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

Year 3

WEST VIRGINIA
Department of
Health & Human Resources

Table of Contents

1. Introduction

On May 14, 2019, West Virginia (the State) 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 as operated by the 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 the West Virginia 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:
- 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 (RMHTFs)

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, 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 Collaborative (the 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. 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. DHHR will conduct programs 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 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 home and community-based services, including wraparound facilitation, Children's Mobile Crisis Response and Stabilization (CMCRS), Therapeutic Foster 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.
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 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 (SED) that results in a functional impairment, and (i) who are placed in an RMHTF or (ii) who reasonably may be expected to be placed in a RMHTF 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% 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% 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 (PBS) 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 (ISP), otherwise referred to as the wraparound plan of care. The Child and Family Team is led by the wraparound facilitator.
4. "Children's Mobile Crisis Response and Stabilization" (CMCRS) 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.

[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.

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. “Home and Community-Based Services” (HCBS) or “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

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

14. "Wraparound facilitator" (WF) 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 home and community-based services and experience serving children with SEDs.

6. West Virginia Wraparound and Pathway to Children's Mental Health Services

West Virginia offers wraparound services to children with mental health disorders that can currently be accessed through the Bureau for Social Services (BSS),[2] Bureau for Behavioral Health (BBH), and Bureau for Medical Services (BMS) within DHHR. While the programs have historically operated separately, the State is aligning the programs to ensure that there is consistency in the provision and availability of the service.

DHHR has been working across bureaus to improve access and availability of community-based services for children and youth with SED or serious mental illness (SMI). To make navigating the State's system of care easier for families and reduce the reliance on residential placement or court involvement to receive services, DHHR designed a pathway for assessing children so that children and youth with SED or SMI, as well as all families and youth needing home and community-based services (HCBS) for behavioral health, receive the most appropriate services that meet the needs of the children and families.

The pathway to children's mental health services was designed over the past year in partnership among BBH, BSS, and BMS, to support children and families with HCBS and help prevent unnecessary out-of-home placements of children. As the pathway to assessing children's mental health was designed and prior to its first soft launch, BSS has held monthly discussions with statewide stakeholders such as residential providers, the Managed Care Organization (MCO) that is Aetna Better Health, the West Virginia Child Care Association (WVCCA), and the Supreme Court of West Virginia's Court Improvement Program (CIP) to receive feedback on the pathway, its implementation, and the goal to reduce the reliance on out-of-home placements.

The programs, collectively known as West Virginia Wraparound, operate with the goal of high fidelity to the National Wraparound Initiative (NWI) model. A key method of funding and delivering West Virginia Wraparound is the Children with Serious Emotional Disorder (CSED) Waiver. The CSED Waiver is a Medicaid HCBS waiver program authorized under §1915(c) of the Social Security Act. The CSED Waiver permits DHHR to provide an array of HCBS that enables children

[2] DHHR has recently divided the Bureau for Children and Families (BCF) into the BSS and the Bureau for Family Assistance (BFA). BSS now oversees the child welfare system.

who would otherwise require institutionalization to remain in their homes and communities. Service planning and coordination on the CSED Waiver is done through the Wraparound model.

While the CSED Waiver will be a primary mode of access to HCBS services, some children will not be eligible for waiver services or will choose not to participate. DHHR is committed to ensuring equal access to Wraparound for waiver and non-waiver children. All details about Wraparound services, whether received from or not from the waiver, are contained in the WV Wraparound manual that will be finalized in Year 3 (see Open Tasks section below). For instance, BBH contacts the family and refers them to the waiver if not already applied. Any child who does not currently have a Wraparound facilitator (WF) should have a WF assigned to them during the CSED application process.

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 intended result is a reduction of children and youth removed from their homes due to an SED or SMI and increased quality of life as evidenced in school, housing, interpersonal relationships, and employment stability.

DHHR's pathway to children's mental health services will help ensure that children who receive West Virginia Wraparound receive HCBS through application for the CSED Waiver. Waiver services ensure adequate provider and service availability for the child in the community. DHHR is focusing on aligning providers by making contract changes that require all providers become waiver providers to avoid disruption of services once approved for the waiver.

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 HCBS, 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) 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 home and community-based services. The CANS assessment 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 in RMHTFs, the wraparound plan of care will include discharge planning.

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

6.2 Accomplishments

Centers for Medicare & Medicaid Services (CMS) approved the CSED Waiver amendment on June 8, 2021, to be effective July 1, 2021. The State was able to make permanent changes to the

waiver that align with the NWI model. The amendment required providers to submit initial Wraparound Plans of Care within seven days from the day the Managed Care Organization (MCO) receives the referral. BMS was able to expand the pool of evaluators to include State licensed clinical social workers, licensed professional counselors, and state-supervised psychologists. Additionally, the amendment included the change from the term "case managers" to "wraparound facilitators," the change in wraparound facilitators' caseloads from 1:20 to 1:15, and the added requirement that any wraparound facilitators be certified in the CANS assessment.

BBH drafted the West Virginia Wraparound Manual in collaboration with BMS and BSS. The three bureaus provided "Applied Wraparound" training to all providers in June 2021 and began pathway for children's mental health services webinars and technical assistance (TA) for wraparound providers and facilitators in September 2021.

CSED Waiver enrollment has more than doubled since implementation of the program in 2020. From March through December 2020, 105 children were enrolled in the CSED Waiver program; from January through October 2021, 250 children enrolled. DHHR anticipates that CSED Waiver enrollment and utilization of waiver services will continue to increase as the pathway to children's mental health services is implemented through phased approaches with BSS, Division of Juvenile Services (DJS) and Division of Probation Services in early 2022.

BBH secured funding and issued a grant to Marshall University to develop training and curriculum for both West Virginia Wraparound fidelity and CMCRS teams. Currently BBH, BMS and BSS meet with Marshall University weekly to build out the training for wraparound facilitators.

6.3 Open Tasks

Table 1 represents the continued project tasks.

Table 1: West Virginia Wraparound action items and related outcomes

Outcome	No.	Action	Owner	Projected Timeline
Clear operating procedures	1	Demonstrate connection to evidence-based programs such as PBS, and include TFC, in the pathway to children's mental health services for diversion and transition from placement.	BBH and BSS Program Managers	December 2021
	2	Finalize West Virginia Wraparound manual.	BBH	March 2022
	3	Finalize CSED Waiver enrollment process.	BBH, BMS, BSS	February 2022
	4	Finalize policy to detail how individuals will be offered choice between ACT and wraparound.	BMS	July 2022
Trained and equipped workforce	5	Initiate ongoing training on the above policies and process for relevant staff/entities.	BBH, BMS, BSS	January 2022

Outcome	No.	Action	Owner	Projected Timeline
	6	Implement training plan and technical assistance (TA) for wraparound facilitators (WF) and providers and other stakeholders as necessary.	BBH, BMS, BSS	January 2022
Youth and families are aware of available services	7	Coordinate with MCO to continue enhancing outreach for members and enhance communication between members and care managers.	BBH, BMS, BSS	December 2021
Services are available and accessible to families	8	Develop and monitor the plan/timeline for Phase 1 implementation of pathway to children's mental health services and wraparound services.	BBH in partnership with BMS, BSS	October 2021
	9	Develop and monitor the plan/timeline for future phases of implementation of pathway to children's mental health services and wraparound services.	BBH in partnership with BMS, BSS	January 2022
Evidence-based practices are utilized	10	Monitor ongoing fidelity of wraparound services to NWI model.	BBH Program Manager in collaboration with Marshall University	January 2022 and ongoing
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	11	In collaboration with the Quality Assurance and Performance Improvement (QAPI) team, identify key performance indicators, data collection, analysis, and reporting associated with wraparound facilitation and CSED Waiver services.	BBH Program Manager	April 2022 and ongoing
Sufficient provider capacity to meet needs	12	Complete review, as reflected in DHHR's CQI Plan, of wraparound provider capacity. If applicable, recruit for additional providers to meet needs.	BBH, BMS, BSS	April 2022 and ongoing

7. Children's Mobile Crisis Response and Stabilization (CMCRS)

CMCRS 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. Stabilization services are provided to allow an opportunity for children to return to routine functioning and ensure they are maintained in their homes or current living arrangements, schools, and communities whenever possible. The program is initiated by calling the regional CMCRS team or statewide Children's Crisis and Referral Line, which has been available since October 1, 2020.

The CMCRS 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 a telehealth option when appropriate. Staff are available 24 hours a day, seven days a week to respond within an hour on average and offer intensive support and stabilization for up to 72 hours. The CMCRS 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 CMCRS 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.
- At risk of placement, or currently placed, in a psychiatric treatment facility or acute care psychiatric hospital and who cannot return home without additional support.

DHHR has developed a protocol that guides decisions by crisis hotline staff in responding to crisis calls. The protocol requires the following:

DHHR is finalizing the CMCRS manual (see Open Task 1 in Table 4 below) that guides decisions by Children's Crisis and Referral Line (CCRL) staff in responding to crisis calls. The CMCRS manual Introduction section includes the following:

> MCRS teams shall be available to youth up to age 21, regardless of funding eligibility, in their homes and communities to prevent unnecessary out-of-home placements of youth with serious behavioral health crises. Youth and families can access MCRS through the toll-free, 24/7 statewide Children's Crisis and Referral Line (844-435-7498) or through the direct toll-free number of the MCRS if known to the caller. The MCRS will be available throughout the region and staffed 24-hours per day, seven days per week. Callers will be directly connected to a trained mental health professional with experience or competency-based training in working with youth in crisis. Intensive support and stabilization services will be offered and delivered in-person, within an average of **one** hour of the call, and **can last** up to 72 hours **to stabilize the crisis event**. **MCRS services will be provided up to eight weeks; will take place** in family homes, schools, group care, and other settings **that are** natural to the youth and family; **and will include such services as**:

crisis intervention, crisis assessment, the development of a crisis plan which will include presumptive eligibility for crisis services (i.e., the family and youth determine whether it is a crisis), engagement, de-escalation, assessment, planning, and **the** coordination of supports and **other** services **as needed**. (Intensive support and stabilization services will be offered within two episodes of care (EOC): a 72 hour EOC for those children who are in crisis and need immediate services to de-escalate the crisis situation and return to family to a functioning status and a 6-8 week EOC for children currently in, or at immediate risk of a family-defined crisis. The 6–8-week EOC will address ongoing needs of the family and are designed to ensure that all referrals and linkages have been completed by the families. This is voluntary for families and is used as part of ongoing services to help ensure families are working to get all services necessary and to prevent recidivism. Families and individuals can request EOC. Services will take place in the home, agency or other designated location as defined by family and agreed upon by agency if the location provides for privacy and safety.

The CMCRS manual Initial Response section includes the following:

At initial family engagement, the family defines the crisis. The family decides how they would like MCRS to respond, which includes: in-person, telephone, or telehealth. In-person response provides face-to-face response and interaction with the family on location, within an average of one hour. MCRS will include the completion of the Crisis Assessment Tool (CAT) and the development of the Individualized Crisis Plan (ICP) as coordinated by the MCRS team during the first 72 hours.

ICPs are individualized, collaborative, and flexible based on the needs of the youth and family.

MCRS is a foundational component of SOC and embraces core principles and values. Interventions may include, but are not limited to, crisis intervention, counseling, behavioral assistance, intensive in-community services, skill building, mentoring, medication management and/or caregiver stabilization interventions and focuses on creating community connections. Coordination of specialized services to address the needs of youth with co-occurring intellectual/developmental disabilities and substance use are also available through MCRS. The MCRS program is managed and monitored by the Bureau for Behavioral Health.

The CMCRS manual shall include language on requiring sharing of information before finalized. The DHHR CQI plan outlines the data collection process to review CMCRS data as outlined in Open Task 4 in Table 4 below.

7.1 Expected Goals

Goal 1: CMCRS services are available to all children, regardless of eligibility. BBH ensures there are sufficient crisis response teams to respond in person to a call within an average time of one hour.

Goal 2: CMCRS 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 CMCRS services, 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/or an ISP).

7.2 Accomplishments

The State has made significant progress in implementing robust CMCRS services with providers in all six regions. First Choice continues as the crisis hotline provider; it is fully staffed and has an initial and ongoing training focus. Furthermore, BBH streamlined the Children's Crisis and Referral Line (CCRL) so that one hotline is needed, which is the Help4WV statewide service.

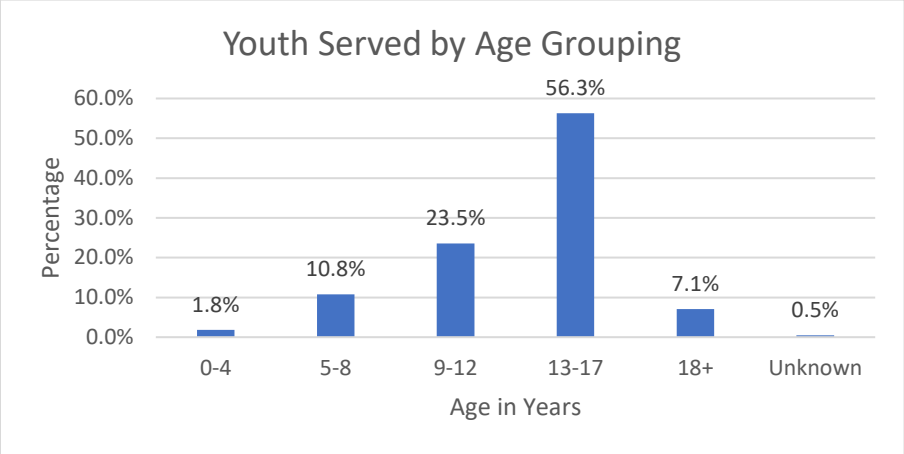
Statewide outreach continues with a comprehensive approach using website information at www.help4wv.com, written material billboards, and stakeholder communication. The CMCRS provider manual has been drafted and is in final stages of development; it is projected to be completed by January 2022.

BBH secured funding to increase capacity of staffing by one person in each BBH region and issued a grant to Marshall University to develop a training and curriculum program for both CMCRS teams and West Virginia Wraparound. Currently BBH, BMS and BSS meet with Marshall University weekly as part of the continuing efforts to have a solid written training plan in place by January 2022. Data gathering and evaluation work is underway to assess and modify services, as needed.

The CMCRS program consists of seven provider organizations that served 833 youth via phone and in person services from July 2020 to June 2021. It should be noted two providers began services for the first time during this period, resulting in a lower number of youth served in the respective regions for the time period. This is reflective of less individuals served in regions 2 and 4, which serves the state's eastern and northern panhandle. It is expected that youth served will increase in the next period as these new providers grow in rapport and awareness with their communities. The BBH has also launched a new data system which will allow improvements in data reporting and accuracy. Additional demographics of youth served through CMCRS includes the following:

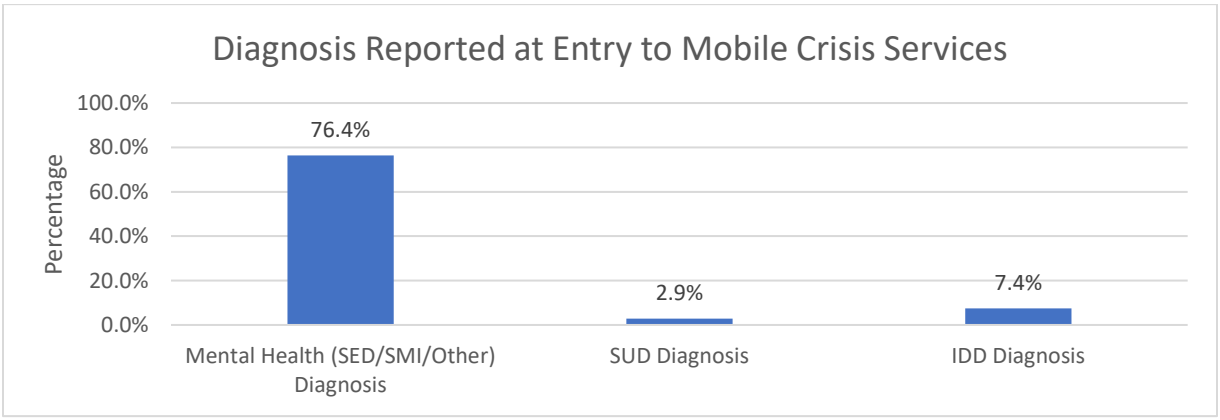
Fifty-six percent (56%) of individuals served were ages 13 to 17. It should be noted that often an individual in crisis may be a parent or caregiver with a small child. In these cases, the child would also be enrolled in the program to help provide services for the family as a whole. Some of these instances may make up the nearly two percent (2%) of children ages 0 to 4.

Table 2: Percent of children served, by age group



Of the same youth served, 76% reported a mental health diagnosis upon entry. Individuals may have reported co-occurring conditions. Note, diagnoses in this instance are self or caregiver reported only, individuals may not have a confirmed diagnosis, not know their diagnosis, or need referral for further revaluation.

Table 3: Reported diagnosis upon entry to CMCRS Services



7.3 Open Tasks

Table 4 represents the continued project tasks.

Table 4: CMCRS action items and related outcomes

Outcome	No.	Action	Owner	Projected Timeline
Clear operating procedures	1	Finalize the CMCRS manual.	BBH Program Manager	January 2022

Outcome	No.	Action	Owner	Projected Timeline
Trained and equipped workforce	2	Centralize core training for CMCRS providers and other stakeholders or system providers to begin/continue delivery of training.	BBH Program Manager in collaboration with Marshall University	March 2022
	3	Develop oversight plan for training content delivered by contracted CMCRS providers.	BBH Program Manager	March 2022
Youth and families are aware of available crisis response services	4	Coordinate outreach and education efforts with contracted vendors informed by data collection associated with CMCRS services.	BBH, BMS	April 2022 and ongoing
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	5	In collaboration with the QAPI team, identify key performance indicators, data collection, analysis, and reporting associated with CMCRS services.	BBH Program Manager	April 2022 and ongoing
Crisis response teams sufficient to respond within an average time of one hour	6	Complete review, as reflected in DHHR's CQI Plan, of CMCRS provider capacity compared with average response time data. If applicable, recruit for additional CMCRS providers to ensure sufficient coverage and required response time.	BBH Program Manager	April 2022 and ongoing

8. Behavioral Support Services

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

PBS embraces the conceptual approaches of wraparound or person-centered planning for children 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 through 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 West Virginia University (WVU) Center for Excellence in Disabilities (CED) who receives referrals and offers resources online at www.pbs.cedwvu.org and by email at pbs@hsc.wvu.edu. The purpose of this center is to build both PBS workforce capacity and systemic capacity, and to provide PBS services to individual clients through trainings, PBS brainstorming telehealth sessions, person-centered planning, and intensive services. The application for PBS intensive services can be found online at pbs.cedwvu.org/pbs-intensive-services/.

8.1 Expected Goal

Goal 1: DHHR will ensure statewide, timely access to PBS services for children in the target population who need those services. 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 PBS 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 Accomplishments

BBH secured and provided additional funding to the current PBS grantee, West Virginia University Center for Excellence in Disabilities, to hire four additional staff to increase PBS workforce capacity in the state.

BBH issued a grant to Concord University, which will develop and implement a training and curriculum plan to increase capacity in PBS workforce of training behavior support services professionals. This curriculum and training will include certification and recertification.

BBH worked in collaboration with BMS to develop Medicaid billing modifier codes to the current behavior support codes to allow billing of mental health PBS services. Upon approval, these Medicaid billing modifiers will go into effect in July 2022.

Once the Medicaid billing modifier is operational, additional data and reporting for PBS services can be included in future implementation plans and semi-annual reports.

8.3 Open Tasks

Table 5 represents the continued project tasks.

Table 5: PBS action items and related outcomes

Outcome	No.	Action	Owner	Projected Timeline
Certified workforce for behavioral support services	1	Finalize PBS credentialing plan.	BBH Program Manager	January 2022

Outcome	No.	Action	Owner	Projected Timeline
Trained and equipped behavioral support services workforce	2	Finalize PBS training plan.	BBH Program Manager	January 2022
Monitoring to ensure behavioral support services are available and accessible	3	Implement PBS modifier code to allow for additional monitoring of service utilization. Build into relevant documents, including the provider billing guide.	BMS Program Manager	July 2022
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	4	In collaboration with the QAPI team, identify key performance indicators, data collection, analysis, and reporting associated with PBS services.	BBH Program Manager	April 2022 and ongoing
Sufficient provider capacity to meet needs	5	Complete review, as reflected in DHHR's CQI Plan, of provider capacity to meet needs. If applicable, recruit for additional providers to meet needs.	BBH Program Manager	April 2022 and ongoing

9. Therapeutic Foster Family Care (Treatment Home)

West Virginia's Treatment Home program is a family-based, therapeutic, trauma-informed service delivery approach. The program provides individualized services for children and their families. It is designed to ensure the child is safe while working toward permanency such as reunification, adoption, or legal guardianship. The specialized initial and ongoing training provides the Treatment Home parents with the knowledge and skills needed to care for children who meet the criteria. The service is provided through 11 child placing agencies statewide. In partnership with West Virginia Wraparound and funded through the CSED Waiver, Treatment Homes are designed to provide intensive treatment services to children with SED who can be served in a family-like setting, ultimately diverting children from placement in RMHTFs. Treatment Home parents are specifically recruited and trained to provide intensive support for these children so they can remain in and actively participate in their home, school, and local community. West Virginia seeks to improve its Treatment Home program through development of model standards that clearly define services and activities that support Treatment Home parents, the child and the family of origin, and clarify the role of the child-placing agency's case manager.

9.1 Expected Goal

Goal 1: The West Virginia Treatment Home model will be accessible and sustainable statewide for all eligible children in the child welfare population[3] who are in need of out-of-home placement and can be safely served in a foster family care setting. The goal of Treatment Home services is to ensure that children are timely placed 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 in conjunction with West Virginia Wraparound.

9.2 Accomplishments

The workgroup has completed the development of a revised Treatment Home model to serve children with SED who are at risk of out-of-home placement or are currently placed in an RMHTF. The Treatment Home model defines the overall workflow, the service array, and the roles and responsibilities of all parties. A level of foster care (either Traditional or Treatment Home) will be determined for CSED Waiver-eligible children, based on the child's individual needs, exhibited behaviors and current placement stability. Should a child's needs rise to the level of requiring Treatment Home intervention services, they will be placed in a qualified treatment home that has been validated by a DHHR Review Team to ensure that the home has the appropriate training to handle the complex needs of the child.

Treatment Home providers and stakeholders provided valuable consultation and feedback through various face-to-face and virtual engagements on the proposed model and associated outcome measurements. The Treatment Home workgroup conducted analysis regarding children receiving current TFC model services as well as children in RMHTFs to determine the appropriateness of current placement setting and necessary level of care. Using this information, the model is designed to assure that children with SED can receive services in a family-like setting, ultimately diverting children from RMHTFs.

[3] 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.

9.3 Open Tasks

Table 6 represents the continued project tasks.

Table 6: Treatment Home action items and related outcomes

Outcome	No.	Action	Owner	Projected Timeline
Clear operating procedures	1	Complete Draft Treatment Home workflow and policy based on new model and input from providers. Treatment Home workflow will accommodate the following scenarios: • New children to foster care • Children currently in traditional foster care • Children transitioning from RMHTF • Children cared for under the prior TFC model	BSS Children and Adult Services Director	January 2022
Trained and equipped workforce	2	Complete curriculum on the training for new workflow and policy, to include roles and responsibilities.	Children and Adult Services Director	February 2022
	3	Schedule and complete training on the new workflow and policy, to include roles and responsibilities, with relevant staff/entities.	Children and Adult Services Director	March 2022
TFC services are available and accessible	4	Amend Treatment Home provider contracts to align with the new model, roles, and responsibilities.	Grants Director	February 2022
Children are appropriately placed	5	Develop a plan for phase-in of the new model with input from provider agencies.	Children and Adult Services Director	March 2022
	6	Begin phase-in of new model as outlined in Treatment Home Standard Operating Procedure.	Children and Adult Services Director	April 2022
Open communication and feedback from stakeholders	7	Collaborate with youth and families receiving Treatment Home services to evaluate performance and seek input.	Foster Care Specialist	December 2022
Trained and equipped foster parents	8	Develop requirements and an oversight plan for the Child Placing Agency specialized training for Treatment Home parents.	Children and Adult Services Director	April 2022

Outcome	No.	Action	Owner	Projected Timeline
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	9	In collaboration with the QAPI team, identify key performance indicators, data collection, analysis, and reporting associated with TFC services.	Children and Adult Services Director; QAPI Team	April 2022 and ongoing
Sufficient provider capacity to meet needs	10	Complete review, as reflected in DHHR's CQI Plan, of TFC provider capacity compared to forecasted needs.	DHHR Leadership	April 2022 and ongoing

10. Assertive Community Treatment (ACT)

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 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 ACT team provides the majority of direct services 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% of services must be delivered outside 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 for 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 ISP, 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 ACT provider workforce capacity issues to ensure that ACT is available statewide and that services are delivered in a timely manner.

10.2 Accomplishments

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 these areas were identified, DHHR was able to secure a provider in the northern panhandle to create an ACT team. As of the summer 2022, DHHR anticipates offering ACT services in the eastern panhandle through Mountaineer Behavioral Health. Furthermore, Kepro conducts fidelity reviews to demonstrate quality and service access for ACT.

10.3 Open Tasks

Table 7 represents the continued project tasks.

Table 7: ACT action items and related outcomes

Outcome	No.	Action	Owner	Projected Timeline
ACT services are available statewide	1	Initiate ACT vendor contract in the eastern panhandle.	BBH	December 2021
	2	Collaborate with the eastern panhandle provider to begin ACT service provision.	BBH	August 2022
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	3	In collaboration with the QAPI team, identify key performance indicators, data collection, analysis, and reporting associated with ACT services.	BBH, BMS	April 2022 and ongoing
Sufficient provider capacity to meet needs	4	Complete review, as reflected in DHHR's CQI Plan, of provider capacity. If applicable, recruit for additional providers to meet needs.	BBH, BMS	April 2022 and 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 primary care providers, providing education to enhance implementation, promoting quality of care, and assessing progress.

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 improves children's outcomes and enables 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. OMCFH has drafted changes to its HealthCheck screening forms to include additional behavioral health questions.

BSS Youth Services conducts a Family Advocacy and Support Tool (FAST) for every youth to address the needs of families who are at risk of child welfare involvement. The FAST includes a mental health section to describe the youth's current mental health without performing a formal mental health diagnosis.

The Massachusetts Youth Screening Instrument (MAYSI-II) is a brief behavioral health screening tool designed especially for juvenile justice programs and facilities. It identifies youth ages 12 to 17 who may have dire behavioral health needs. It is currently conducted at intake on youth entering detention or commitment programs. The MAYSI-II is a self-report inventory of 52 questions (requiring about 5 – 10 minutes to answer) regarding whether the individual has experienced certain thoughts, feelings, or behaviors in the past few months.

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 BSS 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% of West Virginia Medicaid-eligible children who are not in the BSS Youth Services, child welfare, or juvenile justice system will receive annual trauma-informed psychosocial screening.

11.2 Accomplishments

DHHR approved standardized children's mental health screening tools among the bureaus using different tools and standard operating procedures (SOPs) that will become one umbrella policy for the pathway to children's mental health services. BSS requires Youth Services workers use FAST per the BSS Youth Services policy, and drafted SOP language for screening. Additionally, BSS drafted SOP language for CPS workers for mental health screening via the modified CPS Ongoing Assessment, implemented in May 2021 at which time BSS began tracking completed CPS assessments. BSS developed job aides for screening and provided a training overview and memo regarding referrals for CSED services.

BPH added mental health screening questions to the HealthCheck form and implemented annual retrospective analysis of medical records. Discussions are in process to define mental health screening for ages 0 to 5. Additionally, BPH enhanced mental health surveillance and screening as part of the EPSDT standard of care in coordination with the pediatric medical advisory board. An infographic to serve as a catalyst for ongoing discussions with primary care providers was developed.

Bureau for Juvenile Services (BJS) continues to use the MAYSI-II for screening purposes and the associated SOP is in process. The Division of Probation Services has determined its standardized screening tool as the MAYSI-II in coordination with BJS and awaits approval. The integration of screening through the pathway to children's mental health services has served to improve interagency communication and collaboration.

BPH and BBH are partnering to provide primary care providers (PCPs) details on how to make referrals to the Children's Crisis and Referral Line. In the fall 2021, the bureaus began distributing flyers to PCPs with a QR code and URL to make referrals online here: https://hipaa.jotform.com/PGHN/help4wv-PCP-referral. The flyers state that any electronic referral can be made anytime (24 hours/day, seven days/week) and the family will be contacted within 24 hours of receipt of the referral. All electronic referrals will receive an automatic reply confirming receipt of referral.

11.3 Open Tasks

Table 8 represents the continued project tasks.

Table 8: Mental Health Screening action items and related outcomes

Outcome	No.	Action	Owner	Projected Timeline
Clear operating procedures	1	Finalize screening tools and HealthCheck guidance for physicians with additional detail on how different referrals are handled.	BPH Program Manager, and BBH Program Manager	December 2021
	2	Draft CPS and BSS Youth Services screening procedure.	BSS Policy	December 2021
	3	Draft Probation screening and referral procedure.	Director of Probation Services	December 2021
	4	Draft BJS screening and referral procedure.	BJS	December 2021
Trained and equipped workforce	5	Complete training and job aids as appropriate for relevant entities on the screening and referral procedures.	BSS Training division, BPH/BBH	December 2021

Outcome	No.	Action	Owner	Projected Timeline
Individuals are consistently identified	6	Implement EPSDT mental health screening modifier code to differentiate when a mental health screen is conducted.	BMS	March 2022
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	7	In collaboration with the QAPI team, identify key performance indicators, data collection, analysis, and reporting for screening.	BMS, BSS, BJS, Probation	April 2022 and ongoing

12. Quality Assurance and Performance Improvement System

DHHR's Office of Management Information Services (OMIS) reports directly to the DHHR Cabinet Secretary and is charged with providing the leadership, innovation, and services needed to achieve efficient and effective technology solutions to meet the goals for the DHHR.

DHHR maintains multiple data systems that serve the child welfare population. OMIS has established a Data Warehouse/Decision Support System that includes data from the Medicaid Management Information System and the Families and Children Tracking System (FACTS). In an effort to improve coordination of care for children and youth served across multiple bureaus, DHHR is in the process of converting the existing FACTS system to a new and enhanced Peoples Access To Help (PATH) system for use across multiple bureaus.

House Concurrent Resolution 35 passed on April 6, 2021, during the West Virginia legislative session, requires DHHR to continuously evaluate the availability and quality of services provided to children in the child welfare system. The Resolution also requires DHHR to establish a continuous evaluation and improvement system that measures outcomes for children and families in the child welfare system and outcomes for children with SED served by DHHR across the bureaus of the department and other state agencies serving children, in collaboration with existing divisions or units within DHHR that measure and evaluate performance. The passage of this resolution provides for a new Office of Quality Assurance for Children's Programs to oversee and coordinate quality improvement efforts across DHHR.

12.1 Expected Goals

Goal 1: DHHR will develop a 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 QAPI of the Agreement goals, West Virginia will focus on the collection, synthesis, and analysis of various known 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 BJS or DHHR, or being prescribed three or more antipsychotic medications.

- All children receiving services under the Agreement, including the types and number 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 an 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 assessment and the quality sampling review process.
- The fidelity of child and family teams to the NWI model.
- Data from the crisis response team encounters, including timelines of response and data on connection to services.

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

12.2 Accomplishments

A direct outcome of the work performed during the first year of analyzing the data sources available was the decision to segment the child population to align with the DOJ target population as follows: children residing in a RMHTF and those who reasonably may be expected to be placed in a RMHTF. Year two focused on developing a data dashboard for reporting information about children residing in a RMHTF, considered as Phase 1 culminating in a dashboard in October 2021, which has started the pilot phase of user testing. Phase 2 data elements focused on CSED Waiver services were developed in year two, and build-out of these elements in the data store and associated dashboards will continue in year three.

As a first step toward development of the Continuous Quality Improvement Plan for children's mental health services, SMEs for the services and pathways associated with the Agreement defined the data and indicators needed to assess service delivery and measure implementation of the Agreement and the impact on children with SED. Work is underway to identify the data sources for these prioritized indicators and the process for integrating the data into a suite of reports to be used by cross-program, cross-bureau teams for purposes of analysis to identify strengths and areas for improvement as well as for incorporation in the semi-annual reports to DOJ. Build-out of the CQI process will be a key focus for year three implementation.

The minimum data DHHR plans to collect and analyze through efforts with its partners, West Virginia University and Marshall University, include the following metrics and measures:

- All children receiving services under this agreement, including the types and amounts of services they are receiving;
- All children screened pursuant to paragraph 31 of the agreement, including dates of screening and the dates of engagement in services;
- All children living in a Residential Mental Health Treatment Facility, including admission dates, length of stay, and number of prior placements in Residential Mental Health Treatment Facilities;
- The outcomes of children in the target population, including whether they have juvenile petitions filed, have been committed to the custody of the Bureau for Juvenile Services or DHHR, have been suspended or expelled from school, and have been prescribed three or more anti-psychotic medications;
- Changes in functional ability of children in the target population, both statewide and by region, including data from the CANS assessment and the quality sampling review process;
- The fidelity of Child and Family teams to the National Wraparound Initiative model; and
- Data from Crisis Response Team encounters, including timelines of response and data on connection to services.

Additional data may be collected and analyzed as continuous quality improvement efforts evolve, based on learning and experience, and/or increased data availability.

The new Office of Quality Assurance for Children's Programs will provide the infrastructure to drive implementation and continued evolution of the CQI plan and process. The Director of the Office of Quality Assurance position has been posted and recruiting efforts are underway.

Under contract with DHHR, West Virginia University submitted an evaluation plan for children's in-home and community-based mental and behavioral health services in April 2021. The evaluation includes measures aligning with the DOJ agreement, youth/caregiver level outcomes, community/provider level outcomes, and system level outcomes. Caregiver, provider, and youth surveys have been initiated. The first report of results from the evaluation is anticipated in the first half of 2022 with a second report to follow later in the year. These results will be reviewed along with the measures outlined above by cross-functional, cross-bureau quality committees.

A target population test plan was developed and presented to the DOJ in October 2021 to ensure the agreed-upon criteria in the target population definition are sufficient in scope to identify the children within the intended population. Initial testing is expected to occur during year three.

12.3 Open Tasks

Table 9 represents the continued project tasks.

Table 9: QAPI action items and related outcomes

Outcome	No.	Action	Owner	Projected Timeline
Data is available to DHHR staff to	1	Complete Phase 1 indicators Dashboard pilot group user testing.	DHHR User Test Group	December 2021

Outcome	No.	Action	Owner	Projected Timeline
monitor, analyze, and drive decisions to improve services	2	Rollout DHHR training on the Phase 1 Dashboard indicators.	DHHR User Test Group, DHHR Trainers	February 2022
	3	Complete Phase 2 indicators development, testing, environment setup, deployment, and user testing.	OMIS	July 2022
	4	Phase 2 indicator Dashboard rollout and training for DHHR staff.	Arbiter Team, DHHR Trainers	November 2022
Children are consistently identified and engaged in services	5	Develop and implement testing plan for the target population to ensure the definition is sufficient in scope to identify the children within the intended population.	QAPI	December 2021
Performance measurement of children's services related to the Agreement	6	Develop and submit semi-annual reports to DOJ to evaluate the quality of services and outcomes for children and families.	Office of Quality Assurance (QA), BMS, BBH, and BSS	January 2022 then every six months thereafter
Quality infrastructure for children's services	7	Define roles and responsibilities for Office of QA and QA functions within each bureau.	Office of QA, BMS, BBH, and BSS	June 2022
Statewide access to services	8	Develop plan for routine provider capacity review to meet forecasted needs and to ensure statewide access to services.	Office of QA, BMS, BBH, and BSS	April 2022 and ongoing
Continuous quality improvement and sustainability	9	Continue development and implementation of annual quality sampling review plan/process.	Office of QA, BMS, BBH, and BSS	June 2022
	10	Develop plan for oversight, monitoring, and accountability for DHHR staff to follow workflows, policies, and procedures.	Office of QA, BMS, BBH, and BSS	December 2022
	11	Develop plan for oversight, monitoring, and accountability for vendor contracts.	Office of QA, BMS, BBH, and BSS	December 2022
Reports are available to DHHR staff to monitor, analyze, and drive	12	Continue development of key performance indicators, data collection, analysis, and reporting of performance	Office of QA, BMS, BBH, and BSS	April 2022

Outcome	No.	Action	Owner	Projected Timeline
decisions to improve services		measures and outcomes associated with services.		
Consolidated, cross-bureau data is available to DHHR staff to monitor, analyze, and drive decisions to improve services	13	Based on the prioritized data/indicators, continue build-out of the data store and associated dashboards.	Office of QA/ OMIS	Ongoing
Continuous quality improvement and sustainability	14	Complete review of data/indicators on an ongoing basis to drive policy and practice decisions.	Office of QA, BMS, BBH, and BSS	April 2022 and ongoing
Ongoing stakeholder education and involvement	15	Develop and implement a plan for sharing information/results and obtaining feedback from stakeholders and other key partners in service delivery (e.g., West Virginia Department of Education [WVDE], Department of Homeland Security [DHS]).	Office of QA, BMS, BBH, and BSS	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 Collaborative, which is a broad group of independent stakeholders with participation from the DOJ and the SME, to share information, ideas, and feedback regarding major child welfare initiatives throughout the State. Meetings are facilitated by DHHR and open to the public. Regular attendees include representatives of the legislature, 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 meetings.

The most critical, and often overlooked, stakeholder is the child and their family. DHHR continues to work with the MCOs that serve children with SED and those at risk of out-of-home placement to identify and provide programs and service-specific educational materials regarding home and community-based mental health services available to children and families. DHHR also intends to solicit and use feedback from children and families in its implementation and monitoring of services, programs and activities under the DOJ Agreement through information obtain during the WVU evaluation and survey process and enhancements to the Collaborative website. With the focus on family-centered care, other helping professionals in roles outside mental health service

provision, including, caseworkers, teachers, or judges, will streamline their outreach and education materials to emphasize screening and assessment. Outreach and education materials should be paired with interim services which the family can access for stabilization and de-escalation of potential crisis situations during any interval between assessment and treatment.

13.1 Expected Goals

Goal 1: Maintain the information contained in the Collaborative website as the primary source for DOJ-related communications about program- and service-specific materials regarding home and community-based mental health services.

13.2 Accomplishments

The State continues to utilize the Collaborative website, which can be accessed at https://childwelfare.wv.gov/, as a primary hub for stakeholder communication as the State moves forward with its broader child welfare reform efforts and implementation of the Agreement. The services section of the website provides a high-level program overview of various services available for children with mental health and behavioral challenges. Using this format simplifies outreach and education for families, as well as stakeholders. Utilizing the Collaborative website paves the way for consistency in the coming year, as messaging will evolve to focus on the screening and pathway to children's mental health services as an avenue to access children's mental health services and supports. Additionally, home and community-based services will be a continued focus of messaging through the Collaborative website.

The outreach and education workgroup used PowerPoint presentations and memos focused on consistent messaging for both internal and external audiences. The messaging focused on two identified areas:

1. System and process changes that are needed to shift the focus from residential treatment as the primary intervention to considering the least-restrictive care possible when developing the service plans; and
2. Communication, outreach, and education to all stakeholders on the screening and assessment pathway, which will alter the current process in which assessments and evaluations occur at each potential program level.

A DHHR Internal Staff Outreach Communication Memo confirmed the practice and procedure for review of communications related to internal subject matter expertise as well as a new tracking of external communications through the DHHR Office of Communications.

Representatives from the MCOs were invited to the Outreach and Education workgroup mid-year 2020 and will continue as major partners in the outreach and education efforts in future years.

DHHR is drafting a communication plan between WVDE, DHS, and DHHR at the department level to effectively coordinate the provisions of the Agreement and to provide effective and consistent community-based mental health services. Coordination and involvement of SMEs from within those organizations has been occurring at the workgroup level.

13.3 Open Tasks

Table 10 represents the continued project tasks.

Table 10: Outreach and Education action items and related outcomes

Outcome	No.	Action	Owner	Projected Timeline
Robust and engaging Collaborative website	1	Develop Collaborative website SOP to include the process to communicate stakeholder meetings and engaging providers/families/youth/stakeholders to provide feedback.	Outreach and Education workgroup in collaboration with BMS, West Virginia University	December 2021
Families and stakeholders have information regarding available services	2	Finalize internal communication SOP to include ongoing development and approval of written materials as program needs change.	Outreach and Education Workgroup	January 2022
	3	Publish guidance for bureaus related to monitoring outreach and education efforts of contracted vendors.	BMS	April 2022
Open communication and feedback from stakeholders	4	Publish guidance for bureaus on methods for enhancing two-way communication with stakeholders and periodic review of stakeholder feedback.	Outreach and Education Workgroup	April 2022
Improved communication and collaboration among child-serving agencies (DHHR, WVDE, and DHS)	5	Draft a Memorandum of Understanding to establish semi-annual communication between DHHR, WVDE, and DHS.	Outreach and Education Workgroup	June 2022

14. Reducing the Reliance on RMHTFs

The heart of the Agreement is to increase the home and community-based services available to children in the target population, thereby reducing the reliance on RMHTFs. In addition to building out those services, DHHR will review the current RMHTF program and children placed in care in West Virginia to determine the type of programming and services being provided. Once DHHR completes these processes, it will develop a new model for RMHTF care so that children who are in need of this intensive level of service will receive it in the least-restrictive setting and for a length of time that meets their needs.

14.1 Expected Goals

Goal 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.

Goal 2: Ensure that children have access to the mental health services they need in their communities to avoid placement in RMHTFs.

Goal 3: Reduce the number of children living in RMHTFs to 822 or fewer children[4] by December 31, 2022.

Goal 4: Reduce the number of children living in RMHTFs to 712 or fewer children[5] by December 31, 2024.

Goal 5: Use data to propose the goals for reduction of children living in RMHTFs in years beyond the Agreement.[6]

Goal 6: Ensure that any child residing in an RMHTF on December 31, 2024, is in the least-restrictive setting appropriate to meet their individual needs, as determined through an assessment by a qualified professional.

14.2 Accomplishments

West Virginia continued to leverage the workgroup that meets weekly and is specifically tasked with reviewing all aspects of the residential mental health treatment program. Additionally, the DHHR developed an external stakeholder workgroup that meets monthly. The workgroup designed a new model of care with input from several internal and external stakeholders.

Activities began in late 2020, including gathering data from current RMHTFs to better understand the services they provide during the child's stay in the facility and what aftercare/transition services RMHTFs provide during the child's transition out of the facility.

In March 2021, DHHR began work with Marshall University to conduct and analyze stakeholder feedback on a cluster analysis of children currently in RMHTF placement.

DHHR created a pathway for entry to, diversion and transition from RMHTFs and drafted criteria for the types of future programming necessary to meet the identified needs of children per the cluster analysis. This is referred to informally as the Reducing Reliance on Residential Pathway (R3 Pathway). DHHR implemented Commissioner-level authorization for out-of-state residential placements.

In collaboration with the QAPI team, DHHR identified key data elements related to RMHTF care to develop Phase 2 of the data dashboard from tracking data.

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[4] This number is calculated by reducing by 25% the number of children who were living in an RMHTF as of June 1, 2015.
[5] This number is calculated by reducing by 35% the number of children who were living in an RMHTF as of June 1, 2015.
[6] The goals established for years beyond December 31, 2024, do not create additional requirements to the Agreement and are not binding on West Virginia to exit the Agreement.

14.3 Open Tasks

Table 11 represents the continued project tasks.

Table 11: Reducing the Reliance on RHMTF action items and related outcomes

Outcome	No.	Action	Owner	Projected Timeline
Children are evaluated and placed appropriately	1	For children with Child and Adolescent Functional Assessment Scale under 90 in an RMHTF, collaborate with the facility, caseworker, and other stakeholders to create appropriate discharge plans.	BSS liaison to MCO	January 2022
	2	Draft a model for residential continuum of care that supports the needs of the children.	BSS Licensing	January 2022
	3	In collaboration with the Treatment Home workgroup, review children currently placed in an RMHTF for possible placement in Treatment Homes.	BSS liaison to MCO	January 2022
	4	Children with Child and Adolescent Functional Assessment Scale score of 90 or higher in an RMHTF will be evaluated to determine if they can transition to a lower level of care and create appropriate discharge plans.	BSS liaison to MCO	March 2022
Clear operating procedures	5	Finalize RMHTF referral policy.	BSS Policy, MCO	December 2021
	6	Finalize policy on monthly assessments for children placed in a RMHTF.	BSS Policy	January 2022
	7	Finalize policy on transitioning children from a RMHTF.	BSS Policy	February 2022
Trained and equipped workforce	8	Develop and initiate training for relevant staff/entities on the finalized policies and processes.	BSS	January 2022
Children are appropriately placed	9	Develop and implement the plan/timeline for phased implementation of R3 pathway and processes.	BSS	January 2022
	10	Develop and implement a plan for ongoing outreach and education with judges with a focus on decreasing placements in RMHTFs.	BSS leadership	March 2022 and ongoing
	11	Through referral tracking and providers, identify most common referral sources to RMHTFs. Provide communication and education to reduce the number of unnecessary referrals to RMHTFs.	BSS with assistance from QAPI	April 2022 and ongoing

Outcome	No.	Action	Owner	Projected Timeline
	12	Monitor phased implementation of R3 pathway.	BSS	June 2022
	13	Develop and/or amend RMHTF contracts that support the R3 pathways and processes.	BSS Contracts Director	July 2022
Reports are available to DHHR staff to monitor, analyze, and drive decisions to improve services	14	In collaboration with the QAPI team, identify key performance indicators, data collection, analysis, and reporting associated with services.	R3 Workgroup Leads with assistance from QAPI	April 2022 and ongoing
Sufficient community-based provider capacity and workforce to meet needs	15	Once continuum of care model is established, complete initial and ongoing review of provider capacity and workforce data. If applicable, recruit additional providers to meet needs and/or address workforce challenges, in partnership with providers.	BSS, BMS	April 2022 and ongoing

15. Workforce Development and Provider Capacity

The State has a workforce workgroup to identify and address healthcare resource and provider needs to fulfill the Agreement. The State has identified multiple issues impacting workforce, the array of services West Virginia is implementing, and the bureau staff's limited bandwidth.

The State has begun work to focus on workforce-related requirements, which includes preparedness of providers to deliver services.

The following list identifies the ongoing work to improve provider capacity for services under the Agreement:

- The State has initiated training and coaching contracts for CMCR, wraparound, and behavioral support services.
- The State has continued to focus on requirements for training for existing services incorporated under the Agreement such as ACT, screening, and CANS assessment.
- The State has developed an agreement with Marshall University to implement a workforce training center named the West Virginia Behavioral Health Workforce and Health Equity Training Center. The initial contract with Marshall University focuses on wraparound and CMCR, with future activities focused on additional training and coaching topics.
- The State continues to contract with West Virginia University Centers for Excellence in Disabilities PBS Program and has entered into an agreement with Concord University to also support the development of behavioral support services-related training and certification.

Additionally, the State reviews comparison data of wraparound facilitator capacity and availability of Wraparound services by region. During this period the State plans to expand this comparison review to include provider capacity review for CMCR, ACT and PBS.

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 Accomplishments

The workgroup identified relevant DHHR studies that helped determine a baseline of current workforce and provider capacity. Conducting additional analysis on provider capacity began in 2021.

The DHHR submitted a request for funding to the Centers for Medicare and Medicaid Services (CMS) and the Children's Health Insurance Program to support enhancement of home and community-based provider services and workforce capacity through the American Rescue Plan. DHHR received approval in October 2021.

15.3 Open Tasks

Table 12 represents the continued project tasks.

Table 12: Workforce action items and related outcomes

Outcome	No.	Action	Owner	Projected Timeline
Sufficient provider capacity to meet needs	1	In collaboration with TFC, ACT, PBS, wraparound, and CMCRS workgroups, as well as the MCO and other vendors, develop a written plan for completing a routine analysis of provider capacity and workforce data.	BBH, BSS and BMS	April 2022 and ongoing
Sufficient provider capacity to meet needs	2	Complete provider capacity reviews, as reflected in DHHR's CQI Plan. If applicable, recruit for additional providers to meet needs.	BBH, BSS and BMS	January 2022 and ongoing

Outcome	No.	Action	Owner	Projected Timeline
Trained workforce	3	Finalize contract with Marshall University to establish Trauma-Informed Care Center for Excellence.	Coordinator Community-Based Strategies	January 2022
	4	Establish Workforce Development and Training contract with West Virginia University.	BMS	January 2022
Sufficient provider capacity to meet needs	5	Track outreach and mental health and behavioral provider enrollment related to the Loan Repayment Program through BBH.	BBH	Ongoing

Appendix: Glossary of Acronyms and Abbreviations

Table 13: Glossary of Acronyms and Abbreviations

Acronym	Description
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
BSS	Bureau for Social Services (formerly Bureau for Children and Families)
CANS	Child and Adolescent Needs and Strengths
CMCRS	Children's Mobile Crisis Response and Stabilization
CMS	Centers for Medicare & Medicaid Services
CSED	Children with Serious Emotional Disorder
DACTS	Dartmouth Assertive Community Treatment Scale
DHHR	Department of Health and Human Resources
DHS	Department of Homeland Security
DOJ	United States Department of Justice
DSM	Diagnostic and Statistical Manual of Mental Disorders
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FACTS	Family and Children Tracking System
FAST	Family Advocacy and Support Tool
HCBS	Home and Community Based Services
ICD	International Classification of Disease
ISP	Individualized Service Plan
MAYSI-II	Massachusetts Youth Screening Instrument
MCO	Managed Care Organization
MDT	Multidisciplinary Team
NWI	National Wraparound Initiative
OMCFH	Office of Maternal, Child and Family Health
OMIS	Office of Management Information Services
PBS	Positive Behavioral Support
QAPI	Quality Assurance and Performance Improvement

Acronym	Description
R3	Reducing the Reliance on Residential
RMHTF	Residential Mental Health Treatment Facility
SED	Serious Emotional or Behavioral Disorder or Disturbance
SME	Subject Matter Expert
SMI	Serious Mental Illness
SOP	Standard Operating Procedure
TFC	Therapeutic Foster Care
WVDE	West Virginia Department of Education