- Number/proportion of negative screens
- **Number/proportion of annual EPSDT screenings including a mental health component**
- Number/proportion of referrals to Assessment Pathway
- Timeliness of referral to the Assessment Pathway

Assessment Pathway Indicators

- **Number and source of referrals to the Assessment Pathway, including number/proportion of family-based referrals**
- Status of child's progression through the Assessment Pathway
- Number/proportion of families declining to complete CSED Waiver applications, and reason for decline
- Number/proportion of families failing to respond during the CSED Waiver application process
- Timeliness of Assessment Pathway process and relevant steps
- Service connection following Assessment Pathway interaction
- **Number/proportion on waitlist for assignment of Wraparound Facilitator**
- Average time on Wraparound waitlist
- Reason for removal from the Wraparound waitlist
- Wraparound capacity (estimated need for capacity based on new Wraparound cases and waitlist)

RMHTF Referral Indicators (Qualified Independent Assessment [QIA] Process and Out of State Risk Referral System)

QIA Process

- Number of referrals to QIA process for RMHTF placement (in-state versus out-of-state), and percentage expedited
- Count/proportion of referrals by system the individual is entering from (i.e., Youth Services, CPS, BJS, Probation Services)
- Reason individual was considered high risk for residential placement
- Number/proportion of QIA placement recommendations by type
- Number/proportion of QIA recommendations that are followed if recommended for home and community-based placement

    - Number/proportion diverted from RMHTF
- Number/proportion of Decision Support Model recommendations that are not followed and the corresponding reason why
- Number/proportion of automated placement referrals (APR) who have been referred to and/or completed the QIA process and timeliness associated with QIA referral compared to APR referral
- **Number/proportion of RMHTF admissions who have been referred to and/or completed the QIA process and number/proportion of children in RMHTF placement who have been referred to and/or have completed the QIA process**

Out of State Risk Referral System

- Number/proportion of approvals for out-of-state placement
- Reason why the child cannot be served in the community
- **Reason for approval of out-of-state placement**
- **Number/proportion of diversions from out-of-state placement and associated alternative disposition**

RMHTF Service Indicators

- **Census by in-state versus out-of-state**
- **Admissions and discharges in-state and out-of-state**
- **Admissions and transfers out-of-state by originating source/placement**
- **Length of stay in-state and out-of-state**
- CAFAS/PECFAS scores at admission and at discharge
- Residential provider capacity
- Number/proportion of children in care at least six months
- **Number/proportion of readmissions following discharge to the community and timeline to readmission following discharge to the community**
- **Placement following discharge from out-of-state and in-state placement**
- Relevant services accessed following discharge to the community and timeline to these services
- Number/proportion of individuals with discharge plans
- **Number/proportion of individuals with a discharge barrier, by type of discharge barrier**
- Distribution of CAFAS/PECFAS scores for individuals ready for discharge to the community
- Number/proportion of children prioritized for discharge
- Timeline to anticipated discharge, including children prioritized for discharge
- **Discharge status and updates over time for children prioritized for discharge**

- Family finding results for children prioritized for discharge

Children's Crisis and Referral Line Indicators

- **Number of crisis line contacts (calls, chats, or texts) received by the Children's Crisis and Referral Line, including by call acuity**
- Comparison of total calls to crisis line vendor for children by line type (i.e., 988 versus CCRL)
- Caller relation to individual in need
- Referral source for calls
- Presenting need
- Number/proportion of calls connected via warm transfer to mobile response team, including by call acuity
- Timeliness of warm transfer to mobile response team
- Number/proportion of referrals to other services and supports by service type

Children's Mobile Crisis Response and Stabilization (CMCRS) Indicators

- Number of children served per month
- Number of mobile crisis response encounters (overall and per child served)
- Number of follow-up calls
- Response type (response: in-person versus phone or telehealth; follow-up responses: prevention vs. response)
- Timeliness of mobile crisis response
- Number of CMCRS providers and coverage areas
- Number/proportion of children accessing CMCRS who are referred to the Assessment Pathway
- Number/proportion of referrals/connections to other services by service type
- Number/proportion of repeat mobile response encounters
- Number/proportion of initial crisis plans completed

CSED Waiver Enrollment Indicators

- Number of CSED Waiver applications
- Proportion by referral source of applications submitted
- Timeliness of the CSED Waiver eligibility determination process
- Distribution of CAFAS/PECFAS scores
- Number/proportion of applications by status (e.g., approved, denied, pending, closed)

- CAFAS/PECFAS scores and assessment status for closed applications
- Number/proportion of applications closed and reason for closure
- Number/proportion of Freedom of Choice forms completed

Foster Care Home/Community-Based Placement Indicators

- **Number of active, certified foster homes (with a breakout of homes willing to accept children ages 13 and older)**
- **Number of certified foster homes licensed for two or more years**
- Number of active, certified foster homes with a placement
- Number of newly certified foster homes (with breakout of homes willing to accept children ages 13 and older)
- **Number of foster home closures and associated reason (net change in homes)**
- **Number/ratio of youth in a kinship placement**
- Ratio of children in placement compared to number of certified homes
- Number of youth placed in an emergency shelter
- Length of stay in emergency shelter
- Number of youth in foster care with a substantiated Institutional Investigation Unit (IIU) investigation by foster family
- **Number of youth in foster care with an initial CANS completed**
- Number of youth in foster care with repeat CANS completed
- **Number of youth aged 14 or older in foster care with a transition plan in place**
- **Percent of youth in foster care receiving visitations in accordance with their visitation plan**
- **Youth receiving at least two visits per month from CPA worker**
- Capacity and occupancy for Transitional Living for Vulnerable Youth (TLVY) homes

Child Welfare Indicators

- **Number of children in the Child Welfare system, in home and placement cases**
- **Placement disruptions (within DoHS custody) and number/proportion subsequently placed out of the community-setting**
- Reason for child welfare involvement
- Reunifications
- Reentries into the Child Welfare system
- Number/proportion of children in care with final termination of parental rights and related time frames

- Number of new final terminations of parental rights
- **Number of children in hotel and shelter settings**
- **Length of stay in hotel and shelter settings**
- First placement by type in child welfare episode
- **Permanency/Child Welfare exit outcomes (reunification, adoption, guardianship, aging out) and related time frames**
- **Worker caseloads**

Assertive Community Treatment (ACT) Indicators

- Number of youth enrolled in ACT services
- ACT service utilization

Indicators Associated with Services and Child/Youth Outcomes

- Child population and associated demographics
- Service connection and utilization following referral to the Assessment Pathway, timeline to services, and associated outcomes (e.g., impact on out-of-home placement)
- **Changes in functioning levels based on program interaction, as measured by CANS Assessment results, determined based on CANS domain scores over time**
- Commitments to custody of BJS
- Number/proportion of children prescribed three or more psychotropic medications
- **Emergency department visits for psychiatric episodes**
- **Acute psychiatric stays**
- Involvement with law enforcement
- **Performance at school**

Outreach Measures

- Number/proportion of outreach events by month and purpose
- Number/proportion of outreach events by audience type and reach
- Number/proportion of outreach events to the judicial community by BSS Social Service Managers
- Number/proportion of targeted outreach events in DoHS's high-priority counties

WV Wraparound Facilitation Indicators (inclusive of BMS' CSED Waiver, BBH's Children's Mental Health Wraparound, and BSS' Safe at Home)

- Number of children receiving Wraparound Facilitation services (by funding source and in total)
- Timeliness and completion of the initial and subsequent CANS assessment
- **Timeliness of Wraparound Facilitation services**
- Wraparound Facilitation length of service
- Wraparound provider capacity and caseload analysis
- Wraparound Facilitator waitlist, the reason for being on the waitlist, and average time on the waitlist

CSED Waiver-Specific Services Indicators

- Number of children actively enrolled in CSED services
- Number/proportion of children on hold for CSED services, time on hold, and reason for being on hold
- Number of children on waitlist for CSED services and time on waitlist
- CSED service utilization overall and by service type
- CSED length of service distribution

Behavioral Support Services Indicators

- Number of children engaged in behavioral support services
- Behavioral support services utilization, including by month
- Total monthly outreach
- Monthly training participants
- Monthly participants in case consultation

Appendix B: Glossary of Acronyms and Abbreviations

Table 2: Glossary of Acronyms and Abbreviations

Acronym	Description
ACT	Assertive Community Treatment
APR	Automated Placement Referral
BBH	Bureau for Behavioral Health
BJS	Bureau of Juvenile Services
BMS	Bureau for Medical Services
BPH	Bureau for Public Health
BSS	Bureau for Social Services (formerly Bureau for Children and Families)
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Needs and Strengths
CMCR	Children's Mobile Crisis Response
CMS	Centers for Medicare & Medicaid Services
CSED	Children with Serious Emotional Disorder
CPS	Child Protective Services
CQI	Continuous Quality Improvement
DACTS	Dartmouth Assertive Community Treatment Scale
DHS	Department of Homeland Security
DoHS	Department of Human Services
DOJ	United States Department of Justice
DSM	Diagnostic and Statistical Manual of Mental Disorders
ESC	Executive Steering Committee
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FACTS	Family and Children Tracking System
FAST	Family Advocacy and Support Tool
HCBS	Home- and Community-Based Services
ICD	International Classification of Disease
IIU	Institutional Investigation Unit
ISP	Individualized Service Plan
KPI	Key Performance Indicator
MAYSI-II	Massachusetts Youth Screening Instrument
MCO	Managed Care Organization
MDT	Multidisciplinary Team
NWI	National Wraparound Initiative
OMCFH	Office of Maternal, Child and Family Health
OMIS	Office of Management Information Services
PBS	Positive Behavioral Support
PCP	Primary Care Provider

Acronym	Description
PECFAS	Preschool and Early Childhood Functional Assessment Scale
PQI	Prioritized Quality Initiative
QA	Quality Assurance
QAPI	Quality Assurance and Performance Improvement
QIA	Qualified Independent Assessment
RMHTF	Residential Mental Health Treatment Facility
R3	Reducing the Reliance on Residential
SED	Serious Emotional or Behavioral Disorder or Disturbance
SME	Subject Matter Expert
SMI	Serious Mental Illness
SOP	Standard Operating Procedure
TFC	Therapeutic Foster Care
TLVY	Transitional Living for Vulnerable Youth
WV	West Virginia
WVU	West Virginia University
WVDE	West Virginia Department of Education
YS	Youth Services