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SCHOOL OF SOCIAL WORK
THE INSTITUTE FOR INNOVATION
AND IMPLEMENTATION

Agreement between the State of West Virginia and the United States Department of Justice:

Report By Subject Matter Expert

December 13, 2019

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. The contract to provide these services was fully executed on October 29, 2019 with an effective date of October 1, 2019. In accordance with the Agreement, this contract requires that every six months, the Institute draft and submit to both the State and the DOJ a comprehensive report on West Virginia's compliance with the Agreement, including recommendations to facilitate or sustain compliance, **with the first report requested for December 2019.**

This is the first SME report. Given that The Institute's active engagement with West Virginia began in mid-October, with one day-long onsite visit in November, this report reflects the fact that **the Institute is in the nascent stage of learning about West Virginia's efforts. The Institute fully anticipates that, as it actively works with State leadership, team leads, and staff, subsequent reports will provide greater specificity and a deeper account of the State's efforts and successes to fulfill the Agreement.** Because of the timing of this first report, there is much that is not yet known about the State's work; as such, this report cannot fully detail the State's efforts to-date. Consequently, some of the recommendations provided in this report may already be underway, and we look forward to accounting those efforts in future reports. Additionally, given the scope of the work underway, it is anticipated that work may not yet have commenced in all areas. For example, a final workforce training plan would not be expected until after service descriptions and provider requirements were developed. We look forward to learning about the State's anticipated sequencing of activities.

Information reflected in this report is derived from the single day-long onsite visit to meet with State leadership and team leads; a review of information provided by the State (detailed in Table 1); and, multiple calls with the DOJ and the State to clarify the scope of the Agreement and roles. Additionally, The Institute has reviewed the State's initial implementation plan, the DOJ's response and comments to that plan, and both West Virginia's response to the DOJ's comments and their proposed revisions to the plan. Given the purpose of the reports is to report on the State's efforts during the previous six months and to provide recommendations for the coming six months of work and beyond, **this initial report focuses much of the recommendations on what The Institute seeks to further understand**

within the next six months, as well as initial recommendations based on information gleaned from a review of written information and from the state's implementation plan.

The State is entering into an intense period of work—moving from exploration of possible activities and committing planned activities to paper, to installing new activities and refining existing ones. The purpose of the required Agreement implementation plan is to provide clarity on the direction that the State is moving and the steps to be taken to achieve the State's goals for complying with the Agreement. To fully assess the State's progress and provide the most beneficial recommendations to support the State in its efforts, it is essential that The Institute have access to as much detail as possible regarding planned or undertaken activities. We understand that DOJ and the State have arrived at an approach for details to be shared at an activity-specific level between the parties, and with the Institute. The Institute has received from the State activity-level plans of its workgroups; and meetings with each of the state teams will commence in January. The Institute acknowledges the willingness of West Virginia to provide these team specific work plans and make team leads and staff available.

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 & Strengths (CANS) assessment or other assessment tool to develop an individualized service plan (ISP). Additionally, for any child who has a multidisciplinary treatment team (MDT), the screening and assessment and ISP must be made available to the MDT.

Assessment: As indicated previously, due to the timing of the first report and the initiation of the Institute's involvement, the Institute is in the process of learning about all of the State's activities to date. The Institute anticipates that future reports will detail the State's efforts more specifically than possible in this first report. From review of the information provided (listed in Table 1), the one onsite visit, and a conference call with Ms. Cammie Chapman, Ms. Laura Barno, and the contracted leads from BerryDunn, it is The Institute's understanding that WVDHHR is currently engaged in efforts to unify their two existing Wraparound programs, described above, along with a new, third Wraparound program, soon to be implemented, funded through a pending 1915(c) Medicaid waiver. The State intends to align as many aspects of the three programs as possible, while acknowledging that some differences will continue to exist. The two existing programs, *Safe at Home* (a Title IV-E child welfare program) and the Bureau of Behavioral Health's (BBH) Children's Mental Health Wraparound, currently serve different populations and use different provider networks, though some providers are providers of both currently operating programs. Regarding the third Wraparound program, with the 1915(c) waiver in near-final negotiation with Centers for Medicare & Medicaid Services (CMS), some initial provider network development has occurred for the 1915(c), with additional work planned to commence once the waiver is finalized. The 1915(c) Wraparound program may share some providers with the existing programs as well.

Recommendations

- **Continue planned efforts to align the three Wraparound programs.** West Virginia has indicated its intent to align as many features as possible across the three Wraparound programs, and to operate them as West Virginia Wraparound (as opposed to separate programs) by October 2020. Aligning existing programs, and initiating a third new program, all under one common name, West Virginia Wraparound, will require concerted efforts in multiple areas. We recognize that the state is beginning the process of identifying key features and implementing solutions to ensure a unified West Virginia Wraparound by October 2020.

- As the State moves towards its goal to implement a common entry point for all three Wraparound programs, to be called West Virginia Wraparound by October 1, 2020, the State will need to **develop and implement a new, common referral and assessment pathway.** The Institute seeks **to understand the States plan for a common pathway and how the State plans to convey this pathway to providers, public child- and family-serving agencies, families and youth.** Benefits of a common referral pathway include providing accurate and timely information for children and families, appropriate to their health literacy level, regarding how to access services in the home or community and ameliorating common issues with communication and information sharing that may exist when there are many entry points to access care. It also reduces provider administrative burden for referrals, aligns language across disparate entities to begin or continue developing a shared culture and common goal-setting, and supports consistent and comprehensive data collection.

- **The Institute seeks to understand the State's plan for how it will address eligibility and eligibility processes for the new West Virginia Wraparound.** The Institute understands that, historically, referrals were made to the existing Wraparound programs based largely on state agency involvement (e.g., if child welfare involved, the child is referred to *Safe at Home*). With the availability of 1915(c) covered Wraparound, **the pathway to care will need to consider complexity of need so that any child, regardless of state agency involvement, is considered first for the 1915(c) covered Wraparound services**. The Institute recognizes that some historical pathways to programs will continue to exist. For example, child welfare will continue to use its *Safe at Home* program to achieve youth goals of safety, permanency and well-being. Developing a clear pathway to West Virginia Wraparound will support children receiving access to the service that aligns with their needs while providing clarity to providers, state workers, managed care partners and families. The Institute understand that the State is actively engaged in internal discussions on the issue to ensure that historic referral patterns and policies do not constrain access to 1915(c) waiver services. Additionally, we anticipate that the State will want to ensure a single point of eligibility so that families are not re-assessed and re-referred to different programs if they do not qualify for one but could benefit from another.

- **Specific to 1915(c), we seek to understand how the State will address conflict-free case management requirements and the impact on providers and referrals.** The Medicaid conflict-free case management requirement may affect providers' willingness to refer to the 1915(c) Wraparound program, particularly if they are a provider of other medically necessary services. The Medicaid conflict-free case management prohibits an agency or organization (or their employees) from providing both direct service, including HCBS, and case management to the

same individuals.[1] CMS recognizes that many states, like West Virginia, have a small network of providers to provide medically necessary care and case management activities. Data analysis, including qualitative provider data, will assist the State in determining if it has a sufficient provider network, or if it needs seek technical assistance to develop options that both meet the federal regulatory requirements and take full advantage of its existing providers.

- **Specific to alignment across all three Wraparound programs under the West Virginia Wraparound by October 2020, we seek to understand the scope of what the State plans to align.** The State will need to **consider how regulations, operations, policies, provider requirements, contracts, eligibility and discharge criteria, authorization requirements, and data and reporting requirements and rates across all three Wraparound programs are supporting the State's desired pathway to care**. For example, The Institute understands the State has addressed a potential rate difference between the BBH Wraparound and the *Safe at Home* Wraparound, by ensuring children are not only or primarily referred to the higher reimbursing program, with an effective date of January 1, 2020. **This is an important step for West Virginia to take and is an example of the types of operational alignment activities critical to meet the goals articulated in the Agreement.**

- The Institute seeks clarification on how the State **plans to ensure continuity across separate provider networks, given that there may be differences in provider networks across the three Wraparound programs**. This will be of particular importance in instances when a child is discharged from one program and referred to or enrolled in another, including: ongoing, uninterrupted access to specific behavioral services; a choice of providers; quality of care over time; developmental appropriateness; child and family satisfaction with care; and information-sharing. In addition, if it is decided that the three Wraparound programs will vary in a significant detail (such as admission or discharge criteria, operational requirements, etc.) The Institute seeks to understand how the State intends to oversee service providers who contract with multiple programs (e.g., under the 1915(c) and via a second funding stream) to ensure that the child receives care according to the State's standards and fidelity to the model, as applicable, particularly if the requirements of one program are more burdensome than another.

- **As The Institute seeks to learn more about the State's efforts to increase access to Wraparound and other HCBS, The Institute seeks to understand how the State intends to monitor referrals, acceptance and denial rates, train providers to understand the medical necessity criteria for all services across the new combined West Virginia Wraparound; and how it will identify barriers to accessing services, including reasons why parents/guardians decline service provision.** The Institute understands that the State is in initial stages of identifying and reviewing available data and considering measures to track as part of its quality and performance improvement system. We note available information on historical referral and acceptance rates that could provide insights into the challenges that may need to be addressed to support access. The State's *Advancing New Outcomes: Findings, Recommendations, and Actions* report from the Commission to Study Residential Placement of Children notes that in State Fiscal Year 2018, the Children's Mental Health Wraparound program had 118 referrals, but only 43 children were accepted (36%) and 39 were not eligible (33%). The report notes "[an]y referrals not accepted received

[1] 42 CFR 441.301(c)(1)(vi)

recommendations and referrals for other services to help meet the family's needs." Understanding the drivers for these numbers such as needing to provide additional information to referral sources and training providers on medical necessity criteria can support the States goals for access. The SFY 2020 Exhibit A Children's Mental Health Wraparound Services, which covers July 1, 2019 through June 30, 2020 requires providers to "accept all referrals made for Children's Mental Health Wraparound from BBH." The Institute supports the State in its efforts to provide clarity in expectations and contract language with providers as this is a critical step to ensuring access for children.

- The Institute seeks to further understand how the State plans to **ensure quality, demonstrate and maintain fidelity, through a tool, process, and other monitoring elements.** The Institute noted the State's implementation plan for the Agreement included a goal to maintain a 1:15 Wraparound Facilitation ratio. When using an NWI model to inform its efforts, the recommended case ratio is 1:10; this recommendation is based on studies,[2] which have found that that ratio supports maintaining fidelity to the model. The Institute recognizes that some jurisdictions using High Fidelity Wraparound have allowed for higher than 1:10 case ratios to account for transitions (e.g., a youth graduating while beginning to work with a new family: vacations and hiring) but most states do not allow for continuous operations at a 1:15 ratio. Given the complexity of the populations to be served and the robust data available regarding case ratios in Wraparound, we would like to further understand if this decision is driven by anticipated demand for service, workforce and hiring shortages, a difference in the Wraparound model and staffing composition planned for West Virginia Wraparound, lessons learned from prior Wraparound programs, or other data.

- **The Institute seeks to understand the states plan for the use of the CANS; and how it plans to monitor standardization across the three Wraparound programs for the adoption, training, and consistent use of CANS or other validated assessment tool, process or elements.** The Institute recognizes that decisions are made at all levels of child-serving systems; as such, we recommend a concerted effort to standardize the use of CANS to increase effective, reliable, valid, and data-driven decision-making. Further, the CANS can inform eligibility, serve as a decision support tool for the child and family teams and providers as they develop plans of care, and provide a source for outcome data over time.

- **The Institute seeks to understand how the State plans to recruit and train Wraparound facilitators and supervisors for its West Virginia Wraparound; and how lessons learned and data on this training that occurred through the IV-E waiver be incorporated into plans not only to expand Wraparound statewide, as well as to children younger than 12 and older than 17.** The Institute understands that Local Coordinating Agencies (LCAs) began recruiting and training Wraparound facilitators in 2015 via a Request for Application (RFA). Two more RFAs were

[2] Cf. Schurer Coldiron, J., E. J. Bruns and H. Quick (2017). A Comprehensive Review of Wraparound Care Coordination Research, 1986–2014. *Journal of Child and Family Studies*: 1-21. doi:10.1007/s10826- 016-0639-7. See also, Pires. S. (2013). Customizing Health Homes for Children with Serious Behavioral Health Challenges. Prepared for: U.S. Substance Abuse and Mental Health Services Administration. Retrieved from: https://nwi.pdx.edu/pdf/CustomizingHealthHomes.pdf and Bruns, E. (2015). Wraparound is worth doing well: An evidence-based statement. In Bruns, E. J., Walker, J. S. (Eds.), The resource guide to wraparound (pp. 1-7). Portland, OR: National Wraparound Initiative. Retrieved from: https://nwi.pdx.edu/NWI-book/Chapters/Bruns-5e.4-wraparound-is-worth-doing-well.pdf

released by BCF in 2016 and 2017. The grants awarded to the LCAs included Results Based Accountability outcomes and performance measures. The Institute looks forward to reviewing this data, which will assist the State in understanding historical training successes and future needs. Further, given the sequencing of implementation activities, we would not anticipate these training plans to be finalized at this time; but under development as a parallel activity to development of other Agreement requirements.

- The Institute seeks to understand the State's plan and **defined role for all of the managed care organizations (MCOs), including the Mountain Health Promise (MHP), which will serve children in state custody, in overseeing referral pathways, availability, accessibility, and quality of Wraparound and other services**. The Institute reviewed a publicly available draft of the MHP contract released with the RFP. The draft did not include several critical elements for ensuring quality provision of services. These include: a definition of Wraparound; how MHP will assist the State in quantifying current system capacity, projecting needed system capacity, and ensuring access; the MHP role related to workforce development and sustainability; the MHP's role, if any, in supporting staff recruitment; the frequent reporting of referrals (to enable the State to quickly respond and correct referral pathways that are not improving outcomes and reducing residential treatment); and requirements for the MHP to track and report on the number and type of request for assistance from child welfare workers, and foster, adoptive, or kinship caregivers.

- The Institute understands that the MHP draft contract reviewed was just that – a draft – which did not include all planned requirements that the State intended. The Institute emphasizes this point of **greater specificity in all MCO contracts given the critical functions the MCOs will perform on the State's behalf.** The MCOs – and especially the MHP - will be the State's "right hand" in its efforts to meet its obligations under the Agreement. Greater specificity in the MCO contracts ensures access for youth and families, provides clear guidance to the MCO partners about what they need to do on the States behalf, and supports West Virginia's success. The Institute looks forward to learning more about the State's expectations for its MCO partners and reviewing final contracts or an updated draft of the MCO contracts for the integrated plans designed to serve more children, and the specialty MHP plan designed to meet the needs of children in state custody.

- The Institute seeks to understand the role of the MDT, required in child welfare, in working with the Wraparound CFT and Wraparound Facilitator in developing an ISP that ensures access to medically necessary services, while aligning with overarching child welfare goal of permanency. Based on written information received to date, it appears that the scope and role of the MDT could conflict with the scope and role of the Wraparound facilitator and CFT. The Institute seeks to understand how the State plans to **ensure the fidelity of its Wraparound model while clarifying the role and scope of the MDT so that the MDT does not inadvertently usurp or duplicate the role of the CFT while maintaining its regulatory functions**. For example, in other states, when a CFT is in place, the MDT may still have oversight responsibilities, but rather than making decisions, it refers questions and recommendations back to the CFT for discussion in order to maintain fidelity to Wraparound. Still other jurisdictions suspend the MDT while Wraparound is involved, later reactivating the MDT upon a child's graduation or discharge from Wraparound. Additionally, a State report noted that the Court Improvement Program and WVDHHR were developing a survey to identify where MDTs are working well, and where program

improvements are needed. The Institute looks forward to reviewing the survey results and how the State intends to use survey findings to develop or strengthen existing processes and policies to ensure a seamless plan of care that minimizes duplication and administrative burden.

- The Institute understands that analysis of existing Wraparound program data has occurred and continues to be underway to plan for projected need for Wraparound services, and other services, to ensure capacity. The Institute looks forward to reviewing the data the State has analyzed to **project need for Wraparound services, and for other services, and plans to augment capacity, if needed, to ensure timely access to this service**.
- While the data, quality and performance improvement plan required under the agreement is discussed in the section below, initial ramp-up and implementation of a new service typically requires **time-limited use of sentinel or red-flag indicators to alert the State to early difficulties in service delivery**. Given the Medicaid claim lag that naturally occurs in every system, establishing a time-limited process, outside of tracking claims, to gather a few metrics that provide real- or near-real-time data on access can help provide early indications that the system is operating as expected or indicate early risk. Early warning affords the State the opportunity to identify nascent trends, and more nimbly adjust policy and practice. Without these early red-flag indicators, it can be months before a State is aware of a problem, and by then, it can be more difficult to fix. Red-flag indicators could include weekly or bi-weekly referral and enrollment numbers, provider hiring and/or FTE availability so the state knows capacity to meet need, and days from referral to engagement in a service.

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 a plan to respond to crises by telephone or in-person, and to report data related to timeliness and engaging families in HCBS following a crisis.

Assessment: A review of the provided documents describes the State's efforts to date to pilot CMCR in several counties with United Summit Center, which served Barbour, Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, and Upshur counties; and FMRS Health Systems, Inc. which served Raleigh County. In May 2019, the state released an Announcement of Funding Availability to build upon the pilot and support statewide provision of CMCR. As part of the effort to expand CMCR services, the State has identified the following mobile crisis providers, by region:

- Region 1 & 2 - have not yet been determined;
- Region 3 - Westbrook Health Services, Inc. – Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt, and Wood;
- Region 4 - United Summit Center – Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Taylor, and Preston; and Appalachian Community Mental Health, Inc. – Randolph, Tucker, Barbour, and Upshur Counties;
- Region 5 Prestera Center, Inc. – Mason, Putnam, Cabell, Kanawha, Clay, Lincoln, Boone, Logan, Mingo, and Wayne;

- Region 6 FMRS, Inc. – Webster, Nicholas, Fayette, Raleigh, Wyoming, McDowell, Pocahontas, Greenbrier, Summers, Mercer, and Monroe.

In addition, The Institute understands that mobile crisis is included the State's pending 1915(c) waiver, which will widen availability to any Medicaid-enrolled child who meets the waiver eligibility criteria.

Recommendations

- Available information indicates that Providers for two regions have not been determined. **The Institute seeks to learn about the State's plans for provider selection in Regions 1 and 2; and any challenges that the State has identified in those regions.**
- The Institute seeks to **understand the existing and/or planned model or models of crisis response** including its planned approach and definition for the service, staff/team composition, hotline operation; triage and response policies and procedures; staff recruitment, retention, training, and supervision; data collection; quality monitoring; initial crisis plan development and subsequent revision; and warm hand-offs to other services and/or referral pathways for ongoing stabilization.
- Since CMCR will be available to all children, The Institute understands that the State will be using a variety of funding mechanisms, including the Medicaid 1915(c) waiver. The Institute seeks to understand the State's **financing plan; and if the State is operating a single mobile crisis service or multiple crisis services based on funding source; and if different, how the State will align with or account for differences in key elements of CMCR across funding sources,** including eligibility and other policies, service delivery model, reimbursement and billing codes, and any modifiers or new codes the State intends to use to collect data on the provision of CMCR to children and families.
- The Institute seeks to understand the State's **plan for readying providers to deliver CMCR**, policies to support the recruitment, training, and retention of mobile crisis staff, including supervisors; and how these policies are informed by families and providers. Given that United Summit Center and FMRS piloted mobile response in 14 counties, The Institute looks forward to understanding lessons learned and how those lessons informed the State's plans for statewide CMCR.
- **Clarify what the State has analyzed of its current capacity to meet projected need for this service, and plans to augment capacity, if needed, to ensure timely access to CMCR.** The Institute seeks to understand if the state has anticipated and planned for variations in demand based on available data (i.e., program data from the two pilots) in order to ensure the statewide hotline is adequately staffed to respond to crises. For example, The Institute notes that the State's *Advancing New Outcomes: Findings, Recommendations, and Actions* report states, "The Children's Mobile Crisis Response has served 445 children/youth. Of the 928 crisis calls taken, 345 were managed by phone, 566 required an in-person response, 335 crisis plans were completed." Although no additional information is included, these numbers suggest that crisis response teams served the same family/child more than once. If that assessment is correct, The Institute seeks to learn if the State reviews or has a plan to **review common reasons for requesting crisis response; pre- and post-crisis intervention service utilization patterns** (especially for children and families who use the service with any frequency), particularly post-development of a crisis plan**; and most**

common services delivered during and immediately following the crisis. This data will assist the state in anticipating which services are likely to be in demand as the program expands statewide.

- From the review of the draft MHP contract, it appears that CMCR is not available to children in therapeutic foster care. Through discussion, the Institute understands that the State intends to require the therapeutic foster care agency to provide an equivalent response for children enrolled in therapeutic foster care. **The Institute seeks to clarify this policy, the equivalent response that will be provided and how the urgent psychiatric or behavioral needs of families and youth in therapeutic foster care will be met** (for example, if a different crisis response model will be available to therapeutic foster parent families, and if so, how that model will be developed, overseen, and evaluated). As therapeutic foster care is not a service provided by psychiatrically trained Masters- or Doctoral-degreed persons, but rather by parents who are provided additional training to respond to unique behavioral health needs in a family-setting, therapeutic foster care parents will need access to psychiatrically trained professionals to deescalate and maintain the child experiencing a psychiatric health crisis in a home setting.
- Given the overall goal to reduce unnecessary use of placements under the Agreement, CMCR is a highly effective and low-cost intervention to prevent out-of-home placements or disruptions in placement that affect a child's ability to achieve and sustain healthy outcomes. The Institute seeks to learn about how **the State has/plans to identify and address gaps in the provision of CMCR to ensure that all children and families are able to access the service**.
- Given the Medicaid claims lag that naturally occurs in every system, **establishing a time-limited process outside of Medicaid claims data to gather a few real- or near-real-time metrics on access** can help provide early indications that the system is operating as expected or indicate early risk (e.g., disrupted placements, increasing emergency department use by children and families). Early warning affords the State the opportunity to identify nascent trends, and more nimbly adjust policy and practice. Without these early red flag indicators, it can be months before a State is aware of a problem; and by then, it can be more difficult to fix.
- **Clarify what the State has (1) analyzed of its current capacity to meet projected need for CMCR, and plans to augment capacity, if needed, to ensure timely access and (2) how the State intends to, in partnership with the integrated and specialty MCOs, quantify current system capacity, project needed system capacity** – particularly the required partnership with PBS and Regional Youth Service Centers – a**nd anticipate future growth areas**.

Behavioral Support Services

Agreement Requirements: The Agreement requires the State to implement statewide Behavioral Support Services (BSS), which include mental and behavioral health assessments, 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.

Assessment: The Institute's review of provided documents indicates the State has launched the Positive Behavior Support (PBS) Program at West Virginia University's Center for Excellence in Disabilities to build workforce capacity and provide short-term consultation, technical assistance, training opportunities, and person-centered planning. The State also released an Announcement of

Funding Availability for behavioral health providers with experience delivering positive behavioral support. The funding announcement explicitly requires applicants to build workforce capacity while working with Children's Mental Health Wraparound Facilitators and Children's Mobile Crisis Response and Stabilization Teams. This is an important step to ensure alignment of the training, coaching, and provision of services for children in the target population. In addition, it is The Institute's understanding that behavioral support services are included in the State's pending 1915(c) waiver application.

Recommendations

- Clarify how, after the award of funding for provision of positive behavioral support (expected in early December 2019) and once the 1915(c) is approved, the State intends to **communicate how BSS are available to children and families**, including specific, measurable outreach activities with system partners such as the MCOs and pediatric providers, and common referral pathways to receive BSS. Specifically, The Institute understands that the State conceptualizes BSS as both an approach that clinicians will use as they deliver services, such as outpatient and other services; as well as a specific service that provides behavioral supports.

- The Institute seeks to **understand how the State will track both service provider efforts to adopt the Positive Behavioral Approach and efforts to design, implement and track a new specific service called behavioral support services**.

- As with other new or expanding services, **The Institute seeks to understand how the State will monitor provider recruitment, retention, training, and supervision to ensure services are readily available to eligible children and families.**

- **Clarify how this effort may partner with the existing Expanded School Mental Health Initiative** (ESMH), especially Tier 3 interventions, which operate in a significant plurality of the State's counties. The funding announcement requires the vendor to reduce school disciplinary actions and days absent from school, and to complete a CANS assessment for each referred individual within five days if one has not already been completed. The Institute anticipates requesting additional information on how children assessed under BSS will be referred to other services, if eligible, and how the State plans to coordinate across services, and avoid duplication of screening and assessment.

- Given the Medicaid claims lag that naturally occurs in every system, **establishing a time-limited process outside of Medicaid claims data to gather a few metrics that provide real- or near-real-time data on access** can help provide early indications that the system is operating as expected or indicate early risk. Early warning affords the State the opportunity to identify nascent trends, and more nimbly adjust policy and practice. Without these early red flag indicators, it can be months before a State is aware of a problem; and by then, it can be more difficult to fix.

- **Clarify what the State has analyzed of its current capacity to (1) meet projected need for BSS; (2) how it plans to augment capacity, if needed, to ensure timely access to this service; and (3) how the State intends to, in partnership with the integrated and specialty MCOs, quantify current system capacity, project needed system capacity** – particularly the required partnership with mobile crisis; and anticipate future growth areas.

Therapeutic Foster Care

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 timely placed, with trained foster parents, ideally in their home community.

Assessment: The Institute understands that the State released an application in 2016 for a tiered Therapeutic Foster Care (TFC) program. The three tiers are (1) Traditional Foster Family Care, (2) Treatment Foster Care, and (3) Intensive Treatment Foster Care. The grant supported recruitment and retention of eight Tier 2 and three Tier 3 foster family homes in each of the four Bureau of Children and Families regions. In addition, the State released a bid for a specialized MCO to manage the provision of health services to specified populations involved with the child welfare system.

Recommendations

- Based on a review of the State's implementation plan, and comments between DOJ and State, The Institute seeks to **clarify if TFC will be a medically necessary service available to any child who may need a placement outside of their home, or if it a service that will be solely available to children in the custody of child welfare who need a highly trained foster parent**. There is a growing recognition of the clinical and cost-effectiveness of this service. A 2019 report to Congress from the Medicaid and CHIP Payment and Access Commission noted that "[a]lthough some view the practice as a more intensive form of foster care, children outside the child welfare system may benefit from and receive these services.… Therapeutic foster care provides a less restrictive environment than congregate care settings and allows the needs of the children to be met in the community."[3] In addition, youth in TFC are more likely to receive community-based services, proactive services (e.g., a physician's office versus an emergency department), and had fewer inpatient days than youth in congregate care settings.[4] Given West Virginia's efforts to divert children from residential and maintain children in home settings, we look forward to learning about the State's short, mid and long range plans for this service.
- Seek to **understand findings from evaluations of the 2016 tiered foster care grant, particularly (1) successes and challenges in recruiting and retaining families, including by geographic region, racially, ethnically, and culturally diverse families; (2) any qualitative or self-reported data regarding the reasons families stop accepting children (e.g., difficulty effectively coordinating amongst the child's providers, including the educational system); (3) placement disruptions that resulted in higher or more restrictive levels of care** (e.g., inpatient hospital, residential

[3] Medicaid and CHIP Payment and Access Commission. (2019). Report to Congress on Medicaid and CHIP (Ch. 4, Mandated Report on Therapeutic Foster Care). Retrieved from: https://www.macpac.gov/wp-content/uploads/2019/06/June-2019-Report-to-Congress-on-Medicaid-and-CHIP.pdf *See also*, Seibert, J., Feinberg, R., Ayub, A., Helburn, A., & Gibbs, D. (2018). State Practices in Treatment/Therapeutic Foster Care. Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Retrieved from: https://aspe.hhs.gov/system/files/pdf/259121/TREATMENTFOSTERCARE.pdf

[4] Breland-Noble, A.m., Farmer, E.M.Z., Dubs, M.S., Potter, E., & Burns, B.J. (2005). Mental Health and Other Service Use by Youth in Therapeutic Foster Care and Group Homes. Journal of Child and Family Studies 14(2): 167–180. DOI: 10.1007/s10826-005-5045-5. *See also*, Substance Abuse and Mental Health Services Administration. (2013). *See also*, What does the research tell us about services for children in therapeutic/treatment foster care with behavioral health issues? Report of the SAMHSA, CMS and ACYF Technical Expert Panel, September 27–28, 2012. HHS Publication No. (SMA) 14-4842. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

treatment, juvenile detention); **and (4) how the State's plan to strengthen existing referral pathways and address past practices that directed children to restrictive residential care** rather than HCBS. These findings can information the State's planning and implementation of new and expanded services necessary to reduce residential placement.

- The Institute seeks to **clarify the role of the treatment foster care case manager, including their expected functions and responsibilities to coordinate with the BCF, the Wraparound facilitator and CFT (if children in treatment foster are eligible for Wraparound services), and MDT**.
- How the State plans to **define the role of the integrated MCOs and MHP in overseeing referral pathways, availability, accessibility, and quality of Therapeutic Foster Care and related services**. For example, the pending 1915(c) waiver requires out-of-home respite services be provided by a certified therapeutic foster parent in a certified therapeutic foster care home. The Institute seeks to understand the State's plan for ensuring sufficient capacity for the service itself and for families with planned or emergency respite needs.
- The draft contract requires the MHP to "conduct at least twelve (12) focus groups throughout the year with youth, families and foster parents that have received services within a residential treatment facility. **The Institute looks forward to learning about how the State plans to use the focus groups as an opportunity to determine where services are being most impactful, and any unmet needs of youth and families,** so programmatic changes may be made to improve the overall health of the program." This type of focus group is critical to understanding child and family perspectives on system reform. The qualitative data gathered from these focus groups will be critical to improving family satisfaction and service accessibility.
- We understand that the State has procured a specialty MCO for children in foster care, MHP. As the State develops its integrated MCO and MHP contract language, and details reporting measures and their frequency, we seek to **understand the specific quality measures to be used; and** if that specific plan will include **measures of particular relevance for children in foster care** such as continuity with/having an identified primary care provider. The Institute anticipates that the State may be planning consistency in data and reporting measures across all of its MCO products as it relates to child measures (given that children may be enrolled/disenrolled from various MCO products), and we seek to learn about any additional measures of relevance to the foster care population.
- Given the Medicaid claims lag that naturally occurs in every system, **establishing a time-limited process outside of Medicaid claims data to gather a few metrics that provide real- or near-real-time data on access** can help provide early indications that the system is operating as expected or indicate early risk. Early warning affords the State the opportunity to identify nascent trends, and more nimbly adjust policy and practice. Without these early red flag indicators, it can be months before a State is aware of a problem; and by then, it can be more difficult to fix.
- **Clarify what the State has analyzed of its current capacity to (1) meet projected need for TFC; (2) how it plans to augment capacity, if needed, to ensure timely access to this service; and (3) how the State intends to, in partnership with the integrated and specialty MCOs, quantify current system capacity, project needed system capacity** –and anticipate future growth areas.

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.

Assessment: An initial review of the provided documents indicates that the State began providing ACT services in 2003. Given timing and the sequencing of implementation activities, the Institute has not had an opportunity to discuss this service with the State. We look forward to commencing discussions with the State's team in January. Recommendations below are based on information The Institute is seeking in order to better assess State progress. The Institute recognizes that some of these activities could already be underway; or may not yet be implemented due to the sequencing of activities.

Recommendations

- **Clarify the decision point(s) for whether a young adult will be referred to Wraparound or ACT services**; that is, will youth be offered the option of either service, or will age at the time of referral drive which service is offered? Young adults can be difficult to engage and retain in care, especially at a time of life when they are seeking independence. Both service approaches are different, providing an opportunity to offer the approach that could best engage the young adult. While engagement can be challenging in either model, there are lessons learned. For example, the National Wraparound Initiative (NWI) recommends a series of best practices around initial and ongoing engagement.[5]

- **Review existing medical necessity for ACT and align it with the language in the 1915(c)**, once approved. Chapter 503, *Licensed Behavioral Health Center Services*, in the State's Medicaid manual, restricts eligibility for ACT to individuals with (1) three or more hospitalizations in a psychiatric inpatient unit or psychiatric hospital in the past 12 months; (2) five or more hospitalizations in a psychiatric inpatient unit, psychiatric hospital, or Community Psychiatric Supportive Treatment Program in the past 24 months; (3) 180 days total length of stay in a psychiatric inpatient unit or psychiatric hospital within the past 12 months; or (4) the State may also authorize the service for target populations who exhibit medical necessity for the service.
    - In addition, as ACT explicitly includes assessment, crisis response, and behavior management, how the State and MCOs intend to **monitor provision of ACT to avoid duplication with other services specified in the Agreement**.

- **Examine prior barriers to participation in ACT, including service capacity**, as each team has a 1:10 care ratio. The Institute notes that this care ratio is lower than that specified for Wraparound (1:15), and is interested in learning more about the State's decision-making around care ratios.

- **Consider additional youth-specific language in ACT policies and procedures**. For example, Minnesota has an ACT for youth ages 16 through 20 that requires the inclusion of a peer support

[5] Walker, J. S., Gaonkar, R., Powers, L., Friesen, B. J., Child, B., & Holman, A. (2007). Best Practices for Increasing Meaningful Youth Participation in Collaborative Team Planning. Portland, OR: Research and Training Center on Family Support and Children's Mental Health, Portland State University. Retrieved from: https://www.pathwaysrtc.pdx.edu/pdf/pbAMPYouthParticipation.pdf. *See also*, Walker, J. S., Pullmann, M. D., Moser, C, L. & Bruns, E.J. (2012). Does team-based planning work for emerging adults? Findings from studies of Wraparound. Psychiatric Rehabilitation Journal, 35, 189-198.

provider in the ACT team, and a board-certified child and adolescent psychiatrist or advanced practice registered nurse with expertise in pediatric care to prescribe and monitor medications. In addition, medical necessity includes "probable need for services from the adult mental health system within the next two years." Transition age youth (generally 16-24; The Institute recognizes that the Agreement includes children and youth under 21) with complex behavioral needs are at high risk of not successfully transitioning to independent adulthood due to the challenges in moving from the child-serving system – which generally offers more robust services, including familial support – to the adult system. Recognizing that youth with complex needs are likely to need transition support and planning for it reduces the likelihood that these youth will experience future disconnection from needed services, education, and employment.

- As noted above, given the Medicaid claims lag that naturally occurs in every system**, establishing a time-limited process outside of claims to gather a few metrics that provide real- or near-real-time data on access can help provide early indications that the system is operating as expected or indicate early risk.** Early warning affords the State the opportunity to identify nascent trends, and more nimbly adjust policy and practice. Without these early red flag indicators, it can be months before a State is aware of a problem; and by then, it can be more difficult to fix.
- **Clarify what the State has analyzed of its current capacity to (1) meet projected need for this service; (2) how it plans to augment capacity, if needed, to ensure timely access to this service; (3) how the State intends to, in partnership with the integrated and specialty MCOs, quantify current system capacity, project needed system capacity; and anticipate future growth areas.**

Screening and Assessment

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, juvenile justice; and outreach and training on the use of the screening tools for physicians of children who are Medicaid eligible.

The Agreement requires the State to use the CANS tool (or 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 and for the State to report on changes in functional ability of children in the target population, both statewide and by region, including data from the CANS assessment.

Assessment: Regarding screening, The Institute understands from the review of documents provided and an initial discussion with the State that the State is currently reviewing its screening tools and processes to determine if any modifications are needed. The Institute also understands that the HealthCheck screening form is used with Medicaid providers, and that child welfare and juvenile justice systems each use an agency-specific screening form. In addition, the State's revised implementation plan notes ongoing efforts to integrate age appropriate HealthCheck forms and/or protocols into the electronic health record system, with an early 2020 deadline to ensure that Medicaid MCOs require the use of HealthCheck screening forms and conduct outreach to caregivers to encourage the use of the EPSDT benefit.

Regarding assessment, The Institute understands from the review of information provided and an initial discussion with the State, that the State's IV-E *Safe at Home* waiver uses the CANS to identify strengths and needs of youth referred to *Safe at Home*. The State uses an online CANS system to track referrals to *Safe at Home*, transmit data between the local coordinating agencies and regional offices, and facilitate on-demand management reporting. All WVDHHR youth service workers have been trained on the use of the CANS and received annual certification/recertification, and an algorithm utilizing CANS data is currently used to inform decisions for placement and treatment in the *Safe at Home* West Virginia Wraparound program, the regional clinical reviews and the out-of-state clinical reviews.

Recommendations

- The Institute seeks to understand the State's plan to **ensure that a mental health screening, using an approved tool, is completed for every child in a timely manner**, including via MCO quarterly reporting on EPSDT services. We understand that the State is in the process of reviewing tools and processes and the plan may not yet be developed.
- The Institute seeks to understand the State's plan to **ensure that health check forms are available to all relevant health care providers, and that providers are trained to use forms appropriately and consistently**.
- The Institute seeks to learn how the CANS tool is currently used, and how the State intends to **use the CANS for all eligible children, to assess and inform the need for services, to develop data-informed care planning, and monitor ongoing service delivery consistent with identifying needs**. CANS is more than an assessment tool. For example, the CANS offers decision support at the individual (e.g., to select amongst various evidence-based practices), program (e.g., eligibility or transition guidance), and systems (e.g., resource management/right-sizing) levels. Similarly, it also provides actionable information for quality improvement at the individual (e.g., via supervision), program (e.g., program reform or redesign), and system (e.g., value-based purchasing) levels.[6]
    - The Institute understands that Hornby Zeller Associates was awarded the evaluation contract for the State's IV-E waiver. The evaluation included utilizing quantitative data from the State's child welfare case management system and the CANS database to measure outcomes, such as, congregate care entry, length of stay in congregate care, maltreatment, and improved well-being. The Institute looks forward to reviewing the evaluation and building upon the State's preexisting work and lesson learned to identify additional indicators that could assist the State in its efforts to reduce residential placement.

- **Cross-walk all assessments in various programs to ensure that eligibility requirements are consistent, to the extent practicable; and if not consistent across programs, that the rationale for clinical differences is clearly communicated**. For example, although *Safe at Home* uses the

[6] Cf. Burton, B., Christiansen, E., Taycher, K., Hensley, S., & Bruns, E. (2019). Using Data to Adjust a Population of Focus for Wraparound. National Wraparound Implementation Academy. Retrieved from: https://www.cmhnetwork.org/wp-content/uploads/2019/04/S6C-BRUNS.pdf. *See also*, Estep, K., Lyons, J.S., Bruns, E.J., & Zabel, M.D. (2019). Effectively Integrating the CANS into the Wraparound Process. Baltimore, MD: National Technical Assistance Network for Children's Behavioral Health. Retrieved from: https://nwi.pdx.edu/pdf/Integrating-CANS-Into-Wraparound.pdf

CANS, the pending 1915(c) waiver defines medical eligibility as, "having 1) an overall Child and Adolescent Functional Assessment Scale (CAFAS) / Preschool and Early Childhood Functional Assessment Scale (PECFAS) score of 'severe' (90 or higher)." The Institute seeks to understand how program requirements align, and how the State anticipates the CANS assessment will inform initial and continuing eligibility for services and continuity of high-quality care.

- The Institute seeks to learn the State's plan to **ensure that children receive timely screening and assessment to encourage early identification, particularly in primary care settings consistent with the Medicaid EPSDT periodicity schedule**. The Institute seeks to understand the State's plan for screening and assessment, including: current partnerships, the 0-3 early intervention programs, the expanded school mental health initiative, families enrolled in in the State's neonatal abstinence treatment programs, etc. The Institute looks forward to providing technical assistance on strengthening collaborations between child-serving agencies and stakeholders in support of these efforts.
- The Institute seeks to learn how the State plans to **understand provider and State screening rates and develop a plan to track what happens after a child has a positive screen**, including timely referral pathways and assistance locating a culturally responsive provider. The Institute recommends the State and MCOs consider conducting quality reviews of negative screens to ensure that there is appropriate identification, train providers on the importance of screening and assessment for early intervention, and track provider screening rates. The Institute looks forward to learning about the State's intended measures and providing technical assistance on relevant measures.
- The Institute seeks to understand if the State will require **training of MCO and MHP staff to use the CANS to inform their authorization, utilization review, and provide quality review processes** to emphasize consistency for children and youth in need of behavioral health services. Given the integrated and specialty MCO's likely role in overseeing providers, supporting quality, and ensuring medical need for services, they will need to understand and utilize CANS data to perform certain functions. In addition, The Institute seeks to understand how the integrated and specialty MCOs and State anticipate **using CANS data over time to drive quality improvement**. For example, by asking questions like: What is the variation in CANS profiles across the State and across providers? What are the typical strengths and needs of Wraparound-enrolled youth and families? What demographic trends do we see and how might we work to ameliorate any racial and ethnic disparities? What services or interventions are most associated with positive change over time? CANS data can be utilized to answer these questions and drive service improvement over time.
- The Institute seeks to understand how **enrollment in the 1915(c) waiver will be facilitated by the Medical Eligibility Contracted Agent (MECA, Psychological Consultation & Assessment) and an Administrative Services Organization (KEPRO)**. It is our understanding that the waiver intends to use the Child and Adolescent Functional Assessment Scale (CAFAS) and Preschool and Early Childhood Functional Assessment Scale (PECFAS) to determine functional eligibility for waiver services. The waiver requires the ASO to report on performance measures and to facilitate quarterly improvement advisory council meetings with the Bureau for Medical Services. The Institute anticipates that the State may need technical assistance in **mapping that data collected**

by the ASO and MECA, and mapping it to the longitudinal CANS data from their existing programs.

- The Institute seeks to understand the State's plan to **develop and/or revise policies, procedures, and/or manual for CANS training**, especially for new providers. The Institute recognizes this may already be in the planning or early operationalization stages. Although the CANS has demonstrated reliability and validity, using it consistently and correctly requires ongoing training, coaching and supervision. The Institute seek to understand how the State intends to offer training, and how it, perhaps in partnership with the MCOs, intends to ensure the quality of assessments, including but not limited to audits.

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 as of June 1, 2015, with additional benchmarks to be established and met over time.

Assessment: The Institute understands from the review of documents provided that, in addition to awarding a specialized MCO contract, as mentioned above, the State has a Commission to Study Residential Placement of Children, an Education of Children in Out-of-Home Care Advisory Committee, a court improvement program, and has established a regional clinical review process to serve as a resource to MDTs. In addition, the State has developed a pending 1915(c) Medicaid waiver to expand its service array to prevent residential placement. These committees and processes provide opportunities for cross-system review and alignment to ensure a common goal, and are expected to play a critical role in supporting the State in meeting its placement reduction goals.

Recommendations

- Based on the State's revised implementation plan, The Institute seeks to understand the State's **plan for collecting data regarding children who are entering or currently placed in residential and how they plan to identify services that the child or youth needs to develop an individualized plan of care and return home**. Committing to a regular review of data will assist the State and its partners in improving practice and outcomes.
- The Institute seeks to understand how the State intends to **integrate and expand upon the findings and recommendations from the various interagency commissions and workgroups** (see above). The data reviewed and analyzed, gaps identified, information shared, and consensus achieved by these groups could assist the State as it builds capacity to measure a wide breadth of child's behavioral health services. In addition, respecting past interagency work further strengths a culture of collaboration, in which child-serving systems regularly work together to improve outcomes.
- The Institute seeks to review the State's **plan to reduce residential placement along with its intended specific, measurable inputs and activities** by agency, bureau, etc. The Institute recommends this plan **include the red flag indicators** referred to in each section above. The Institute also seeks to understand how the state would **respond to any lagging indicators**, how it would initiate corrective action plans or items, each with its own agency, bureau, or staff owner.

The Institute also seeks to understand how these **indicators are reported at regular, frequent intervals** to achieve Agreement goals, and how issues would be escalated to senior leaders across agencies, if needed.

- The State's current implementation plan calls for a regular review of children in residential placement. The Institute seeks to understand how the State plans to **monitor and ensure more real-time diversions from residential placement**. The Institute understands that the MHP, with direction from the State, will be responsible for diversion; The Institute looks forward to reviewing the final MHP contract language and further discussing this with the State.
- **The Institute seeks to understand the States intended pathway for entry into residential placement and its plan to address existing and new referral points.** Given referrals to residential services can often be driven by factors not specific to a medical need for behavioral health treatment, but due to concerns for community safety, or an inability to find a placement in a family setting, pathways need to account for these system pressure points in order to reinforce that placement outside of the home is for behavioral health needs only. A pathway that supports home- and community-based options as the default must **address services, supports, training, coaching, or other activities to change referrers' historical patterns of referral and address concerns about HCBS as a viable option**. Within the model, the State should **indicate the role of the MCOs and MHP in the referral pathway**, including levels of approval and possible points of diversion.
- The Institute seeks to understand how the State plans to and/or is **building consensus on diversion with agency partners**, including with the courts, child welfare and juvenile justice. The Institute also seeks to understand any specific best practice models the State is using or considering to support diversion, such as approaches cited in a 2018 literature review[7] or the Crossover Youth Practice Model, developed by the Center for Juvenile Justice Reform, which addresses the "unique needs of youth that are at risk of or are fluctuating between the child welfare and juvenile justice systems."
- The Institute seeks to understand the State's plan to **review current placement and continued stay criteria for children and youth already in residential treatment**, as well as **planning for discharge and transition** to family, kinship care, foster care, or adoption; including how existing entities will assist with this work. (For example, in 2017-18, the Regional Clinical Review Teams (RCRT) reviewed 16 children, 148 were reviewed by Out-of-State Review Teams, and 98 were reviewed via conference call. It appears that the RCRT is focused on preventing out-of-state placement; The Institute seeks to understand how the State is utilizing the RCRT as the number of children in out-of-state placement has slightly increased over the past year (from the high 300s/low 400s in late 2018 to the mid-to-high 400s in late 2019). As the number of children in out-of-state placement rises, does the RCRT have the capacity to increase reviews to facilitate timely and appropriate discharge?)

[7] Farrell, J., Betsinger, A., Hammond, P. (2018). Best Practices in Youth Diversion. The Institute for Innovation & Implementation University of Maryland School of Social Work. Retrieved from: https://theinstitute.umaryland.edu/media/ssw/institute/md-center-documents/Youth-Diversion-Literature-Review.pdf

- Given that reductions in placement can raise concerns from congregate care providers, The Institute seeks to understand the State's plan to **activate congregate care providers as part of the broader community-based response and identify how the clinical and institutional expertise of this provider community will be redeployed** to meet the goals specified in the Agreement.

Implementation: Interagency Considerations

Access

Although the Agreement between the State and DOJ is focused on reducing residential placement, many – perhaps most – of the services vital to create this change lie outside the child welfare agency. To that end, The Institute strongly recommends that the State implement and monitor ongoing work as an interagency effort that will ultimately assess the strengths and needs of children and families across systems, and timely address identified needs with an individualized array of services that enable children to receive appropriate care in their home and community. Child welfare; physical, behavioral and public health; social services; education providers; as well as families and communities, must partner together in an integrated, aligned system to improve outcomes. The Institute understands this interagency effort is well-underway, and that the goals of this Agreement are shared by all agencies. **The Institute looks forward to learning more about the State's interagency efforts and providing guidance to help further strengthen these collaborative efforts.**

The Institute commends the State's efforts to date to deepen and broaden the array of services available to children and families via the 1915(c) Medicaid waiver and specialized MCOs for children, as well as to build its infrastructure such as hiring BerryDunn Consulting to provide project management and information system support, redeploying Laura Barno to support interagency activities and inter-related deliverables across the teams, and prioritizing staff time for this effort to fulfill the Agreement despite the reality of multiple, competing demands on staff time. The initial recommendations contained in this report not only consider these new services, but are grounded in past experience and understanding that system reform cannot occur solely by offering services. There must be a concerted, **interagency effort to identify, construct, and validate new entry and referral processes for children and families, including dismantling historical pathways that fail to avert or divert from higher levels of care. Concomitant with the interagency collaboration must be an external effort to assess the readiness of providers, families, and other non-State system partners for these new policies and practices.**

Data Collection and Validation

Using and sharing data effectively is the foundation of building a high quality, transparent, and accountable child-serving system. Publicly available data must be current and disaggregated into usable units (e.g., age, diagnosis, geographic area). In its revised implementation plan, the State adopts the following outcome measures: disrupted foster home placement; institutionalization; arrest or involvement with law enforcement and the juvenile or criminal courts; suspended or expelled from school; or prescribed three or more anti-psychotic medications. **The Institute looks forward to providing technical assistance necessary to achieve these and any future outcomes that may be helpful in programmatic and system-wide progress in reducing residential placement, including indicators that allow the State to identify its strengths.**

The Institute looks forward to providing technical assistance to the State on measures, data collection and validation, including efforts to comply with the Center for Medicaid and CHIP Services' August 5, 2019 State Guidance on Implementation of Medicaid Drug Utilization Review (DUR) provisions included in Section 1004 of the *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act* (P.L.115-271), which requires states to monitor Medicaid-enrolled children receiving any antipsychotic medication. Specifically, given the requirements of the SUPPORT Act to monitor all psychotropic usage, The Institute seeks to clarify if the State's quality and performance improvement plan as required under the Agreement will include data from this broader Medicaid requirement or only the already listed metric regarding three or more anti-psychotic medications. Since the State will already have to track this information, use of these broader metrics for the Agreement is a labor-minimal way to provide data for this Agreement that will offer important information about the State's efforts.

The State, in its revised implementation plan, outlines plans to gather, analyze, develop, and test specific data sets and reports, with a final data set by November 2020. The Institute encourages the State to clearly and publicly adopt a set of expected outcomes and provide the data to all interested parties so all stakeholders can clearly measure their progress toward these outcomes. Transparency is essential to assessing what works, for which populations, getting buy-in from staff and the public, and identifying outstanding areas for improvement. Sharing data includes sharing successes and positive outcomes; these are critical to building public confidence and reassuring all parties that their respective efforts are valuable in achieving and sustaining systems change.

The Institute seeks to understand how the State will use existing data resources, as noted in the revised implementation plan, but also how the State will identify the resources needed to develop new metrics and data sources, and share, acquire, repurpose, store (e.g. encryption) , and analyze large data sets securely (e.g., compliance with the Health Insurance Portability and Accountability Act of 1996, encryption, server space and maintenance, interoperability of data systems, data workflows, and security threats such as ransomware).

Building and Strengthening Infrastructure

Building a sustainable infrastructure requires assessing (1) training and support needs at the departmental, regional, and local levels; (2) staff readiness for change and plans to overcome structural obstacles or skepticism; and (3) understanding the human and financial resources needed by direct care staff to implement system reforms. As the State continues its work, **The Institute also anticipates providing technical assistance on strengthening infrastructure across agencies, including fostering a continuous quality improvement processes for skill acquisition; developing and implementing a recruitment and retention strategy for child welfare workers by addressing workloads and trauma-informed supervision; and identifying resource allocation that shifts federal, State, and local funds away from expensive residential placement and toward evidence-based HCBS.**

Recognizing the sequencing of Implementation activities and that workforce planning is in initial stages, **the Institute seeks to understand the State's plan to: begin or continue efforts to train, coach, and supervise staff consistent with Wraparound principles; align contracts for staff with known gaps, and gaps revealed by forthcoming data analysis; and how the State will revise or restructure professional development requirements based on the desired outcomes.**

Planning and Communication Processes

As the State undertakes this lengthy and complex reform process, The Institute encourages the State to develop a plan to clearly and consistently communicate its vision for reform internally, as well to agency partners, legislators, and children and families, including desired outcomes, root causes, and theory of change. The State must plan to meaningfully engage families at all levels, including where policies and procedures are created and revised. This engagement is consistent with the values and principles of high-fidelity Wraparound and has the potential to reduce siloing, ameliorate barriers to accessing care, improve trust and satisfaction, and improve health outcomes by centering the lived experiences of children and families. The 2018 *Framework for Assessing Family Engagement in Systems Change* notes four domains to measure family engagement: representation that reflects the community and partnership with family-led organizations; transparency; impact that identifies what's changed via family involvement; and commitment to engagement at all levels.

The Institute seeks to understand the State's internal and external communication plans, its current communication efforts, and any new considerations, especially those in partnership with family- and youth-led organizations. The Institute seeks to understand how the State currently shares and plans to share updates on a regular and routine basis and advertises stakeholder meetings and opportunities to engage in system reform. The Institute seeks to understand the plan to communicate the availability of services to children and families, including the availability of family support and training services and in-home services, as included in the Agreement. In addition, The Institute seeks to understand the State's and/or partner's options for compensating youth and families for the costs related to participation, plans ensure that spaces are ADA accessible and comfortable for families and youth, and scheduled at times that encourage participation.

Conclusion

As the Institute begins to work with the State, we commend the work completed to date, and the State's efforts to develop the necessary inter-agency infrastructure to develop, implement and monitor effective services for youth and their families. As mentioned, given the timing of this first report, the Institute is in the nascent stage of learning about West Virginia's efforts. The Institute fully anticipates that as it commences work with the State's teams in January, our next report will provide greater specificity about the State's efforts.

During the next six months, the State will need to move from planning service specific tasks (e.g., Wraparound or MRSS specific tasks) to identifying the interdependencies of tasks across working groups; and ready for implementation of several critical tasks and activities. While there are tasks that are particular to a given service, many of these tasks are similar for each program: establishing a clear pathway to care that indicates how a child's initial and continued eligibility is determined, and how services are authorized and delivered; aligning eligibility, programmatic, and reimbursement requirements across payers; finalizing contractual expectations for all MCO partners; readying provider, agency and all MCO staff; and developing quality and performance improvement indicators. A final area of focus for the State over the next six months is engagement of stakeholders. It is critically important that the State continue its efforts to inform stakeholders regarding activities that are related to the Agreement; and engage stakeholders, especially families, in providing feedback, and incorporating that feedback into its efforts.

Table 1: Information Requested and Provided for Review

Documents Requested	Documents Provided
Materials specific to services such as provider lists, operations manuals, contracts, policies and regulations, including Mobile Crisis, Wraparound, and Respite Care	• BCF Socially Necessary Services (SNS) Code of Conduct • Communication Protocol for SNS, 2007 • SNS Background Check Clarification • BCF 2018 Letter to SNS Providers clarifying background check process and expectations • BCF Provider Letter RE Background Checks and WV CARES • WV CARES Administrator Account Registration Form • WV CARES Morpho Trust Escrow Account Process Letter and Account Application Form • BMS Provider Manual, Applied Behavior Analysis Chapter • Instructions for Invoicing SNS • BCF Invoice for SNS Template • BCF 2018 Memo RE New Provider Agreement for SNS Agencies • BCF 2018 SNS Provider Letter RE Response to Questions regarding the new SNS Agreement • SNS Provider Agreement • SNS Monthly Report • SNS Monthly Report Desk Guide • Mobile Crisis and Children's Mental Health Wraparound Providers List by Region • Foster Care Providers and Other Service Providers Contact List • WV Family Resource network Contacts by County • DHHR Child or Family Case Plan • Out-of-Home Observation Report for Child Safety, Wellbeing, and Permanency <u>Mobile Crisis</u> • Children's Mobile Crisis Response and Stabilization FY20 Scope of Work <u>Wraparound</u> • Children's Mental Health Wraparound FY20 Scope of Work • Children's Mental Health Wraparound Referral Form 2018 • BCF Local Coordinating Agency Wraparound Facilitation Agreement, 2017 • Wraparound Review Team Decision Form • Multidisciplinary Treatment Teams (MDT) Training PowerPoint • MDT Case Plan Content Requirements • MDT Desk Guide • MDT Training Case Scenario • MDT Case Scenario: Role Profiles • MDT Case Scenario: Derek doing well • MDT Case Scenario: Derek not doing well <u>Respite Care</u> • Social Necessary Service Providers: Respite Services in West Virginia Provider List

Focus group reports, if any, from family support and training	• Medically Necessary Services-Behavioral Health, Residential Facilities Annual Youth Stakeholder Focus Group Summary 2018 • Medically Necessary Services-Behavioral Health, Out of State Residential Facilities Annual Youth Stakeholder Focus Group Summary FY19 • SNS-Community/Behavioral Health Groups Annual Youth Stakeholder Focus Group Summary FY19
Regional Youth Service Centers	• Regional Youth Service Center FY20 Scope of Work • Regional Youth Service Center Family Coordinator FY20 Scope of Work
BCF Data Committee Reports (the committee is mentioned here: https://dhhr.wv.gov/bcf/Reports/Documents/2018AnnualProgressSrvcsRpt.pdf)	
Family Resource Network/Community Collaborative Group focus group reports related to child welfare, if any	• Community Collaborative and Family Resource Network Structure Model • 2017-18 Family Resource Networks Annual Report • 2018 Family Resource Network Manual • Family Resource Networks Statement of Work
Multidisciplinary Treatment (MDT) Team Curriculum and Training Package	
West Virginia Court Improvement reports http://www.courtswv.gov/court-administration/CIP/court-improvement-program.html, especially those related to youth services	• WV Supreme Court of Appeals Division of Children and Juvenile Services Org and Responsibility Chart
Juvenile Justice Reform Oversight Committee Reports. Referenced here: http://www.wvlegislature.gov/WVCODe/ChapterEntire.cfm?chap=49&art=2&section=913 (the link to any details is broken http://www.courtswv.gov/court-administration/juvenlie-justice-commission/juvenile-justice-commission.html)	• Juvenile Justice Commission 2017 Annual Report • 2011 Review of Juvenile Justice Facilities by Adjudicated Juvenile Rehabilitation Review Commission • Juvenile Justice Committee Commission Committee List • Juvenile Justice Commission Mission Statement • WV Supreme Court of Appeals Administrative Order RE Access to witnesses, records, documents, and any other evidence relevant to the Juvenile Justice Commission
Governor's Advisory Council on Substance Abuse latest report. *Note*: The Advisory Council was reconvened in late 2018. https://governor.wv.gov/News/press-releases/2018/Pages/Gov.-Justiceannounces-formation-of-Governor%E2%80%99s-Council-on-Substance-Abuse-and-Prevention.aspx	• Governor's Advisory Council on Substance Abuse Report 2016

Data Requested	Data Provided
Inpatient and residential admissions by age, total count of admissions	
Average length of stay data for inpatient and residential, by age and by facility	
Medicaid Claims data for targeted case management, by age	
Child welfare caseworker load and turnover, by county	
Child welfare caseworker supervisory load and turnover, by county	
Data on children and families served by regional youth service centers	
State children and family services performance indicator definitions and data manual (they are listed here, on p238 https://dhhr.wv.gov/bcf/Reports/Documents/2018AnnualProgressSrvcsRpt.pdf)	
Manual for FREDI, including data indicators collected.	

Table 2: Summary of Recommendations and Information Sought

Wraparound Facilitation		
Recommendation		**Status Updates**
1	Continue efforts to align the State's three Wraparound programs (Title IV-E, BBH, and forthcoming 1915(c)), including (a) regulations, (b) operations, (c) policies, (d) provider requirements, (e) contracts, (f) eligibility and discharge criteria, (g) authorization requirements, (h) data and reporting requirements, and (i) rates.	
2	Develop and implement a new, common referral and assessment pathway.	
3	Develop a plan to convey the Wraparound pathway to providers, public child- and family-serving agencies, families and youth.	
4	Develop or continue planning and implementing eligibility and eligibility processes for the new West Virginia Wraparound based on child complexity.	
5	Develop a plan to address conflict-free case management requirements and any potential impact on providers and referrals.	
6	Develop or continue planning and implementation efforts to ensure continuity across separate provider networks across the three Wraparound programs.	
7	Develop or continue planning and implementation efforts to increase access to Wraparound and other HCBS, including referrals, acceptance and denial rates, provider training, medical necessity criteria, and barriers to accessing services.	
8	Develop or continue planning and implementation efforts to to ensure quality, demonstrate and maintain fidelity, through a tool, process, and other monitoring elements.	
9	Understand the State's plan for the use of the CANS, including plans to monitor standardization across the three Wraparound programs for the adoption, training, and consistent use of CANS or other validated assessment tool, process, or elements.	
10	Develop or continue planning and implementation efforts to recruit and train Wraparound facilitators and supervisors, including lessons learned from its IV-E Wraparound program and as the State expands services to children younger than 12 and older than 17.	
11	Develop or continue defining the for all the managed care organizations (MCOs) in overseeing referral pathways, availability, accessibility, and quality of Wraparound and other services.	
12	Develop or continue adding greater specificity to MCO contracts given the critical functions the MCOs will perform on the State's behalf.	
13	Ensure the fidelity of its Wraparound model while clarifying the role and scope of the MDT so that the MDT does not inadvertently usurp or duplicate the role of the CFT while maintaining its regulatory functions.	
14	Project need for Wraparound services, and for other services, and plans to augment capacity, if needed, to ensure timely access .	
15	Adopt time-limited use of sentinel or red-flag indicators to alert the State to early difficulties in service delivery.	

Children's Mobile Crisis Response (CMCR)		
Recommendation		**Status Updates**
1	Understand the State's plans for provider selection in Regions 1 and 2; and any challenges that the State has identified in those regions.	
2	Understand the existing and/or planned model or models of crisis response.	
3	Understand the State's financing plan for mobile crisis, including alignment of key elements across funding sources.	
4	Understand the State's plan for readying providers to deliver CMCR.	
5	Understand the State's current capacity and capacity analysis to meet projected need for this service, and plans to augment capacity, if needed, to ensure timely access.	
6	Develop or continue planning and implementing a review of common reasons for (a) requesting crisis response, (b) pre- and post-crisis intervention service utilization patterns (especially for children and families who use the service with any frequency), particularly post-development of a crisis plan; and (c) most common services delivered during and immediately following the crisis based on pilot and other data.	
7	Understand how the urgent psychiatric or behavioral needs of families and youth in therapeutic foster care will be met if not via CMCR.	
8	Develop or continue planning to identify and address gaps in the provision of CMCR to ensure that all children and families can access the service.	
9	Develop or continue implementing a time-limited process outside of Medicaid claims data to gather a few real- or near-real-time metrics on access.	
10	Clarify what the State has (a) analyzed of its current capacity to meet projected need for CMCR, and plans to augment capacity, if needed, to ensure timely access and (b) how the State intends to, in partnership with the MCOs, quantify current system capacity, project needed system capacity – particularly the required partnership with PBS and Regional Youth Service Centers – and anticipate future growth areas.	
Behavioral Support Services (BSS)		
Recommendation		**Status Updates**
1	Develop or continue planning how to communicate that BSS are available to children and families.	
2	Understand how the State will track both service provider efforts to (a) adopt the Positive Behavioral Approach and (b) efforts to design, implement and track a new specific service called behavioral support services.	
3	Understand how the State will monitor provider recruitment, retention, training, and supervision to ensure services are readily available to eligible children and families.	
4	Clarify how the State may partner with the existing Expanded School Mental Health Initiative in offering and delivering BSS.	

5	Establish a time-limited process outside of Medicaid claims data to gather a few metrics that provide real- or near-real-time data on access.	
6	Clarify what the State has analyzed of its current capacity to (a) meet projected need for BSS; (b) how it plans to augment capacity, if needed, to ensure timely access to this service; and (c) how the State intends to, in partnership with the MCOs, quantify current system capacity, project needed system capacity.	
Therapeutic Foster Care		
Recommendation		**Status Updates**
1	Clarify if TFC will be a medically necessary service available to any child who may need a placement outside of their home, or if it a service that will be solely available to children in the custody of child welfare.	
2	Understand how findings from evaluations of the 2016 tiered foster care grant are informing planning, including (a) successes and challenges in recruiting and retaining families, including by geographic region, racially, ethnically, and culturally diverse families; (b) any qualitative or self-reported data regarding the reasons families stop accepting children; (c) placement disruptions that resulted in higher or more restrictive levels of care; and (c) how the State plans to strengthen existing referral pathways and address past practices.	
3	Clarify the role of the treatment foster care case manager, including their expected functions and responsibilities to (a) coordinate with the BCF, (b) the Wraparound facilitator, (c) CFT (if children in treatment foster care are eligible for Wraparound services), and (d) MDT.	
4	Define the role of the MCO and MHP in overseeing (a) referral pathways, (b) availability, (c) accessibility, and (d) quality of Therapeutic Foster Care.	
5	Develop or continue planning efforts to use focus groups to gather qualitative data.	
6	Understand how MCO and MHP contract language will incorporate quality measures measures, including measures of particular relevance for children in foster care.	
7	Establish a time-limited process outside of Medicaid claims data to gather a few metrics that provide real- or near-real-time data on access.	
8	Clarify what the State has analyzed of its current capacity to (a) meet projected need for TFC; (b) how it plans to augment capacity, if needed, to ensure timely access to this service; and (c) how the State intends to, in partnership with the MCOs, quantify current system capacity, project needed system capacity.	
Assertive Community Treatment (ACT)		
Recommendation		**Status Updates**
1	Clarify the decision point(s) for whether a young adult will be referred to Wraparound or ACT services.	
2	Review existing medical necessity for ACT and align it with the language in the 1915(c).	
3	Monitor provision of ACT to avoid duplication with other services.	

4	Examine prior barriers to participation in ACT, including service capacity to meet the 1:10 ratio.	
5	Consider additional youth-specific language in ACT policies and procedures.	
6	Establish a time-limited process outside of claims to gather a few metrics that provide real- or near-real-time data on access can help provide early indications that the system is operating as expected or indicate early risk.	
7	Clarify what the State has analyzed of its current capacity to (a) meet projected need for this service; (b) how it plans to augment capacity, if needed, to ensure timely access to this service; (c) how the State intends to, in partnership with the MCOs, quantify current system capacity, project needed system capacity; and anticipate future growth areas.	
Screening and Assessment		
Recommendation		**Status Updates**
1	Develop or continue planning to ensure that every child receives a mental health screening, using an approved tool.	
2	Develop or continue planning to ensure that health check forms are available to all relevant health care providers, and that providers are trained to use forms appropriately and consistently.	
3	Understand how the State intends to use the CANS for all eligible children to (a) assess and inform the need for services, (b) develop data-informed care planning, and (c) monitor ongoing service delivery consistent with identifying needs.	
4	Review existing evaluations to identify additional indicators that could assist the State in its efforts to reduce residential placement.	
5	Cross-walk all assessments in various programs to ensure that eligibility requirements are consistent, to the extent practicable; and if not consistent across programs, that the rationale for clinical differences is clearly communicated.	
6	Develop or continue planning to ensure that children receive timely screening and assessment to encourage early identification, particularly in primary care settings consistent with the Medicaid EPSDT periodicity schedule.	
7	Develop or continue planning to track what happens after a child has a positive screen.	
8	Develop or continue planning to train or monitor MCO staff's use of the CANS to inform their (a) authorization, (b) utilization review, and (c) provide quality review processes.	
9	Develop or continue planning for the MCOs and State's efforts to use CANS data over time to drive quality improvement.	
10	Understand how enrollment in the 1915(c) waiver will be facilitated by the Medical Eligibility Contracted Agent (MECA, Psychological Consultation & Assessment) and an Administrative Services Organization (KEPRO).	
11	Develop a plan to incorporate technical assistance in mapping that data collected by the ASO and MECA, and mapping it to the longitudinal CANS data.	

12	Develop or continue revising (a) policies, (b) procedures, and/or (c) manual for CANS training for existing and new providers.	
Reductions in Placement		
Recommendation		**Status Updates**
1	Develop or continue planning and implementing data collection for children who are entering or currently placed in residential, including plans to identify needed service specified in the individualized plan of care.	
2	Develop or continue planning and implementing integrating and expanding upon the findings and recommendations from the various State interagency commissions and workgroups.	
3	Develop or continue planning and implementing reductions in residential placement along with its intended specific, measurable inputs and activities by agency, bureau, etc., including (a) red flag indicators; (b) how the state would respond to any lagging indicators, and (c) how it would initiate corrective action plans or items, each with its own agency, bureau, or staff owner.	
4	Develop or continue implementing to monitor and ensure more real-time diversions from residential placement.	
5	Develop or continue planning and implementing a (a) pathway for entry into residential placement and (b) its plan to address existing and new referral points.	
6	Develop or continue planning and implementing the (a) services, (b) supports, (c) training, (d) coaching, or (e) other activities to change referrers' historical patterns of referral, including (f) the role of the MCOs in the referral pathway.	
7	Develop or continue building consensus on diversion with agency partners.	
8	Develop or continue reviewing (a) current placement and continued stay criteria for children and youth already in residential treatment and (b) planning for discharge and transition.	
9	Develop or continue planning to (a) activate congregate care providers as part of the broader community-based response and (b) identify how the clinical and institutional expertise of this provider community will be redeployed.	
Interagency Considerations: Access		
Recommendation		**Status Updates**
1	Develop or continue providing providing guidance to further strengthen interagency efforts to improve access to HCBS while reducing residential placement.	
2	Develop or continue planning to (a) identify, construct, and validate new entry and referral processes for children and families, including (b) dismantling historical pathways that fail to avert or divert from higher levels of care, and (c) assess the readiness of providers, families, and other non-State system partners for these new policies and practices.	
3	Develop a plan to incorporate technical assistance to develop or further refine (a) critical measures and (b) data collection and validation, including compliance with federal requirements.	

Interagency Considerations: Building and Strengthening Infrastructure		
Recommendation		**Status Updates**
1	Develop and plan to incorporate technical assistance on (a) strengthening infrastructure across agencies, including fostering a continuous quality improvement processes for skill acquisition; (b) developing and implementing a recruitment and retention strategy for child welfare workers by addressing workloads and trauma-informed supervision; and (c) identifying resource allocation that shifts federal, State, and local funds away from expensive residential placement and toward evidence-based HCBS.	
2	Begin or continue efforts to (a) train, coach, and supervise staff consistent with Wraparound principles; (b) align contracts for staff with known gaps, and gaps revealed by forthcoming data analysis; and (c) revise or restructure professional development requirements based on the desired outcomes.	
Interagency Considerations: Planning and Communications		
Recommendation		**Status Updates**
1	Understand internal and external communication plans, its current communication efforts, and any new considerations, especially those in partnership with family- and youth-led organizations.	
2	Understand the plan to communicate the availability of services to children and families, including the availability of family support and training services and in-home services.	
3	Understand the State's and/or partner's options for compensating youth and families for the costs related to participation, plans ensure that spaces are ADA accessible and comfortable for families and youth, and scheduled at times that encourage participation.	