The Implementation Plan of the Memorandum of Understanding between the State of West Virginia and the United States Department of Justice

Revised February 24, 2021

WEST VIRGINIA
Department of
Health & Human Resources

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1. Introduction

On May 14, 2019, West Virginia entered an agreement (the Agreement) with the United States' Department of Justice (DOJ) to address the DOJ's allegations regarding the state's service system for children with serious mental health conditions by West Virginia Department of Health and Human Resources (DHHR). The DOJ recognized the current reform efforts underway in West Virginia and the Agreement reflects DHHR's commitment to improving West Virginia children's mental health system to ensure that children can receive mental health services in their homes and communities.

Pursuant to the Agreement requirements, West Virginia must develop an Implementation Plan (the Plan) that describes the actions West Virginia will take to ensure that programs memorialized in the Agreement are sustainable, statewide, and accessible to children in the target population, as defined in Section 3. The Plan describes West Virginia's efforts to uphold its obligations by outlining the steps to realize each program, including ensuring statewide access and services, as listed in the Agreement:

- West Virginia Wraparound
- Children's Mobile Crisis Response
- Therapeutic Foster Family Care
- Positive Behavioral Support
- Assertive Community Treatment
- Mental Health Screening Tools and Processes
- Evaluation, Quality Assurance, and Performance Improvement
- Outreach and Education to Stakeholders
- Workforce Development and Provider Capacity
- Reducing the Reliance on Residential Mental Health Treatment Facilities

2. Time Frames and Working Documents

Pursuant to the Agreement, West Virginia may revise the Plan annually and submit the revised Plan to the DOJ and to the public for comments before finalizing amendments to the Plan. Prior to finalizing the Plan and future updates, DHHR will accept public comments for a minimum of 15 days. All comments will be considered. Although there is no requirement that DHHR provide formal responses to any public comment, DHHR may do so in its sole discretion.

Once the revised Plan is finalized, it will supersede any previous Implementation Plan. For the purposes of historical information, all finalized Implementation Plans will be stored on the West Virginia Child Welfare Reform Collaborative website (https://childwelfare.wv.gov/).

In addition to the Plan, West Virginia utilizes detailed work plans that further describe the steps and actions it will take each year to develop the processes and services required by the Agreement. In order to better explain the intricacy of the tasks outlined in the Plan, West Virginia provides the work plans to the DOJ and the Subject Matter Expert (SME). These documents are not "supplements" or "schedules" to the Plan and shall not be construed as

"supplements" or "schedules," and therefore, not enforceable provisions of the Agreement. Only documents specifically labeled "supplements" or "schedules" shall become enforceable provisions of the Agreement.

3. Statement of Principle

The mission of DHHR is to promote and provide appropriate health and human services for the people of West Virginia in order to improve their quality of life. Programs will be conducted in an effective, efficient, and accountable manner, with respect for the rights and dignity of the employees and the public served.

DHHR is committed to preventing children with serious mental health conditions from being needlessly removed from their family homes in order to obtain treatment, to prevent those children from unnecessarily entering residential mental health treatment facilities (RMHTFs), and to transition children who have been placed in these settings back to their family homes and communities. DHHR is also committed to providing in-home and community-based services including wraparound facilitation, children's mobile crisis response (CMCR), therapeutic foster family care (TFC), and assertive community treatment (ACT) to children in the target population. Through these programs, children will receive services in the most integrated setting appropriate to their needs. It is the goal of DHHR to ensure that children covered by the Agreement receive sufficient community-based services to prevent unnecessary institutionalization.

4. Agreement Goals

The overarching goal of the Plan, as outlined in the Agreement, is to reform West Virginia's children's mental health system to ensure that children can receive mental health services in their homes and communities. The Plan will lead West Virginia to successful reform in a timely manner to reduce the number of children unnecessarily placed in RMHTFs and the length of stay for children at these facilities, when appropriate. Specifically, the goal is three-fold:

1. Prevent children with serious mental health conditions from being needlessly removed from their family homes in order to obtain treatment;
2. Prevent children with serious mental health conditions from unnecessarily entering RMHTFs; and
3. Transition children with serious mental health conditions who have been placed in a RMHTF back to their family homes.

To support these goals, DHHR is committed to providing in-home and community-based services to children in the target population. These programs will be family-driven, youth-guided, and culturally and linguistically competent, and will include a broad and diverse array of community-based services that are individualized as well as strength- and evidence-based. DHHR will ensure statewide access to these programs to prevent crises and promote stability in the home.

The target population of these services, as defined in the Agreement, includes all children under the age of 21 who:

1. Have a serious emotional or behavioral disorder or disturbance that results in a functional impairment, and (i) who are placed in a residential mental health treatment facility or (ii) who reasonably may be expected to be placed in a residential mental health treatment facility in the near future; and
2. Meet the eligibility requirements for mental health services provided or paid for by DHHR.

The expected goal by December 31, 2022, is a 25 percent reduction from the number of children living in RMHTFs as of June 1, 2015.[1] The expected goal by December 31, 2024 is a 35 percent reduction from the number of children living in RMHTFs as of June 1, 2015. Additionally, any children residing in a RMHTF on December 31, 2024, will have been assessed by a qualified professional and determined to be in the most integrated setting appropriate to their individual needs.

West Virginia is also committed to setting long-term goals regarding the reduction of children living in RMHTFs that will not be recognized during the life of this Agreement. These long-term goals will not create any new requirement to exit the agreement.

5. Definitions

1. "Assertive Community Treatment" (ACT) is a treatment model in which a multidisciplinary team assumes accountability for a small, defined caseload of individuals and provides the majority of direct services to those individuals in their community environment and that operates with high fidelity to an assessment tool, such as the Dartmouth Assertive Community Treatment Scale (DACTS).
2. "Behavioral Support Services" are services that address a child's behaviors that interfere with successful functioning in the home and community. These services include mental health and behavioral assessments; development and implementation of a positive behavioral support plan as part of the treatment plan; modeling for the family and other caregivers on how to implement the behavioral support plan; and skill-building services.
3. "Child and Family Team" is a group of people, chosen with the family and connected to them through natural, community, and formal support relationships, that develops and implements the Individualized Service Plan, otherwise referred to as the Wraparound Plan of Care. The Child and Family Team is led by the wraparound facilitator.

[1] The number of foster children living in RMHTFs as of June 1, 2015, was 1,030 children as reported by DHHR's Foster Care Placements Report. This number includes children placed in Group Residential Care, Psychiatric Facilities (Long-Term), and Psychiatric Hospital (Short-Term).
https://dhhr.wv.gov/bcf/Reports/Documents/2015%20June%20Legislative%20Foster%20Care%20Report.pdf

The number of children in a RMHTF placed by their parents as of June 1, 2015, was 66.

4. “Children’s Mobile Crisis Response” (CMCR) is a crisis response program for children that includes a hotline and mobile crisis response teams that assess and evaluate the presenting crisis, provide interventions to stabilize the crisis, and provide timely supports and skills necessary to return children and their families to routine functioning and maintain children in their home, whenever possible. These services are delivered in a non-clinical setting. Mobile crisis response teams consist of a clinical supervisor and crisis specialists who will provide direct services to children and families.

5. “Children with a serious emotional disorder” is defined by West Virginia as children who, currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Disease (ICD) equivalent that results in functional impairment substantially interfering with or limiting the child's role or functioning in family, school, and/or community activities.

6. “DHHR” is the West Virginia Department of Health and Human Resources and includes those bureaus with the responsibility for providing services to the target population.

7. “In-Home and Community-Based Services” or “In-Home and Community-Based Mental Health Services” are mental health services provided in the child’s family home (or foster or kinship care home, where applicable) and in the community.

8. “Individualized Service Plan” (ISP) is the comprehensive plan developed by the Child and Family Team that is person-centered and includes the child’s treatment goals and objectives, methods of measurement, the timetables to achieve those goals, a description of the services to be provided, the frequency and intensity of each service, and which service providers will provide each service. This term is synonymous with the Wraparound Plan of Care.

9. “Residential Mental Health Treatment Facility” (RMHTF) is a structured 24-hour group care treatment and diagnostic setting for children with serious emotional or behavioral disorders or disturbances. These facilities include the following provider types as listed on DHHR’s Legislative Foster Care Placement Report: Group Residential Care, Psychiatric Facilities (Long-Term), and Psychiatric Hospital (Short-Term). The names and/or functions of these provider types may change as the requirements of the Family First Prevention Services Act are implemented in West Virginia.

10. “Serious Emotional or Behavioral Disorder or Disturbance” (SED) is the presence of a diagnosable mental, behavioral, or emotional disorder that results in functional impairment that substantially interferes with or limits the child’s role or functioning in family, school, or community activities.

11. “Serious Mental Health Condition” is a serious emotional or behavioral disorder or disturbance.

12. “Therapeutic Foster Family Care” (TFC) is a trauma-informed clinical intervention that is an alternative to residential placement for children and youth who have severe emotional

and behavioral needs. This service is provided to children who exhibit mild to significant levels of trauma or behavioral or emotional issues, and this service includes placement of a child in a home with specially trained foster parents.

13. "Wraparound Facilitation" is a service that facilitates care planning and coordination for children in the target population. The core components of the service are:

    a.) Meetings of child and family teams that drive the service delivery process;

    b.) Interagency collaboration to develop the supports to help the child succeed in the community; and

    c.) Strengths-based planning and facilitation to assist the child and family team to meet the child's needs.

14. "Wraparound Facilitator" is the leader of the child and family team and is responsible for coordinating the provision of services for children under the Agreement. Wraparound facilitators have knowledge of in-home and community-based services and experience serving children with serious emotional behavioral disorders or disturbances.

6. West Virginia Wraparound

West Virginia offers a network of wraparound services to children with mental health disorders that can currently be accessed through the Bureau for Children and Families (BCF), Bureau for Behavioral Health (BBH), and Bureau for Medical Services (BMS) within DHHR. The programs, collectively known as West Virginia Wraparound, are Safe at Home West Virginia (SAH), West Virginia Children's Mental Health Wraparound (Children's Mental Health Wraparound), and the Children's Serious Emotional Disorders (CSED) waiver, funded through a Medicaid 1915(c) waiver. The CSED waiver provides funding to serve children with a serious emotional disorder at risk of a psychiatric residential treatment facility (PRTF) placement in an effort to address the issue in the home or in the community. The programs provide similar services, with the goal of operating with high fidelity to the National Wraparound Initiative (NWI) model. The goal across DHHR agencies is to help children, youth, and families thrive in their homes, schools, and communities through a seamless system of care that includes statewide wraparound services available through a "no wrong door" approach, with consistently trained wraparound facilitators and high-fidelity wraparound services.

DHHR is working to standardize these wraparound programs' processes and services, with only the funding streams varying (i.e., state revenue, Medicaid, or other funding sources). The goal across DHHR agencies is to help children, youth, and families thrive in their homes, schools, and communities through a seamless system of care that includes statewide wraparound services available through a "no wrong door" approach, with consistently trained wraparound facilitators and high-fidelity wraparound services. The result should be a reduction of children and youth removed from their homes due to a serious emotional disorder or serious mental illness and increased quality of life as evidenced in school, housing, interpersonal relationships, and employment stability.

Wraparound services using the NWI model take place across four phases of effort: engagement and team preparation, initial plan development, implementation, and transition. During the wraparound process, a team of people who are relevant to the life of the child or youth (e.g., family members, members of the family's social support network, service providers, and agency representatives) collaboratively develop an individualized wraparound plan of care, implement this plan, monitor the efficacy of the plan, and work toward success over time. A hallmark of the wraparound process is that it is driven by the perspectives of the family and the child or youth. The plan should reflect their goals and their ideas about what sorts of service and support strategies are most likely to be helpful to them in reaching their goals. The wraparound plan of care typically includes formal services – including, but not limited to, research-based interventions as appropriate to build skills and meet youth and family needs – together with community services and interpersonal support and assistance provided by friends, kin, and other people drawn from the family's social networks. Examples of formal, evidence-based services families might receive based on their individual needs include parent-child interaction therapy (PCIT), trauma-focused cognitive behavioral therapy (TF-CBT), positive behavior support (PBS), first episode psychosis (FEP) coordinated specialty care, and functional family therapy (FFT).

After the initial plan of care is developed, the team continues to meet often enough to monitor progress in implementing the plan, which it does by measuring the plan's components against the indicators of success selected by the team. Plan components, interventions, and strategies are revised when the team determines that they are not working, i.e., when the relevant indicators of success are not being achieved. The final stage is transitioning the family from intensive wraparound services with added skills and resources to continue to thrive.

Children in the target population who do not meet the eligibility requirements of the CSED waiver but who meet the eligibility requirements of West Virginia Wraparound will be offered West Virginia Wraparound services and necessary community-based services identified in their wraparound plan of care.

6.1 Expected Goals

Goal 1: West Virginia Wraparound will be available statewide accessible to children in the target population who have been identified as needing in-home and community-based services, including children for whom placement in an RMHTF is recommended or who have received mental health crisis intervention services.

Goal 2: West Virginia Wraparound will operate with high fidelity to the NWI model.

Goal 3: The Child and Adolescent Needs and Strengths (CANS) Tool will assess the child and assist the Child and Family Team, led by the wraparound facilitator, in the development of wraparound plans of care for each child within the target population who has been identified as needing in-home and community-based services. The CANS Tool will be conducted by a qualified individual, which is defined as a trained professional or licensed clinician who is not a DHHR employee and not connected to or affiliated with any RMHTF.

Goal 4: For children who are in RMHTFs, the wraparound plan of care shall include discharge planning.

Goal 5: For children with a Multidisciplinary Treatment Team (MDT), the children's screening, assessments, and wraparound plan of care will be provided to the MDT.

6.2 Year 1 Highlights

The Wraparound Workgroup received technical assistance on four occasions with the focus on developing the single West Virginia Wraparound model with fidelity to NWI standards. The State reviewed the Wraparound Implementation Standards – Program (WISP) and scored the three current wraparound programs in accordance with the standards. The State is drafting a West Virginia Wraparound manual for the single program and incorporating the standards into the document. Marshall University conducted a review of 50 wraparound cases; this review provided insight in how the wraparound programs are currently operating.

The State identified Marshall University as the statewide training and technical assistance entity for all wraparound programs and providers. Contract non-negotiables have been identified and will be incorporated into the statement of work that is currently under development. Marshall University also manages the DHHR's CANS database, in which SAH and Children's Mental Health Wraparound CANS Tools are currently stored, and has explored developing algorithms for levels of care.

Requirements for modifications to the CANS system, which stores CANS Tool data across DHHR bureaus, and revisions to the CANS algorithms to address Goal 3 are currently under way.

With technical assistance from the SME, DHHR selected a strategy in December 2020 to simplify access to high-fidelity wraparound services for the target population of this agreement. DHHR chose a blended model that will decouple the target population from bureau-specific service delivery, resulting in tiers of Wraparound. In this scenario, non-SED, child-welfare-involved youth would continue to receive safety and permanency services through BCF's SAH program, while all children with SED, including those in child welfare, would be served by a common Wraparound approach, with services driven by a common assessment tool. This approach will be jointly designed and managed by BMS and BBH.

6.3 Completed Tasks

No.	Tasks/Activities for Ensuring Accessibility Statewide Completed Activities
1	Using a competitive bid process, BBH procured Children's Mental Health Wraparound agencies to expand statewide.
2	BBH conducted onboarding and training of Children's Mental Health Wraparound providers.
3	BBH began providing Children's Mental Health Wraparound services in the expanded areas.
4	DHHR made a formal decision on the WV Wraparound model in December 2020.

6.4 Open Tasks

No.	Tasks/Activities for Ensuring High Fidelity to the NWI's Model	Owner	Deadline
1	Develop written policies and procedures for West Virginia Wraparound that incorporates the NWI's model, CSED waiver requirements, and programmatic goals set forth above.	BCF, BBH, BMS	June 2021
2	Develop a training protocol for wraparound facilitators on the NWI's model, funding streams, billing requirements, referral process, and programmatic reporting requirements.	BCF, BBH, BMS	January 2021

3	Develop an evaluation plan for West Virginia Wraparound that ensures high fidelity to the NWI's model.	BCF, BBH, BMS	March 2021
4	Conduct ongoing training for wraparound facilitators on West Virginia Wraparound.	BCF, BBH, BMS	March 2021, and ongoing
5	Educate stakeholders regarding the referral process and the eligibility standards.	BCF, BBH, BMS	March 2021, and ongoing
6	Transition from the CSED waiver, Safe at Home, and Children's Mental Health Wraparound to West Virginia Wraparound.	BCF, BBH, BMS	March 2021
7	Assess West Virginia Wraparound services across the state using the evaluation plan to ensure adherence to the NWI's model.	BCF, BBH, BMS	October 2021, annually
8	Modify training and services, as needed, based on data from assessment to ensure adherence to Goals 2 through 5.	BCF, BBH, BMS	January 2022, annually

No.	Tasks/Activities for Ensuring Accessibility Statewide	Owner	Deadline
9	Develop an evaluation tool for West Virginia Wraparound that ensures accessibility for the target population.	BMS, BCF, BBH	April 2021
10	Evaluate all wraparound services statewide to ensure adherence to goals set forth above.	BMS, BCF, BBH	August 2021
11	Modify services, as needed, based on data from assessment to ensure adherence to Goal 1.	BMS, BCF, BBH	October 2021

No.	Tasks/Activities for Ensuring Sustainability	Owner	Deadline
12	Assess the West Virginia Wraparound program to determine ongoing sustainability.	BMS, BCF, BBH	September 2021
13	Modify services, as needed, based on data from assessment to ensure sustainability of West Virginia Wraparound for the target population.	BMS, BCF, BBH	October 2021

7. Children's Mobile Crisis Response Program

Children's Mobile Crisis Response and Stabilization Teams help children and youth who are experiencing emotional or behavioral crises by interrupting the immediate crisis, and ensuring youth and their families in crisis are safe and supported, so they can return to routine functioning and maintain children in their homes or current living arrangements, schools, and communities whenever possible. The program is initiated by calling the regional Mobile Crisis Response and Stabilization Team or statewide Children's Crisis and Referral Line, which went live on October 1, 2020, and provides the support and skills needed to return youth and families to routine functioning and maintain children in their homes or current living arrangements, schools, and communities whenever possible. The Children's Mobile Crisis Response and Stabilization model is part of a continuum of community-based services designed to provide a toll-free crisis line, crisis intervention and stabilization, evaluation and assessment; and transition planning and

follow-up. The service is provided in family homes, schools, group care, and other settings, including by telehealth when appropriate. Staff are available 24 hours per day, seven days per week to respond within an hour on average and offer intensive support and stabilization for up to 72 hours. The Children's Mobile Crisis Response and Stabilization model links children and their families or caregivers to services in the community, involves families in treatment, and avoids unnecessary hospitalization or residential placement. Specifically, the target population for Children's Mobile Crisis Response and Stabilization are children with the following characteristics:

- Current symptoms or behaviors indicating the need for a crisis intervention;
- Symptoms and behaviors that are unmanageable at home, school, or in other community settings; or
- At risk of placement, or currently placed, in a psychiatric treatment facility or acute care psychiatric hospital and who cannot return without extra support.

7.1 Expected Goals

Goal 1: Children's Mobile Crisis Response and Stabilization Services continue to be available to all children, regardless of eligibility. BBH ensures that there are sufficient crisis response teams to respond in person to a call within an average time of one hour.

Goal 2: Children's Mobile Crisis Response and Stabilization Services continue to ensure that families will be connected with longer term services, as needed and help them navigate the process to access those services.

Goal 3: As part of the Children's Mobile Crisis Response service, West Virginia maintains a toll-free crisis hotline that is staffed 24 hours per day, seven days per week. Callers will be directly connected to a mental health professional with competency-based training and experience working with children in crisis. BBH maintains criteria for how the hotline staff will assist with immediate stabilizations and guidelines to assess the crisis and determine whether it is appropriate to resolve the crisis through a phone intervention or in-person intervention. Hotline staff will be given access to needed information regarding the child and family when the family provides consent (including any existing crisis plans and the Individualized Service Plan).

7.2 Year 1 Highlights

The State has identified the mobile crisis providers for all six regions and First Choice as the crisis hotline provider. The crisis hotlines are all fully staffed, and staff has been trained. Mobile crisis services are currently being provided in all regions but the Eastern Panhandle. A provider has been identified for the Eastern Panhandle with an anticipated service delivery date of January 2021. Outreach brochures have been developed for statewide distribution. Data gathering and evaluation work are underway to assess and modify services, as needed.

7.3 Completed Tasks

No.	Tasks/Activities for Mobile Crisis Expansion
1	Completed initial trainings of current mobile crisis providers, and developed training materials.

No.	Tasks/Activities for Mobile Crisis Expansion
2	Began providing mobile crisis services in the newly expanded areas.
3	Procured mobile crisis agencies to expand statewide, using a competitive process.
4	Implemented grant agreement for a Children's Crisis Hotline provider to work with all mobile crisis response teams.

7.4 Open Tasks

No.	Tasks/Activities for Mobile Crisis Expansion	Owner	Deadline
1	Continue training for mobile crisis providers.	BBH	December; annually
2	Develop an evaluation plan for mobile crisis services to measure and improve the quality of crisis response, including timeliness of the crisis response, timeliness of the intake process, and effectiveness of engaging families in home and community-based services following the crisis.	BBH	February 2021
3	Assess mobile crisis services statewide using the evaluation plan to ensure adherence to goals set forth above.	BBH	April 2021, ongoing
4	Modify services, as needed, based on data from assessment to ensure adherence to Goal 1.	BBH	May 2021, ongoing
5	Develop a client pathway flow to outline how participants access and receive services.	BBH	March 2021
6	Create the CMCR policy manual and other supporting documents to describe CMCR criteria and processes on access and delivery of services.	BBH	May 2021

No.	Tasks/Activities for Children's Crisis Hotline	Owner	Deadline
1	Work with stakeholders and providers of the mobile response team to develop Children's Crisis hotline criteria according to the goals stated above.	BBH, BMS, BCF	December 2020
2	Ensure the functioning and communication of the Children's Crisis Hotline and its availability statewide.	BBH	December 2020
3	Develop an evaluation plan for the Children's Crisis Hotline to measure and improve the quality of crisis response.	BBH	February 2021
4	Assess the Children's Crisis Hotline to ensure adherence to the goals set forth above.	BBH	April 2021, ongoing
5	Modify services, as needed, based on data from assessment to ensure adherence to Goal 2.	BBH	October 2021, ongoing

8. Positive Behavioral Support Services

Positive Behavioral Support (PBS) services focus on providing prevention and intervention supports for individuals who are demonstrating significant maladaptive behaviors, are at risk of out-of-home placement or involuntary commitment at a psychiatric hospital or PRTF or are transitioning to the community from an out-of-home placement. PBS is an evidence-based strategy to improve independence, decrease behavioral challenges, teach new skills, and improve

overall quality of life of individuals who are experiencing significant maladaptive behavioral challenges.

PBS embraces the conceptual approaches of wraparound or person-centered planning for individuals who have challenging behavioral needs requiring intensive support to help them demonstrate competencies to participate in community life, develop satisfying relationships, make choices, and gain personal dignity and respect. Services are designed to assist individuals to remain in or return to their homes or communities, or to facilitate return from residential treatment programs, psychiatric hospitals, or residential Crisis Response Units. PBS services can be accessed in a variety of methods, such as: self-referral, provider referral, community agency referral or when it is deemed necessary by the MDT, wraparound plan of care, or other treatment team recommendation.

The current PBS program coordinator is the WVU CED. The purpose of this program is to build both workforce capacity and systemic capacity, and to serve individual clients.

8.1 Expected Goal

Goal 1: DHHR will ensure statewide, timely access to PBS services for children in the target population who need it. Services will be provided to help prevent crises, enable children to remain with or return to the family, where possible, and promote stability in the family home. DHHR will utilize mental health and behavioral assessments; a positive behavioral support plan as part of the treatment plan; modeling for the family and other caregivers on how to implement the behavioral support plan; and skill-building services to ensure timely PBS services meet the needs of the children in the target population.

8.2 Year 1 Highlights

The State launched the PBS program at WVU's CED to build workforce capacity and provide short-term consultation, technical assistance, training opportunities, and person-centered planning. The State hired and trained behavioral health providers with experience delivering positive behavioral support. BMS enrolls licensed behavioral health centers which hire credentialed staff who meet the eligibility criteria to provide Medicaid-funded Behavior Management Services, including but not limited to PBS.

BBH used an Announcement of Funding Announcement (AFA) process to initially obtain its lead PBS agency, WVU CED. Since being selected, WVU CED has conducted ongoing trainings each month for both parents or guardians and provider agency staff. BBH will be hosting a variety of trainings throughout 2021 for providers targeted at skill development. BBH, BMS and BCF have staff participating in a state-level PBS workgroup which has, among other things, begun to develop a state credentialing and certification process as part of standardizing the PBS training requirements. BMS identified existing billing codes and a plan for certification and training of staff to deliver the services. Information from the State of Virginia was gathered to better identify processes used in the certification and credentialing of service providers and develop standardized training to ensure fidelity. A potential provider was also identified to assist the state in establishing the accreditation process for implementation of behavioral support services.

8.3 Completed Tasks

No.	Tasks/Activities
1	Using a competitive process, procured a PBS program coordinator grantee who will build workforce and systemic capacity.
2	Provided technical assistance for the PBS program coordinator grantee on service expectations, funding streams/billing, and programmatic reporting requirements.
3	The CED provided training to families, agencies, and community partners, such as de-escalation techniques for agencies, providers, law enforcement and families, and PBS plan development.

8.4 Open Tasks

No.	Tasks/Activities	Owner	Deadline
1	Develop training materials and opportunities to educate families about PBS services.	BBH, BMS	January 2021
2	Assess the availability of PBS services to ensure statewide access.	BBH, BMS	January 2021
3	Develop an evaluation plan for PBS that ensures statewide quality services and training opportunities for agency providers and families who serve the target population.	BBH, BMS	January 2021
4	Modify program, as needed, based on data from assessment to ensure adherence to goals.	BBH	June 2021; ongoing
5	Create and implement a credentialing process and program for agency providers.	BBH	June 2021

9. Therapeutic Foster Family Care

West Virginia's TFC program is a family-based, therapeutic, trauma-informed service delivery approach. The program provides individual services for children and their families. The program is designed to ensure the child is safe while working toward permanency such as reunification, adoption, or legal guardianship. The specialized initial and on-going training provides the foster parents the knowledge and skills needed to care for children that meet the criteria. The service is provided by five child placing agencies statewide. West Virginia seeks to improve its program through development of model standards that clearly define services and activities that are to be provided to support the therapeutic foster parents, the child and his or her family of origin and clarify the role of the child placing agency's case manager.

9.1 Expected Goal

Goal 1: The West Virginia Therapeutic Foster Family Home model will be accessible statewide for all eligible children in the child welfare population[2], will ensure that children are timely placed

[2] The parties acknowledge that there is a disagreement as to whether therapeutic foster family homes must be available to children outside of the child welfare population. Nevertheless, West Virginia's goal is to expand this service to be accessible statewide for the child welfare populations. When the parties reach an agreement, this goal will be modified, if needed.

in a home in their own community with specially trained treatment foster parents who act as resource parents to the child's family of origin, and will provide children with high quality treatment services in a foster family home setting.

9.2 Year 1 Highlights

The TFC workgroup received technical assistance on three occasions which focused different TFC models and how different states implemented TFC. The State met with representatives from the states of Oklahoma and New Jersey for peer-to-peer learning.

The workgroup has drafted a TFC model based on the services to be provided and by whom in the TFC home, the TFC foster parent training required, and defining how TFC differs from traditional foster care.

9.3 Completed Task

No.	Tasks/Activities
1	Assessed current capacity and determine number of Therapeutic Foster Family Care homes needed to ensure least restrictive placement is available.

9.4 Open Tasks

No.	Tasks/Activities	Owner	Deadline
1	Determine TFC model including target population, eligibility, foster parent requirements and training, and staff training.	BCF, BBH, BMS	March 2021
2	Assess current capacity and determine number of Therapeutic Foster Family Care homes needed to ensure least restrictive placement is available and develop corresponding recruitment initiatives.	BCF	April 2021, annually
3	Develop and award procurement vehicle for child placing agencies to build capacity to provide the treatment foster care model statewide.	BCF	September 2021
4	Assess the child placing agencies' performance with meeting outcome measures identified in the model such as recruiting, training, and maintaining treatment foster family homes; and treatment related outcomes for children receiving the service.	BCF	September 2022, biannually
5	Modify capacity, as needed, based on data from assessment to ensure adherence to the above goals.	BCF	September 2023, biannually

10. Assertive Community Treatment

ACT is an inclusive array of community-based rehabilitative mental health services for West Virginia Medicaid members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization requiring a well-coordinated and

integrated package of services provided over an extended duration to live successfully in the community of their choice. Eligible members will have a primary mental health diagnosis and may have co-occurring conditions, including mental health and substance use disorder or mental health and mild intellectual disability. ACT is a very specialized model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which the majority of direct services are provided by the ACT Team in the member's community environment.

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

ACT is a recovery-oriented program. Because ACT is a community-focused treatment modality, a minimum of 75 percent of services must be delivered outside of program offices. The team must develop an initial service plan for the ACT member within seven days of admission into the program that authorizes the services to be provided to the member until the comprehensive plan for the member is complete. BMS offers ACT services to Medicaid members 18 years and older, with no limitation on length of services. Individuals receiving ACT services are currently required to have an Individualized Service Plan, and BMS uses DACTS to ensure that fidelity is met for this evidenced-based practice.

10.1 Expected Goal

Goal 1: DHHR will increase capacity and address any related workforce issues to ensure that ACT is available statewide and that services are delivered in a timely manner.

10.2 Year 1 Highlights

DHHR conducted baseline assessment of program and provider capacity and modified existing contracts to ensure statewide coverage of ACT services. DHHR reviewed the Northern, Southern, Eastern, and Western parts of West Virginia and identified that the Northern Panhandle and Eastern Panhandle as areas that did not have an ACT Team within a 100-mile radius. Once identified, DHHR was able to find a provider in the Northern Panhandle to create an ACT Team. DHHR is still actively recruiting in the Eastern Panhandle. DHHR also utilized survey data to develop and deploy training through the Blackboard platform to BCF case workers.

10.3 Completed Tasks

No.	Tasks/Activities
1	Assessed current ACT capacity and need to determine where additional providers or increased awareness is needed.
2	Created ACT capacity by modifying existing behavioral health center contracts or through a competitive procurement process.
3	Educated stakeholders to increase awareness of the ACT program.

10.4 Open Tasks

No.	Tasks/Activities	Owner	Deadline
1	Assess ACT capacity to ensure adherence to the goals set forth above.	BMS, BBH	December; annually
2	Modify capacity or increase stakeholder education, as needed, based on data from assessment to ensure adherence to the above goals.	BMS, BBH	December; annually
3	Develop targeted outreach to families and youth-serving agencies to ensure children in the target population are identified and receive ACT services.	BMS, BBH	February 2021, ongoing

11. Mental Health Screening Tools and Processes

DHHR's Office of Maternal, Child and Family Health (OMCFH), located within BPH, is West Virginia's Title V Maternal and Child Health Agency and is responsible for the utilization of funds provided by the Maternal and Child Health Block grant of title V of the Social Security Act of 1935, 42 U.S.C. § 701 *et seq.* Federal policy requires state Medicaid agencies to coordinate with Title V grantees, especially regarding Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. OMCFH provides administrative oversight for West Virginia's EPSDT program, also known as HealthCheck. Consequently, OMCFH has a major role in establishing standards, policies, and procedures for health care services, interpreting standards to providers, providing education to enhance implementation, promoting quality of care, and assessing progress.

Developed in coordination with the OMCFH Pediatric Medical Advisory Board and BMS, HealthCheck preventive health screening forms and health history forms aid the determination of trauma history and any current trauma-related symptoms. These forms integrate socio-behavioral factors examined in the Adverse Childhood Experiences (ACEs) study and beginning at age nine, an abbreviated Post-Traumatic Stress Disorder (PTSD) Checklist – Civilian Version (PCL-C).

The emphasis of EPSDT is preventive and primary care, with the overall goal of preventing childhood illnesses or disabilities and identifying children's and young adults' problems early on, before they become severe and disabling. Early identification and treatment improve children's outcomes and enable families to access important resources to improve family functioning and outcomes. The intended outcome is for EPSDT to provide a uniform, comprehensive benefit for children enrolled in Medicaid coverage across all state programs. There is no separate eligibility standard for the EPSDT program. Every West Virginian eligible for Medicaid coverage up to 21 years of age is entitled to the EPSDT benefit.

HealthCheck age-appropriate screening forms are revised with each iteration of the American Academy of Pediatrics' *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, and are available (free of charge) to all health care providers who see West Virginia Medicaid members.

HealthCheck employs community-based program specialists who collectively visit medical providers to:

1. Equip medical providers with the necessary tools and knowledge to carry out EPSDT services that meet reasonable standards of medical practice, i.e. Bright Futures
2. Ensure that West Virginia Medicaid providers understand requirements and expectations of the Bright Futures standard; and
3. Promote the medical home as both a setting and approach to providing comprehensive primary care and EPSDT support services.

11.1 Expected Goals

Goal 1: West Virginia will ensure that a mental health screening using an approved screening tool is completed for any child not already known to be receiving mental health services when the child enters DHHR Youth Services, the child welfare system, or the juvenile justice system; or when the child or family requests mental health services or that a screen be conducted.

Goal 2: West Virginia will ensure that HealthCheck forms are available for health care providers who serve these children, and that these providers are trained on and have access to HealthCheck age-appropriate screening forms, so that West Virginia Medicaid-eligible children are screened to determine if they should be referred for further mental health evaluation or services. By 2022, no less than 52 percent of West Virginia Medicaid-eligible children who are not in the Youth Services, child welfare, or juvenile justice systems will receive annual trauma-informed psychosocial screening.

11.2 Year 1 Highlights

The State documented the various entry points to DHHR youth services and identified the mental health screen tool utilized. The list of approved screening tools include but are not limited to; Early Periodic Screening an Diagnosis Tool (EPSDT) - Medicaid's well-child exam; Family Advocacy and Support Tool (FAST) - BCF's Youth Services tool that addresses the needs of families at risk of child welfare involvement; MAYSI-2 a national youth screening tool conducted within 24 hours of any child entering a WV BJS facility as well as, early screening and detection in schools via the Expanded School Mental Health (ESMH) system.

In addition, DHHR conducted chart audits to determine how consistently the screening process was performed, as well as the resulting referral for further evaluations. An analysis was conducted to determine how often mental health screenings were performed during EPSDT visits. The analysis involved standardized medical record reviews of an age and geographically representative sample of 713 EPSDT exam records, and identified that 82.3% of EPSDT exams included a mental health screening. Both the West Virginia Medicaid and foster care Managed Care Organization (MCO) contracts were confirmed to contain language requiring the usage of mental health screenings, as well as outreach to providers and families.

11.3 Completed Tasks

No.	Tasks/Activities to ensure children are provided an appropriate mental health screening and referral when needed
1	Assessed the current system and identified any gaps where children entering DHHR youth services, the child welfare system, or the juvenile system are not receiving timely mental health screenings.
2	Ensured Medicaid MCOs contracts require the use of the HealthCheck screening forms and/or protocols in the individual provider's screening tool, as well as outreach to parents to encourage use of the EPSDT benefit.

11.4 Open Tasks

No.	Tasks/Activities to ensure children are provided an appropriate mental health screening and referral when needed	Owner	Deadline
1	Ensure that the foster care MCOs provides mental health screenings and services, as appropriate, and upon the request of the family, foster family, or kinship care family.	BMS	December 2020 and ongoing
2	Modify practice, as needed, based on data from the EPSDT chart audits to ensure West Virginia Medicaid-eligible children, children in the child welfare and juvenile justice system are provided an appropriate mental health screening.	BPH, BCF, BMS	January 2021
3	Monitor MCO reporting and quality of HealthCheck forms on an ongoing basis using meetings and documentation.	BMS	Ongoing, in process as designed
4	Conduct training and outreach with health care systems to integrate age appropriate HealthCheck forms and/or protocols into the electronic health record system.	BMS	January 2021
5	Conduct outreach with families regarding the availability of mental health screening.	BCF, BPH	January 2021
6	Develop an evaluation plan that ensures mental health screenings are available to all children and referrals to physicians are occurring when needed.	BMS, MIS	January 2021

12. Quality Assurance and Performance Improvement System

12.1 Expected Goals

Goal 1: DHHR will develop a Quality Assurance and Performance Improvement (QAPI) System, including a data dashboard, which provides data and analytic capability necessary to assist with the assessment of service delivery and support the development of semi-annual reports in alignment with the goals and objectives of the Agreement.

To support quality assurance and performance improvement of the Agreement goals, West Virginia will focus on the collection, synthesis, and analysis of various DHHR data sources in the following areas:

- Examination of the quality of mental health services funded by the state, measured by improved positive outcomes, including remaining with or returning to the family home; and decreased negative outcomes, including disrupted foster home placement, institutionalization, arrest or involvement with law enforcement and the juvenile or criminal courts, suspension or expulsion from school, commitment to the custody of the Bureau of Juvenile Services or DHHR, or being prescribed three or more anti-psychotic medications.
- All children receiving services under the Agreement, including the types and amount of services they are receiving.
- All children screened pursuant to the Agreement, including the dates of screening and the dates of engagement in services.
- All children living in a RMHTF, including admission dates, length of stay, and number of prior placements in RMHTFs.
- Changes in functional ability of children in the target population, both statewide and by region, including data from the CANS Tool and the quality sampling review process.
- The fidelity of child and family teams to the NWI's model.
- Data from the Crisis Response Team encounters, including timelines of response and data on connection to services.

Goal 2: On an annual basis, DHHR will conduct quality-sampling reviews of a statistically valid sample of children in the target population.

12.2 Year 1 Highlights

Requirements were mapped to the Agreement and initial data sources were identified. Ad hoc reports were provided to the SME and DOJ for the population of children residing in a residential mental health facility. This segment of the DOJ target population can be defined by known sources and has been determined to be the focus of a first phase of data reporting. A Dashboard Roadmap Plan has been devised and will be reflected in the Work Plan Tasks.

The criteria for defining those children most likely to enter a RMHTF or the 'at-risk' segment of the DOJ population has been determined. The two components defined as: 1) a clinical diagnosis in the ICD-10 F series, excluding F 15.20, along with 2) a functional impairment defined as either, a CANS score (40 or higher) or a CAFAS score (90 or higher). This segment of the DOJ target population is not easily defined, as the sources for the required data do not exist in a single data source. This segment will be the focus of a second phase of data reporting.

A direct outcome of the work performed during the first year of analyzing the data sources is the decision to segment the rosters of children to align with the DOJ target populations: children residing in a RMHTF and those who reasonably may be expected to be placed in a RMHTF. Year two will begin by focusing on developing a data dashboard for reporting information about children in the first population who enter a RMHTF, considered as "Phase 1".

12.3 Completed Tasks

No.	Tasks/Activities for the Quality Assurance and Performance System
1	Gathered Requirements/Data Sources

12.4 Open Tasks

No.	Tasks/Activities for the Quality Assurance and Performance System Phase 1: Data regarding children in Residential Mental Health Facilities	Owner	Deadline
1	Analysis of Requirements/Data Sources	BCF, BMS, OMIS	November 2020
2	Draft Phase 1a Improvement Measure and supporting Indicators for Each Requirement	BCF, BMS	December 2020
3	Development of Phase 1 Specific Data Sets and Reports	BCF, BMS, OMIS	March 2021
4	Testing of Specific Phase 1 Data Sets and Reports	BCF, BMS	May 2021
5	Revisions to Specific Phase 1Data Sets and Reports	BCF, BMS, OMIS	July 2021
6	Production of Final Phase 1 Data Sets and Reports	BCF, BMS, OMIS	September 2021
7	Begin Reporting Phase 1 Improvement Measure and supporting indicators / Dashboard Live	BCF, BMS, OMIS	October 2021
No.	**Tasks/Activities for the Quality Assurance and Performance System Phase 2: At-Risk Population**	**Owner**	**Deadline**
8	Gather Requirements/Data Sources	BBH, BMS, BCF, OMIS	June 2021
9	Analysis of Requirements/Data Sources	BBH, BMS, BCF, OMIS	August 2021
10	Draft Phase 2 Improvement Indicators for Each Requirement	BBH, BMS, BCF	October 2021
11	Development of Specific Data Sets and Reports	BBH, BMS, BCF, OMIS	January 2022
12	Testing of Specific Data Sets and Reports	BBH, BMS, BCF	March 2022
13	Revisions to Specific Data Sets and Reports	BBH, BMS, BCF, OMIS	May 2022
14	Production of Final Data Sets and Reports	BBH, BMS, BCF, OMIS	July 2022

15	Begin Reporting Phase 2 Improvement Indicators	BBH, BMS, BCF, OMIS	September 2022
No.	**Tasks/Activities for the Quality Assurance and Performance System: Create a Quality Sampling Review Process**	**Owner**	**Deadline**
16	Define sample size with a reasonable confidence level	BBH, BMS, BCF, OMIS	January 2022
17	Develop sampling methodology that is representative of the target population	BBH, BMS, BCF, OMIS	March 2022
18	Develop key benchmarks to identify strengths and areas for improvement	BBH, BMS, BCF, OMIS	May 2022
19	Identify how cases will be reviewed and evaluated against the benchmarks	BBH, BMS, BCF, OMIS	June 2022
20	Conduct quality improvement reviews on the Phase 1 population sample	BBH, BMS, BCF, OMIS	August 2022

13. Outreach and Education for Stakeholders

DHHR has instituted a more unified, department-wide approach to engaging stakeholders in its services and programming for children.

DHHR hosts an open stakeholder association, the West Virginia Child Welfare Reform Collaborative (the Collaborative). The Collaborative is a broad group of independent stakeholders, with meetings facilitated by DHHR, with participation from the DOJ and the SME, to share information, ideas, and feedback surrounding major child welfare reform initiatives throughout the state. Meetings are open to the public, and regular attendees include representatives of the legislative, judicial, and executive branches of state government, foster and adoptive families, residential care providers, socially necessary service providers, educational institutions, social work organizations, advocacy organizations, law enforcement, and concerned citizens. Representatives of press organizations have also attended the Collaborative meetings.

The most critical stakeholder, and often overlooked, is the child and his or her family. DHHR continues to work with the MCOs that serve the target population and those at risk of becoming part of the target population to identify and provide program- and service-specific educational materials regarding the in-home and community-based mental health services available to the child and his or her family. In keeping with the focus on family-centered care, other helping professionals in roles outside of mental health service provision, for example, caseworkers, or, in the justice system, judges, will have their outreach and education materials streamlined to emphasize screening and assessment, paired with interim services that the family can access for stabilization and de-escalation of potential crisis situations during any interval between assessment and the treatment based on the individualized assessment.

Expected Goals

Goal 1: Maintain the information contained in the Child Welfare Collaborative website, "Services" sub-site as the primary source for DOJ related communications.

Goal 2: Implement the Outreach and Education Plan.

13.1 Year 1 Highlights

The State established a list of stakeholder groups and created an Outreach and Education Plan. Representatives from the MCOs were added to the workgroup structure mid-year 2020 and will continue into future years as major partners in the outreach and education efforts.

A website for the Collaborative was developed and can be accessed here (https://childwelfare.wv.gov/). This site and its associated email list are intended to serve as a primary hub for stakeholder engagement as the state moves forward with its broader child welfare reform efforts, as well as with the implementation of the Agreement, specifically.

In addition to the multiple stakeholders' meetings, an established communication plan is being developed for the state departments (DHHR, West Virginia Department of Education [WVDE], and the Department of Homeland Security [DHS][3]) to effectively coordinate the provisions of the Agreement and to provide coordinated community-based mental health services.

13.2 Completed Tasks

No.	Tasks/Activities
1	Created a website to complement the Collaborative and its meetings.
2	Identified established stakeholder groups, including groups outside of the child welfare and juvenile justice systems, to provide educational materials regarding the expansion of the services and programs set forth in the Agreement.
3	Worked with DOJ to establish regional meeting with stakeholders regarding children's mental health services.

13.3 Open Tasks

No.	Tasks/Activities	Owner	Deadline
1	Maintain the Child Welfare Collaborative website sub-site called "Services," including the links to program outreach materials.	DHHR	Ongoing
2	Work with DOJ to establish regional meeting with stakeholders regarding children's mental health services.	DHHR, DOJ	Ongoing
3	Maintain a resource library/toolbox of educational materials that can be updated and utilized across multiple disciplines to keep stakeholders informed.	BBH, BMS, BCF	December 2020
4	Consult with Program Workgroups on suggested formats and timelines for conducting outreach and education	BBH, BMS, BCF	December 2020

[3] The Department of Homeland Security is formally known as the Department of Military Affairs and Public Safety.

No.	Tasks/Activities	Owner	Deadline
5	Develop targeted mental health education in conjunction with the MCOs.	BMS	April 2021
6	Expand the communication plan to include WVDE and the Department of Homeland Security to ensure the implementation of the Agreement and identify any barriers to effective coordination among these agencies and the steps needed to remedy these barriers.	DHHR	April 2021; ongoing

14. Reducing the Reliance on RMHTFs

The heart of the Agreement is to increase the in-home and community-based services available to children in the target population and thereby, reducing the reliance on RMHTFs. In addition to building out those services, the RMHTF program in West Virginia will be reviewed and improved so that children who are in need of this intensive level of services receive it in the most integrated setting and for a length of time that meets their needs.

14.1 Expected Goals

1. Assess the strengths and needs of children in and entering residential placement, identify services those children need to return to their communities, and develop a plan to address barriers to accessing those services;
2. Ensure that children have access to the mental health services they need in their communities to avoid placement in RMHTFs;
3. Reduce the number of children living in RMHTFs to 822 children[4] by December 31, 2022;
4. Reduce the number of children living in RMHTFs to 712 children[5] by December 31, 2024;
5. Use data to propose the goals for reduction of children living in RMHTFs in years beyond the Agreement[6];
6. Reach the goal of ensuring that any child residing in a RMHTF on December 31, 2024, has been assessed to be in the most integrated setting appropriate to their individual needs.

14.2 Year 1 Highlights

West Virginia created a workgroup specifically tasked with review all aspects of the residential mental health treatment program. The workgroup consists of DHHR stakeholders with residential provider engagement and guidance from Casey Family Programs. The workgroup developed a logical model with input from a number of internal and external stakeholders. Based upon the

[4] This number is calculated by reducing the number of children that were living in a RMHTF as of June 1, 2020 by 25%.
[5] This number is calculated by reducing the number of children that were living in a RMHTF as of June 1, 2020 by 35%.
[6] The goals established for years beyond December 31, 2024, do not created additional requirements to the Agreement and are not binding on West Virginia to exit the agreement.

logic model an initial work plan was created. Immediate activities related to assessing the data processes and contracts of current RMHTFs. DHHR also began working with Marshall University to review the CANS tool for each child in placement in August 2020 and prepare a cluster analysis.

WV DHHR has engaged WVU to conduct the system outcome evaluation. During Phase I of this evaluation project, WVU and ICF Macro, Inc. ("ICF"), WVU's sub-awardee, developed an outcome evaluation plan for the overall Children's In-Home and Community-Based Services Improvement Project, as well as for the component workgroups, except for the Quality Assurance and Performance Improvement workgroup. The development of the evaluation plan began in August 2020 with the construction of nine component logic models and one initiative-level logic model, which will help guide the implementation activities for the workgroups. The logic models also serve to help in the development of survey questions and materials, as well as identify new data collection that will be needed.

Also, in August 2020, the state partnered with Marshall University's Center for Excellence for Recovery and Dr. John Lyons from the University of Kentucky's Center for Innovation in Population Health to identify the similarities among children residing in residential mental health treatment facilities and their needs through a latent class analysis. This analysis was commissioned to assist the state in undertaking the work needed to meet the requirements of paragraph 52(b) of the agreement, as well as helping provide deeper insight to the types of interventions necessary to keep these youth in a home-like setting and any barriers that would need to be addressed. This analysis will also be used to better understand the services that residential treatment programs may be lacking that increase a youth's chances of longer lengths of stay or a child's risk of being placed in an out-of-state residential mental health treatment program to receive needed services. The anticipated date of delivery of the cluster analysis is February 2021.

14.3 Open Tasks

No.	Tasks/Activities	Owner	Deadline
1	Gather data from the current providers of residential mental health treatment facilities to better understand the services they provide during the child's stay in the facility and what aftercare/transition services they provide during the child's transition out of the facility.	BCF	March 2021
2	Standardize and improve the mental health assessment process to ensure it provides for a cross-agency pathway for entry to, diversion from, and transition from residential mental health treatment.	BCF	June 2021
3	Provide educational activities on best practices and develop a suite of materials on topics related to residential mental health treatment, such as when it is appropriate in the continuum of care, the role of family during treatment, role of assessment during and prior to placement, and the unintended consequences of repeated assessment and	BCF	June 2021

	inappropriate placement, that can be provided to all stakeholders.		
4	Establish a new model of care for residential facilities, which includes non-treatment residential care (transitioning care), aftercare services, family engagement services, in-home reunification services and transitioning services for youth moving towards independence, to ensure that the services being provided are meeting the needs of the children being placed in residential care.	BCF	May 2021
5	Build on transition and aftercare activities to provide best practices for aftercare programs and transitional living programs to assure uniform standardized programming across the State.	BCF	October 2021
6	Review and then modify RMHTF contracts to reflect service expectations and performance measures that are uniform for all residential providers and reflect the state's vision for residential care.	BCF, BMS	June 2021

15. Workforce Development and Provider Capacity

15.1 Expected Goals

Goal 1: Assess the provider capacity needed to comply with the agreement;

Goal 2: Develop programs to increase provider capacity throughout the state for the programs outlined in the Agreement to ensure statewide access to children in the target population;

Goal 3: Evaluate the outcomes of West Virginia's efforts to increase provider capacity and the mental health workforce, and make changes where necessary.

15.2 Year 1 Highlights

The workgroup and work plan were created. The workgroup identified relevant DHHR studies that helped determine a baseline of current workforce and provider capacity. The 2020 Legislative Session House Bill 4434 passed, which requires the West Virginia Department of Commerce to conduct a study of the health care workforce by February 1, 2021. The study includes individuals who provide behavioral health services. The Cabinet Secretary of the Department of Commerce is required to publish a report on the existing workforce in the continuum of care, including behavioral health services, as well as the anticipated future workforce needs over the next 15 years.

15.3 Completed Tasks

No.	Tasks/Activities
1	Identified baseline of current provider capacity in West Virginia for services outlined in the Agreement.

15.4 Open Tasks

No.	Tasks/Activities	Owner	Deadline
1	Review and confirm that the baseline of current provider capacity provided in the identified report (Task #1 from Section 15.3) reflects provider capacity concerns as expected	BBH	January 2021
2	Develop provider workforce recruitment initiatives to increase workforce capacity that includes recommendations from previous, relevant workforce studies.	DHHR	May 2021
3	Implement training, professional development and other support services to build workforce knowledge and skills.	DHHR	January 2022
4	Create and implement retention incentives to keep workforce.	DHHR	January 2022
5	Develop an evaluation plan that ensures statewide workforce capacity to meet the needs of the target population.	DHHR	January 2022
6	Modify workforce strategies, as needed, based on data from evaluation to ensure adherence to the goal.	DHHR	July 2022; ongoing

Appendix: Glossary of Acronyms and Abbreviations

Table 1: Glossary of Acronyms and Abbreviations

Acronym	Description
ADA	Americans with Disabilities Act of 1990
AFA	Availability of Funding
ACE	Adverse Childhood Experiences
ACF	Administration for Children and Families
ACT	Assertive Community Treatment
BBH	Bureau for Behavioral Health
BCF	Bureau for Children and Families
BJS	Bureau for Juvenile Services
BMS	Bureau for Medical Services
CED	Center for Excellence in Disabilities
CMS	Centers for Medicare and Medicaid Services
CSED	Children with Serious Emotional Disorder
DACTS	Dartmouth Assertive Community Treatment Scale
DHHR	West Virginia Department of Health and Human Resources
DSM	Statistical Manual of Mental Disorders
DMAPS	Department of Military Affairs and Public Safety
WVDE	West Virginia Department of Education
DOJ	United States Department of Justice
DSM	Diagnostic and Statistical Manual of Mental Disorders
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ICD	International Classification of Disease
MCO	Managed Care Organization
MDT	Multidisciplinary Team
NWI	National Wraparound Initiative
OMCFH	West Virginia Office of Maternal, Child and Family Health
OMIS	West Virginia Office of Management Information Services
PBS	Positive Behavioral Support
PHS	Preventive Health Screening
PCL-C	Post-Traumatic Stress Disorder Checklist – Civilian Version
PRTF	Psychiatric Residential Treatment Facility

Acronym	Description
PTSD	Post-Traumatic Stress Disorder
RMHTF	Residential Mental Health Treatment Facility
SAH	Safe at Home West Virginia
SME	Subject Matter Expert
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance/Disorder
TFC	Therapeutic Foster Care
WVU	West Virginia University
WISP	Wraparound Implementation Standards – Program