

Children's Mental Health and Behavioral Health Services Quality and Outcomes Report

Reporting Period: July 2020 – June 2021

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1.0 Executive Summary

The West Virginia Department of Health and Human Resources (DHHR) is actively working to reform mental and behavioral health services for children with serious emotional disorders and their families across West Virginia. Since 2019, DHHR has facilitated in-depth discussions and planning meetings with multiple bureaus, community partners and stakeholders to design and develop new pathways, processes, and services to help ensure home and community-based services are available and accessible statewide and to reduce the risk of out-of-home placement in institutional or other settings. In recent months, DHHR began implementing new processes and pathways meant to identify children’s mental health needs and provide families with timely connections to services and to transition children currently placed in residential settings back to their family homes or other least restrictive setting. DHHR’s goal is to reduce the number of children placed in Residential Mental Health Treatment Facilities (RMHTFs) to 822 by December 31, 2022, and to 712 by December 31, 2024.

Given the importance of utilizing data to evaluate systems and processes and make policy and program adjustments, DHHR implemented a Continuous Quality Improvement plan for children’s mental and behavioral health services in December 2021, which includes ongoing quality reviews of available data associated with children’s mental health services. The purpose of this report is to capture the results of these quality reviews for the period July 2020 to June 2021. DHHR is in the early stages of implementing program and process changes; therefore, the data included in this report are initial and emerging. As implementation progresses, DHHR will continue to expand data collection to measure the impact on outcomes for children and families as well as assist in making programmatic adjustments to further enhance services. DHHR is utilizing the data in this report to begin establishing baselines for home and community-based programs and services, which will be used for comparison in future semi-annual reports.

The review period (July 2020 – June 2021) for this report was impacted by the COVID-19 pandemic, which reduced the prevalence of in-person services and caused individuals and families to be more hesitant to seek care. This impact is noted in the information presented throughout this report.

DHHR is making significant progress in its reform efforts. Key accomplishments include:

- Implementation of the Children with Serious Emotional Disorder Waiver, which provides an array of home and community-based services for eligible children with serious emotional disorders. For the review period, 138 children were using these services.
- Implementation of a statewide Children’s Crisis and Referral line, which provides a centralized resource for children and families in crisis to receive immediate support while also providing a connection to statewide Children’s Mobile Crisis Response and other services to meet their needs.
- Launch of the Pathway to Children’s Mental Health Services (Assessment Pathway) to streamline access to mental and behavioral health services for children and families while quickly

connecting them with a Wraparound Facilitator to help children and families navigate the process.

- Reduction in the number of children in RMHTF placements to 764 as of January 21, 2022, which exceeds the December 2022 reduction goal.

Recommendations based on the data reviews include:

- Continue implementing the new pathways, processes, and services.
- Continue expanding data collection, identifying any gaps in reporting, exploring data system solutions to address needs, and building out the data store and associated suite of reports for use in ongoing quality committee reviews.
- Continue efforts to capture data at the child level for aggregation across bureaus and child-serving entities.

DHHR has made meaningful progress in program design and process changes related to serving children with mental and behavioral health needs. Implementation will continue in the months and years ahead. The details of specific service reviews as well as identified strengths, opportunities for improvement, and recommendations are included in the full report.

2.0 Introduction

The West Virginia Department of Health and Human Resources (DHHR) is actively working to reform and enhance programs and services for children¹ with serious mental health conditions.

The primary goals of this reform are as follows:

- Prevent children with serious mental health conditions from being unnecessarily removed from their family homes in order to obtain treatment.
- Prevent children with serious mental health conditions from unnecessarily entering RMHTFs.
- Transition children with serious mental health conditions who have been placed in an RMHTF back to their family homes.

To support these goals, DHHR is committed to providing home and community-based services to allow children to remain in their homes and communities. Home and community-based services include Wraparound Facilitation, Children’s Mobile Crisis Response (CMCR), Treatment Homes as a short-term intervention foster care option, Positive Behavior Support (PBS), and Assertive Community Treatment (ACT). In February 2020, DHHR implemented the Children with Serious Emotional Disorders (CSED) Waiver to expand the array of home and community-based services available for children with serious emotional disorders (SED) and their families. Over the last two years, DHHR has worked collaboratively with community partners and stakeholders to design and expand services to better meet the needs of children and families statewide. DHHR is currently in the early stages of implementing these new processes and pathways to improve access to home and community-based services across the state of West Virginia.

In December 2021, DHHR began implementation of the Continuous Quality Improvement (CQI) plan for children’s mental and behavioral health services. The purpose of the CQI plan is to take a proactive approach to continually improve child welfare services and services for children with mental and behavioral health needs, including SED. Ongoing quality improvement will help ensure all eligible children and families are provided timely, effective, high-quality, and individualized care that is appropriate in scope, intensity, and duration to meet their needs.

As part of the CQI process, DHHR held a series of five cross-functional, cross-bureau quality committee review meetings between December 2021 and January 2022 to review and analyze data associated with children’s mental and behavioral health services. The discussions during these quality review meetings informed the findings—including strengths, opportunities, and recommendations—captured in this report.

Representatives from across DHHR participated in the quality reviews and included the following:

¹ The terms “child” and “children” will be used throughout this report and are meant to be inclusive of children and youth ages 3 to 21.

- Representing DHHR: Jeremiah Samples, Deputy Secretary; Cammie Chapman, Associate General Counsel; Shaun Charles, Chief Information Officer; Laura Barno, Coordinator of Community-Based Strategies.
- Representing the Bureau for Behavioral Health (BBH): Commissioner Christina Mullins; Laura Hunt, Epidemiologist II; Sarah Sanders, Epidemiologist; Nikki Tennis, Officer Director III for the Office of Children, Youth, and Families; Cassandra Tolliver, Program Manager.
- Representing the Bureau for Medical Services (BMS): Commissioner Cynthia Beane; Cynthia Parsons, Program Director for Behavioral Health and Long-Term Care Services; Rachel Goff, Program Manager.
- Representing the Bureau for Social Services (BSS): Commissioner Jeff Pack; Michelle Dean, Interim Deputy Commissioner; Carla Harper, Director of Children and Adult Services; Christina Bertelli-Coleman, Program Manager II for Children and Adult Services Regulatory Management; Terri Miller, Program Manager I for IIU/Licensing.

DHHR will produce reports on the quality and outcomes of children’s mental health services on a semi-annual basis, including strengths, opportunities for improvement, and recommendations to enhance services. The purpose of this initial report is to begin establishing baseline data to use for comparison in future reports. Data collection over time as well as further progress in implementation of the new pathways, processes, and services will allow more robust discussion, assessment of progress against baselines, and the formation of conclusions and recommendations for inclusion in future reports.

3.0 Systems and Data Sources

Data and information to evaluate and monitor services and outcomes will be drawn from a variety of sources, including multiple data systems, quality sampling reviews, fidelity reviews, and feedback from staff, children, families, providers, caregivers, and other stakeholders. Data sources used to aggregate data for this initial report include:

- DHHR BSS Family and Children Tracking System (FACTS) of children in DHHR custody.
- DHHR Data Warehouse/Decision Support System (DW/DSS) of Medicaid and Children’s Health Insurance Program (CHIP) data, including data from the CSED Waiver.
- DHHR BBH grantee reporting for PBS, CMCR and stabilization, BBH Wraparound, and Children’s Crisis and Referral Call Line.
- DHHR BMS CSED Waiver applications data from the contracted Administrative Services Organization (ASO) provider, including the results of the application process.
- Bureau of Juvenile Services (BJS) Offender Information System.

DHHR is currently developing a data store to house data from multiple sources across DHHR’s child welfare and mental and behavioral health services systems with the goal of aggregating data from child-serving bureaus. To date, the data store captures data associated with RMHTF services. In 2022, the data store will be expanded to include data elements associated with CSED Waiver services. Over time, additional community-based behavioral health data elements will be included in the data store as record-level data becomes more available and accessible.

As the mental health system and programs in the state continue to grow and evolve, so do the data systems that support these activities. DHHR is working toward system changes that will allow increased data collection at the child and encounter level. In October 2021, the BBH System of Care, which includes the BBH-funded PBS, Wraparound, Children’s Crisis and Referral Line, and CMCR and stabilization programs, began utilizing a new data reporting system that allows collection of record-level child data for all programs. These steps will support greater focus on data quality, program planning, and improvement reviews. In addition, the information will be in a format that will allow it to be added to the data store. The BSS plans to implement the People’s Access to Help (PATH) system to replace the current FACTS system. BMS plans to implement an Enterprise Data Solution (EDS) to replace the current DW/DSS warehouse. Both new systems will improve and expand data collection associated with BSS and BMS services and integration of data across bureaus. BSS, BBH, and BMS have been working with vendors and providers to implement and refine data collection at the child level. It is anticipated that the data processes will be constantly evolving as the DHHR continues to implement more robust CQI processes.

In addition to internal data systems, DHHR uses the expertise of community partners for support in quality and evaluation initiatives including:

- West Virginia University (WVU): Contracted to complete an ongoing evaluation of West Virginia’s children’s home and community-based services. WVU will provide routine reports of the evaluation to DHHR.
- Marshall University: Contracted to complete an ongoing evaluation of service fidelity to the National Wraparound Initiative (NWI) and will provide routine reports to DHHR.

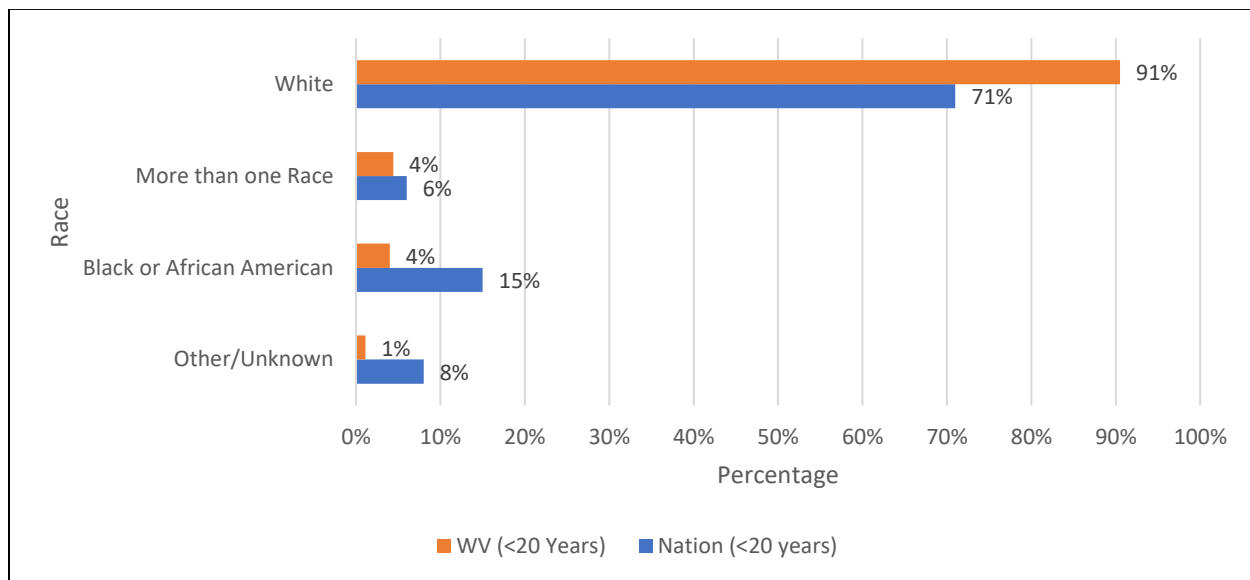
Reports from these contracted vendors will serve as data sources in the quality committee review cycle as outlined in the CQI plan for analysis and incorporation in quality improvement recommendations and associated action. Results of these analyses can be expected in future semi-annual reports.

4.0 West Virginia’s Child Population

West Virginia has a unique demographic and geographic makeup, which varies significantly from most of the rest of the nation. Reference to the state’s population is important as DHHR looks at baseline service utilization and for future reports to track whether the populations reached are representative of the state’s population.

The state has a large proportion of white children compared to the nation (91% in the state compared to 71% nationwide). People of color represent 9% of the West Virginia population compared to 29% of the nation’s distribution of race. See Figure 1.

Figure 1: Racial Distribution of West Virginians Less Than Age 20 Compared to the Nation²



In addition to consideration of racial distribution, geographic makeup of the state is an important consideration for service utilization and outreach. According to the United States Office of Management and Budget, only 21 of West Virginia’s 55 counties are considered urban. Children and families who live in rural areas may have additional barriers and considerations to accessing services. Figure 2 represents the population in each county less than 18 years of age, with Figure 3 referencing BBH regions for context of service utilization as referenced throughout sections of this report.

² Single-race Population Estimates, United States, 2010-2020. July 1st resident population by state, age, sex, single-race, and Hispanic origin, on CDC WONDER Online Database. Vintage 2020 estimates released by U.S. Census Bureau on July 27, 2021. Accessed at <http://wonder.cdc.gov/single-race-single-year-v2020.html> on January 13, 2022.

Figure 2: West Virginia Child Population Under Age 18

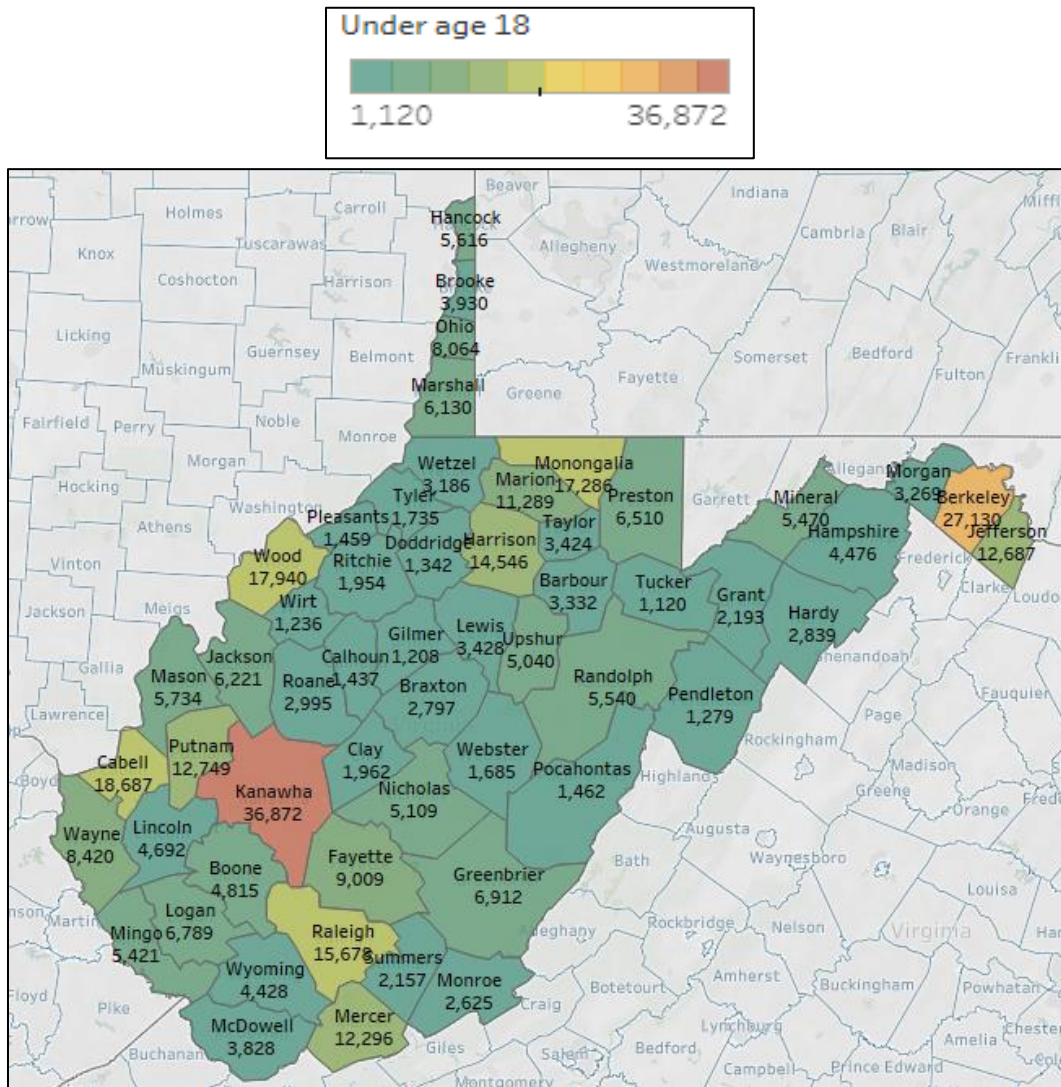
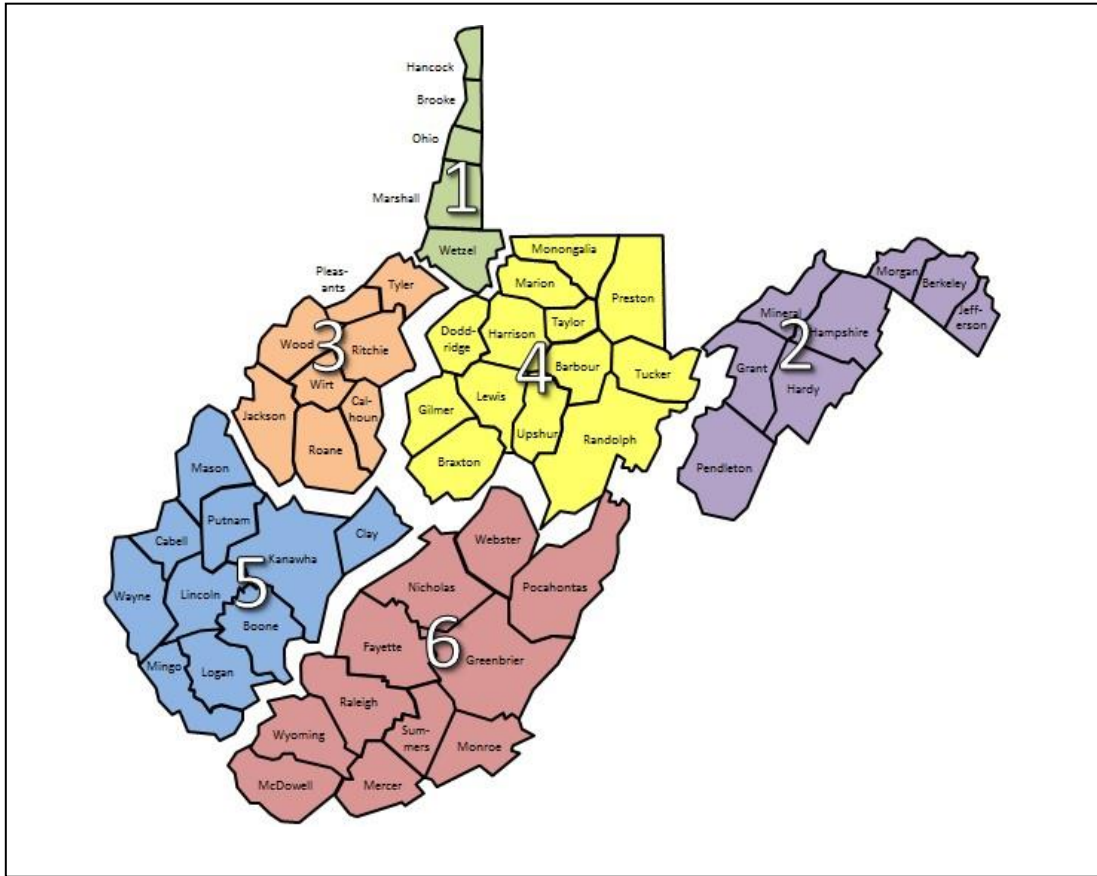


Figure 3: BBH Regions by County



5.0 Screening

Screening for possible mental health needs is a critical first step in identifying children for further evaluation to determine treatment needs, with subsequent referrals to appropriate home and community-based services. To help ensure broad reach to children across the state who may benefit from behavioral and mental health services, the following entities complete screenings:

- Primary Care Providers: Provide screening for Medicaid- and CHIP-eligible children through West Virginia's HealthCheck (i.e., Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] program).
- BSS, Youth Services (YS): Provides screening for children referred to DHHR for services related to status offenses or juvenile delinquencies.
- BSS, Child Protective Services (CPS): Provides screening for children in a child abuse and neglect case.
- Division of Corrections and Rehabilitation, BJS: Provides screening for children in juvenile detention and commitment facilities.
- West Virginia Judiciary, Division of Probation Services: Provides screening for children on probation.

Children with an identified potential mental health need (i.e., positive screen) are then referred to the Pathway to Children's Mental Health Services (Assessment Pathway) for additional evaluation and referral to home and community-based services.

5.1 Review Period, Data Sources and Limitations, Population Measured

Data collection associated with screening for possible mental health needs is in the early stages of development. The data included in this report are meant to begin to establish a baseline of the number of children being screened by each screening entity. Based on current data collection limitations, the presence of a screening does not imply a mental health need was identified, it simply means a screening was conducted. As data collection expands to include positive screens (i.e., those children with a possible mental health need) and those referred to the Assessment Pathway, this information can be used to forecast provider capacity needs for Wraparound and other home and community-based services.

Reporting on primary care screenings or EPSDT with mental health screens is based on chart reviews. DHHR conducted a medical chart review of a random sample of Medicaid members between ages 0 and 20 for calendar year 2020 that had a well-child visit. The random sample is a subset of the total children screened.

Screening data collection for children in YS was initiated in December 2019 and is captured in Excel spreadsheets that are reported monthly. Screening data collection for children involved in CPS was initiated in May 2021 and is captured via Excel spreadsheets that are reported monthly. Screening data

for children in the custody of the BJS is collected in the Offender Information System. A mechanism for capturing the screening data for children involved with Probation is being developed and will be implemented in 2022.

5.2 Review Summary

Eighty percent of children’s medical charts reviewed indicated a mental health screening was included during the primary care provider exam. The percent of children with a completed mental screening increased with age, from 70% for 0 – 5 years olds to 91% for 19 – 20 years olds. The average age of the children sampled was seven.

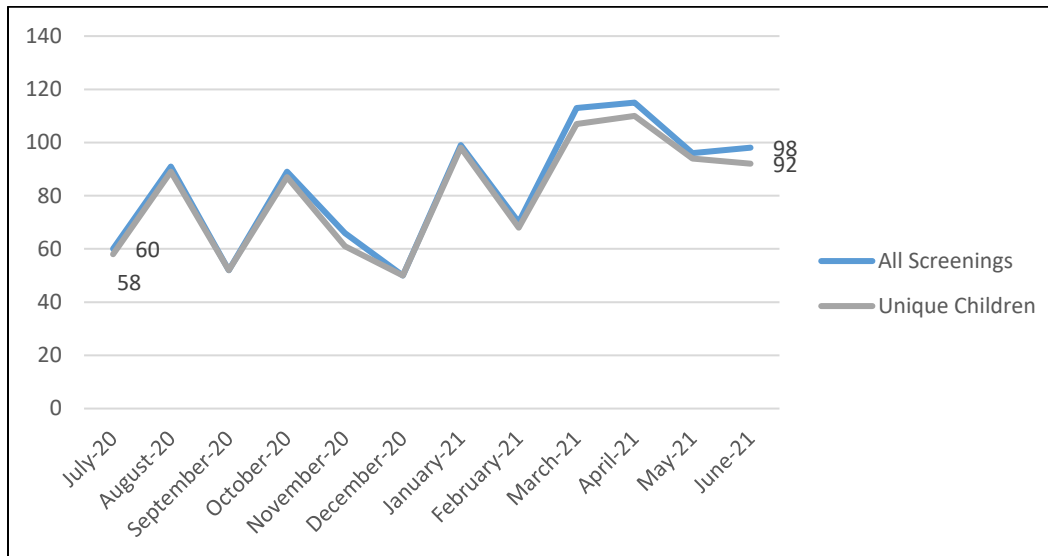
Figure 4: Medical Chart Review Summary

	Screened		Not Screened		
	n	%	n	%	n Total
0 – 5 years old	264	70.2%	112	29.8%	376
6 – 8 years old	84	80.8%	20	19.2%	104
9 – 18 years old	271	90.3%	29	9.7%	300
19 – 20 years old	10	90.9%	1	9.1%	11
Total	629	79.5%	162	20.5%	791

Owing to limited data and data-quality issues, screening data for children involved in YS and CPS are not included in this report. Retraining of staff and refinements to the data-collection process are underway, and data is anticipated for future reports. As mentioned above, data is not available for screening of children involved in Probation.

Figure 5 below captures screening for children in the custody of the BJS. Much of the review period was impacted by the pandemic; therefore, fewer screenings were conducted throughout the period although an increase was noted in the second half. For the first half of the review period, an average of 68 screenings were completed per month while in the second half, screenings increased to an average of 98.5 per month. As the pandemic becomes less of an impact, a further increase in screenings from BJS is expected.

Figure 5: BJS MAYSI-2 Screenings, July 2020 – June 2021



5.3 Provider Capacity/Statewide Coverage

To increase the number of primary care providers completing an EPSDT screen with mental health check, outreach to primary care providers about the Assessment Pathway started on November 8, 2021. From November 8 to December 31, 2021, 73 clinic sites were provided information. Distribution of educational materials and discussion of mental health screening has occurred at 214 of the 659 clinic sites. Outreach and education to clinic sites continues.

5.4 Strength, Opportunities, Barriers, and Recommendations

Data collection associated with screening is largely a manual process, which has created barriers to accessing and aggregating the data needed to calculate the indicators DHHR has identified. Given this challenge, DHHR is coordinating with the screening entities to determine whether the following additional indicators associated with screening can be captured:

- Number/proportion of screenings by screening entity.
- Number/proportion of positive screens (i.e., identified possible mental health need for referral to the Assessment Pathway).
- Number/proportion of referrals to the Assessment Pathway.
- Number/proportion of refusals of referral to the Assessment Pathway.

6.0 Pathway to Children’s Mental Health Services

West Virginia is phasing-in a Pathway to Children’s Mental Health Services (Assessment Pathway) to improve access to and quality of mental health services, especially for children with SED or serious mental illness (SMI). The Assessment Pathway intersects with multiple initiatives under the agreement, including:

- Screening
- CSED Waiver
- CMCR and stabilization teams
- Children’s Crisis and Referral Line
- West Virginia Wraparound
- BSS programs and services

The Assessment Pathway provides:

- A mechanism for assessment for children who may have a need for mental or behavioral health services.
- Appropriate linkage to services while the assessment process is being completed.
- Linkage to services when children are transitioning back to their home or community settings after an out-of-home or residential placement.
- Multiple avenues for a family or healthcare professional to request assessment.

Children who enter the Assessment Pathway will be referred to home and community-based services appropriate for their needs including CSED Waiver services for those who are eligible.

The Assessment Pathway is designed to:

- Streamline behavioral and mental health service entry for children and families.
- Allow children to be quickly connected to Wraparound services.
- Aid families with the CSED Waiver application process.

Because children can access the behavioral health service system via multiple avenues, DHHR is implementing the Assessment Pathway in multiple phases. DHHR completed a soft launch of the first phase October 31, 2021.

Phase 1 established a mechanism for entry into the pathway for:

- Requests directly from families and children via the Children’s Crisis and Referral Line.

- Call agents are asked to conduct Assessment Pathway screening with callers and assist them with entry into the pathway if the child screens as potentially eligible and consent to proceed is given.
- Referrals on behalf of families from primary care providers.
- Referrals on behalf of families from CMCR and stabilization teams.
- Connection to services during the CSED application process.
 - Direct application to the contracted vendor for the CSED Waiver occurred prior to October 31, 2021, but connection to Wraparound services were added in the initial phase of implementation.

Planning for the implementation of Phase 2 is currently underway with a primary focus on BSS staff beginning to use the Assessment Pathway to divert children from unnecessary out of home placement. Additionally, BSS is collaborating with the Managed Care Organization (MCO) on discharge planning for children currently placed in RMHTFs to determine if they can be transitioned out of residential placements into home and community-based settings and services.

6.1 Review Period, Data Sources and Limitations, Population Measured

Figure 6: Assessment Pathway Data Overview

	Data Review Period	Data Source	Limitations	Population Measured
Phase 1 Assessment Pathway	October 31, 2021 – January 11, 2022	BBH Assessment Pathway Tracking Portal	The portal is a stand-alone site that allows monitoring of progress but will need to be connected to other data via the data store	Number of referrals to BBH and the Children’s Crisis and Referral Line
CSED Assessment	For CSED data, see the CSED Waiver Enrollment and Services Section			

6.2 Review Summary

BBH implemented the Assessment Pathway Tracking Portal on January 1, 2022, as a means of data collection associated with the early stages of the Assessment Pathway. Referrals received prior to January 1, 2022, have been added to the portal. However, reconciliation processes are occurring to help ensure accurate reporting; therefore, the data included in this report are limited to referral numbers shown in Figure 7 below. The data are preliminary and subject to change as data are analyzed, potential training opportunities are identified, and reconciliation occurs. It is important to note these data are

from a limited period (October 31, 2021, to January 11, 2022), and it would be premature to draw any conclusions.

As shown in Figure 7 below, the majority of referrals are received via email. This is expected due to the established processes BBH providers use. In the future, BBH will enhance data collection to identify the source of referrals via email. While most of the referrals to date have come via email, as outreach to primary care providers expands, it is anticipated that referrals will increase via the Children’s Crisis and Referral Line.

Figure 7: Referrals to the BBH Inbox, October 31, 2021 - January 11, 2022

	CPS Submitted Application	Email	Incoming Call	Primary Care Provider via Electronic Referral	Unknown	Total
Submitted to BBH Directly	1	53	0	0	4	58
Children’s Crisis and Referral Line	0	0	1	1	0	2
Total	1	53	1	1	4	60

6.3 Provider Capacity/Statewide Coverage

Over the past two years, DHHR has emphasized building and expanding the capacity to provide statewide services. This is demonstrated in the enhancements in the number of providers and counties the programs serve. DHHR is working concurrently to enhance the capacity of providers to provide high-quality services. Training has been completed with the Children’s Crisis and Referral Line staff members, DHHR staff, and external partners to formalize processes, work toward implementation of the Assessment Pathway, and help ensure accuracy in data collection.

For the Assessment Pathway to be effective, statewide coverage of referring entities is needed as well as sufficient personnel at the provider level who accept and process referrals. In general, the initial phase of implementation focused on recruiting provider agencies to offer services. DHHR will continue and enhance activities that support providers and agencies being able to attract and retain adequate staffing. This document reports workforce numbers when applicable and available in each service section.

Currently, BBH has eight staff processing referrals, with an additional position approved that will also have duties related to the Assessment Pathway. Seven of these nine personnel are BBH employees, and two are at agencies that work on behalf of the BBH.

Section 12.0 Children’s Crisis and Referral Line and Section 7.0 CSED Waiver Enrollment and Services provide more information on provider capacity related to processing referrals and assessments. Section 5.0 Screening, Section 13.0 Children’s Mobile Crisis Response, and Section 8.0 Wraparound Facilitation offer additional information on provider capacity of entities that would refer children and link them to services.

6.4 Strengths, Opportunities, Barriers, and Recommendations

- The Assessment Pathway was designed to centralize and streamline entry to services for families. Families are provided assistance in the process to access covered long-term services, as well as other home and community-based services to meet needs while waiting for CSED Waiver determination.
- The Assessment Pathway offers multiple points of entry, which will allow greater identification of children in need.
- Regardless of CSED Waiver determination, a child is connected to services appropriate to their level of need; if denied for the CSED waiver, the child is referred to other home and community-based services.
- DHHR conducted training for all entities assisting with the Assessment Pathway and the associated data collection and tracking portal. The data collection tool will allow DHHR to more easily and often review data regarding the portal to promote continuous quality improvement of the services and coordination with children and families.
- Given the early stages of this project’s implementation, additional time and reviews will be needed to identify strengths and opportunities related to the Assessment Pathway. BBH should review data monthly for the first six months after implementation of the data portal (February – July 2022) to assess any immediate needs or strengths regarding timeliness of response, completeness of data, and any barriers for families or workforce. After that time, BBH should assess data at least quarterly.

7.0 Children with Serious Emotional Disorder (CSED) Waiver Enrollment and Services

West Virginia defines the term "children with a serious emotional disorder" as children with an SED who are ages 3 to 21 and who currently have 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 Diagnostic and Statistical Manual of Mental Disorders (DSM) (or International Classification of Disease [ICD] equivalent) that is current at the date of evaluation and results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and community activities.

DHHR implemented the CSED Waiver effective February 1, 2020. The CSED Waiver provides services that are additions to Medicaid State Plan coverage for members ages 3 to 21 who are enrolled in the CSED Waiver program. The CSED Waiver permits DHHR to provide an array of home and community-based services that enable children who would otherwise require institutionalization to remain in their homes and communities. It is anticipated this waiver will reduce the number of children placed both in-state and out-of-state in Psychiatric Residential Treatment Facilities (PRTFs) and other out-of-home placements and shorten the lengths of stay for children in placement who require acute care.

This waiver prioritizes children with SED who are:

- In PRTFs or other residential facilities either out-of-state or in-state.
- Other Medicaid-eligible children with SED who are at risk of institutionalization.

The CSED Waiver provides services to children with SED based upon the National Wraparound Initiative model. This model is strengths-based, meaning it uses the strengths of families and individuals as a starting point for growth and change, with a goal of helping waiver members and their families develop skills to cope with challenges and stabilize children in their homes. The model is also centered on the needs of the child and their family, in that the child experiencing challenging behaviors is central to the process and engaged in a plan to help develop the skills necessary to achieve stability and improve coping strategies, ideally enabling the child to achieve their personal goals.

The following services are available under the CSED Waiver:

- Wraparound Facilitation
- Mobile Crisis Response
- Independent Living/Skills Building
- In-Home Family Support
- Job Development
- Individual Supportive Employment

- Specialized Therapy
- Assistive Equipment
- Community Transition
- In-Home Family Therapy
- In-Home and Out-of-Home Respite Care
- Peer Parent Support
- Non-Medical Transportation

DHHR contracts with Kepro, an ASO, to address program eligibility and enrollment. DHHR contracts with Aetna Mountain Health Promise, an MCO, responsible for CSED service authorization and utilization management.

7.1 Review Period, Data Sources and Limitations, Population Measured

The period reviewed is July 2020 through June 2021. CSED Waiver enrollment data are sourced from Kepro data systems. CSED service use is sourced from DW/DSS paid claims for services rendered July 2020 through June 2021 and paid through September 2021. Because West Virginia Medicaid providers have up to 12 months from the date of service to submit claims, results for the more recent months in the analysis period will likely change over time as providers submit remaining claims.

The population served includes children with an SED who are ages 3 to 21 and who currently have 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 DSM (or ICD equivalent) that is current at the date of evaluation and results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities.

7.2 Review Summary

For the review period (July 2020 – June 2021), Kepro reports the following for the CSED Waiver (reference Figure 8):

- 361 applications received
- 198 (54.8%) applications approved
- 70 (19.4%) applications denied
- 93 (25.8%) applications pending

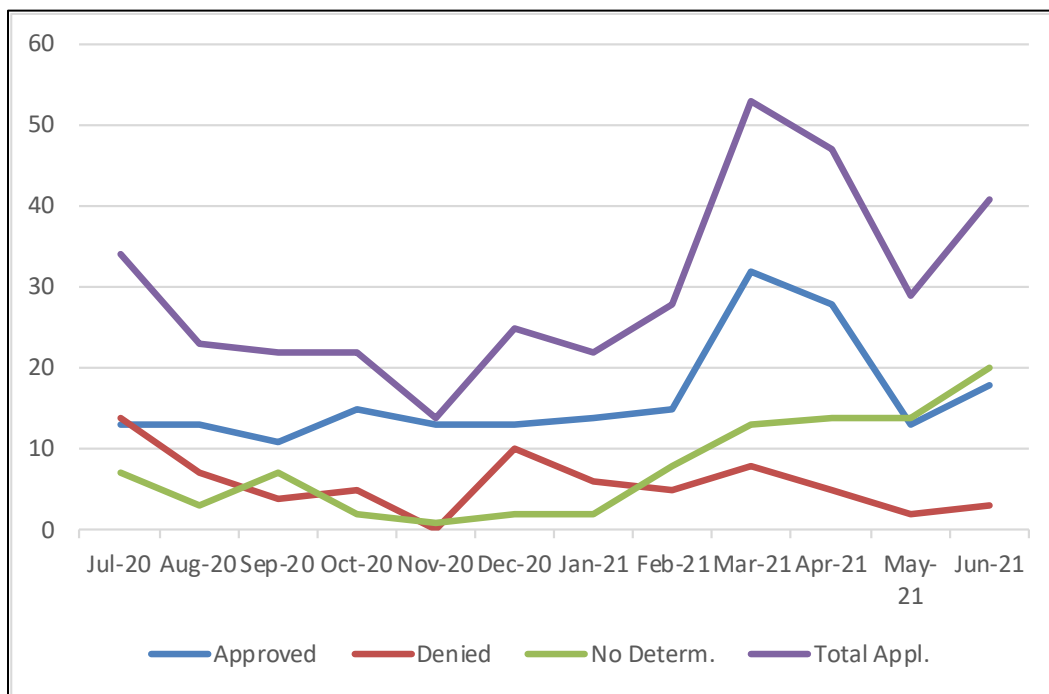
In the latter half of the review period, applications increased. As of the writing of this report, a detailed breakdown of the reasons for denials and non-determinations is unavailable. In general, denials are primarily due to lack of an eligible Child and Adolescent Functional Assessment Scale (CAFAS) score, Preschool and Early Childhood Functional Assessment Scale (PECFAS) score, Basic Assessment System

for Children (BASC) score or lack of an eligible diagnosis. In a few cases, denials were based on the family’s request to pursue the Intellectual and Developmental Disabilities Waiver rather than the CSED Waiver after starting the application process.

Reasons for pending applications included the following: lack of response from family, repeated no calls/no shows for appointments, and challenges with families completing the process to select an Independent Evaluator. In limited instances, pending cases were closed based on the children moving out of state or the family no longer being interested in pursuing the services. Based on the high level of pending cases, DHHR made changes to the waiver effective July 2021, including Kepro assisting families with completing the selection of an Independent Evaluator. The review of application data was also used to inform future data collection to be requested of Kepro in order to provide more clarity to assist DHHR in addressing any barriers to accessing the CSED Waiver.

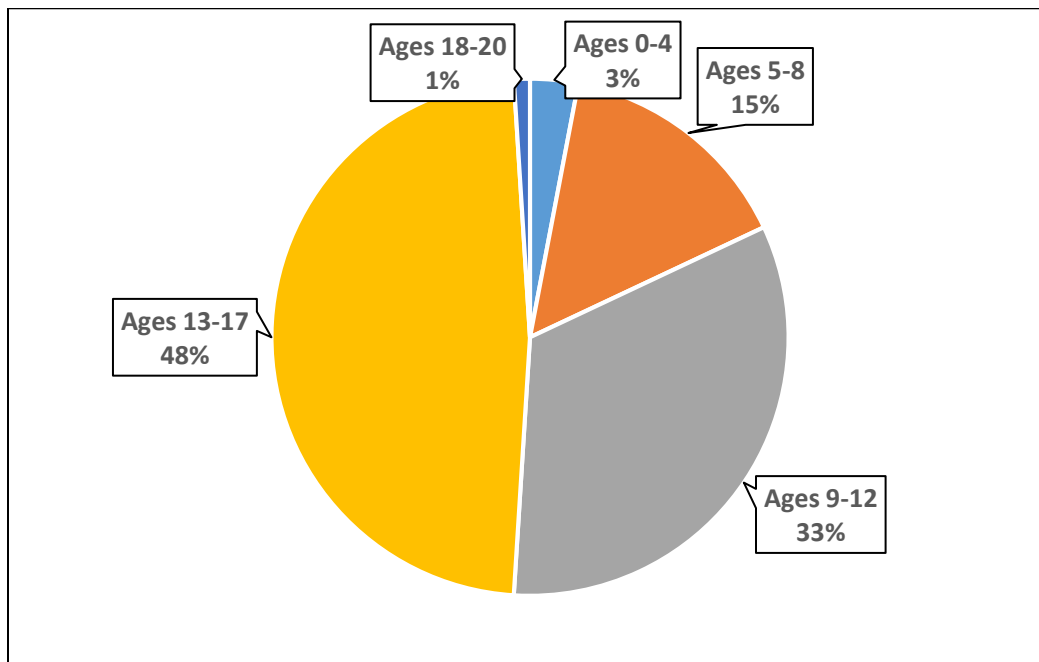
Of note, the COVID-19 pandemic affects service use and these initial CSED Waiver service utilization data. Home and community-based services are traditionally rendered in-person. The pandemic has reduced the prevalence of in-person services and has made some individuals and families more hesitant to seek care. Ongoing monitoring and reporting will assess the continued effects of the pandemic and the behavior changes resultant from years of living under the influence of COVID-19.

Figure 8: CSED Waiver Applications by Month, July 2020 – June 2021



Of CSED Waiver applicants, 48% were children ages 13 to 17, followed by 33% of children ages 9 to 12.

Figure 9: CSED Waiver Applications by Age Group, July 2020 – June 2021



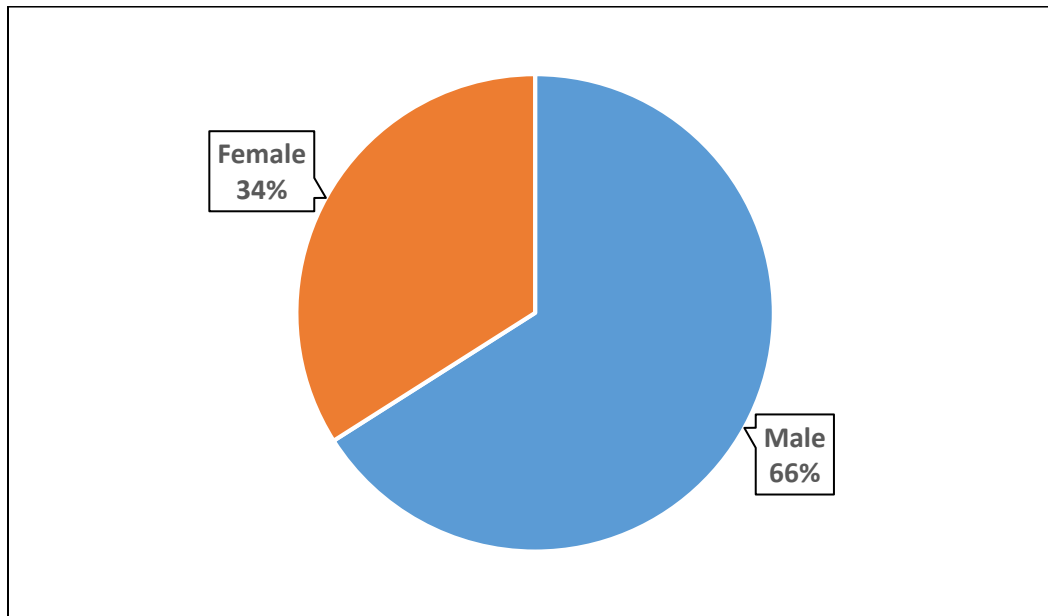
The timeline from receipt of application to eligibility determination was an average of 68.3 days. One of DHHR’s goals is timely access to services. In an effort to improve timeliness, DHHR made changes to the CSED Waiver process, which were implemented in July 2021, including expanding the pool of evaluators for the initial eligibility assessment and streamlining the eligibility process. Subsequent to these changes, the average time from receipt of application to eligibility determination reduced by more than half—to an average of 29 days (based on data from July through early November 2021).

Per DW/DSS paid claims for services rendered July 2020 through June 2021 and paid through September 2021, 138 children accessed CSED Waiver services. One hundred six children received independent evaluations for the CSED Waiver but did not access any other waiver services during the review period. The reasons for completing an evaluation but not accessing services may include the following: timing issues associated with billing for services rendered, children who were evaluated and found ineligible for the waiver, those still pending, or families choosing to pause services due to concerns related to the pandemic. Over time, DHHR anticipates being able to collect and analyze the data at a more granular level to better understand any barriers to access services.

Waiver services are predominantly used by male children by almost 2 to 1 compared to female children (Figure 10).

Figure 10: CSEDW Waiver Services Utilization by Gender, July 2020 – June 2021

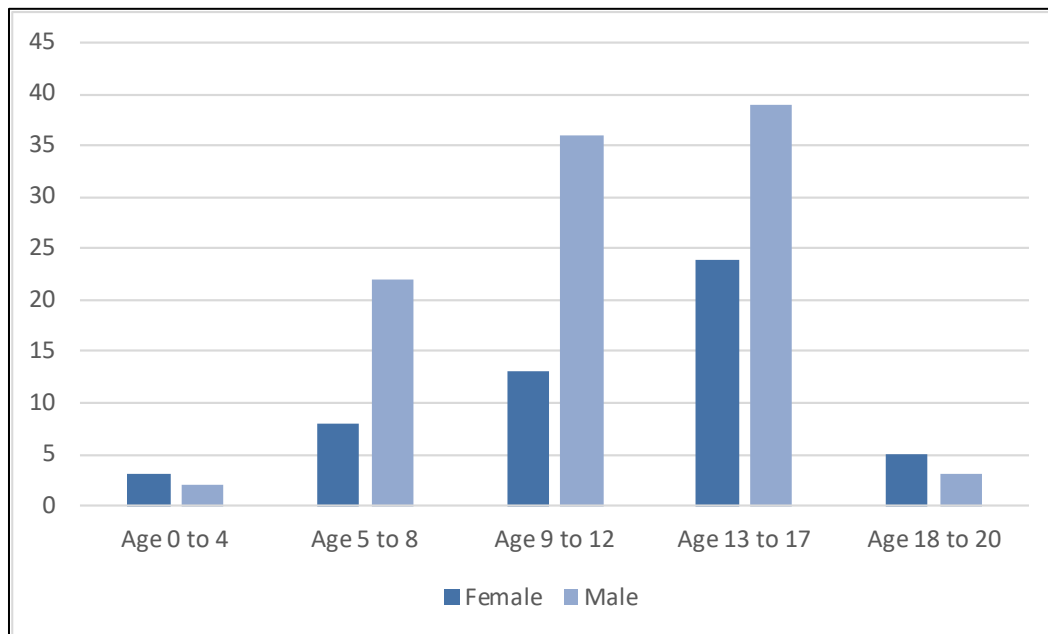
(Excluding Independent Evaluations)



Age demographics for children accessing CSED Waiver services are as follows: 45.7% ages 13 – 17, 35.5% ages 9 – 12, followed by 21.7% ages 5 – 8. The 9 – 17 age demographic aligns with the population of children most frequently accessing RMHTF services, which may indicate the CSED Waiver is reaching the right population of children to prevent institutionalization.

Figure 11: Number of Children Accessing CSEDW Services by Age Group and Gender, July 2020 – June 2021

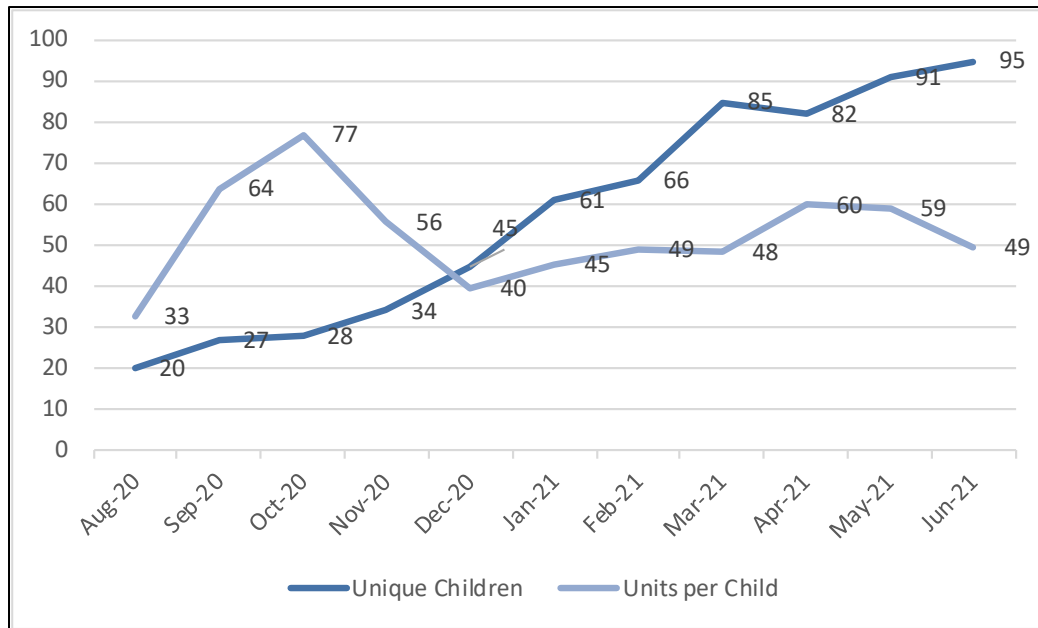
(Excluding Independent Evaluations)



The number of children accessing services has continued to increase over time while the units of service per children has remained relatively consistent,³ as shown in Figure 12, below.

Figure 12: CSEDW Service Utilization, July 2020 – June 2021

(Excluding Independent Evaluations)



³ The graph truncates the July 2020 data because the July 2020 units-per-user results are skewed by a clearly inaccurate claim record reporting an implausibly large number of units of service.

A summary of CSEDW services used during the reporting period is captured in Figure 13 below:

Figure 13: CSEDW Service Utilization by Service Type, July 2020 – June 2021

July 2020-June 2021 Totals	Units	Unique	Units per
Service Description	Provided	Children	Child
CSEDW Assistive equipment	973	4	243
CSEDW Wraparound Facilitation	7920	118	67
CSEDW Community Transition	2370	1	2370
CSEDW In-home family Support	7960	75	106
CSEDW In-home family Therapy	12024	105	115
CSEDW Mobile response	192	18	11
CSEDW Peer parent support	524	13	40
CSEDW Respite (in home)	672	9	75
CSEDW Respite (out of home)	686	7	98
CSEDW Independent Evaluation	181	178	1
CSEDW Spec Therapy	297	1	297
CSEDW Supported employment, individual	8	1	8
CSEDW Transport	2205	16	138
All CSEDW Services	36012	244	148
		138	<--Total Children excluding CSEDW Independent Evaluations

The services most used during the reporting period include: In-Home Family Therapy (12,024 units), In-Home Family Support (7,960 units), followed by Wraparound Facilitation (7,920 units). These services are particularly helpful in supporting families while assisting children to remain at home. Respite use, although low, may be occurring in other capacities. Wraparound teams encourage natural supports within families and communities to assist with respite services. In these instances, respite is not reimbursed and would not be captured within claims data. Need for paid respite services will continue to be assessed as more data become available and trends become established across programs. Given the importance of respite in allowing children to remain in their family home and reduce the risk of out-of-home placement, additional focus may be needed on outreach and education regarding the availability of respite services under the waiver.

The charts (reference Figures 14, 15, and 16) below show the trends for the most-used services, including In-Home Family Therapy, In-Home Family Supports, and Wraparound Facilitation, for the period under review. All of these services show an increase in the number of children accessing these services over the review period, which is a positive sign, given the goal of increasing usage of home and community-based services to reduce the risk of residential placement. Additionally, the average number of units of service accessed by each child throughout the reporting period remained steady even with the increase in demand indicating adequate provider capacity.

Figure 14: CSEDW In-Home Family Therapy Monthly Utilization, July 2020 – June 2021

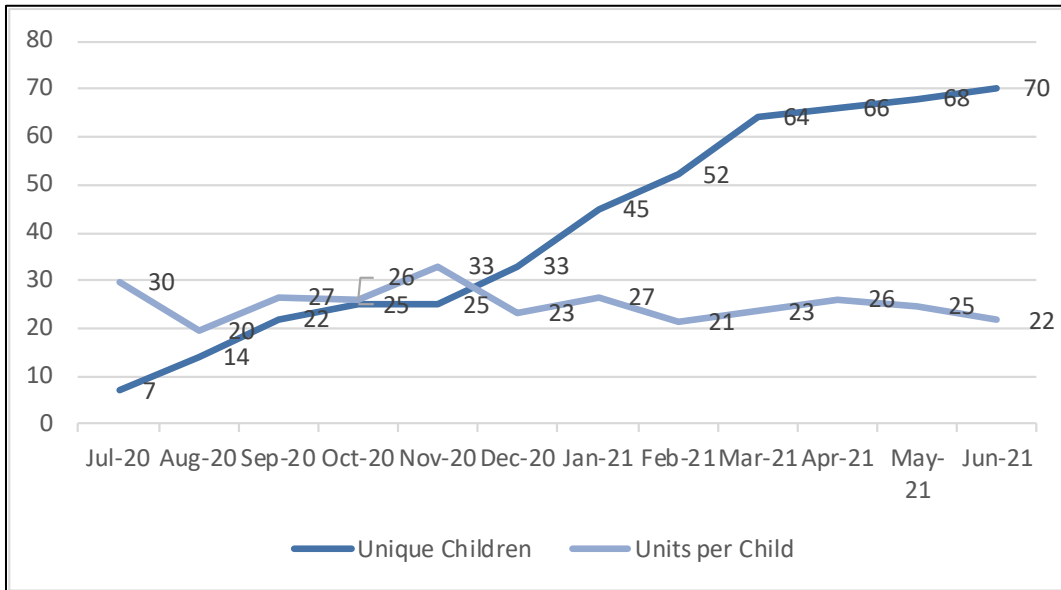


Figure 15: CSEDW In-Home Family Support Monthly Utilization, July 2020 – June 2021

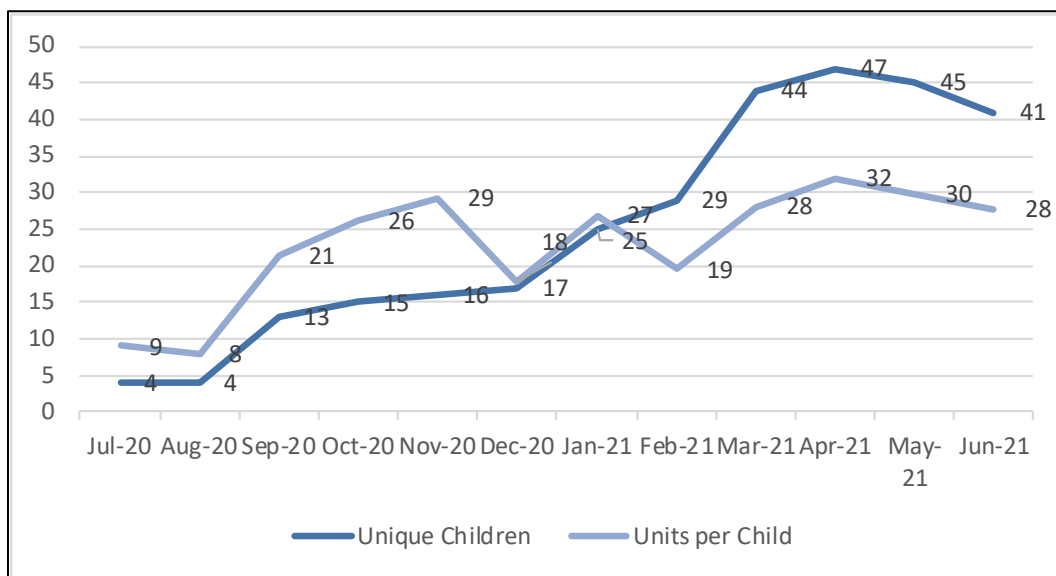
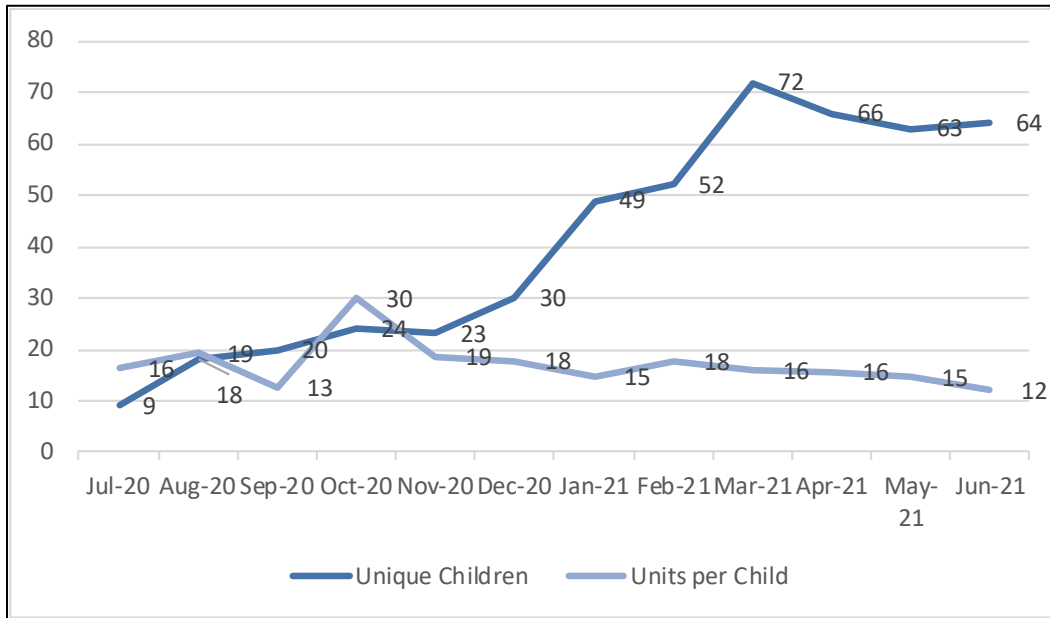


Figure 16: CSEDW Wraparound Facilitation Monthly Utilization, July 2020 – June 2021



The average number of days from a CSED Waiver eligibility determination to the first provision of CSED Wraparound Facilitation was 57 days. The median was 42 days, meaning that half of members with Wraparound Facilitation services received their first service 42 days or less after their eligibility determination and half received their first service more than 42 days after their eligibility determination. One quarter of children received their first service within 22 days.

7.3 Provider Capacity/Statewide Coverage

There are 22 providers currently contracted with the MCO to provide CSED Waiver services across West Virginia. The MCO is offering monetary incentives to providers in an effort to enhance the provider network, given the anticipated continued increase in demand for waiver services as the Assessment Pathway is more fully implemented. Twelve providers are actively providing services to children. The remaining 10 approved providers have struggled with staffing challenges due to the pandemic as well as national labor shortages. Providers are continuing recruiting efforts in a difficult labor market and report a lack of applicants.

Other efforts by DHHR to expand the CSED Waiver provider network include the following:

- Effective July 2021, BBH and Safe at Home⁴ provider contracts were updated to require these providers to become CSED Waiver providers.
- Effective July 1, 2021, DHHR implemented temporary rate increases for some CSED Waiver services.
- DHHR expanded the list of eligible degree types for non-licensed clinicians for two CSED Waiver services to expand the available workforce.

Provider capacity and waiver service utilization trends will continue be monitored over time to help ensure an adequate provider network.

7.4 Strength, Opportunities, Barriers, and Recommendations

CSED Waiver services are targeting the right population of children for support in their homes and communities and to decrease or prevent institutionalization. More time is needed to continue to monitor the effectiveness of the enrollment process and any barriers that may exist as well as trends in service utilization and the impacts on placement in residential settings. BBH is working closely with families and Kepro to improve efficiencies in the waiver application process and make access easier for families.

Recommendations:

- Follow up with Kepro to request the following additional child-level data collection to be reported monthly to DHHR:
 - Reason for denial
 - Reason for non-determination
 - Dates of all ongoing child/family contact attempts

⁴ Safe at Home is a program for children served by the child welfare agency using a wraparound-like model. This program is focused on the safety, welfare, and permanency for the child.

- Dates of referrals to other programs/services broken out by type of programs/services (e.g., referral to Safe at Home, referral to BBH Children's Mental Health Wraparound)
- CAFAS/PECFAS scores
- Gender, race/ethnicity, and diagnosis information for each child
- Gain an understanding of the areas impacting the timeline to access services and make needed process changes to reduce this timeline.
- Continue monitoring data over time to identify strengths and opportunities for improvement associated with the CSED Waiver application and enrollment process.
- Continue monitoring service utilization trends and impact on residential placements.

8.0 Wraparound Facilitation

West Virginia offers Wraparound services to children with mental health disorders; these services can currently be accessed through the West Virginia Wraparound program provided by:

- BBH: Children’s Mental Health Wraparound
- BMS: CSED Waiver Wraparound

DHHR has been working across bureaus to improve access and availability of community-based services for children and children with SED or SMI. To make navigating West Virginia’s system of care easier for families and reduce the reliance on residential placement or court involvement to receive services, DHHR redesigned its Wraparound programs so that children with SED or SMI, as well as all families and children needing community-based behavioral health services, receive the most appropriate services to meet their needs.

The goals across DHHR agencies are:

- To help children and families thrive in their homes, schools, and communities.
- To implement a seamless system of care that includes statewide Wraparound services available through a “no wrong door” approach.
- To provide consistently trained Wraparound facilitators and high-fidelity Wraparound services.
- To reduce the number of children removed from their homes due to an SED or SMI.
- To provide increased quality of life as evidenced in school, housing, interpersonal relationships, and employment stability.

8.1 Review Period, Data Sources and Limitations, Population Measured

As DHHR aligns services to meet the National Wraparound Initiatives model across the agencies, efforts are underway to enhance data collection and upgrade systems to allow interconnectivity of data sets across DHHR for record-level data through the data store. DHHR has also contracted with Marshall University to assess fidelity, and WVU to provide an overall evaluation of the children’s home and community-based services system. DHHR will incorporate data shared from those collaborations in future reports as the data become available. A major accomplishment over the past year was the implementation of the BBH System of Care Epi Info Interface that captures more service-level data and identified data that will result in enhanced reporting for subsequent reports.

Figure 17: Wraparound Facilitation Data Overview

West Virginia Wraparound DHHR Provider	Data Review Period	Data Source	Limitations	Population Measured
BBH Children’s Mental Health Wraparound	July 1, 2020 – June 30, 2021	BBH Grant Reporting	Prior to October 1, 2021, reporting was a combination of de-identified and aggregated data, which prohibited the ability to report unique numbers served across programs.	Children ages 0 – 21 served by the program who meet the following criteria: <ul style="list-style-type: none"> • Have a mental health or co-occurring diagnoses that substantially interfere with or limit their functioning in family, school, or community activities; • Are at risk of placement, or are currently placed in a PRTF or an acute-care psychiatric hospital, and cannot return home without extra support, linkage, and services provided by Wraparound; and • Are emancipated or in the legal custody of their parent or caregiver.
CSED Waiver	See CSED Waiver Enrollment and Services section for data.			

8.2 Review Summary

As the CQI processes continue to be implemented, the BBH anticipates refinement of indicators. A goal of this first report is to establish baseline quantities of children and services, as well as a baseline profile of who is receiving services and where services are occurring. As reporting becomes more robust and the data store continues to grow, it is anticipated that indicators will also evolve to include more outcome data.

After an initial pilot phase, the BBH released a competitive award process for Children’s Mental Health Wraparound services, with a planned phased implementation of BBH Regions 1, 2, and 3 for July 1, 2019, and Regions 4, 5, and 6 for October 1, 2019. BBH now has statewide Wraparound coverage.

Figure 18: BBH Children’s Mental Health Wraparound Summary, July 2020 – June 2021

	Children Served	Total Services	Providers
BBH Children’s Mental Health Wraparound	310	8,516	5

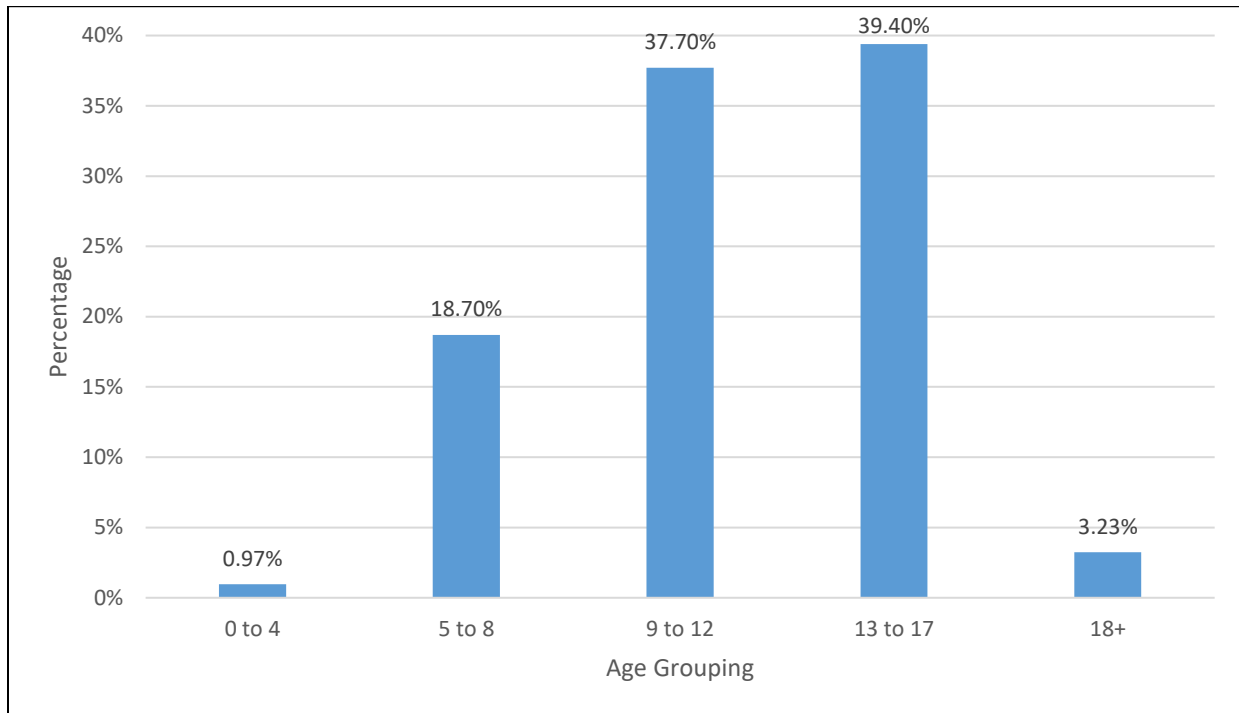
For this first report, data was analyzed to ascertain:

- Number of children served by county
- Age group of children served
- Gender of children served
- Race of children served
- Services provided

Children Served by County

Currently BBH Children’s Mental Health Wraparound has statewide coverage by five regional providers. Services were provided to individuals residing in 78% of counties (43) across the state. Counties with lower enrollment in Wraparound services tend to be lower-population counties (see Section 4.0 West Virginia’s Child Population for data interpretation considerations related to counts of children served and county population). As shown in Figure 19, counties with the highest number of children served included Berkeley (44), Kanawha (29), Wood (25), Raleigh (23), Monongalia (20), and Marion (20).

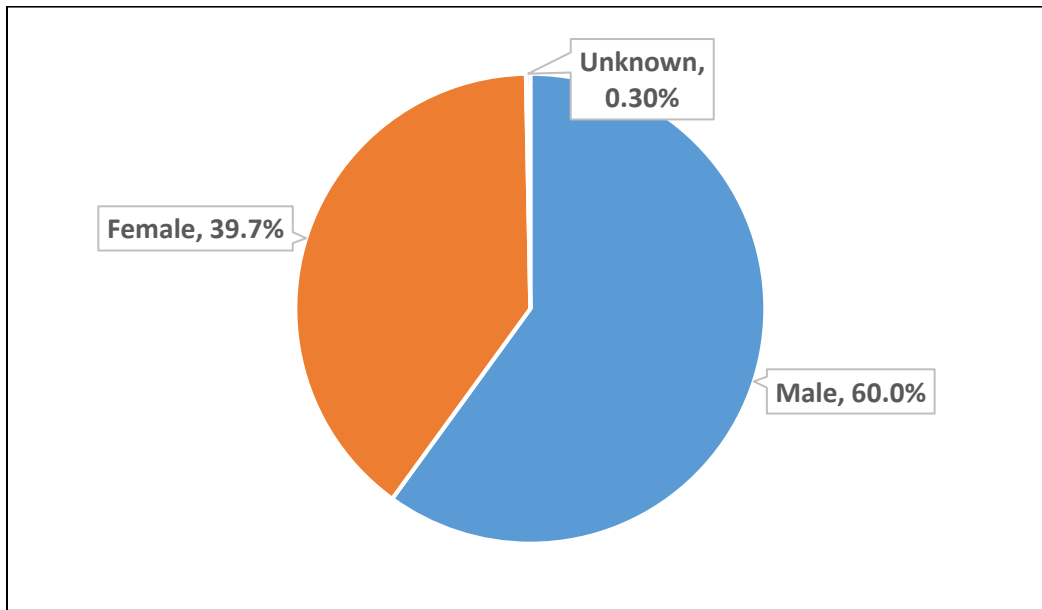
**Figure 20: Children Served via West Virginia’s Children’s Mental Health Wraparound
by Age Grouping, July 2020 – June 2021**



Gender of Children Served

More male children received services compared to female children. This is also comparable to children receiving RMHTF services, which may indicate the program is serving those most in need of these preventative services.

Figure 21: Children Served via West Virginia’s Children’s Mental Health Wraparound by Gender, July 2020 – June 2021

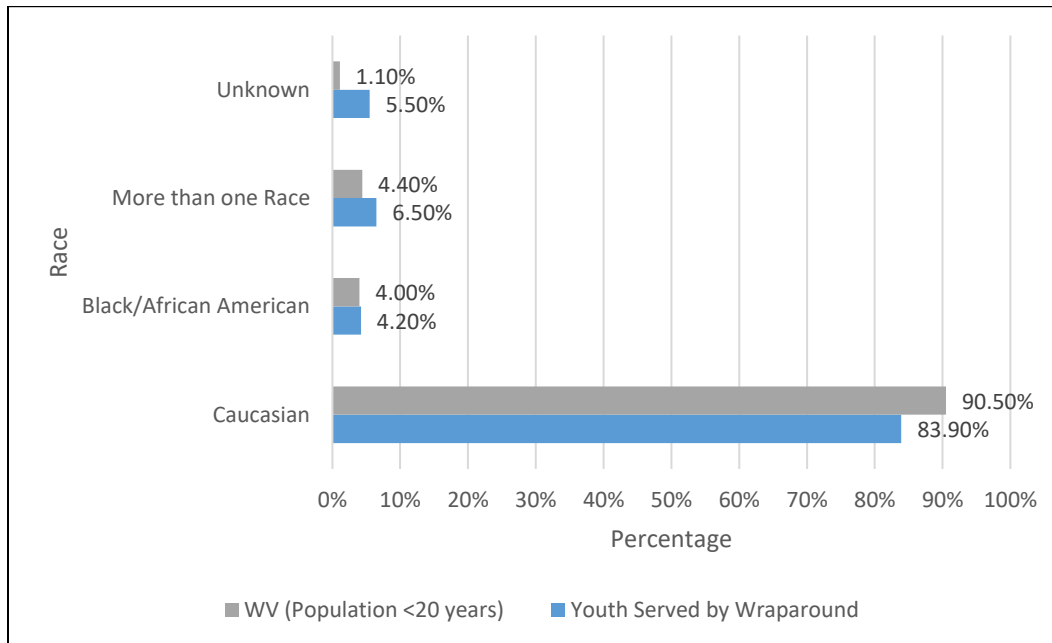


Race/Ethnicity of Children Served

Race and ethnicity data was comparable to West Virginia’s population less than 20 years of age. There was a slightly higher proportion of multiracial children served compared to the state population. The higher rate of unknown race is likely due to data reporting errors. The rate of children served identifying as Hispanic/Latino was 2.26%, which is comparable to the state population.

Caution is needed when interpreting race data, due to low numbers of individuals served. The state population has lower rates of racial and ethnic diversity. This introduces data challenges, which include instability of numbers (i.e., the next report could have significantly different numbers but it could actually only represent a few children). However, it is important to understand who is accessing services to identify which communities may benefit from increased, targeted outreach and education efforts.

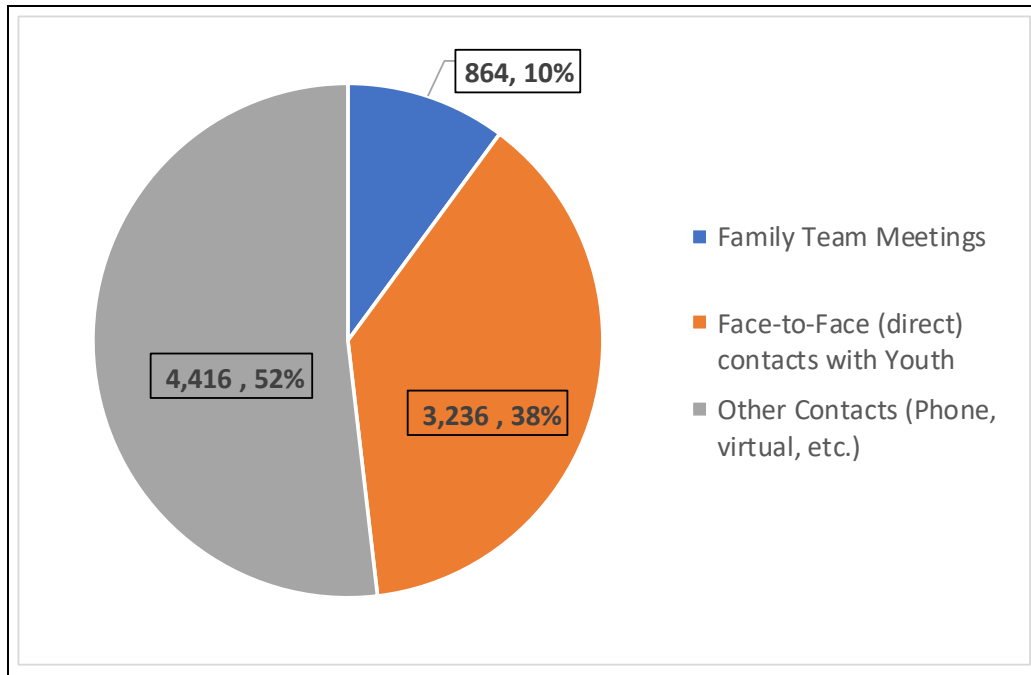
Figure 22: Percentage of Children Served by Race Compared to West Virginia Population Under Age 20



Services

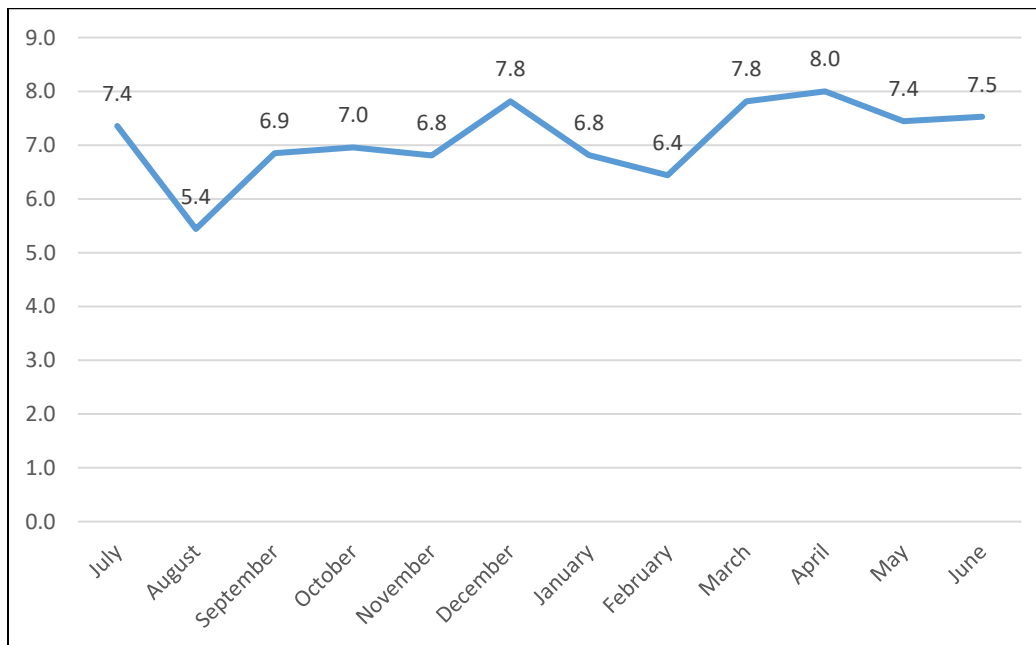
Services since the beginning of the pandemic have shifted to meet needs and safety concerns. Many families did not feel comfortable having face-to-face visits, which resulted in a heavier reliance on telehealth interactions, represented in the Other category in Figure 23. Data collection processes are being refined to better understand the services captured in the Other category.

Figure 23: BBH Wraparound Services by Type, July 2020 – June 2021



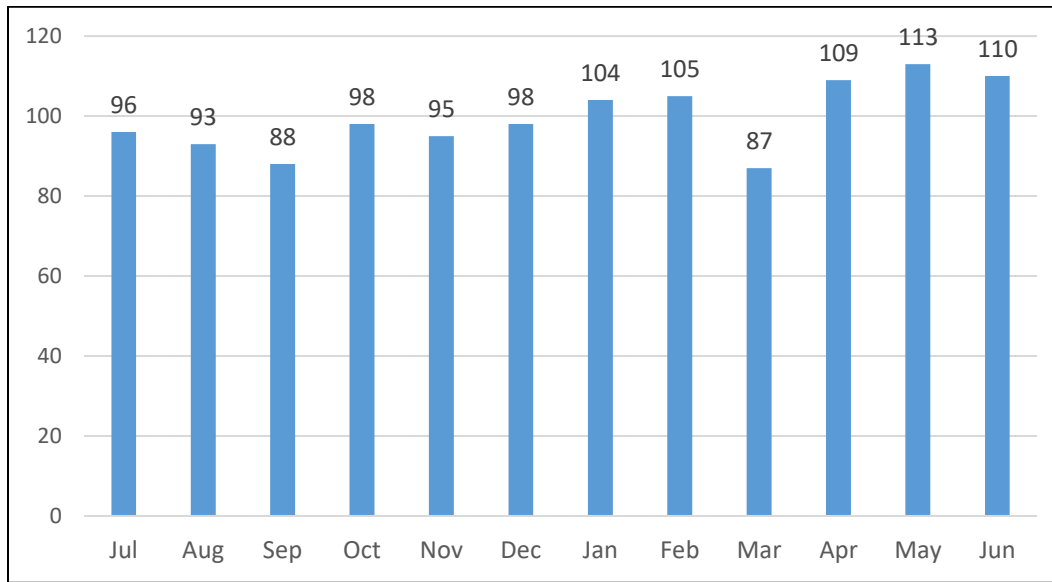
Children averaged seven interactions per month. Interaction and service types are expected to vary based on the child and family’s level of need and amount of time served through the programs, with a higher number of interactions for newer children.

Figure 24: Average Number of Interactions Monthly, July 2020 – June 2021



The number of children served per month also increased slightly during this period (average of 95 per month for the first six months compared to 105 for the last six months).

Figure 25: Children Served per Month, July 2020 – June 2021



While the increase in number of children served per month was slight, the average number of services per child did not decrease. This indicates adequate capacity for current numbers of children being served.

8.3 Provider Capacity/Statewide Coverage

With the implementation of the Assessment Pathway, connection with Wraparound services through multiple entry points will allow children and families expanded opportunities to more quickly connect to services, including those individuals in need of home and community-based services while applying for the CSED Waiver.

Workforce can overlap between the West Virginia Wraparound programs. The state is currently exploring the best way to report provider capacity in terms of number of personnel. A larger number of behavioral health providers should lead to better capacity numbers.

Figure 26: BBH Wraparound Program Capacity

	Current Personnel	Budgeted Personnel	Occupancy Rate
Region 1	2	2	100%
Region 2	1	2	50%
Region 3	3	3	100%
Region 4	4	4	100%
Region 5	2	3	67%
Region 6	2	3	67%
Total	14	17	82%

Work is underway to aggregate capacity for all West Virginia Wraparound service providers. A process for compiling CSED Waiver and Safe at Home agencies' Wraparound Facilitators and their associated caseloads is in development. The next step is to establish the process for including BBH Wraparound Facilitator capacity and caseloads in the report. Once the aggregated report and process is established, DHHR will be able to better assess and manage statewide capacity for Wraparound services by county and provider, which will assist in facilitating rapid assignment of a Wraparound Facilitator for children referred to the Assessment Pathway.

8.4 Strength, Opportunities, Barriers, and Recommendations

Despite unprecedented conditions brought forth by the pandemic, Wraparound providers have continued to provide services to help children stay in their homes and communities. The ability to conduct many of these services via phone or virtual communications has been a strength to the continuation of these important services. With nearly 80% of the counties in the state having a resident who receives services, there is broad reach in coverage across the state.

Recommendations:

- Work with the Children's Crisis and Referral Line to provide referrals to both the Assessment Pathway and Wraparound services.
- Review data from the Children's Crisis and Referral Line, Wraparound services, and the Assessment Pathway to determine opportunities for outreach, strengths, and needs.
- Continue to provide outreach to those in need of Wraparound services with targeted efforts toward communities of color.

9.0 Behavioral Support Services

PBS 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 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 children who are experiencing significant maladaptive behavioral challenges. PBS is an approach that is used widely including within BBH, BSS, BMS, and Department of Education programs and providers.

9.1 Review Period, Data Sources and Limitations, Population Measured

Figure 27: BBH PBS Data Overview

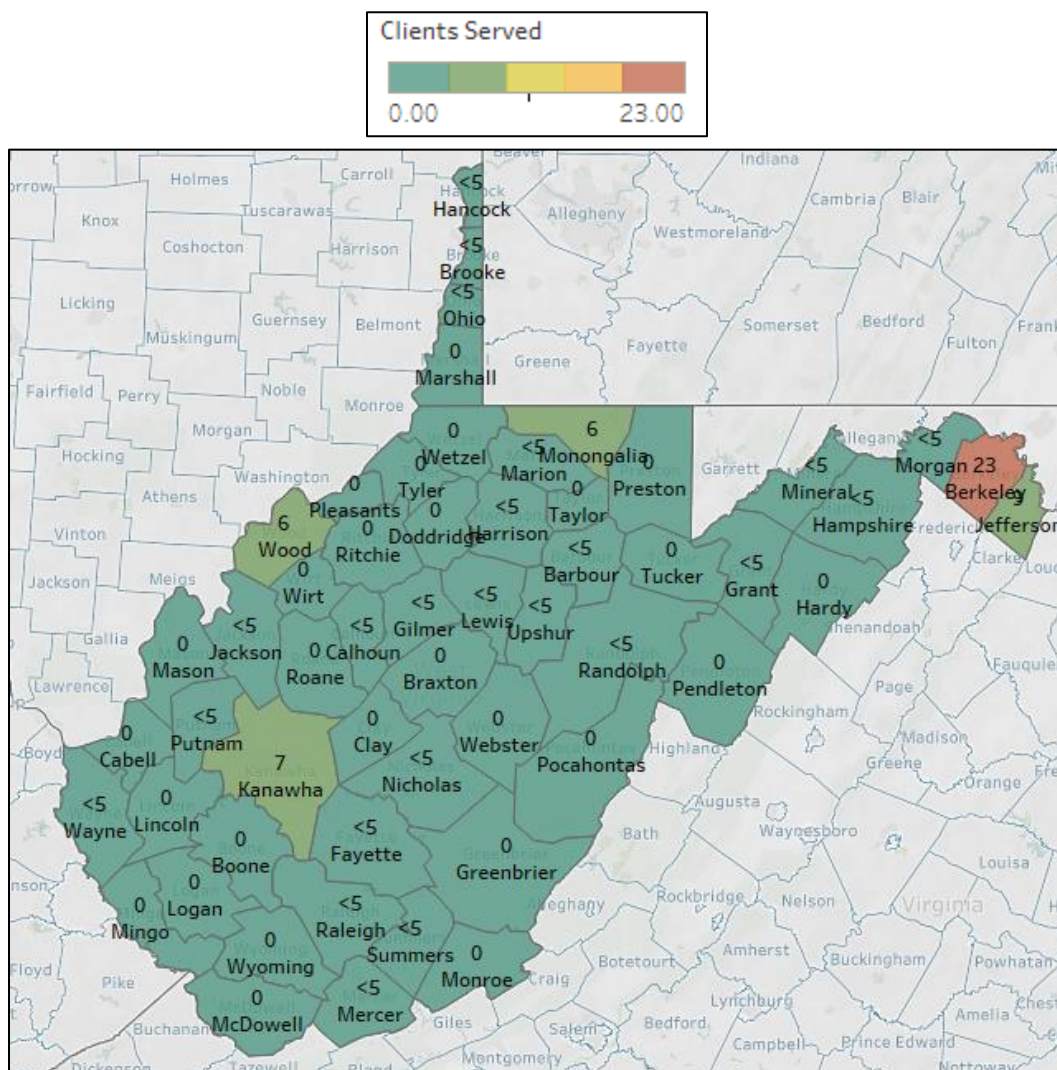
Data Review Period	Data Source	Limitations	Population Measured
July 1, 2020 – June 30, 2021	BBH Children's PBS Grant Reporting	<ul style="list-style-type: none"> • Prior to October 1, 2021, reporting was a combination of de-identified and aggregated data, which prohibited the ability to report unique numbers served across programs. • Includes only children served directly. 	<p>Children served directly through the BBH program.</p> <p>Services are provided to individuals with Intellectual and Developmental Disabilities and/or predefined mental health needs who are ages 0 – 21.</p>

In addition to the BBH Children's PBS program, services are also conducted through trained providers of BBH, BSS, BMS, and Department of Education programs. Data are only currently available for BBH direct services; however, BMS is working to implement a PBS modifier code that will allow PBS-related claims data to be captured for children receiving services through Medicaid. Given time needed to implement the modifier code (expected in July 2022) and standard delays for claims data, these data are not expected to be available for review until 2023.

9.2 Review Summary

Rural counties were less likely to have residents served. Although these counties are typically less populous, needs may still exist for residents of these counties. Interactions and caseload needs have increased for PBS direct services. To better understand geographic need, further assessment of additional PBS services via the BMS claims data, once available, will be helpful to assess the full scope of children reached through these strategies. As stated, one of the goals of this first report is to establish baseline numbers of children and services, as well as understand who are receiving services and where services are occurring. As reporting becomes more robust and the data store continues to grow, it is anticipated that indicators will also evolve to include more outcome data.

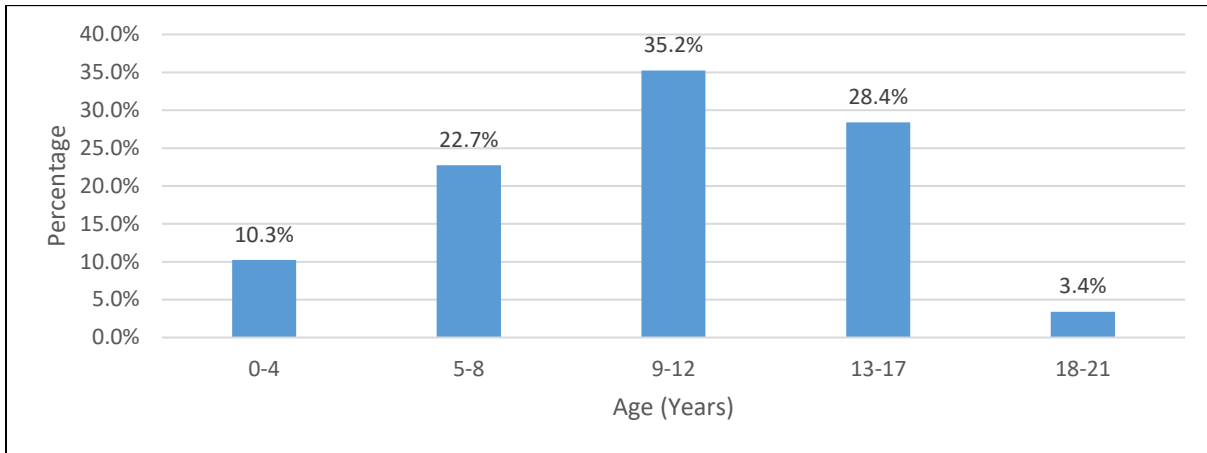
Figure 28: Children Receiving BBH PBS Services by County, July 2020 – June 2021



Child Demographics

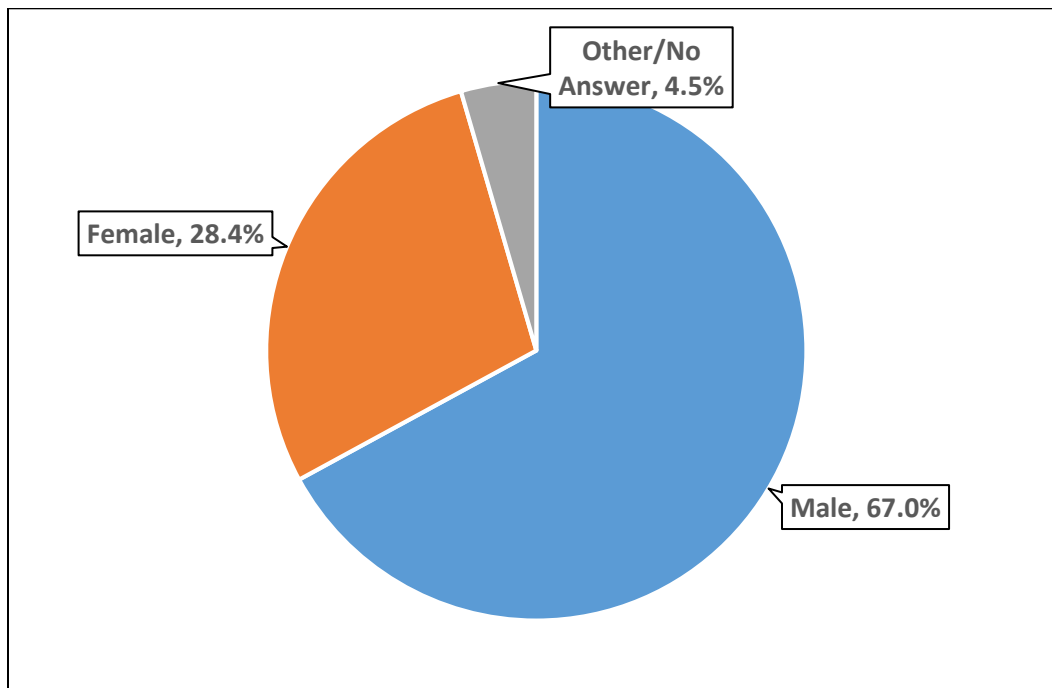
Over 85% of individuals served fall in the 5 – 17 age range, with 35% of individuals served falling in the 9 – 12 age range. The ages of individuals served trended younger compared with individuals served through RMHTFs, demonstrating a key prevention opportunity.

Figure 29: Individuals Receiving PBS Services by Age Group, July 2020 – June 2021



A greater proportion of males were served compared to females, similar as observed with individuals served through RMHTFs.

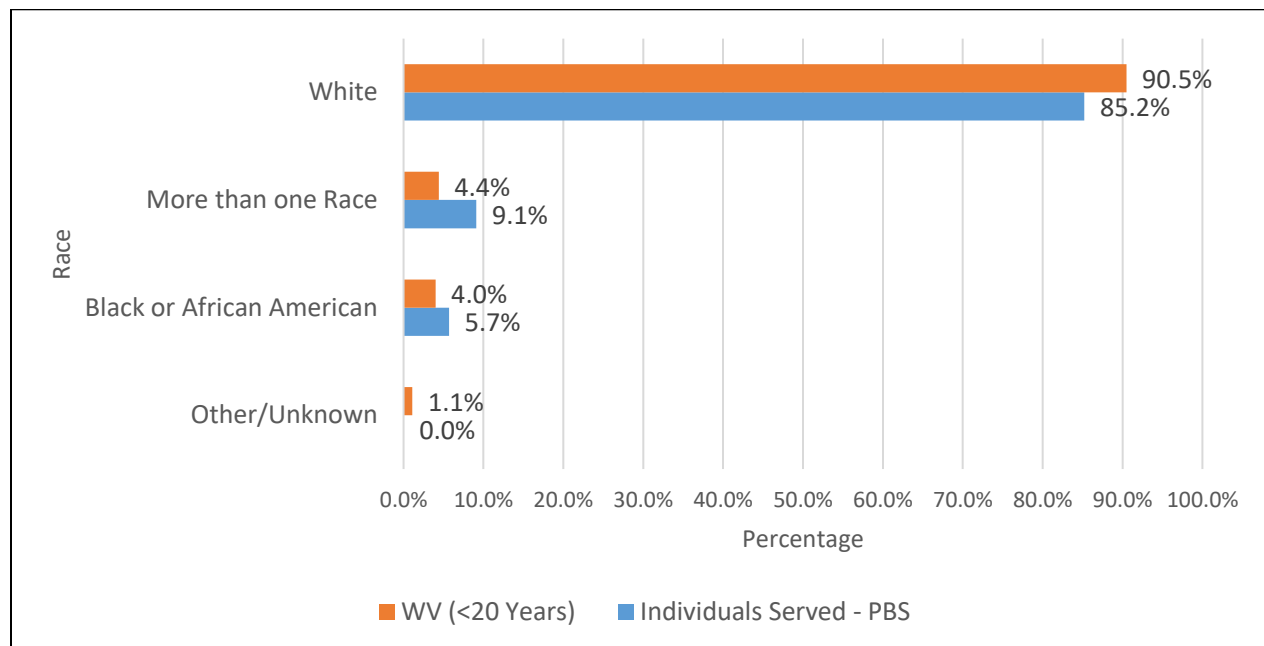
Figure 30: Individuals Receiving PBS Services by Gender, July 2020 – June 2021



Race/Ethnicity of Children Served

Based on comparisons of race data to the West Virginia population age less than 20, the PBS program served a greater proportion of people of color as compared to their representation in the population as a whole—approximately 15% of individuals served compared to 9.5% of the West Virginia population under 20. The small number served should be noted here, as this could be subject to fluctuation with very little change. Small numbers are common with race and ethnicity data reflecting West Virginia residents, as people of color historically maintain a very low percentage of the state’s overall population.

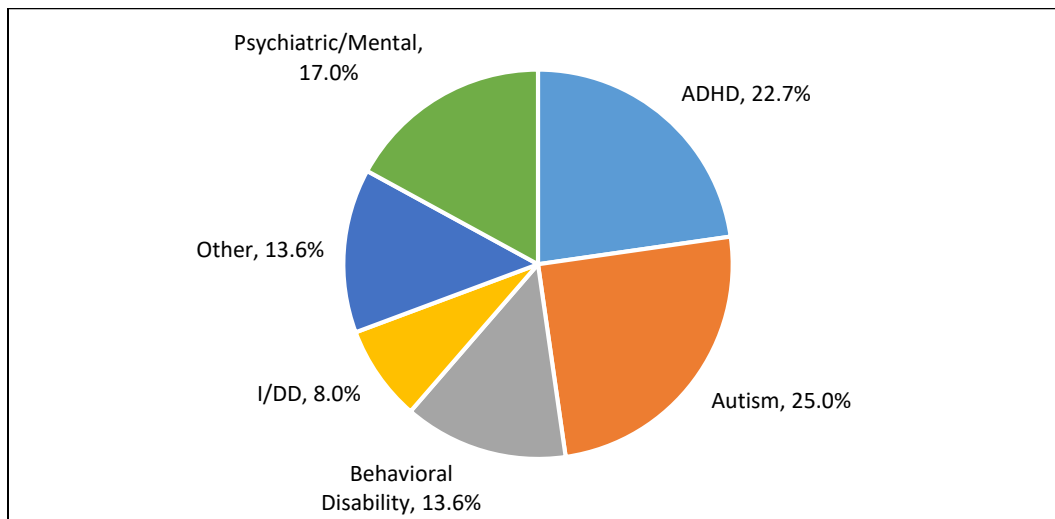
**Figure 31: Percentage of Individuals Served by Race Compared to State Population
Less than 20 Years, July 2020 – June 2021**



Diagnoses and Services

Of children served, 25% reported an autism diagnosis, about 23% of individuals served reported Attention Deficit Hyperactivity Disorder (ADHD), and 17% reported a psychiatric or mental health condition. Note, diagnoses are self- or caregiver-reported and individuals may not have a confirmed diagnosis, not know their diagnosis, or need referral for further evaluation.

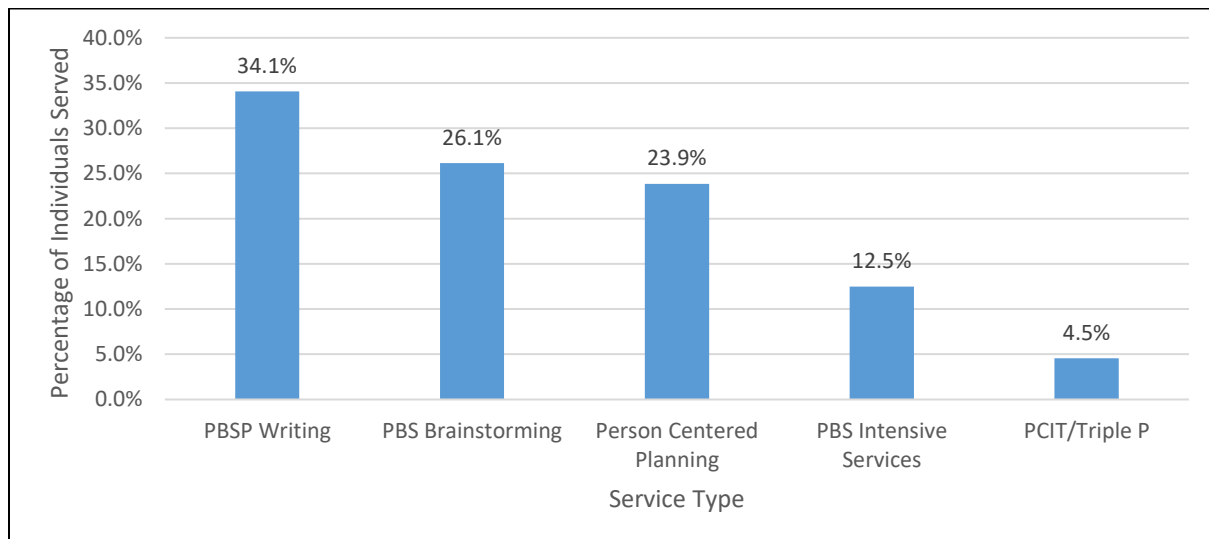
Figure 32: Reported Diagnoses for Individuals Receiving PBS Services, July 2020 – June 2021



Note: Other includes Developmental Delay, Traumatic Brain Injury, Epilepsy/Seizure Disorders, and Neurodevelopmental Disorders, along with other diagnoses. Categories are listed as recorded. I/DD excludes autism diagnoses as this is listed in a separate category.

The most common services provided to individuals were PBS Plan Writing (34%), Brainstorming—a service typically done with lower-need cases to provide ideas and support for families—(26%), and Person-Centered Planning (24%). Intensive services were provided to 13% of individuals, and parenting training (PCIT/Triple P) was provided to 4.5% of families.

Figure 33: PBS Services Provided, July 2020 – June 2021



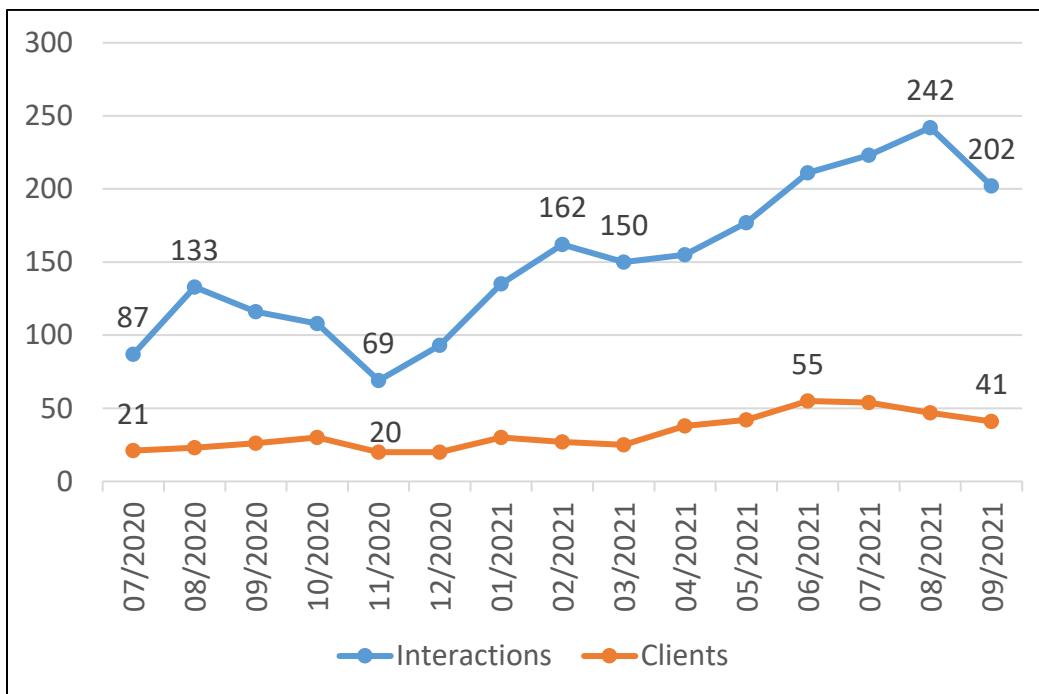
Note: Individuals may have received more than one service or reported more than one diagnosis resulting in totals equaling greater than 100%.

Children and Interactions Over Time

Given the pandemic there was an increased need for mental health services, and PBS referrals significantly increased. BBH responded by expanding PBS services in July 2021 due to the demand to help meet the needs of the children's mental health crisis. PBS staff have increased their caseloads and worked additional hours to meet the needs of children and families as additional staff are recruited. As of this writing, there is a waitlist of approximately 12 children for PBS services, but families have been prioritized based on need, and BBH meets regularly with the provider to troubleshoot workforce shortages and hiring barriers.

In the past year, the number of children served monthly has doubled, from 21 per month in July 2020 to 41 per month in June 2021. Similarly, the total child interactions monthly has increased, from 87 per month in July 2020 to 202 per month in June 2021. The average number of interactions per child remains fairly steady over the year, hovering between four and six interactions per child per month.

Figure 34: Children and Interactions, Monthly, July 2020 – June 2021



9.3 Provider Capacity/Statewide Coverage

BBH contracts with the WVU Center for Excellence in Disabilities to provide the following:

- Direct PBS services to high-acuity children.
- Training and consultation on PBS to agencies across the state with the goal of increasing the number of agencies providing PBS as part of their array of services in order to better support children with mental and behavioral health needs.

The BBH PBS program provides direct PBS services to children and works to build both workforce and systemic capacity for more agencies to serve children across the state. It is common practice for the BBH to have case consultation with trained providers to help support the efforts of these providers across the state.

The BBH PBS program receives referrals directly from other provider agencies across the state as well as other programs across the BBH System of Care, including Wraparound facilitators and CMCR and stabilization teams. To meet this demand, the BBH PBS program has eight full-time equivalent staff and three vacancies. BBH is actively focused on recruiting to fill current vacancies including strategies to address the challenges in hiring a curriculum developer.

Figure 35: BBH PBS Staffing

	Current Personnel	Budgeted Personnel	Occupancy Rate
Program Manager	1	1	100%
Program Assistant	1*	1	100%*
Curriculum Developer	0	1	0%
Behavior Specialists	6	8	75%

*Currently on long-term medical leave

9.4 Strength, Opportunities, Barriers, and Recommendations

PBS services allow children with behavioral health needs to receive individual and family supportive services. Children served include those with a range of diagnoses and levels of need. The BBH PBS program allows direct services and case consultation as a result of referrals from other organizations. A third of individuals served are 9 –12 years old and a quarter are 13 – 17, allowing diversion from more intensive out-of-home services. In addition to current data review, the implementation of a modifier code to expand capacity for data collection for Medicaid PBS data will help influence future planning and quality improvement from review of additional comprehensive services provided.

Recommendations:

- Monitor PBS data by month to assess continued needs and consult program staff to identify trends and potential reasons for changes in service utilization.
- Provide outreach to communities of color to meet needs and work toward overcoming stigma in seeking mental health services.
 - Steps have already been taken to reach out to the diversity, equity, and inclusion workgroup through the BPH to work to lessen disparities among populations in need.
- Further assess training provided to organizations in rural areas to identify whether needs are being met through direct or indirect services (training).

10.0 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.

ACT is a home and community-based service option for youth ages 18 – 21 to prevent unnecessary institutionalization. As part of the Assessment Pathway, youth 18 or older are offered the choice of ACT. Additionally, eligible youth exiting residential placement are offered the choice of ACT to help them remain in their home and community upon discharge.

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.

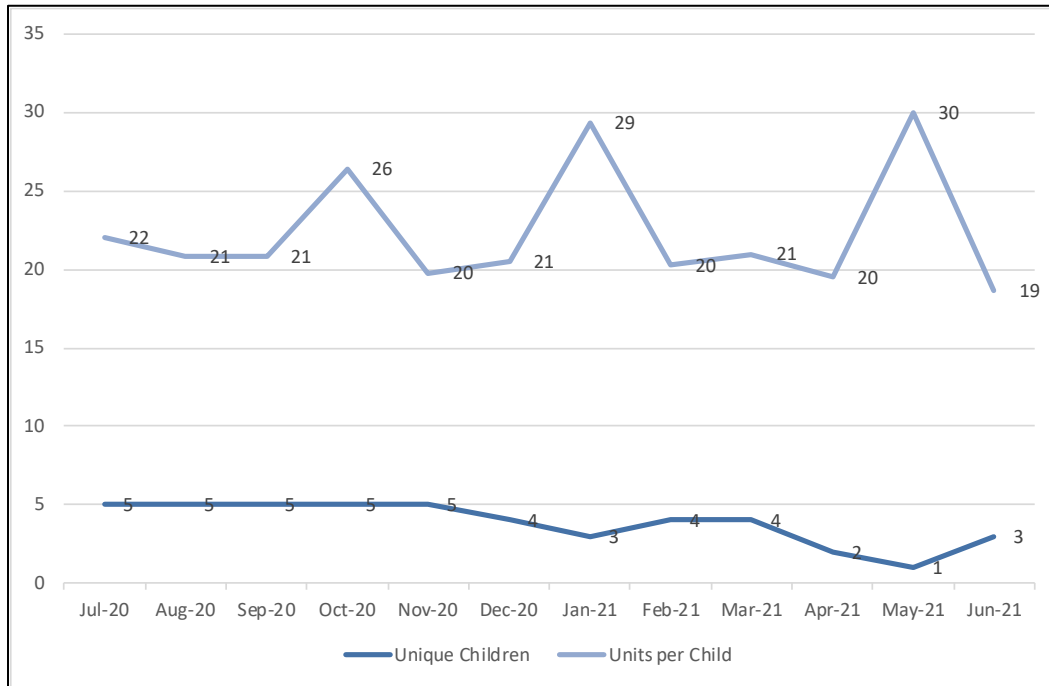
10.1 Review Period, Data Sources and Limitations, Population Measured

The period reviewed is July 2020 through June 2021. ACT enrollment and utilization data is sourced from the DW/DSS data warehouse of Medicaid and CHIP claims. 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. The population served includes Medicaid members 18 years and older, with no limitation on length of service.

10.2 Review Summary

For the review period, ACT enrollment remained low throughout the state. The pandemic created a challenge in enrollment and services as many youth either did not enroll or ended services due to not wanting ACT staff in their homes. Overall, an average of five youth per month received services with nine total enrollments for the year. Of those enrolled, 75% were male. Figure 36 below displays enrollment and the units of service per youth.

Figure 36: ACT Youth and Units per Youth by Month, July 2020 – June 2021



10.3 Provider Capacity/Statewide Coverage

DHHR has been working to increase ACT availability statewide. In November 2021, DHHR executed a start-up contract with Mountaineer Behavioral Health (Mountaineer) to develop an ACT team in the Eastern Panhandle. The target date for the staff to be hired and trained is May 31, 2022. DHHR anticipates that date may be extended due to the challenges with the pandemic. Once Mountaineer is fully operational, ACT services will be available statewide.

10.4 Strength, Opportunities, Barriers, and Recommendations

DHHR expects to have statewide ACT availability by summer 2022. Provider outreach that has been historically conducted via in-person meetings has been put on hold since March 2020 due to the pandemic. DHHR will resume in-person outreach meetings when it is deemed safe to do so.

The high number of interactions per member indicates this is a high-intensity program providing services to individuals who might otherwise have to live in a residential placement for needs to be met.

Additional efforts to increase enrollment include revision of the PRTF policy to include language that will require an ACT service staff meeting with eligible youth and their families prior to discharge. DHHR has ongoing communication with residential providers to help ensure ACT is included as an offered service for eligible participants as part of discharge planning.

11.0 Therapeutic Foster Care (Treatment Home)

West Virginia's Treatment Home program is a family-based, therapeutic, trauma-informed behavioral health intervention. Child placing agencies (CPAs) perform this service statewide. In partnership with CSED Waiver services, 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 strengthen the Treatment Home program through development of model standards that clearly define services and activities that support the Treatment Home parents, the child and the family of origin, and clarify the role of the CPAs' case managers.

11.1 Review Period, Data Sources and Limitations, Population Measured

No Treatment Home data were available during the period under review as the model is still in development. Data are anticipated to be available December 2022.

11.2 Review Summary

During the period under review, CPAs and stakeholders provided valuable consultation and feedback through various face-to-face and virtual engagements on the proposed model and associated performance indicators. The Therapeutic Foster Care workgroup conducted analysis regarding children receiving foster care under the current care model as well as children in RMHTFs to determine the appropriateness of current placement setting and necessary level of care. Using this information, the Therapeutic Foster Care workgroup continued to design the new Treatment Home model to help assure that children with SED can receive services in a family-like setting, ultimately diverting children from RMHTFs.

11.3 Provider Capacity/Statewide Coverage

The Treatment Home model was in development during the period under review. The initial phase-in implementation of the new model will begin in early summer 2022. The model will leverage current Therapeutic Foster Care providers and families that meet the new Treatment Home criteria to provide this service, which will allow statewide coverage.

11.4 Strength, Opportunities, Barriers, and Recommendations

DHHR continues to move forward with Treatment Home implementation. As the model has developed, DHHR has identified key performance indicators for the Treatment Home services. As performance data are collected, the information can be used for ongoing refinement of the Treatment Home model and will help DHHR understand any provider capacity needs.

As DHHR continues to develop this model, it will be critical to encourage support from the CPAs. DHHR will need to help ensure 1) alignment of the model with current licensing standards and expectations for CPAs and 2) transparency in decision-making so that the CPAs remain informed in a timely manner. Regular meetings or roundtables with CPAs to provide information and receive feedback can achieve this flow of communication. Finally, it will be important to support CPAs in recruiting and retaining families to serve as Treatment Home parents in this new model, as the model serves a specific population with a higher level of need that will require additional skills.

12.0 Children’s Crisis and Referral Line

The Children's Crisis and Referral Line operates statewide and 24 hours a day, 7 days a week serving children and young adults ages 0 – 21 who are in emotional distress or have a diagnosis of SED or SMI. The Children’s Crisis and Referral Line also serves families who are in crisis or seeking referrals to appropriate community-based behavioral health services and supports for children and young adults.

DHHR and BBH made significant efforts throughout the reporting period to implement the Children’s Crisis and Referral Line and address evolving data needs, using CQI processes to identify indicators needed to inform planning and quality assurance. The BBH implemented the Children’s Crisis and Referral Line into the existing Help4WV line in October 2020 to expand connection and referral opportunities for families and to provide a centralized entry point for individuals and families to connect with services and resources while simplifying system navigation.

Since the activation of the Children’s Crisis and Referral Line, DHHR has conducted outreach activities, including press releases and media campaigns. Additionally, BBH conducts monthly meetings with the Children’s Crisis and Referral Line provider to identify areas of needed refinement and technical assistance. Examples of outcomes of these touchpoints include reporting changes in May 2021 and additional trainings for Children’s Crisis and Referral Line staff, conducted in fall 2021, to help ensure consistency in call quality and data collection.

12.1 Review Period, Data Sources and Limitations, Population Measured

Figure 37: Children’s Crisis and Referral Line Data Overview

Data Review Period	Data Source	Limitations	Population Measured
July 1, 2020 – June 30, 2021, unless otherwise noted.	Help4WV – iCarol Call Reporting System	<ul style="list-style-type: none"> Children’s Crisis and Referral Line was implemented in conjunction with active Help4WV line October 2020. For this reporting period, some indicators changed, resulting in the inability to report on some measures for the entire period. The summary below lists the specific period for each indicator. Higher rates of incomplete data are expected for demographic information for this call line. When a family/person calls in crisis, it may not be prudent to collect all the desired data fields 	Children served directly through the Children’s Crisis and Referral Line. Services are provided to individuals and families with children 0 – 25 who are in emotional distress or with a diagnosis of an SED or SMI and their families who are in crisis or seeking referrals to related services.

Data Review Period	Data Source	Limitations	Population Measured
		<p>due to the urgent nature of the call or the need to establish a rapport quickly.</p> <ul style="list-style-type: none"> • “Calls” include texts and chats unless otherwise noted. 	

As noted above, the Children's Crisis and Referral Line officially launched services in October 2020. While the Help4WV call line was in place prior to this launch and allowed callers of any age to phone in, the dedicated Children's Crisis and Referral Line offers the added benefit of referral services for children in crisis and their families. Data for callers for the entire period, ages 0 – 25, were included in this review due to constraints of the data system. The data system has since been modified to collect exact ages rather than broader categories; future reports will limit ages to 0 – 21.

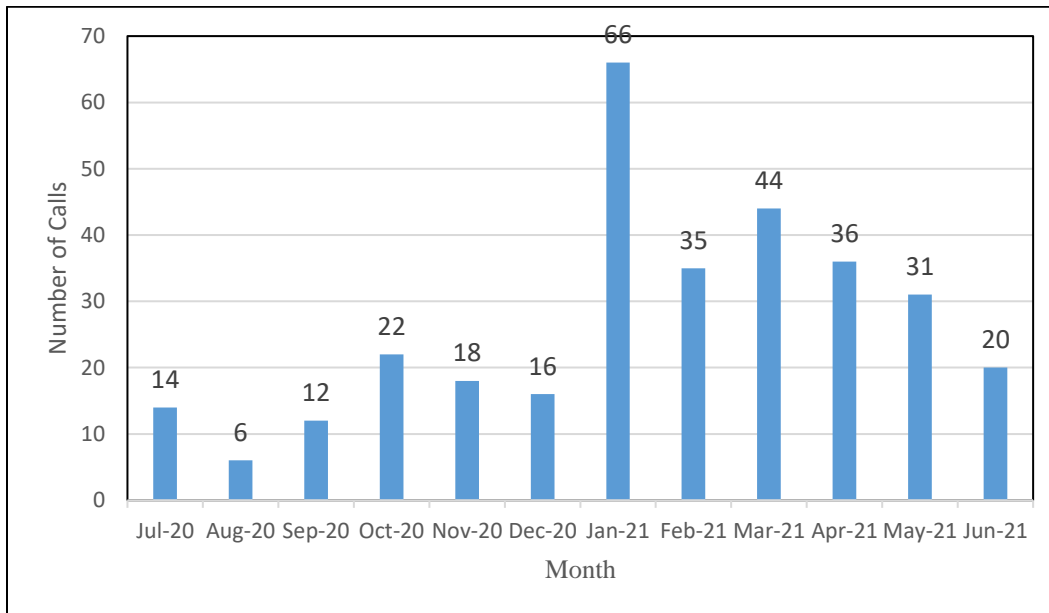
In addition to the implementation of the Children's Crisis and Referral Line during the reporting period, CQI processes allowed identification of additional data needs. Beginning May 2021, BBH implemented more detailed data collection related to referrals, which will be available for future reports. This change in data collection is expected to improve ability to review call and referral quality.

12.2 Review Summary

County-Level Coverage

At least one individual from 43 of the state's 55 counties called the Children's Crisis and Referral line in the reporting period. Given the implementation of the Children's Crisis and Referral Line during the reporting period, changes are expected as further outreach and knowledge of the line are expanded.

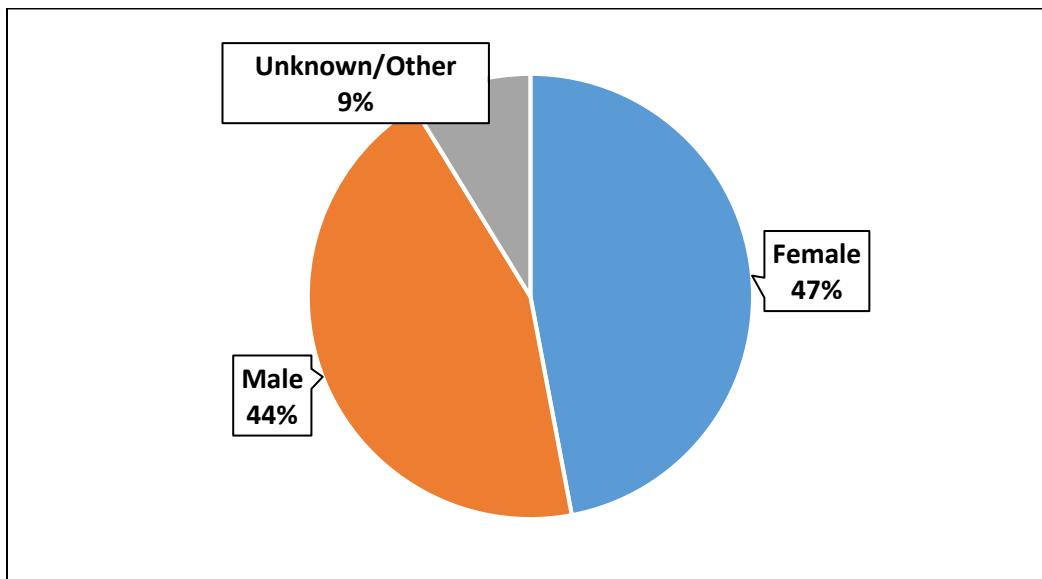
Figure 39: Children’s Crisis and Referral Line Calls by Month, July 2020 - June 2021



Gender of Children Served

While it is still too early to make conclusions about the population served by the crisis line, early data indicate that, generally, slightly more calls may occur for females than males.

Figure 40: Children’s Crisis and Referral Line by Gender, July 2020 – June 2021



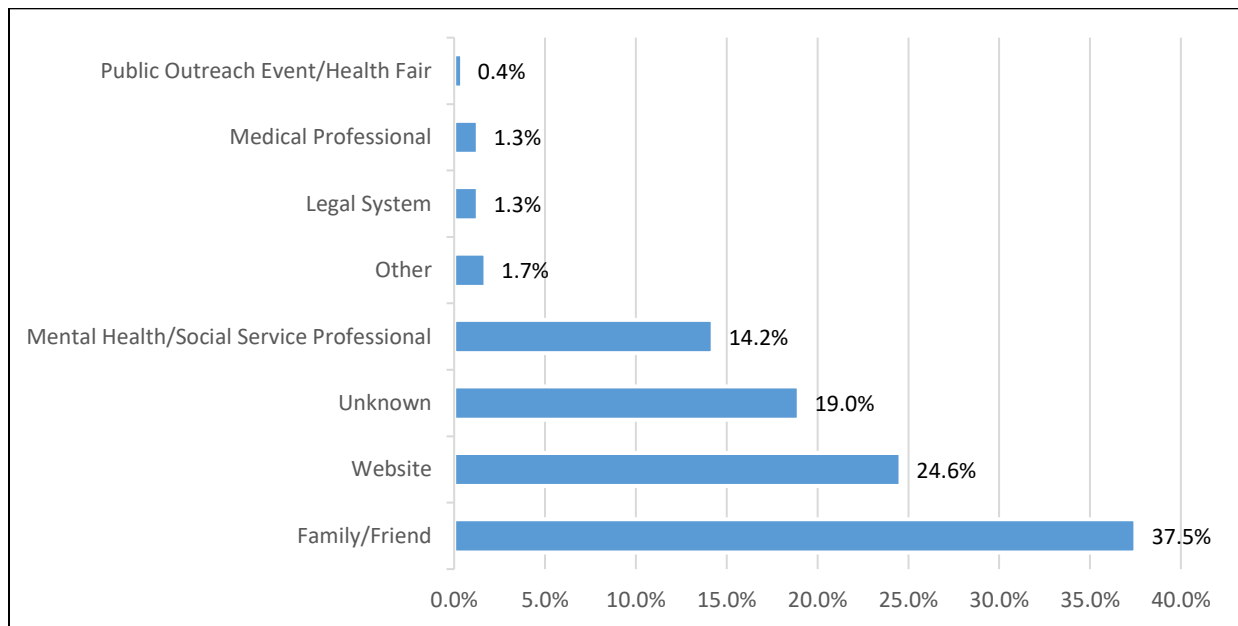
Data regarding race were missing in 78% of call reports, thus race data were not deemed reliable for reporting.

The regular collection and reporting of some data elements expanded as of January 1, 2021, including refinement of question categories as well as changes and additions in types of data collected for

purposes of continuous quality improvement. This resulted in data fields not being comparable to the first six months of the review period. Therefore, the information that follows is based on data for the six-month period from January 1, 2021 through June 30, 2021.

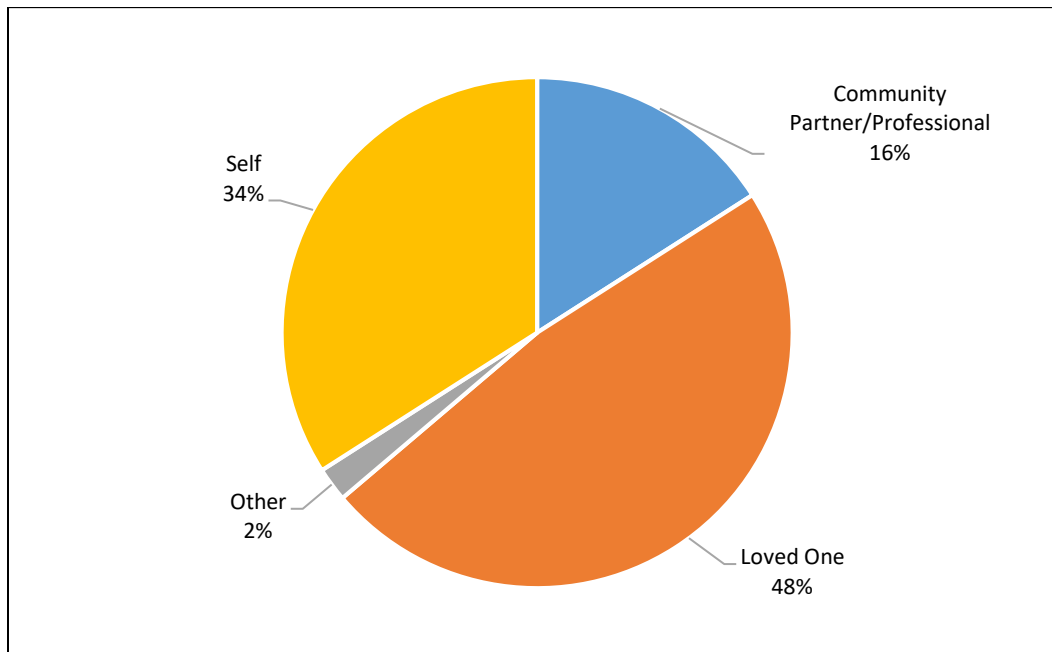
Family/Friend or the Help4WV website was the most common manner by which individuals found out about the call line (62% of reported referral sources).

Figure 41: Referral Source for Call, January 2021 – June 2021



Out of all calls for the Children’s Crisis and Referral Line, 48% came from a loved one, while 34% were the child themselves making the call. “Loved one” includes parent, grandparent, other family, guardian, friend, significant other, and/or spouse.

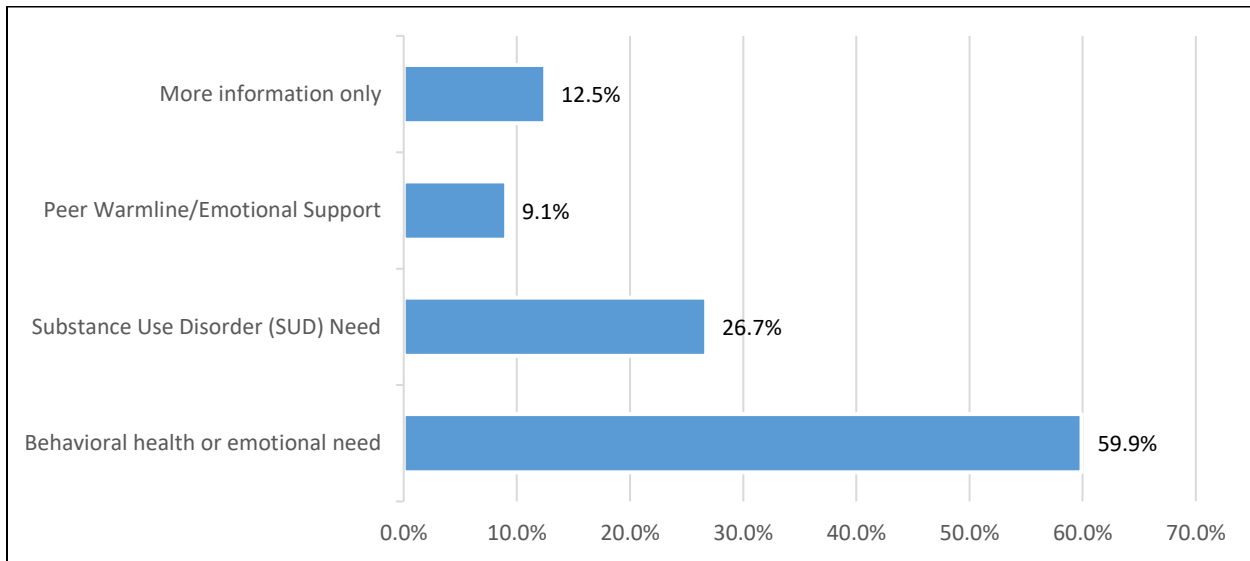
Figure 42: Caller Relation to Individual in Need, January 2021 – June 2021



- 92% of contacts in the January-June 2021 period came via chat or text, highlighting the importance of this feature for children and families in need. It also presents additional challenges for capturing call-related data.
- Individuals reached out to the Children’s Crisis and Referral Line for various reasons: Over half indicated a behavioral health or emotional need, 26% indicated a need related to substance use disorder (SUD), 9% sought connection with Peer Warmline⁵/Emotional Support, and 13% reached out to acquire more information only (individuals may have reported more than one need, making the total add up to greater than 100%). As of January 2022, staff are trained to incorporate the Assessment Pathway screening into calls when appropriate to help individuals further connect to key services to meet their needs.

⁵ Warmline is a line that offers a personal connection, it can be to offer emotional support, help problem solve, or just listen; it can also help connect people to services.

Figure 43: Presenting Need, January 2021 – June 2021



Note: Individuals may have reported more than one need, making the total add up to greater than 100%.

- Referral data are still being refined to reflect the various pathways used to meet individual needs. Of individuals for whom the call was reported as an "emergency/crisis/urgent" call and had a response listed for referral, 47% were reported as being directly transferred to a Mobile Crisis Response Team via "warm transfer."⁶ Note: Warm transfer data are newer fields and might be underreported due to continued training and integration into the reporting system with changes occurring in January and May 2021.

12.3 Provider Capacity/Statewide Coverage

The implementation of the Assessment Pathway as well as media campaigns and other outreach campaigns are anticipated to increase the number of services and awareness of the Children’s Crisis and Referral Line. CQI processes have permitted timely changes to training strategies and data indicators.

Figure 44: Children’s Crisis and Referral Line Capacity

	Current Personnel	Budgeted Personnel	Occupancy Rate
Helpline Specialists	14	16.5	85%
Crisis Counselors	2	2	100%
Shift Leads (shared with other call lines)	2	3	67%

⁶ Warm transfer is when the crisis line staff stays on the line with the caller until the connection to the mobile crisis team is made and introductions are completed.

12.4 Strength, Opportunities, Barriers, and Recommendations

Successful crisis response procedures require a focus on quick rapport building and needs assessment, which can result in barriers in complete data collection. This referral line is still early in its implementation to reach children and their families. BBH and the call line vendor have worked consistently over the past year to improve data collection and be able to more completely tell the story of call outcomes, whether that caller needs a listening ear, additional information, or immediate services with a warm transfer. These services help individuals connect with behavioral health services faster and divert inappropriate use of emergency rooms and 911 calls.

In addition to current efforts, BBH recently received approval for technical assistance and funding from the Transformation Transfer Initiative (TTI) for implementing and expanding the 988 crisis call line and crisis services for children and adolescents with SED or SMI, with an emphasis on children who are lesbian, gay, bisexual, transgender, questioning, and others (LGBTQ+) or black, indigenous, and people of color (BIPOC).

Recommendations:

- Continue to work with the call center provider to help ensure that processes are in place to capture complete data when feasible and to capture missing data on follow-up calls.
- Continue to review call line data routinely to identify opportunities for further outreach to families across the state and provide technical assistance for the call line staff if needed to improve call and referral quality.
- Given the nature of crisis line calls and difficulty with data completion, racial disparities might be examined first in mobile crisis data. The Children's Crisis and Referral Line will continue to work on fully populating requested data inputs when feasible.
- Provide additional outreach to identified access points such as emergency departments, medical offices, schools, etc., with special focus in rural areas.

13.0 Children's Mobile Crisis Response

CMCR and stabilization teams support families with children ages 0 – 21 experiencing an emotional or behavioral crisis through BBH's Children's Crisis and Referral Line. It is not required that families have medical insurance or be enrolled in additional services to access this important service, which is available to help disrupt and de-escalate crises. The crisis specialist will respond immediately once they are called and, if desired, come to the home, school, or community.

On average, the crisis specialist provides on-site support within one hour of the request. Furthermore, CMCR teams help children by interrupting the immediate crisis and ensuring children and their families 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 or centralized statewide Children's Crisis and Referral Line, which has been available since October 1, 2020.

The CMCR teams continue to develop and expand reach; pilot services began in a limited number of counties in 2016 and have expanded to cover services statewide in the reporting period. Despite challenges in finding providers to cover Regions 1 and 2 of the state, Region 1 was able to begin providing services in December 2019, and the final portion of the state in need of coverage began services in May 2021.

13.1 Review Period, Data Sources and Limitations, Population Measured

Figure 45: CMCR Data Overview

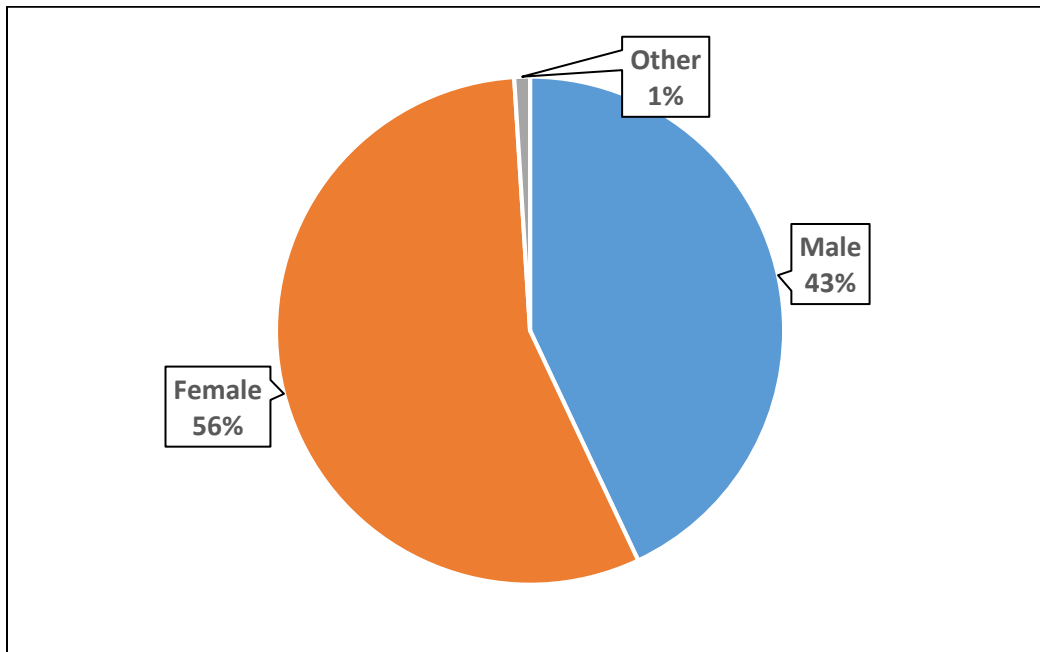
Data Review Period	Data Source	Limitations	Population Measured
July 1, 2021 – June 30, 2021	BBH CMCR and Stabilization Grant Reporting	<ul style="list-style-type: none"> • Prior to October 1, 2021, reporting was a combination of de-identified and aggregated data, which prohibited the ability to report unique numbers served across programs. • At the time of this report, indicators regarding timely provision of services and referral to additional services was unavailable. Indicators have been added to the new reporting system and will be reviewed in future assessments. 	<p>Children served directly through the BBH program.</p> <p>Services are provided to individuals and families with children ages 0 – 21 experiencing an emotional or behavioral crisis initially through BBH's Children's Crisis and Referral Line.</p>

As stated above, the change in data collection mechanism is expected to improve ability to review service level interactions. It should be noted that one provider began services for the first time during this period and another implemented the program only seven months prior to the reporting period, likely resulting in a lower number of children served for the time period in Regions 1 and 2. It is expected that the number of children and families served will increase in the next period as these new providers grow in rapport and awareness within their communities.

13.2 Review Summary

For the review period (July 2020 to June 2021), seven providers served 833 children across six regions. As expected, more individuals were served in counties with the greatest populations, with the exception of the northern and eastern areas of the state. These areas were in early implementation phases during the reporting period, likely accounting for lower numbers of individuals served.

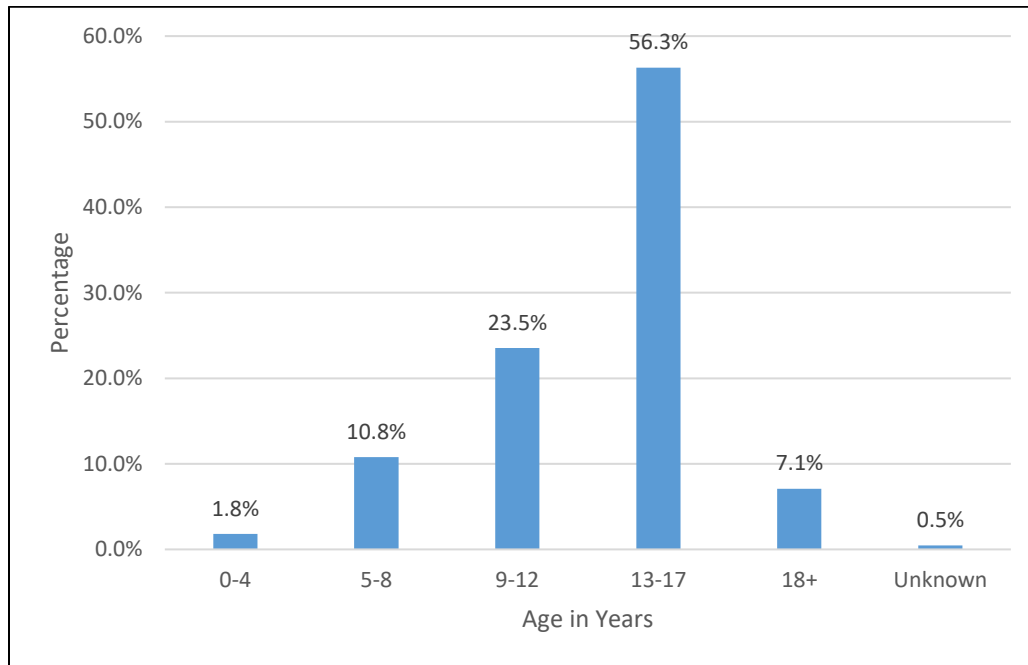
Figure 47: Gender, July 2020 – June 2021



Fifty-six percent of individuals served were ages 13 – 17, which is also the largest age group served by the RMHTFs. This may indicate further opportunity to provide preventative services to children at a critical age.

It should be noted that often an individual in crisis is 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 2% of children ages 0 – 4.

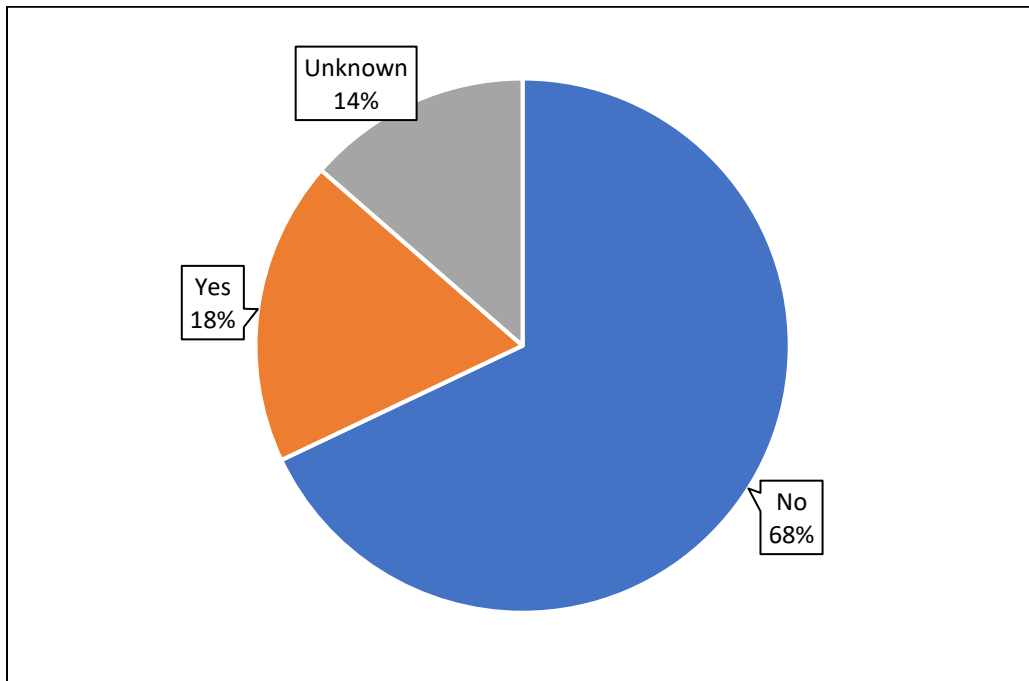
Figure 48: Children Served by Age Grouping, July 2020 – June 2021



CMCR and stabilization teams strive to reach vulnerable and marginalized populations such as children who are adopted from foster care, or children who identify as BIPOC or LGBTQ+. Although the comparison is not exact, as more than one child could be served per family, it should be noted that only 3% of West Virginia households in 2019 identified as adoptive families according to the American Community Survey. The larger percentage of adopted children served by mobile crisis (12%) is indicative of both a continued need to be met for adoptive families and demonstrative of program reach to an identified at-risk group.

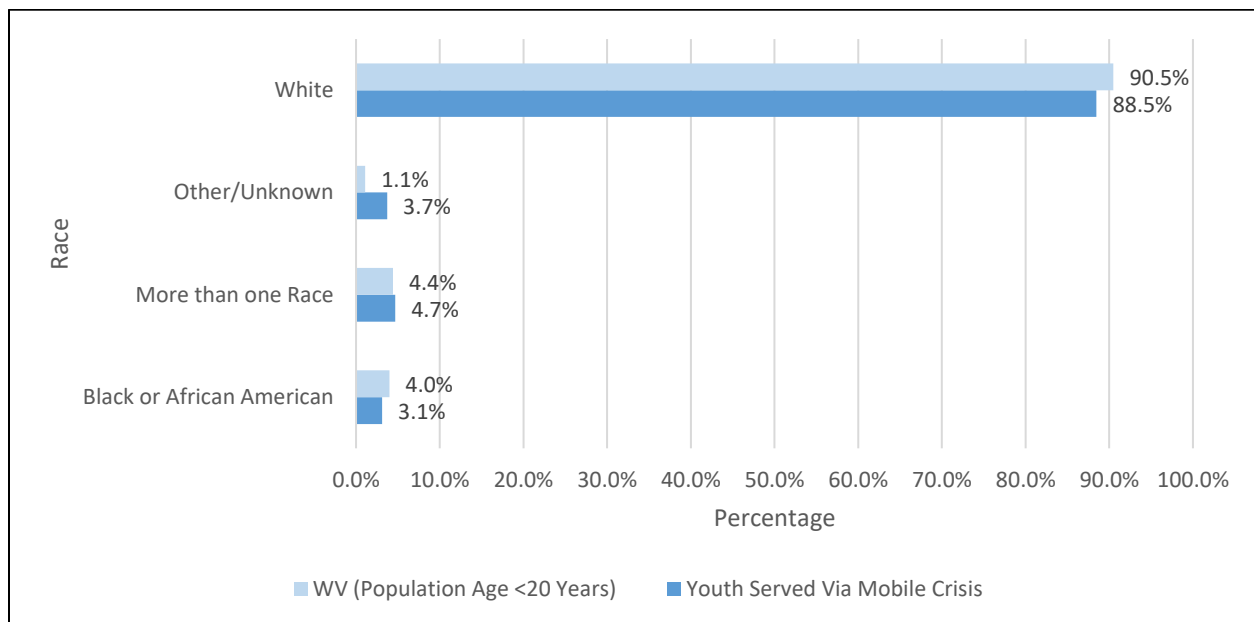
Additionally, mobile crisis appears to serve a greater percentage of children (ages 13 – 21) identifying as LGBTQ+ (18%), as compared to the West Virginia Youth Risk Behavior Surveillance System – 2019 (12% identifying as lesbian, bisexual, or gay).

Figure 49: LGBTQ+ Identifying (Ages 13-21), July 2020 – June 2021



Race and ethnicity data was comparable to West Virginia’s population less than 20 years of age. Of the over 800 total children served, 25 identified as Black/African American and 38 identified as more than one race. These numbers are too small to make any valid comparison of these populations’ use of service relative to their presence within the overall West Virginia population.

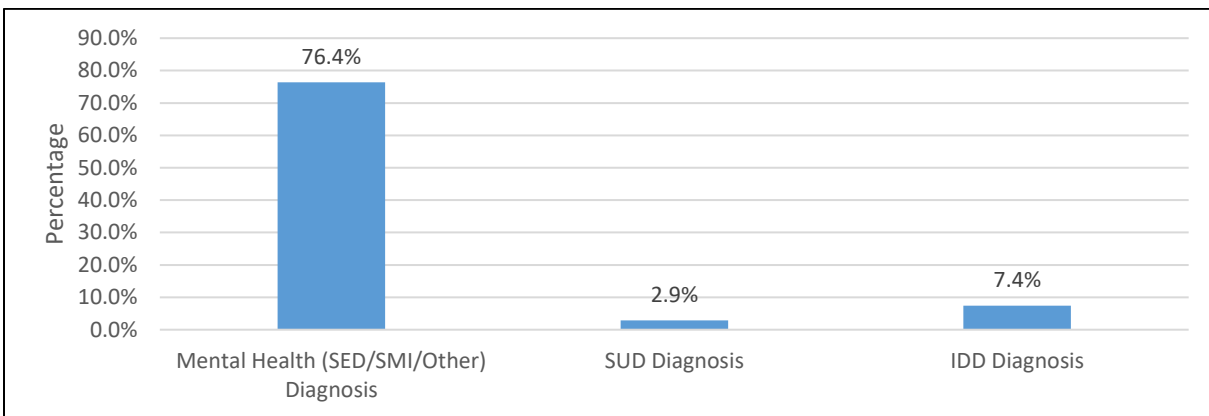
Figure 50: Percentage of Children Served by Race Compared to West Virginia Population Under Age 20, July 2020 – June 2021



Of children served, 76% reported a mental health diagnosis at entry. Individuals may have reported co-occurring conditions. Note that diagnoses in this context are self- or caregiver-reported only. Individuals might not have a confirmed diagnosis, be incorrect about their diagnosis, not know their diagnosis, or need referral for further reevaluation.

CMCR services provide a key opportunity for individuals who need to be connected to preventative and supportive services, such as Wraparound services. While CMCRs services are designed to provide short-term support, the connections and planning developed are meant to provide the family longer-term stability when possible.

Figure 51: Diagnosis Reported at Entry to Mobile Crisis Services, July 2020 – June 2021



*Note: Individuals may have reported co-occurring conditions.

Of children served in the reporting period, 75% had a crisis plan reported to be in place. Typically, crisis plans are developed in the early stages of engagement with the family. It is not expected for all children to have a crisis plan in place, as this must be agreed upon with the family and be family-driven; however, it is viewed as an important step to keep the children in their home and community as well as to connect them with additional services as needed post-crisis.

13.3 Provider Capacity/Statewide Coverage

CMCR services are available statewide as of May 2021. In addition, the Children’s Crisis and Referral Line is transitioning to being the primary source to route individuals in crisis to the appropriate mobile crisis team. Individuals may also be connected to mobile crisis services through the Assessment Pathway. Challenges still exist in providing response within one hour due to the rurality and geography of the state. Data are not yet available regarding timely response but are being refined to address CQI-related processes and needs.

Each BBH region offered increased staffing, with five out of six regions adding one staff. These personnel positions are historically, and continue to be, difficult to fill and maintain. Providers have noted lack of applicants as an issue.

Marshall University is contracted to assist with development of training and curriculum programs for both CMCR and West Virginia Wraparound. Currently BBH, BMS, and BSS staff meet with Marshall University weekly as part of the continuing planning efforts.

Figure 52: CMCR Provider Capacity

	Current Personnel	Budgeted Personnel	Occupancy Rate
Region 1	4	4	100%
Region 2	2	5	40%
Region 3	3	5	60%
Region 4	1	5	20%*
Region 5	2	7	29%
Region 6	3	5	60%**

*There are two providers in Region 4.

**The main provider in Region 6 subcontracts with two other providers to assist with coverage.

13.4 Strength, Opportunities, Barriers, and Recommendations

CMCR coverage in all regions of the state, while newly implemented, has immense opportunities to offer crisis relief and plans for stability to support families and children in need. The implementation of an interconnected network with the Children’s Crisis and Referral Line, Wraparound services, Assessment Pathway, and warm transfer to mobile crisis and stabilization teams allows multiple entryways and connections to longer-term services for children and families with different levels of need. Analysis of current utilization data through these services allows focus on outreach to underserved populations based on both geographic location and demographic populations of high need.

Recommendations:

- Review data per the schedule outlined in the CQI plan to identify opportunities for further outreach and quality improvement.
 - Specific focus should be placed on diverse communities and people of color, children identifying as LGBTQ+, and adoptees.
 - Steps have already been taken to reach out to the diversity, equity, and inclusion workgroup through the BPH to work to lessen disparities among populations in need.
 - As data becomes available on timeliness of response, additional assessment should focus on regional needs and technical assistance.
- Continue to conduct outreach for crisis services based on findings across the state and in key access points, as with Children’s Crisis and Referral Line services.

- Connect families and/or children diagnosed with SED/SMI exiting foster care who are aging out or achieving permanency through adoption with appropriate mental health services such as mobile crisis.
- As with Children’s Crisis and Referral Line, provide additional outreach to identified access points such as emergency departments, medical offices, schools, etc., with special focus in rural areas.

14.0 Residential Mental Health Treatment Facility (RMHTF) Services

The overarching goal to improve outcomes for children is to reduce the reliance on RMHTFs and to increase home and community-based services available to children with SED. In addition to increasing availability of community-based services, DHHR is focused on RMHTF models of care to help ensure children placed in care are served in the least-restrictive setting and for a length of time that meets their needs.

Reducing the overall census in RMHTFs is a primary focus for DHHR. DHHR has a goal of reducing census to 822 by December 31, 2022, and 712 by December 31, 2024. DHHR is committed to reducing census further in future years. The average census in RMHTFs has declined from 1,096 as of June 1, 2015, to 764 as of January 21, 2022. DHHR is on track to meet the census reductions as illustrated in sections below.

Other areas of focus include:

- Ensuring children currently placed in RMHTFs are appropriately placed.
- Reducing the average length of stay for children once residential placement occurs.
- Reducing the number of children placed out of state to allow children to receive treatment closer to their homes and communities.

14.1 Review Period, Data Sources and Limitations, Population Measured

The period reviewed is July 2020 through June 2021. RMHTF enrollment and utilization data for children in state custody is sourced from FACTS. Parental placements of children into PRTFs make up less than 1% of overall placements and are not included in the data represented in this section. Data on parent-placed children, sourced from the Medicaid and CHIP DW/DSS, are being added to the data store and dashboards in January 2022.

14.2 Review Summary

DHHR data reflected in the following figures represent children in state custody placed in residential settings. As noted previously, parental placement data will be added to the data store in January 2022 and will be included in the analysis for future reports.

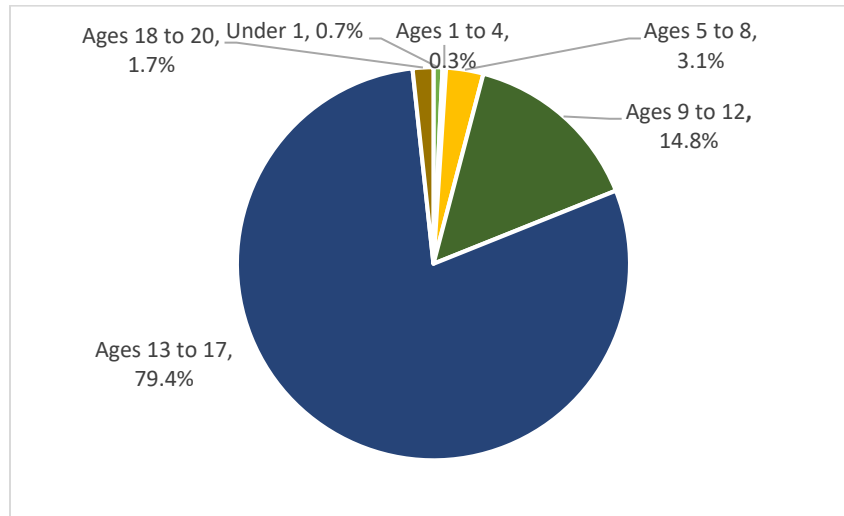
The census trend data are provided for an expanded period outside the typical date range for this report. The January 2020 through October 2021 data show that census numbers continue to decline, which is a primary goal for DHHR. The long-term goal through December 2024 is to reduce the number of children in RMHTF to 712 or fewer.

Age of Children Served

Most of the children served were between 9 and 17 years of age. For the reporting period, the majority of children in RMHTFs were ages 13 – 17 (79%) followed by children ages 9 – 12 (15%). This age group aligns with the data seen in other behavioral health service utilization data which show the majority of

children are between 9 and 17 years of age. Increased focus on home and community-based services for the younger children may be warranted to provide intervention to younger children to reduce the risk of residential placement as children age.

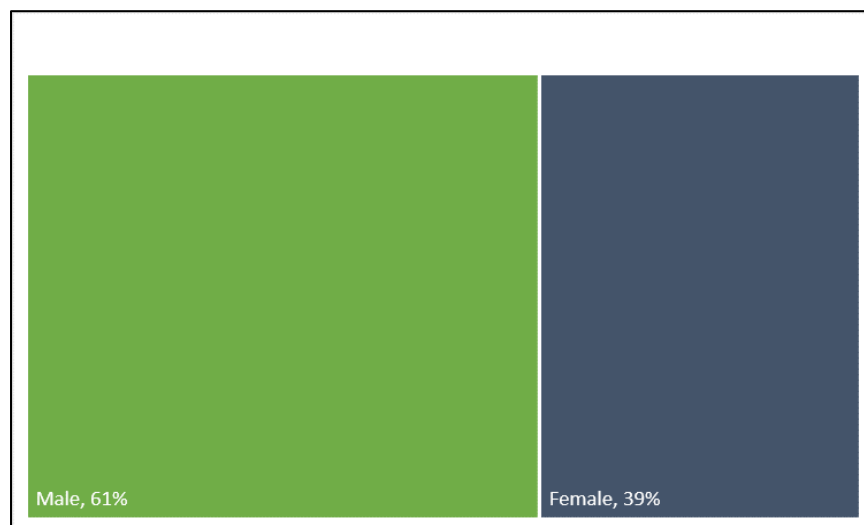
Figure 53: RMHTF Admissions for Children in State Custody by Age Group at Admission



Gender of Children Served

More male children are utilizing RMHTFs for treatment intervention compared to female children. Again, this aligns with observed trends in high-intensity behavioral health service utilization data where the majority of children are male.

Figure 54: RMHTF Admissions for Children in State Custody by Gender at Admission

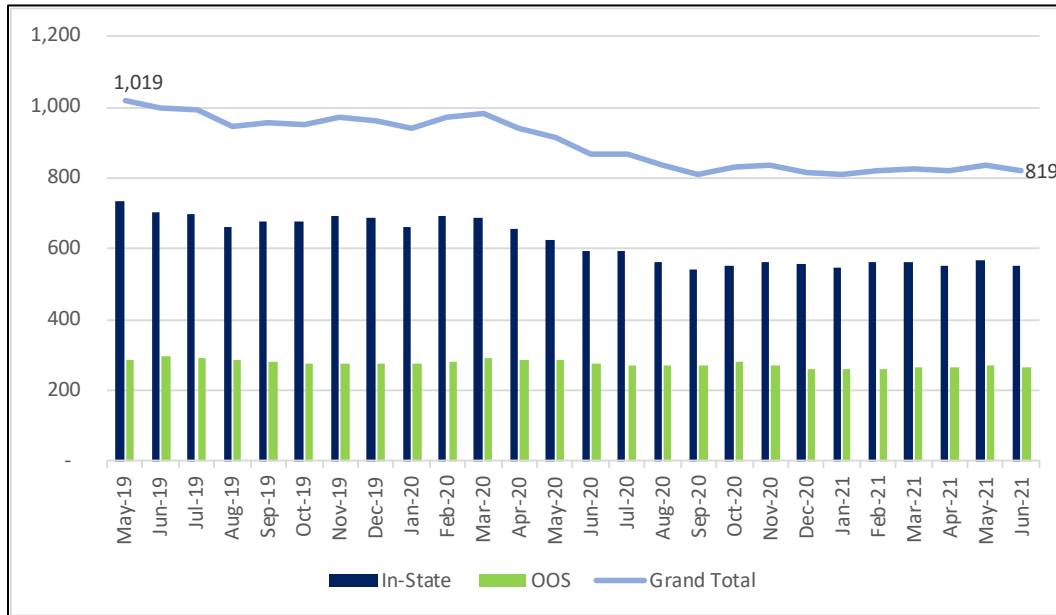


Monthly Bed Utilization

As mentioned earlier in this section, the overall goal is to reduce reliance on residential intervention. The overall decline in census has primarily occurred at in-state facilities, whereas out-of-state facilities

have remained stable. DHHR would expect to see additional declines in bed utilization as the Assessment Pathway and effective discharge planning are more fully implemented.

Figure 55: Average Monthly RMHTF Bed Utilization



Average Length of Stay by Facility Type

Figure 56 (below) displays the rolling 12-month average length of stay by level of care (group residential care, PRTF, or short-term acute psychiatric hospitalization) at discharge for children in RMHTF in-state custody. The rolling average smooths variation and trend sensitivity to outliers by including 12 months’ worth of discharges in each data point. That is, the July 2020 data points include all discharges occurring in the months between August 2019 and July 2020, inclusive; the August 2020 data points include all discharges occurring in the months between September 2019 and August 2020, inclusive; and so on. The June 2021 data point includes all discharges occurring between July 2020 and June 2021, inclusive, and therefore represents the average length of stay over the entire analysis period for most of this report.

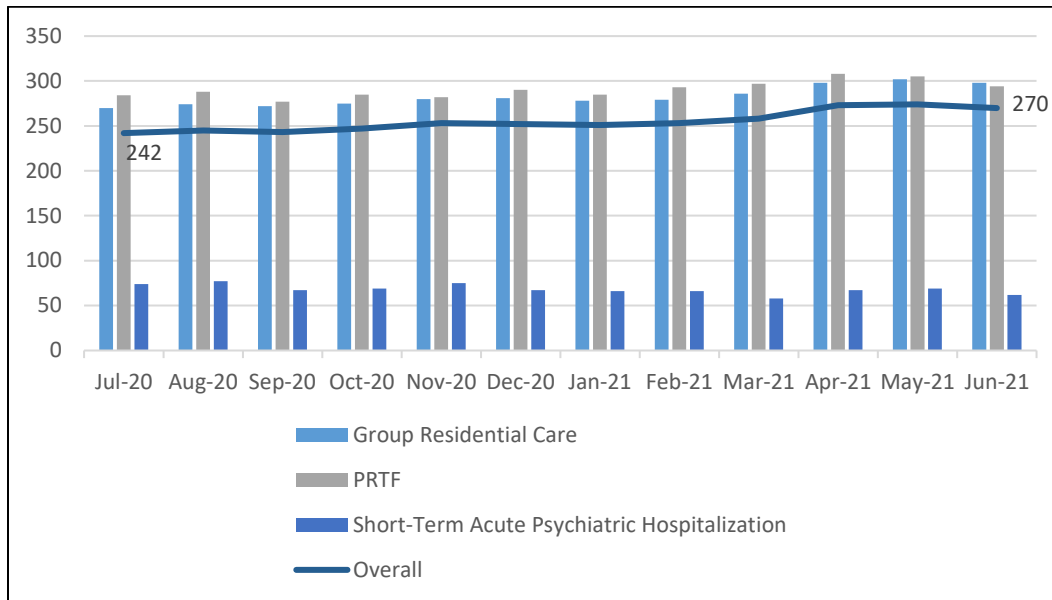
The average lengths of stay by level of care over the reporting period are:

- Group Residential Care: 298 days, or 9.8 months.
- PRTF: 294 days, or 9.7 months.
- Short-term acute psychiatric hospitalization: 62 days, or 2 months.
- Overall: 270 days, or 8.9 months.
- The rolling 12-month view shows a stable average length of stay, rising slightly over the study period, from 242 to 270 days (7.9 to 8.9 months). The increase is largely driven by a jump occurring between the March 2021 (258 days) and April 2021 (273 days) data points, the point

in time when the rolling 12-month periods summarized begin to include only months during the pandemic.

Effective discharge training and discharge planning coordinated through collaboration with the MCO beginning in January 2022 will be instrumental in reducing the length of stay for children once placed in a residential setting.

Figure 56: Rolling Average Length of Stay for a Rolling 12 Months of Discharges by Level of Care at Discharge

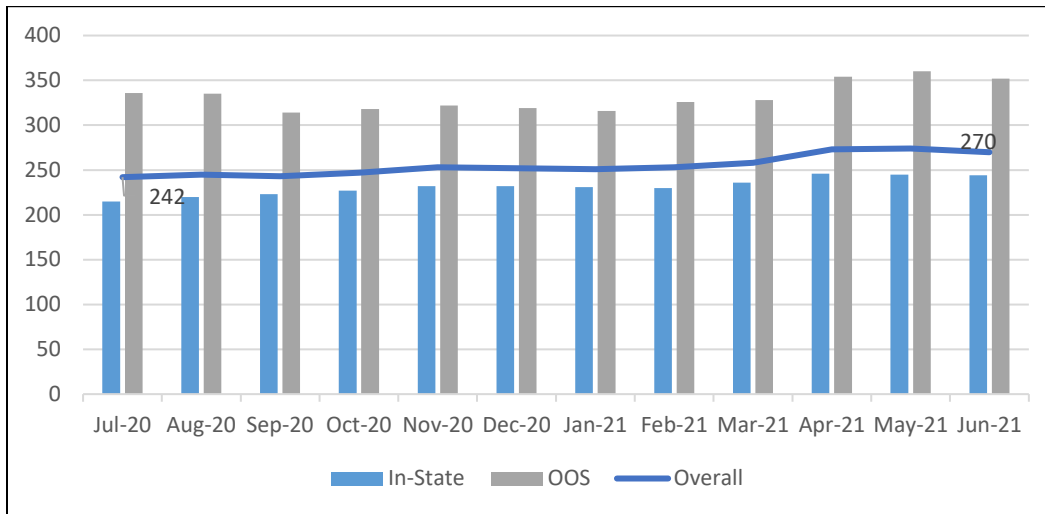


Average Length of Stay for In-State versus Out-of-State Providers

The average lengths of stay over the reporting period are 244 days, or 8 months, for children discharged from in-state providers and 352 days, or 11.6 months, for children discharged from out-of-state providers. As in the level-of-care view, the rolling 12-month view shows a stable average length of stay, rising slightly over the review period, from 242 to 270 days (7.9 to 8.9 months). The increase is largely driven by a jump occurring between the March 2021 (258 days) and April 2021 (273 days) data points, the point in time when the rolling 12-month periods begin to only include months during the pandemic, which resulted in shifts in procedures for congregate care facilities to prevent outbreaks and surges in transmission.

Children placed in out-of-state facilities have a much higher average length of stay than children placed with in-state providers. DHHR is working to ensure children have options to stay closer to home, family, friends, schools, and communities for behavioral and mental health treatment intervention when residential placement is the most appropriate option. DHHR has identified model-of-care changes needed to help ensure high-quality services are available for children with significant needs. DHHR is working with subject matter experts on developing new models of care that will be implemented in the future to facilitate quality outcomes for children in residential placement.

Figure 57: Rolling Average Length of Stay for In-State and Out-of-State: Average Length of Stay for a Rolling 12 months of Discharges, July 2020 – June 2021, by In- or Out-of-State Provider Status at Discharge



RMHTF Admissions and Prior Placements

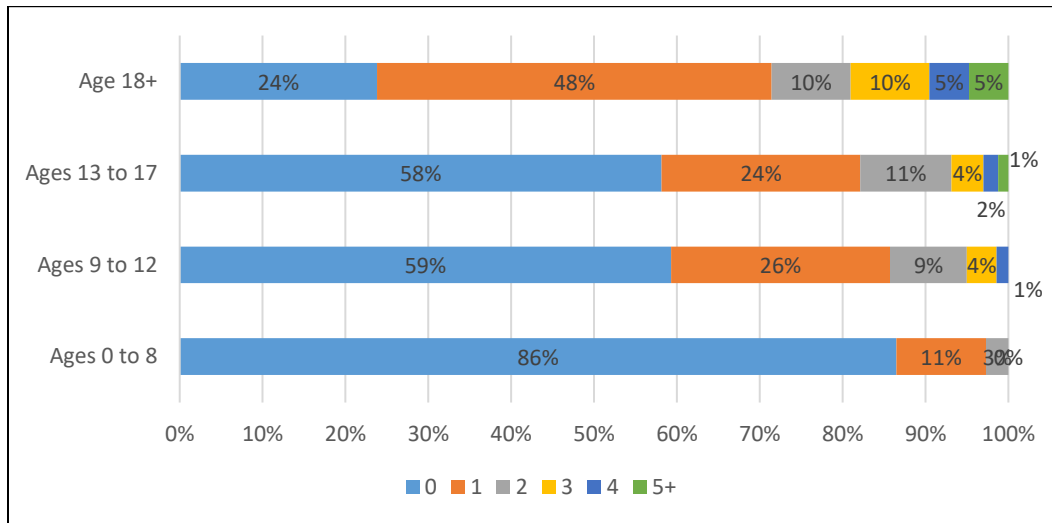
Children often experience multiple stays in RMHTF during their treatment. DHHR is focused on efforts with the Assessment Pathway to offer children and families home and community-based interventions to decrease the number of readmissions children experience.

Figure 58 below summarizes the number of prior RMHTF stays experienced per child by age group for children in RMHTF care during the study period. Please note these figures do *not* tally the number of changes in placement (e.g., change in facility of residence) a child may experience during a continuous stay⁷ in the RMHTF level of care, but the number of prior continuous RMHTF stays each child experienced. For example, a child who resided in three different RMHTF facilities over the course of their first continuous RMHTF stay would be recorded in the “0” category.

Admissions displayed in the light blue “0” color were the first reported state custody RMHTF admission for the child. The majority of admissions for children in all age groups except the 18+ age group are the first admission.

⁷ The dashboard defines a continuous RMHTF stay as a period of time during which a child is placed in group residential care or PRTF with no gaps of 14 days or more between reported exit and entry dates, or in short-term acute psychiatric hospitalization with no gaps of 2 or more days between reported exit and entry dates *or* the exit reason from the stay is a permanent reason such as “Reunification.”

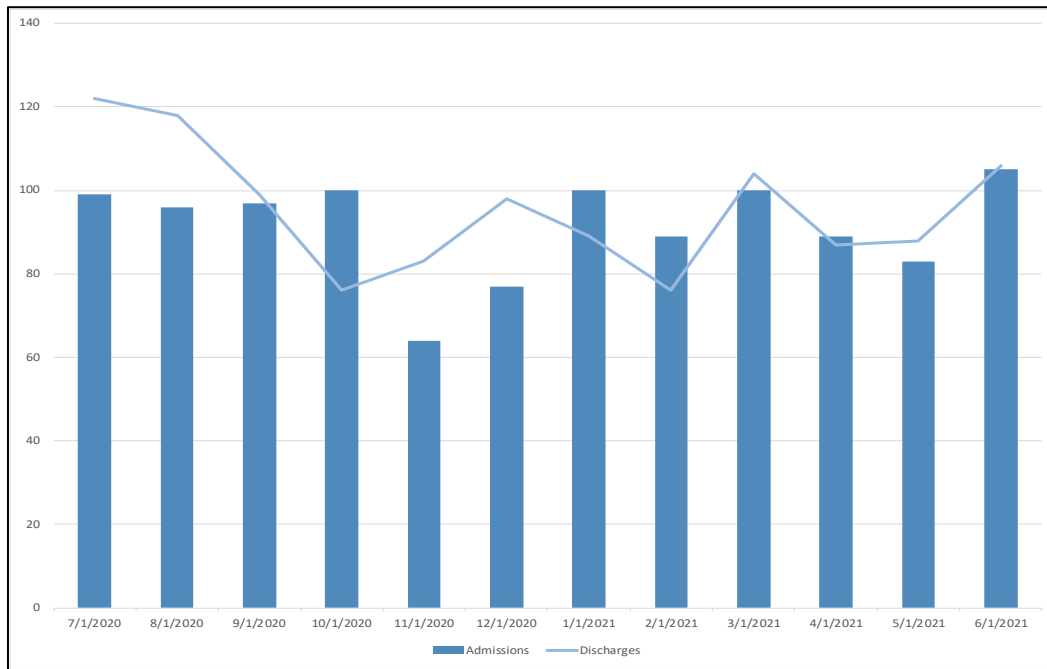
Figure 58: Admissions During the Period July 2020 – June 2021 in Each Displayed Age Group With 0, 1, 2, 3, 4, and 5 or more prior RMHTF stays



RMHTF Admissions and Discharges

DHHR’s focus over the next year is to reduce admissions through implementation of the Assessment Pathway and improved discharge planning to help ensure children who are currently in an RMHTF are transitioned, where appropriate, to a less-restrictive level of care. To reach the target reduction in placements by 2024, discharges need to exceed admissions month over month. The out-of-state census has remained relatively flat, which indicates the number of admissions equals the number of discharges. The census decline to date has occurred through in-state discharges exceeding admissions.

Figure 59: Total Admissions versus Discharges by Month for In-State and Out-of-State Placements



14.3 Provider Capacity/Statewide Coverage

The RMHTF provider capacity statewide is adequate to meet the needs for the number of children placed compared to the number of licensed bed capacity. However, the level of care offered by each provider varies and, in some cases, may not meet the individual needs of the child. The focus over the coming year will be to increase provider capacity and training to serve children with high level-of-care needs who are now being served in out-of-state facilities.

14.4 Strength, Opportunities, Barriers, and Recommendations

Initiatives throughout 2022 will include activities listed below to help divert children from residential interventions and focus on reducing their length of stay once placed in an RMHTF:

- A soft launch for this pathway was implemented in late October 2021, which includes referrals from primary care physicians and mobile crisis and stabilization teams.
- A phased approach for BSS staff to begin referring children to the pathway will begin in the first quarter of 2022, with full implementation for CPS and YS anticipated by mid to late summer.
- Training for impacted DHHR staff on the new policies, pathways, and processes for diversion from RMHTFs and transitions from RMHTFs to community placements is planned for early 2022.

- Discharge planning and training will begin in January 2022 to help ensure children in RMHTFs have meaningful and relevant discharge plans.
- DHHR, the MCOs, and provider agencies are working collaboratively to focus on children currently placed in RMHTFs with CAFAS scores under 90 to prioritize their discharge planning.

15.0 Partner Evaluations

DHHR is partnering with WVU to capture additional outcome measures as outlined in the West Virginia DHHR Children’s In-Home and Community-Based Services Improvement Project Evaluation Plan dated April 8, 2021. The evaluation includes performance measures designated by DHHR, child/caregiver level outcomes, community/provider level outcomes, and system level outcomes. WVU has initiated caregiver, provider, and child surveys and scheduled a series of focus groups.

WVU will provide periodic evaluation reports. The first report of results is anticipated in the first half of 2022, with a second report to follow later in the year. DHHR’s cross-functional, cross-bureau quality committees will review these results as part of the CQI process.

DHHR is partnering with Marshall University to provide Wraparound services training and technical assistance to providers across the state of West Virginia and complete an ongoing evaluation of Wraparound service fidelity to the National Wraparound Initiative standards. To date, Marshall University has established a contract with the University of Maryland to provide the Wraparound training to providers as well as to certify Marshall University staff as Wraparound trainers.

Fidelity reviews are anticipated to begin sometime in the second quarter of 2022. Quality sampling review (i.e., chart reviews) to evaluate the alignment of children and family support plans and services with Child and Adolescent Needs and Strengths (CANS) assessment results are anticipated to begin in the second half of 2022. Once routine fidelity and quality sampling reviews are initiated, Marshall University will publish reports on an ongoing basis. These reports will be incorporated into DHHR’s quality committee review process.

16.0 Outcomes

DHHR continues to establish data sources and systems for collection of outcomes data for children receiving services. Below is an update on the status of data collection and possible data sources for each outcome:

- Arrests or detentions: DHHR is coordinating with Probation Services to establish reporting of juvenile petitions filed. The source for this data is still being determined.
- Commitment to the custody of BJS or DHHR: The data source for commitments to BJS has been identified as the Offender Information System. The data source for commitments to DHHR is FACTS. These data are anticipated to be included in future reports.
- Suspension or expulsion from school: DHHR is collaborating with the MCO to evaluate the possibility of collecting this data at the child level.
- Prescribed three or more anti-psychotic medications: An initial polypharmacy analysis using pharmacy claims data did not identify significant numbers of children with three or more anti-psychotic medications. BMS has policies and processes in place to flag any child where polypharmacy may be an issue and can intervene when needed.
- Changes in functional ability, statewide and by region, including data from the CANS assessment and the quality sampling review process: DHHR is considering requiring all providers to use the CANS automated system to input all CANS assessments completed for children. If this requirement goes into effect, the CANS automated system will be the data source for measures of functional ability based on CANS. DHHR is partnering with Marshall University to complete quality sampling reviews.

As data collection becomes more robust and the data store continues to grow, DHHR anticipates more outcome data will become available for reporting.

17.0 Conclusion

DHHR has made significant progress in designing, developing, and expanding mental and behavioral health services for children and families across the state of West Virginia. As DHHR looks to 2022 and beyond, the primary focus is on implementing the new processes and pathways associated with services and establishing data collection and reporting to allow continuous evaluation and improvement of services.

This report is based on initial and emerging data and is primarily meant to assist with establishing baselines. DHHR's ongoing analysis of data associated with recently implemented CQI processes will assist with measuring implementation progress and identifying strengths and opportunities to continue to enhance the processes, programs, and pathways.

Key accomplishments include:

- Implemented a centralized statewide Children's Crisis and Referral Line.
- Expanded Wraparound services.
- Expanded CMCR and stabilization to statewide coverage.
- Established a training and credentialing center for PBS services.
- Implemented the CSED Waiver and subsequently modified the waiver to remove barriers and improve access.
- Launched phase one of the Assessment Pathway to allow multiple entries into services, including connection with a Wraparound Facilitator during the CSED Waiver application and eligibility determination process.
- Partnered with WVU to field multiple surveys to understand provider, caretakers, and children's experiences with the child welfare system and associated services.
- Partnered with Marshall University to establish evaluation of Wraparound fidelity.
- Expanded provider types that are authorized to provide services under the CSED waiver, and temporarily increased reimbursement rates for CSED services.
- Recruited an ACT service provider for the Eastern Panhandle to ensure statewide coverage.
- Developed a Treatment Home foster care model as a behavioral health intervention.
- Made significant improvement in the intra-agency collaboration, with representatives from across bureaus meeting on a routine basis to improve children's mental health services.
- Completed a reorganization of the Bureau for Children and Families, separating into two distinct bureaus, the BSS and the Bureau for Family Assistance, to allow BSS to increase focus on child welfare outcomes.

- Established a contract with Marshall University for Wraparound Facilitator training.
- Established a contract with Marshall University to provide CMCR training. The contract is anticipated to be fully executed in early 2022.
- Based on initial data, home and community-based services appear to be reaching the right demographic of children to prevent institutionalization or other out-of-home placements.

Overall recommendations include the following:

- Continue implementing the new pathways, processes, and services.
- Continue implementing the CQI Plan to inform ongoing decision-making regarding changes to the new processes, pathways, and services to ensure quality, access, and sustainability of services.
- Continue expanding data collection, identifying any gaps in reporting, exploring data system solutions to address needs, and building out the data store and associated suite of reports for use in ongoing quality committee reviews.
- Continue efforts to capture data at the child level for aggregation across bureaus and child-serving entities.
- Increase use of available sources within the literature and national benchmarks to compare to West Virginia programs and services data.
- Continue to enhance quality infrastructure and processes within DHHR.
- Use review of information to inform and continue outreach and education efforts across the state with special focus on groups with additional needs, such as communities of color, adoptive families, transitional youth, and people in rural areas.
- Use data to provide feedback to providers and ensure accountability to performance outcomes.
- Expand use of geographical comparisons and needs across programs.
- Continue to enhance coordination and communication among child-serving entities and address any barriers.
- Continue efforts to address workforce shortages.
- Adapt as needed as the pandemic continues, to ensure children, families, and staff can be safely supported.

DHHR is committed to continuing to transform the children’s mental and behavioral health programs toward increased use of evidence-based practices and high-quality care that facilitates positive clinical outcomes, improved quality of life, and safety, permanency, and well-being for children and their families.

Appendix A: Glossary of Acronyms and Abbreviations

Figure 60: Glossary of Acronyms and Abbreviations

Acronym	Description
ACT	Assertive Community Treatment
ADHD	Attention Deficit Hyperactivity Disorder
ASO	Administrative Services Organization
BASC	Basic Assessment System for Children
BBH	Bureau for Behavioral Health
BIPOC	Black, Indigenous, and People of Color
BJS	Bureau for Juvenile Services
BMS	Bureau for Medical Services
BPH	Bureau for Public Health
BSS	Bureau for Social Services (formerly Bureau for Children and Families)
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Needs and Strengths
CHIP	Children’s Health Insurance Program
CMCR	Children’s Mobile Crisis Response
CSED	Children with Serious Emotional Disorder
CPA	Child Placing Agency
CPS	Child Protective Services
CQI	Continuous Quality Improvement
DHHR	Department of Health and Human Resources
DOJ	Department of Justice
DSM	Diagnostic and Statistical Manual of Mental Disorders
DW/DSS	Data Warehouse/Decision Support System
EDS	Enterprise Data Solution
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment

Acronym	Description
FACTS	Family and Children Tracking System
ICD	International Classification of Disease
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Questioning, and Others
MAYSI-2	Massachusetts Youth Screening Instrument
MCO	Managed Care Organization
NWI	National Wraparound Initiative
PATH	People's Access to Health
PBS	Positive Behavioral Support
PECFAS	Preschool and Early Childhood Functional Assessment Scale
PRTF	Psychiatric Residential Treatment Facility
RMHTF	Residential Mental Health Treatment Facility
SED	Serious Emotional or Behavioral Disorder
SMI	Serious Mental Illness
TTI	Transformation Transfer Initiative
WVU	West Virginia University
YS	Youth Services