

I: State Information

State Information

Plan Year

Start Year:

2014

End Year:

2015

State SAPT DUNS Number

Number

618137715

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name

West Virginia Department of Health and Human Resources

Organizational Unit

Office of the Secretary

Mailing Address

One Davis Square, Suite 100 East

City

Charleston

Zip Code

25301

II. Contact Person for the SAPT Grantee of the Block Grant

First Name

Melissa

Last Name

Mullins

Agency Name

Bureau for Behavioral Health and Health Facilities

Mailing Address

350 Capitol Street, Room 350

City

Charleston

Zip Code

25301

Telephone

304-356-4990

Fax

304-558-2230

Email Address

Melissa.D.Mullins@wv.gov

State CMHS DUNS Number

Number

618137715

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name

West Virginia Department of Health and Human Resources
Organizational Unit
Office of the Secretary
Mailing Address
One Davis Square, Suite 100 East
City
Charleston
Zip Code
25301

II. Contact Person for the CMHS Grantee of the Block Grant

First Name
Melissa
Last Name
Mullins
Agency Name
Bureau for Behavioral Health and Health Facilities
Mailing Address
350 Capitol Street, Room 350
City
Charleston
Zip Code
25301
Telephone
304-356-4990
Fax
304-558-2230
Email Address
Melissa.D.Mullins@wv.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date
9/3/2013 9:39:35 AM
Revision Date

V. Contact Person Responsible for Application Submission

First Name
Kimberly
Last Name
Walsh
Telephone
304-356-4798
Fax
304-558-2230
Email Address
Kimberly.A.Walsh@wv.gov

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	<input type="text" value="Karen L. Bowling"/>
Title	<input type="text" value="Cabinet Secretary"/>
Organization	<input type="text" value="West Virginia Department of Health and Human Resources"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Karen L. Bowling
Title	Cabinet Secretary
Organization	West Virginia Department of Health and Human Resources

Signature: _____ Date: _____

Footnotes:



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Office of the Secretary

One Davis Square, Suite 100, East

Charleston, West Virginia 25301

Telephone: (304) 558-0684 Fax: (304) 558-1130

Earl Ray Tomblin
Governor

Karen L. Bowling
Cabinet Secretary

August 9, 2013

The Honorable Earl Ray Tomblin
Governor, State of West Virginia
Office of the Governor
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305

Dear Governor Tomblin:

Attached are two letters for your signature authorizing the Secretary of the Department of Health and Human Resources to sign documents related to applications for the **Mental Health Services Block Grant (\$2,473,008)** and the **Substance Abuse Prevention and Treatment Block Grant (\$8,538,760)**. Final allocations are subject to Congressional approval of the FY 2014 budget.

The Department will be submitting a combined application at the suggestion of the funding agency, the Substance Abuse and Mental Health Services Administration (SAMHSA). Two letters of authorization are required since the two Block Grants are authorized in separate laws.

Your assistance in this matter is greatly appreciated.

Sincerely,


Karen L. Bowling
Cabinet Secretary

KLB:dm



STATE OF WEST VIRGINIA
OFFICE OF THE GOVERNOR
1900 KANAWHA BOULEVARD, EAST
CHARLESTON, WV 25305
(304) 558-2000

EARL RAY TOMBLIN
GOVERNOR

August 9, 2013

Karen L. Bowling, Cabinet Secretary
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100, East
Charleston, West Virginia 25301

Dear Cabinet Secretary Bowling:

This letter is to authorize you in your position as Cabinet Secretary of the West Virginia Department of Health and Human Resources to serve as my designee for the purpose of signing the Mental Health Services Block Grant application, certifications, waiver requests, etc.

This authorization will remain in effect until further notice.

With warmest regards,

A handwritten signature in blue ink that reads "Earl Ray Tomblin".

Earl Ray Tomblin
Governor



STATE OF WEST VIRGINIA
OFFICE OF THE GOVERNOR
1900 KANAWHA BOULEVARD, EAST
CHARLESTON, WV 25305
(304) 558-2000

EARL RAY TOMBLIN
GOVERNOR

August 9, 2013

Karen L. Bowling, Cabinet Secretary
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100 East
Charleston, West Virginia 25301

Dear Cabinet Secretary Bowling:

This letter is to authorize you in your position as Cabinet Secretary of the West Virginia Department of Health and Human Resources to serve as my designee for the purpose of signing the Substance Abuse Prevention and Treatment block grant application, certifications, waiver requests, etc.

This authorization will remain in effect until further notice.

Wish warmest regards,

A handwritten signature in blue ink that reads "Earl Ray Tomblin".

Earl Ray Tomblin
Governor



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

Bureau for Behavioral Health & Health Facilities
Commissioner's Office
350 Capitol Street, Room 350
Charleston, West Virginia 25301-3702
Telephone: (304) 356-4538 Fax: (304) 558-2230

Karen L. Bowling
Cabinet Secretary

MEMORANDUM

DATE: August 2, 2013
TO: Karen L. Bowling, Cabinet Secretary
FROM: Victoria L. Jones, Acting Commissioner, BHHP 
RE: Mental Health Services Block Grant
Substance Abuse Prevention and Treatment Block Grant

Attached are two letters requesting Governor Tomblin to authorize you to serve as his designee for signing applications, certifications, waiver requests, and other documents related to the **Mental Health Services Block Grant (MHSBG)** and the **Substance Abuse Prevention and Treatment Block Grant (SAPTBG)**. The MHSBG is expected to total \$2,473,008 and the SAPTBG is expected to total \$8,538,760 subject to Congressional action on the FY 2014 budget.

These are grants awarded by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA). Although they are separate grants with separate authorizations, SAMHSA has encouraged submitting a combined application, which we intend to do. Deadline for submission is September 1, 2013.

Your assistance in forwarding these requests is appreciated.

VLJ:dm

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

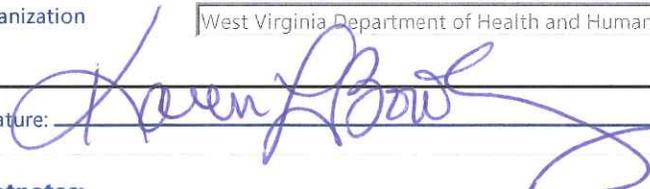
Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Karen L. Bowling
Title	Cabinet Secretary
Organization	West Virginia Department of Health and Human Resources

Signature:  Date: 8/20/2013

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act

Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32

Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee

Title

Signature of CEO or Designee¹: _____ Date: _____

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart I of the Public Health Service Act

Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6

Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee

Karen L. Bowling

Title

Cabinet Secretary

Signature of CEO or Designee¹: _____ Date: _____

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	<input type="text" value="Karen L. Bowling"/>
Title	<input type="text" value="Cabinet Secretary"/>
Organization	<input type="text" value="West Virginia Department of Health and Human Resources"/>

Signature: _____ Date: _____

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

Step 1: Assess the strengths and needs of the service system to address the specific populations

The West Virginia Bureau for Behavioral Health and Health Facilities (BBHBF) operates under the auspices of the West Virginia Department of Health and Human Resources and provides funding for community-based services for persons with behavioral health needs, including those who are either underinsured or uninsured. The Bureau represents a reorganization and integration of the former Offices of Behavioral Health Services (OBHS) and Health Facilities (OHF), emphasizing function rather than disability and improving planning and collaboration between facility and community-based services. The Bureau also administers statutory and court ordered funds to decrease state hospital admissions, maintain individuals in the community and improve the quality of their lives. Within the BBHBF there are three interrelated sections: Operations; Programs and Policy; and Finance and Technology. The Operations section provides oversight and coordination of planning, development, funding, and monitoring of two state-operated psychiatric hospitals for adults, four long-term care facilities, and one acute care facility, and provides oversight of human resources and monitoring and compliance functions. The Programs and Policy section provides oversight and coordination of policy, planning, development, funding and monitoring of statewide community behavioral health services and supports. This section also oversees the development and implementation of intellectual and developmental disabilities services and supports. The Finance and Technology Section provides fiscal management and technology and systems functions development, oversight and support.

An important aspect of the Bureau's reorganization is to integrate the three sections: using data to drive decisions about allocation of resources; developing and delivering an array of evidence based services and supports; and, providing technical assistance and oversight to assure quality. For example, it is critical for the Programs and Policy section to work in concert with the two state-operated psychiatric hospitals to develop services and supports that people want and need to thrive in the most integrated and least restrictive setting possible.

Partnerships and collaboration among public and private systems, as well as with individuals, families, agencies and communities, are important components of the systems of care surrounding each person. The role of the BBHBF is to provide leadership in the administration, integration and coordination of the public behavioral health system. Leadership must be integrity-based and flexible enough to respond to change that is guided by individuals, families and communities. Inclusion of consumer voice in all aspects of programming is a core value. The Programs team "envisions a community that values and respects people and is responsive to their individual needs, wants and desires for the enrichment of their lives." The Programs and Policy section is comprised of two offices, the Office of Programs and Policy and the Office

of Consumer Affairs and Community Outreach. The Office of Programs and Policy includes the Division on Alcoholism and Drug Abuse, Division of Adult Mental Health, Division of Child and Adolescent Mental Health and the Division of Intellectual and Developmental Disabilities. The reorganization also established the Office of Consumer Affairs and Community Outreach to promote increased consumer and family involvement in behavioral health service planning and delivery. All division directors and their staff have significant education and real world experience supporting the provision of technical assistance and modeling best practice.

The Division of Adult Behavioral Health is designated as the Single State Authority for Adult Mental Health and thereby assures and provides access to services and supports to meet the mental health and co-occurring needs of adults and transitional age youth, enabling them to live, learn, work and participate actively in their communities. The Division's priorities include development and expansion of peer and family supports, the West Virginia Leadership Academy, recovery education, housing and homeless outreach to people with mental health issues and co-occurring addictions, and coordination and delivery of services for returning veterans and their families, integrated primary care and mental health services, and operational support for the West Virginia Mental Health Planning Council. Children and Adult Services are separately developed, identified and tracked in accordance with block grant requirements.

The Division of Child and Adolescent Behavioral Health is designated as the Single State Authority for Children's Mental Health, charged with monitoring and improving the child and adolescents' mental health service delivery system. The Division provides leadership, technical assistance and funding to support children and adolescents with serious emotional disturbances and their families. The Division's overarching priority continues to focus on increasing access and building service capacity through key initiatives including, the West Virginia System of Care (WVSOC), Statewide Family Advocacy, Support, and Training (FAST) Program, Expanded School Mental Health (ESMH), Adolescent Suicide Prevention and Early Intervention (ASPEN) and Transitioning Youth.

The Division of Alcoholism and Drug Abuse is the Single State Authority (SSA) responsible for prevention, control, treatment, rehabilitation, educational research and planning for substance abuse related services. The Division's priorities during the past several years include preventing the onset or initiation of substance use by young people, preventing or reducing the consequences of underage and adult problem drinking, reducing prescription drug misuse and abuse in the general population, reducing the number of drug-exposed pregnancies, reducing the number of drug-related deaths, reducing the number of outlets selling tobacco and alcohol to youth, reducing the number of repeat Driving Under the Influence (DUI) offenses, increasing the number of substance treatment services to meet the need of communities, and increasing the number of recovering individuals in stable housing with stable employment.

The Division of Intellectual and Developmental Disabilities provides leadership, facilitation, technical assistance and funding to support children and adults who have intellectual/developmental disabilities. The Division's priorities include increasing self-advocate/family/provider awareness of access to community services and supports, and developing services and supports for individuals with complex support needs such as traumatic brain injury, Autism and youth transitioning to adulthood.

The Office of Consumer Affairs and Community Outreach provides a collaborative support role to the above referenced clinical sections through ongoing collaboration with advocacy groups and local agencies on mental health, substance abuse and intellectual and developmental disability policy issues on designing and implementing the operation of the statewide behavioral health promotion and prevention network. The networks include stakeholder groups, including consumers, family members, advocates, providers, the general public, and service organizations, all of which help increase awareness and provide training opportunities on best practices and health promotion/risk reductions models. Priorities during the past several years have included coordinating Bureau training events, expanding peer supports, behavioral health disaster coordination, planning and response, anti-stigma and health promotion activities, developing a certification process for Peer Support Specialists and Recovery Coaches, tracking legislation and establishing a centralized intake process for issues arising from the general public and other stakeholders.

SSA/SMHA ROLES AND RESPONSIBILITIES

- Comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care.
- Integration and coordination of the public behavioral health system.
- State-level program funding decisions based on behavioral health indicators and program evaluation data.
- Prioritization and approval of all expenditures of funds received and administered by the BBHFF, including the establishment of rates, reimbursement methodologies and fees.
- Oversee implementation of the agreed upon Hartley Consent Decree order related to community support activities, including but not limited to, expansion of Care Coordination services, expansion of group homes and residential services, and the development of additional day supports.
- Partner with DHHR Bureaus for Children and Families, Medical Services, and Public Health, on community issues, including licensure and regulation of behavioral health professionals, programs and facilities.

- Promotion of activities in research and education to improve the quality of behavioral health services; recruitment and retention of behavioral health professionals; and, access to behavioral health programs and services.
- Implementation of the responsibilities related to behavioral health required by state law, as referenced in West Virginia Code, Chapter 27, Article 1A et seq. and all applicable legislative rules.

BEHAVIORAL HEALTH SERVICE DELIVERY

Many positive changes have been made in West Virginia's behavioral health system over the past two years. Infrastructure development, integrated planning and partnership expansion have been cited as key successes resulting in BBHMF's ability to: make better, data informed decisions for allocation and monitoring of the behavioral health system; improve the quality of service provision by educating providers, key stakeholders and communities; and, incorporate the consumer voice in the planning, implementation and evaluation of services.

Currently, West Virginia's priorities address the following critical areas:

- Assessing and improving access to services;
- Provision of primary prevention/promotion activities/services;
- Development of recovery focused service options;
- Provision of public awareness and professional education opportunities;
- Improved coordination of continuum services;
- Funding of specialized services for priority populations; and,
- Effective implementation and compliance with underage tobacco sales.

Since September 2011, Regional Substance Abuse Task Forces have met 60 times with over 3000 participants. The Task Forces have identified local problems and provided valuable insight into the diverse needs of communities to State policymakers. These recommendations have then been subsequently used to prioritize funding decisions. This model will serve as the preferred method to inform, guide and support future funding decisions across all divisions. It is important to note that the public sector is only one part of the overall behavioral healthcare system in West Virginia. Private funding sources, such as insurance companies, private businesses and individuals themselves, also influence both the availability of and manner in which behavioral health services are provided in the State.

Statements of Work (SOW) are incorporated in grant agreements that include grantee deliverables and outcome reporting requirements. The allocation documents were updated to include the SAMHSA Program Service Areas, in alignment with the *Good and Modern Strategies* approach. Data collection and reporting will also be completed within the same program categories, by service area, beginning in fiscal year 2014. Announcements of Funding Availability (AFA) for proposals are solicited publicly through websites and list serve contact lists. Impartial review teams score the proposals and make recommendations to BBHF. Awards are then made based on review team recommendations, established need and the organization's capacity to implement evidence based practices and programs.

FUNDING DIVERSIFICATION

Block grant funding supports individual services and related benefits, as well as costs related to the provision of direct services **not currently reimbursed by other payers**. Governor Tomblin and State lawmakers provided \$7.5 million in new State revenue during the 2012 legislative session to support: detoxification stabilizations units in regions 1, 5, and 6; twelve recovery coaches in region 4; expanded State SBIRT services to regions 2, 4, 5 and 6; intensive support services in region 4; a recovery residence in region 1; a state youth service center in region 3; and, a women's/pregnant women with children's treatment and recovery program in region 2.

The State also receives approximately \$7.5 million in discretionary funds for issues as diverse as Statewide Family Networks, Disaster Relief, Data Infrastructure, Supportive Housing, Primary Care and Behavioral Health Integration, SBIRT, Health Information and Technology (IT), PDMP/HER Integration and Interoperability, Pregnant and Post-Partum Women, and Drug-Free Communities. West Virginia (WV) has also recently submitted proposals for fiscal year 2014, to: include SBIRT services in family planning clinics statewide, Strategic Prevention Framework, Healthy School's Mental Health Expansion, Fetal Alcohol Spectrum Disorders (FASD) Education and Project Choices provided in WV universities, Adolescent Treatment service consistency in assessment and program implementation, and State infrastructure for Adolescent Suicide Prevention and Intervention.

West Virginia's publicly-funded community based behavioral health system is comprised of 13 regional Comprehensive Behavioral Health Centers, operating 54 satellite offices serving all 55 counties, and a myriad of private agencies that provide either stand-alone or a mix of services for children with serious emotional disturbances, adults with serious mental illnesses, individuals with substance use disorders and persons with intellectual and developmental disabilities. Core services provided include: Engagement, Outpatient, Medication and Acute Intensive services.

Partnership funding is awarded to six regional prevention agencies, smaller nonprofit organizations, schools and other state agencies to decrease substance use and promote mental health and wellness, through the building of effective coalitions and implementing evidence based services in 55 Counties. Current data driven **prevention priorities** include: Stigma Reduction, Prescription Drug Abuse, Under-age Drinking, Physician Engagement, Drug Exposed Pregnancy, Suicide, and Bullying.

In addition to providing prevention/promotion services, the block grant is a major source of funding for behavioral health early intervention, treatment and peer and recovery support services in West Virginia. **Early intervention** supported programs include the West Virginia Teen Courts, West Virginia Juvenile Drug Courts and Adolescent Screening, and Consumer and Family Outreach and Engagement Services. Communities have access to Prescription Drug, Gamblers and Suicide prevention phone lines that offer education, brief intervention and referral to treatment. While SBIRT is not currently funded through the SAPT Block Grant, the expansion of early screening and motivational interviewing are embedded in all programs.

Mental Health and Substance Abuse Block Grant funds also support a continuum of **treatment and recovery and peer support service** opportunities that include: intensive support, out of home residential, habilitation, and community support services. Priority populations identified and served include IV drug users, homelessness, pregnant women and women with dependent children, transitioning youth and young adults, and service members, veterans and their families.

The BBHMF works with the Bureau for Medical Services (BMS) and the Office of Health Facility Licensure and Certification (OHFLAC) in providing oversight for public and private programs that provide **medication assisted treatment**. In West Virginia, BMS approved State Medicaid reimbursement for Suboxone treatment effective January 2006. Vivitrol, a time released injection of Naltrexone received State Medicaid reimbursement approval in early 2011. In August 2011, the BMS issued a new Subutex /Suboxone /Vivitrol Policy that mandates adequate therapy services, strict documentation requirements, drug screening requirements, and treatment guidelines. Legislation providing increased coordination and oversight and further regulation of Opioid Treatment Programs (OTP) will go into effect October 2013. The State Opioid Treatment Authority is housed within the BBHMF Programs section and is heavily involved in the implementation and oversight of new legislative requirements

Technology has become an integral educational tool and service modality in coordination with traditional programming in West Virginia. Web-based resource and service identification as well as trainings, meetings and conferences are all essential due to the rural configuration of the State, transportation, workforce, and access issues. The BBHMF continues to collaborate with the State Medicaid Authority on receiving approval to expand the use of **telemedicine** based on

model policies developed by the American Psychiatric Association. West Virginia providers currently utilize technology based services for aftercare interventions, peer support reminders, Assertive Community Treatment team meetings, psychiatric evaluations (when testifying as expert witnesses for the purpose of commitment hearings), some assessments, and medication assisted treatment groups. The BBHMF website is currently being improved to better accommodate consumers and families, in addition to linking communities and providers with services and resources, <http://www.dhhr.wv.gov/bhmf>. Additional websites have been created specifically for the Governor's substance abuse initiatives in partnership with the BBHMF, <http://www.wvsubstancefree.org/> and the Mental Health Planning Council <http://www.wvmhpc.org/>.

Disaster Preparedness for Special Populations

The BBHMF employs a fulltime Disaster Coordinator and a part-time Disaster Planner who collaborates with first responders, hospitals, local health departments, social services, homeland security and emergency management agencies, faith based community, and voluntary organizations to develop disaster response plans, continuance of operations plans and to conduct table top and other exercises across the State. The BBHMF uses \$164,520 in Health Resources and Services Administration (HRSA) funds from the West Virginia Bureau for Public Health (BPH) to support regional preparation, planning, mitigation, response and long term recovery activities across the state, including a 24/7 hotline, an annual integrated disaster summit conference, coordination for activities of the Voluntary Agencies Active in Disasters (VOAD), and disaster mental health training for designated staff at each of the regional CBHCS. The BBHMF is an active member of the BPH's Special Populations workgroup, which has adopted Kentucky's approach to this issue by supporting local relationships between people with disabilities, first responders, health care providers and hospitals. This workgroup assembles resources to help people with disabilities plan for and survive local and regional disasters. Finally, the BBHMF is working with various groups, such as the BPH, the State Red Cross chapter, West Virginia Division of Homeland Security and Emergency Management, and VOAD, to develop processes, policies, plans and annexes for inclusion of those with access and functional needs in the State's various Emergency Operations Plans and for the activities listed in The National Response Framework (NRF) under Emergency Support Function #6, including mass care and sheltering, housing and human resources.

STATE SYSTEM DEVELOPMENT AND SUPPORT FOR INTEGRATING BEHAVIORAL HEALTH

Because of this extensive network, coordination and integration of the behavioral health system is critical. Consumers, advocates and program managers have long recognized that service integration is a first step toward higher quality services, increased access to services, and greater cost savings. The behavioral health service system was originally shaped and

compartmentalized by federal funding availability and program requirements. While some of those barriers still exist, other state and federal mandates create opportunities and expectations for integrated collaboration to help assure access to services that reflect the preferences and needs of behavioral health consumers.

The Medley Consent Decree was signed in 1981 and began changing the conditions in all of West Virginia's institutions for individuals with developmental disabilities, including the closing of several facilities. The Medley Decree, which was grounded in a 1980 U.S. District Court case, Medley v. Ginsberg, mandated that individualized services be delivered in the "least restrictive environment." As a result, a statewide system of family-based and residential services and supports has evolved. An interagency work group, the Medley Management Team, continues to identify and address lack of coordination, gaps in service, and overall service quality.

In 1982, the West Virginia Supreme Court found in the case of E.H. v. Matin that it was contrary to West Virginia law for the West Virginia Department of Health (the predecessor to WV DHHR) to merely "warehouse" an individual in a state mental institution. The matter was then remanded to the Kanawha Circuit Court. The parties then entered into a massive consent order dealing with just about every aspect of the state mental health system, with an assigned Judge and Court Monitor to aggressively oversee the state mental health system. In 1983, the Hartley Plan ordered even more sweeping reforms of the behavioral health system to promote an integrated, coordinated system of community-based resources for individuals with mental health and substance abuse challenges, including care coordination, group homes, day treatment centers and crisis stabilization services.

At the federal level, the United State Supreme Court ruled in Olmstead v. LC, (1999) that services must be provided in the "most integrated setting." This decision has become the legal basis for the movement of expansion of services for people with disabilities away from institutions and toward community-based supports, in order to help people remain in their own homes as long as possible. WV DHHR administers two programs under the auspices of Olmstead:

- The West Virginia Olmstead Office Transition Navigator Program assists West Virginia citizens with disabilities to transition from institutional facilities (including psychiatric hospitals and nursing homes) to live and be supported in their community of choice by offering intensive case management, resource information and support, and flexible start-up funding.
- The Bureau for Medical Services oversees the federal Money Follows the Person (MFP) Rebalancing Demonstration, *Take Me Home, West Virginia*. MFP is a rebalancing method that refers to a system of flexible financing for long term care services that enable funds to move with the individual to his or her most appropriate and preferred

setting. Program participants also receive the services of an intensive case manager to help navigate the system. *Take Me Home, West Virginia* will transition at least 600 individuals from institutional (including from nursing homes and psychiatric hospitals) to community living over the 5 year grant period. This approach is especially notable in that it is among the first federally funded Money Follows the Person projects to prioritize transitioning people with serious mental illness from state run psychiatric hospitals to community-based settings.

The Affordable Care Act (ACA) encourages, supports, and provides funding for the integration of healthcare and behavioral healthcare. West Virginia was one of the first States, in 2010, to submit a combined Substance Abuse Mental Health Block Grant Application. The Governor's decision to **expand Medicaid services** in West Virginia, made on May 2, 2013, will provide insurance coverage to an estimated 91,500 citizens, significantly reducing the number of uninsured West Virginians. Combined with other ACA mandates, the number of uninsured West Virginians is expected to drop from 246,000 to 76,000 by 2016. A large number of individuals will qualify for Medicaid who have substance abuse and behavioral health needs; thus, the State will be able to draw down significant federal funds to treat these problems that are now addressed solely with State funds.

West Virginia participated in a bipartisan and inter-governmental effort to reduce prison growth and prevent crime using a data-driven "**justice reinvestment**" approach. A comprehensive analysis of the criminal justice system was conducted by the Council of State Governments Justice Center, establishing a working group of legislative leaders from across the political spectrum, top court officials, state agency directors, and criminal justice stakeholders to review trends in the state's criminal justice system and develop policy options. The approach resulted in the passage of SB371, the Governor's Prison Overcrowding bill, during the 2013 legislative session. The BBHMF participates at multiple levels within this initiative and has provided technical clinical support and program advisement.

The BBHMF partners with the West Virginia Governor's Highways Safety Program on two important initiatives that promote healthy school and campus environments for youth. The **WV Collegiate Initiative to Address High Risk Alcohol Use (WVCIA)** proactively addresses collegiate alcohol, other drug, and associated violence issues through the use of evidence based strategies, in order to promote healthy campus environments through self-regulatory initiatives, information dissemination, public policy influence, cooperation with prevention partners, and technical assistance. Members include representatives of the state's campuses, agencies, and communities who encourage and enhance local, state, regional, and national initiatives through a commitment to shared standards for policy development, educational strategies, enforcement, evaluation, and community collaboration.

For more than 27 years, SADD has been committed to empowering young people to lead education and prevention initiatives within their schools and communities. In 1997, in response to requests from students themselves, SADD expanded its mission and name, and chapters are now called Students Against Destructive Decisions. SADD continues to endorse a firm “no use” message related to use of alcohol and other drugs. **West Virginia’s 150 SADD Chapters** highlight prevention of many destructive behaviors and attitudes that are harmful to young people, including underage drinking, substance abuse, impaired driving, teen violence and suicide. West Virginia Projects include peer-led classes and theme-focused forums, conferences and the provision of evidenced-based prevention education, leadership training, and legislative advocacy. Independent studies have shown that students in schools with an established SADD chapter are more aware and informed about the risks of underage drinking, other drug use and impaired driving. Students in schools with a SADD chapter are also more likely to hold attitudes reflecting positive reasons not to use alcohol.

The BBHFF is committed to improving outcomes for youth with behavioral health challenges (substance abuse, mental health, and intellectual/developmental disabilities), many of whom are currently served through the child welfare system. West Virginia recognizes that the lack of quality community based behavioral health services is a significant contributor to the number of children and adolescents in state and parental custody living in out of home care, both in-state and outside of West Virginia. In April 2013, the BBHFF initiated a technical assistance **partnership with the Annie E. Casey Foundation** to assist the State in reviewing existing policies and practices, service array, and financing and performance management outcomes, in order to develop strategies for reducing reliance on institutional settings or “congregate care.” The Annie E. Casey Foundation’s Child Welfare Strategy Group has found that helping public systems reduce reliance on institutional settings, or “congregate care,” for children in state custody is the most significant first step in addressing larger systems reform, including access to quality care in the community.

West Virginia has taken steps to integrate **behavioral health and primary care**. Ten of the State’s 28 Federally Qualified Health Centers (FQHCs) now employ a behavioral health provider. These health centers offer behavioral health services coordinated with medical services. Because these healthcare teams are able to simultaneously treat healthcare and behavioral health issues earlier, better healthcare outcomes can be achieved. Three of the State’s largest CBHCs offer coordinated primary health care services in a community mental health setting and share behavioral health staff with rural primary care centers through co-location and integration agreements.

After eighteen years as a statewide initiative, it is widely accepted that **School-Based Health Centers** (SBHCs) provide easily accessible and cost-effective care and they are strongly

supported by students, parents, and school staff. The goal of the statewide initiative is to ensure primary and preventive care for youth, by eliminating access barriers that children and adolescents face. Beginning August 21, 2013, there will be 89 SBHCs serving 106 schools in 32 counties, making health services available to a school-aged population of over 54,000 children. SBHCs are health clinics that bring preventive and immediate care, as well as counseling, health education, and sometimes dental care, to children and adolescents where they spend the majority of their day – at school. Approximately one-third of the SBHCs provide behavioral health services and through continued collaborative efforts that number continues to rise every year.

The federally funded West Virginia **Screening, Brief Intervention and Referral to Treatment** (SBIRT) project is an excellent example of integrating behavioral health with other systems, having established services in 58 sites, having screened over 194,551 individuals, with 31,128 positive screenings, and having provided 14,187 brief interventions, 534 brief treatments and 1,036 referrals to treatment since 2009. Current venues include primary care, trauma centers, hospital emergency departments, school based health centers, workforce development centers, health departments, colleges/universities, obstetric practices, community behavioral health centers, regional jails and free clinics. More recently, SBIRT training was provided for direct line staff and supervisors at county senior service centers. Furthermore, drug diversion training for nurses, as mandated in Senate Bill 437, includes education on screening, brief intervention and referral to treatment.

The **West Virginia System of Care** (WVSOC) is a public /private /consumer partnership dedicated to the mission of building the foundation for an effective community based continuum of care that empowers children and adolescents at risk of out of home care and their families. The framework of the WVSOC is rooted in developing culturally competent agencies, programs and services that are trauma informed and reflect the cultural, racial, ethnic, and linguistic differences of the population served, in order to facilitate timely access to appropriate services and supports and effectively eliminate disparities in care. The WVSOC began in 1999 as a federally funded pilot project for a 12 county region in West Virginia. Lawmakers enacted legislation in 2005 to establish the Commission to Study the Residential Placement of Children (West Virginia Code §49-7-34). In 2010, the Legislature passed Senate Bill 636 to reconstitute the Commission. This Legislative Bill, in addition to the original study areas, includes addressing any ancillary issues relative to foster care placement and requires a reduction in out of state placements. The Commission's findings resulted in the continuation and statewide expansion of the WVSOC as part of the Commission's final 13 recommendations. The West Virginia System of Care Implementation Team (SIT) was established in 2007. It is a public, private, community partnership that oversees the WVSOC initiative. The SIT is

comprised of family, policy, program and fiscal representatives from child welfare and behavioral health, service providers, education, public health, juvenile justice, community representatives, and probation. The SIT serves as the State Steering Team for the State's Service Array statewide needs and gaps assessment process, focusing on the integration of the WVSOC values and principles across all child serving agencies/systems. Ninety-eight services and 29 practices across seven child welfare capacities were reviewed through the service array process. The combination of the work of the SIT and the Children's Community Collaboratives have resulted in the development of evidence based practice resources and a three year strategic plan to address the continuum of services and supports for West Virginia children and their families.

In September 2013, the West Virginia Department of Health and Human Resources, BBHMF, and more than 28 State and National partners are coming together to provide the first **West Virginia Integrated Behavioral Health Conference**, a ground-breaking event with 100 in-depth workshops, plenary sessions and keynote presentations. The conference will provide essential information for addressing behavioral integration and collaboration across populations. The BBHMF anticipates hundreds of behavioral health and other professionals, as well as consumers and families, to be in attendance to learn and share critical knowledge. The conference will focus on various aspects of mental health, substance abuse, and intellectual and developmental disabilities, trauma informed care and treatment, cultural competency, health care reform and infusion of best practice. Attendees will explore solutions for success, create new partnerships, and be inspired by nationally and locally recognized speakers. Immediately following the conference, the West Virginia State Medical Association, in partnership with the BBHMF, the West Virginia Physicians Health Program and West Virginia University, will host the **Appalachian Addiction and Prescription Drug Abuse Conference**.

Brought into existence by the 2006 West Virginia Legislature [via H.B. 4488] and extended by Senate Bill 687, the **Comprehensive Behavioral Health Commission** (Commission), chaired by Dr. Ahmed Faheem, is charged with studying the current behavioral health system and designing a long-term, well-planned development of a comprehensive and cost-effective system of care. The Commission is comprised of members from key state agencies and the private sector. An Advisory Board, that includes clinicians and consumers working in the behavioral health field in West Virginia, provides direct support to the Commission. The overall vision of the Commission is to support a behavioral health system that is well defined, effective at meeting consumers' needs and ever changing for the better.

The BBHMF was recently awarded funding to support participation in the **Bringing Recovery Supports to Scale Technical Assistance Center Strategy** (BRSS TACS). Because of its long history with peer supports and recent changes in its behavioral health system, West Virginia is in a

unique position to promote wellness and wide-scale adoption of quality recovery-oriented supports, services, and systems for people in recovery from substance use disorders, mental health problems, and/or co-occurring disorders. The priorities of the consumer driven team are to 1) develop and implement a respected, evidence-based peer certification process; 2) leverage support by establishing a state-wide consortium dedicated to promoting wide-scale adoption of recovery-oriented supports; and 3) create and organize state-wide, an integrated consumer network designed to engage and recruit peers regarding workforce and leadership development. The BBHMF currently funds several groups across the State to operate peer-operated Wellness and Recovery Centers and has provided funds to the **West Virginia Mental Health Planning Council** to continue implementation of Leadership Academies across the State. The Bureau has also provided ongoing support for the enhancement of the Mental Health Planning Council, with planned linkages to the Governor's Advisory Council on Substance Abuse, as well as established statewide regional substance abuse taskforces. These changes have helped move West Virginia from supporting a single entity for peer-operated services to emphasizing and cultivating development of such services in local communities throughout the State.

Governor Earl Ray Tomblin issued Executive Order No. 5-11 on September 6, 2011, which created the **Governor's Advisory Council on Substance Abuse** (GACSA). Appointed council members include Cabinet level positions in the Department of Health and Human Resources, Department of Military Affairs and Public Safety, and the Department of Veterans Assistance; persons in leadership positions representing the State Police, Chiefs of Police, Sheriffs, Supreme Court, Education, WorkForce West Virginia, Behavioral Health and Health Facilities; experts from the fields of behavioral medicine, substance abuse prevention and treatment, peer and recovery supports, the faith-based and minority communities, homelessness, domestic violence prevention; and, a range of health professionals, among others. The executive order outlines the Council's duties to: provide guidance regarding implementation of the Statewide Substance Abuse Strategic Action Plan; identify planning opportunities with other interrelated systems to increase both public and private support concerning substance abuse initiatives; recommend a list of priorities for the improvement of the substance abuse continuum of care; receive input from local communities throughout West Virginia; and, provide recommendations to the Governor to improve education, data needs, employment opportunities, communication, crime prevention, and other matters related to substance abuse. Governor Tomblin also established six regional sub-state planning regions and 6 Substance Abuse Task Forces. The **Regional Substance Abuse Task Forces** are open to the public and have involved over 3000 West Virginia citizens, including elected officials, service providers, representatives from the court system, the law enforcement and recovery communities and the general public. A celebration is planned preceding the BBHMF's first integrated conference to showcase and celebrate the grassroots efforts launched.

The State’s ability to come together applying a top down, bottom up partnership approach is central to West Virginia’s success and can be directly linked to the progress that the Governor’s Advisory Council on Substance Abuse, Regional Substance Abuse Task Forces and BBHMF have all made since September 2011. Regional projects have been completed, comprehensive substance abuse legislation passed, new funding for substance abuse services awarded, and the *Comprehensive Substance Abuse Strategic Action Plan*, now integrated with the overarching plan for the Bureau for Behavioral Health and Health Facilities, is being implemented. West Virginia citizens are moving from helplessness and hopelessness to empowerment and action.

LEGISLATION SUPPORTING BEHAVIORAL HEALTH OUTCOMES

Legislation 2011-2013	Supportive Action
Executive Order 5-11 signed by Governor Tomblin	<ul style="list-style-type: none"> • Created 6 Regional Task Forces (RTF’s) • Created the Governor’s Substance Abuse Advisory Council (GACSA) • Called for action to implement the Statewide Substance Abuse Strategic Action Plan & Make recommendations regarding service provision, education, policy & legislation • Appointed DHHR to coordinate and facilitate requirements set forth in the Executive Order
Senate Bill 437	<ul style="list-style-type: none"> • Decreases prescription reporting time in the Controlled Substances Database from 7 days to 24 hours • Establishes an advisory council to recommend enhancements to the prescription database and advise on the feasibility of real-time reporting • Creates a review committee to flag irregular prescribing patterns by physicians and abnormal usage by patients • Codifies new licensing regulations to protect legitimate pain clinics and make sure those with real chronic pain can access treatment • Requires penalties for operating a chronic pain clinic without a license • Tightens requirements for dispensing controlled substances from doctor offices • Requires “best practice” prescribing education for health care professionals, as well as education in anti-drug diversion • Tightens program and reporting requirements for opioid treatment centers • Defines the existence of a valid practitioner-patient relationship prior to dispensation of prescriptions • Implements a real-time, stop-sale tracking system for

	<p>pseudoephedrine purchases to block the sale of excess product when attempted</p> <ul style="list-style-type: none"> • Signage for pain clinics
House Bill 4351	Pre-employment and random drug testing for coal miners employed in safety-sensitive positions
Executive Order 8-12	Unemployed West Virginians seeking to enroll in job training programs offered through Workforce West Virginia are now required to pass a 10-panel drug test
Senate Bill 221	Creating the Jason Flatt Act, requiring the Center for Professional Development to provide for the routine education of all professional educators and certain service personnel on warning signs and resources to assist in suicide prevention
Senate Bill 507	Removing the requirement that the minor's consent be secured before they are voluntarily admitted to a mental health facility if the minor is twelve years of age or older and creating standards and procedures for releasing a minor who is fourteen years of age or older from voluntary hospitalization, when the minor objects to the admission or treatment
Senate Concurrent Resolution 50	Requesting Joint Committee on Government and Finance study abuse deterrent formulations for opioid medications
Senate Bill 108	Merging all of the existing Fatality and Mortality Review Teams (including those looking at the deaths involving children, domestic violence, and infants and women who die during pregnancy) into one group and adds a new group to look at, unintentional pharmaceutical drug overdose fatalities, all under the Office of the Chief Medical Examiner
Senate Bill 265	Authorizing DHHR to promulgate legislative rules. The bill includes revisions to the regulation of opioid treatment programs, 69 CSR 7, including but not limited to issues related to increased license fees and inspection costs; required services; counseling; post-admission assessment; unsupervised take-home medications; counseling services and maintenance treatment ; collection and testing; and, pregnant patients
Senate Bill 371	Relating to prison overcrowding. The bill includes, among other things, revisions related to deduction from offender prison sentences for good conduct; pretrial risk assessment; the development of a cognitive behavioral program to address the needs of inmates detained in a regional jail, but committed to the custody of the Commissioner of Corrections; sentencing alternatives, such as weekend jail programs and work programs; home incarceration procedures; adding BBHF as a member of the Community Corrections Subcommittee; adding a person with a background in substance abuse treatment and

	services as a required member of Community Criminal Justice Boards; standardized risk and needs assessment and day report services; probation and parole eligibility and violations; permitting the Division of Corrections to employ or contract for a director of employment and a director of housing for released inmates; creation of a community supervision committee to share information for coordinated supervision; drug courts; development of qualifications for provider certification to deliver a continuum of care to offenders, fee reimbursement procedures, by the Division of Justice and Community Services, in consultation with the Governor's Advisory Committee on Substance Abuse; and, finally, preparation of an annual report prepared by the Division of Justice and Community Services, in consultation with the Governor's Advisory Council on Substance Abuse
House Concurrent Resolution 142	Urging Congress to swiftly take bipartisan, concrete action to address the growing scourge of prescription drug abuse in West Virginia and other states
House Concurrent Resolution 147	Improving enforcement of drugged driving offenses
House Bill 2513,	Requesting a study to consider a sentencing revision for DUI with death cases. The purpose of this bill is to improve enforcement of laws against drugged driving. The bill defines "drug" and provides that implied consent applies to testing for controlled substances or drugs upon arrest of a driver in this state. Among other things the bill requires the Bureau for Public Health to prescribe minimum levels of substance or drugs in order to be admissible; authorizes emergency rules; and, requires the Bureau for Public Health to review current methods and standards

ADDRESSING DIVERSE AND PRIORITY POPULATIONS

Community program examples of reaching diverse and priority populations include the partnership with SAMHSA, CADCA and local providers to provide match funding for 3 VETCORPS positions, working in coordination with prevention organizations to provide outreach to Service Members, Veterans and their Families in Regions 2, 5 & 6. A health literacy program was piloted in Region 4 to distribute family health information workbooks to service members, veterans and their families. The BBHFF also provided funding to the Partnership of African American Churches to increase minority and faith based representation in regional planning, training recovery coaches, and implementing targeted minority youth programming statewide. Additionally, BBHFF entered into a 3-year public/private partnership with the Bureau for

Maternal Child and Family Health, West Virginia Community Voices (WV Perinatal Partnership) and the Benedum Foundation to support OBGYN practices/hospitals in providing early intervention and recovery supports to pregnant women to decrease the number of drug exposed babies. The BBHMF provides state funded grants to support the WVSOC Initiative, expanded school based mental health services and transitioning youth services. Services and supports for children with serious emotional disturbance and their families funded by the block grant include the Children's Homeless Outreach Program; a Statewide Family Advocacy, Support and Training (FAST) Program, the West Virginia Mental Health Planning Council and operational support for the West Virginia Council for the Prevention of Suicide. Services and supports for adults with serious mental illness funded by the block grant include: Peer and family supports, the West Virginia Leadership Academy, recovery education, homeless outreach, integrated primary care and mental health services, and operational support for the West Virginia Mental Health Planning Council and the West Virginia Council for the Prevention of Suicide.

BBHMF System Changes that have addressed meeting the needs of priority populations include:

1. Cultural Competency and Trauma Informed Care are training requirements incorporated into grant agreements
2. Developed and disseminated Cultural Competency and LGBTQ specific presentations in all regions of the State in partnership with the targeted population
3. Partnered with 25 State agency and private organizations to offer an integrated learning opportunity, with keynote/ workshop leaders covering cultural competency in all priority populations
4. Participated on the WVDHHR Secretary's Multi-Cultural Equity Team, with a mission of recruiting and retaining employees and improving services for the consumers BBHMF serves

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Step 2: Identify the unmet service needs and critical gaps within the current system.

COMPEHENISVE APPROACH TO IDENTIFYING NEED

The process for formulating a comprehensive plan for guiding the work of BBHFF has occurred over the past two years in multiple phases for substance abuse, mental health and intellectual disabilities. The *West Virginia Behavioral Health Integrated Strategic Plan* builds on the same approach initially used to develop the *Comprehensive Substance Abuse Strategic Action Plan*, which resulted in significant cross-systems leadership and commitment to address the epidemic of substance abuse in the state. This collective body of qualitative and quantitative data supports on-going planning and decision making with regard to block grant funds, in coordination with state, regional and county profiles developed by the West Virginia State Epidemiological Outcomes Workgroup (WVSEOW).

The **West Virginia planning model** is based on lessons learned and is consistent with Strategic Prevention Framework, CADCA and System of Care approaches. Key elements include: System-wide assessment involving multiple partners; Establishment and continuation of relationships with federal, state and local partners; Consideration of the lives of those impacted by behavioral health needs and encouragement of input regarding local concerns, priorities, solutions and strategies; A top down – bottom up approach in all aspects of planning; Data informed decision making guiding the process; Funding as one part of success – grassroots efforts and collaborations are both impactful and cost effective; and, development of strategies that are flexible to ever changing environments, while always keeping the end in focus.

In addition to overall community concerns, shifts in cultural and social norms were identified during the 18 community forums and key stakeholder meetings and provided insight into the increase in substance use and abuse and co-occurring needs in West Virginia. Specific affected populations were seen as emerging, with considerable “fall-out” with regard to the resulting cost of fiscal and human capital. Multiple generations are being affected by perinatal substance abuse and drug related incarcerations, leaving families separated and children and youth dependent on inexperienced relatives and caregivers trying to access and navigate a challenging social service system.

“There is a sense of hopelessness when it comes to addressing the state’s substance abuse problem”

“The abused drug of choice appears to vary by region of the state”

“There appears to be an overall feeling that all of these substances are equally accessible”

“The substance abuser must make the decision to get treatment”

Executive Briefing, a qualitative summary of the targeted focus groups, completed by R.L.

Shifting Cultural and Social Norms

- Much younger people are using drugs at an alarming rate
- Pregnant women are using drugs
- Synthetic drug use is not considered as bad as other drugs
- A culture of sharing among West Virginians (including prescription drugs)
- Lack of family engagement
- Increase in school drop-out and teen pregnancy rates
- Jail and prison overcrowding due to underlying substance abuse issues

Governor Earl Ray Tomblin conducted additional regional roundtables in 2011, resulting in the appointment of the Governor’s Advisory Council on Substance Abuse (GACSA) and six regional task forces established through Executive Order 5-11. Since that time, the task forces have successfully engaged communities to provide the GACSA with recommendations for: additional support for substance abuse services, realignment or additional funding strategies, legislative action, and other initiatives supporting the overarching goals set forth in the *Comprehensive Substance Abuse Strategic Action Plan*. The GACSA was charged with providing guidance regarding implementation of the approved *Comprehensive Substance Abuse Strategic Action Plan*, identifying partnering opportunities with interrelated systems and receiving recommendations from local communities throughout West Virginia to determine priorities for the improvement of the substance abuse continuum of care.

Regional Specific Substance Abuse Trends Identified 2012-2013

Region 1	<ul style="list-style-type: none"> • Transient population of Marcellus Shale drillers (High rents/more drug use) • K-2 (Synthetic Marijuana) • Cleveland and Detroit Drug Dealers • Increasing homelessness
Region 2	<ul style="list-style-type: none"> • More Synthetics in Recovery Population (Not showing up in urine tests) • Energy Drinks related to deaths • Synthetics-K2 and “Molly” (MDMA or methylenedioxymethamphetamine the main component in ecstasy) • Tobacco Store Spices to smoke
Region 3	<ul style="list-style-type: none"> • Meth • Synthetics (K-2 and Bath Salts)
Region 4	<ul style="list-style-type: none"> • Synthetics (Bath Salts, K-2) • Increase in crime and gun violence • Suboxone/Methadone misuse • Heroin-Laced Marijuana • Drug Use during Pregnancy
Region 5	<ul style="list-style-type: none"> • Heroin • Links with needle and disease transmission from Cabell to Mason County • Drug Exposed Babies • Child Abuse and Neglect

Region 6	<ul style="list-style-type: none"> • Children without Parents due to substance abuse • People dying much younger • General acceptance of drug use by parents and youth • Babies born addicted • Increase in Crime and Gun Violence
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*Regional Task Force Identified Needs and Recommendations 2012-2013**

Improved School system involvement: Need more counselors, social workers and Prevention Resource Officers (PROs) to address SA issues; data exchange and coordination; Secondary School Activities Commission (SSAC) involvement; and, better coordination between schools with local SA programs.	Exploration of city ordinances that facilitate local/state cooperation with regard to jurisdictional authority as it pertains to the WV Alcohol Beverage Control Administration laws and regulations
Increase Faith-based involvement: Participants identified the need to better engage the faith-based community.	Establish a certification/credentialing process for recovery coaching
Additional Transitional Housing: Need for more transitional housing for those coming out of treatment or the correctional system, as a cost-effective way to promote and sustain recovery.	Recovery to Work, allowing fine forgiveness in return for community service
Employment & Workforce: Drug education for businesses and employment for individual's post-treatment or correctional system, including felony forgiveness and the need for more drug counselors/ clinicians.	Establish penalties for intent to sell all classes of psychoactive drugs
Marketing & Outreach: Anti-drug campaigns & marketing and outreach for the programs and services that are currently available.	Explore Medicaid reimbursement for SBIRT and peer recovery coaching services
Stigma related to getting help, future employment and other opportunities.	Increase alcohol/tobacco tax rates and use revenue to establish a set aside a dedicated funding stream to support prevention, early intervention, treatment and recovery services
Lack of Transportation limits access to services.	

*GACSA Recommendations Pending

BUILDING ON A SUCCESSFUL DATA DRIVEN PLANNING PROCESS

In May 2012, BBHMF launched a similar strategic planning process to assess the statewide **treatment needs for children and adults with mental health disorders and intellectual and developmental disabilities**. To assure input from BBHMF’s colleagues and stakeholders across the state, meetings were convened with 21 critical partners in planning, funding and delivering services and supports (e.g. behavioral health providers, consumer and family planning and advocacy groups, and people who work in the field of traumatic brain injury). A series of 12 focus groups was hosted across the state, comprising 105 consumers, family members and caregivers. Four public forums were convened to gather regional and local input about problems and suggested solutions, with a total of 180 individuals attending. Two federally funded consultants provided on-site technical assistance for the public forums and key stakeholder meetings and developed the initial framework and draft action plan.

Stakeholders conveyed a strong message about the desire for accessible services and supports to successfully live in the community. Most notable about results from both the focus groups and public forums was the consistency of responses across geography, disability and regardless of whether participants identified themselves as self-advocates, caregivers, providers, government representatives, or interested outside advocates.

Critical needs emerging from the consumer and family focus groups include:

- Centralized information about availability and access to resources
- Community and home-based options to support living as independently as possible
- Access to specialized treatment and alternatives to medication
- Support groups
- Compassion and empathy from providers
- Desire to educate the community about mental health and ID/DD and

Key Challenges and Recommendations Identified

Fill service gaps and improve access
1. Residential service shortage areas include: transitional housing, assisted living, and affordable, long-term housing
2. Non-residential treatment service shortage areas include: drop-in centers
3. Supportive service shortage areas include: transportation, mobile crisis services, support groups, and peer recovery supports
4. Age-specific needs include: supports for transition-aged youth (e.g. case managers, advocates, mentors), child psychiatry, and children’s services
5. Innovative strategies to be developed include: telemedicine, more home-based solutions, and

more cross-system service integration, e.g. school-based mental health/health centers
Workforce Development
1. Establish a Statewide Training Institute to provide targeted training and technical assistance on topics such as: cultural competency, EBPs, specialized care, and special populations
2. Provide a speaker's bureau, online training and Continuing Education Units (CEUs)
3. Develop professional career ladders and certifications
4. Utilize Professional Learning Communities (PLCs) to cross-train staff and support cross-agency/cross-system training
Better Cross System Collaboration and Information Sharing
1. Use social media and technology, in conjunction with existing collaborative structures, to increase public education messaging and reinforce a shared approach at the regional level
2. Establish a centralized, web-based resource and information site that incorporates a state resource library and links to specific state and local agency websites
3. Identify and engage key and nontraditional partners: P-12 education, workforce, faith groups, child welfare, and higher education
Maximize Existing Resources: Funding and Services
1. Use flexible funding to expand services
2. Improve utilization of prevention and intervention services to reduce dependence on high-cost services
3. Streamline processes and requirements
Focus on Outcomes and Accountability
1. Utilize Evidence-Based Practices (such as TACSEI, PBS, SBIRT, and Trauma-informed Practice)
2. Enforce health, safety and quality standards and improve transparency of funding
3. Use funding to drive outcomes that are based on consumer need
Increased State Leadership
1. Commit to critical policies (such as Hartley & Medley) and change outdated or harmful policies
2. Conduct regular "listening tours" throughout the state
3. Commit to public disclosure of BBHMF's strategic plan and outcomes
4. Improve regular program monitoring
5. Streamline responsibilities across agencies

MAKING DATA INFORMED DECISIONS

The Bureau for Behavior Health and Health Facilities is the designated host agency for the State Epidemiological Outcomes Workgroup (SEOW) project. The West Virginia SEOW was assembled to lead the statewide systematic process to gather, review, analyze, translate and disseminate information about substance use and abuse and mental health in West Virginia. State, Regional and County profiles are compiled for web-based dissemination. Data reported in the West Virginia Behavioral Health Epidemiological Profile (State-level) is compiled by partnering WVSEOW agencies, including: CAMC's Institute Center for Health Services & Outcomes Research, First Choice Services, Inc., the Governor's Highway Safety Program, West Virginia Bureau for Children and Families, West Virginia Bureau for Medical Services, West Virginia Bureau for Public Health-Office of Epidemiology and Prevention Services, West Virginia Bureau for Public Health-Health Statistics Center, West Virginia Bureau for Public Health-Office of

Maternal, Child and Family Health, Division of Research, Evaluation and Planning, West Virginia Coalition Against Domestic Violence, West Virginia Coalition to End Homelessness, West Virginia Department of Education Office of Healthy Schools, West Virginia Department of Education Office of Research, West Virginia Division of Corrections, West Virginia Division of Justice and Community Services-Office of Research and Strategic Planning and Justice Center for Evidence Based Practice, West Virginia Statistical Analysis Center, West Virginia Health Care Authority, West Virginia Higher Education Policy Commission, West Virginia National Guard Prevention, Treatment and Outreach, West Virginia Poison Center Robert C. Byrd Health Sciences Center, Charleston Division, West Virginia State Police, and the West Virginia Supreme Court of Appeals. The BBHFF has expanded research and planning efforts to further enhance the ability and capacity to garner, evaluate and expand behavioral health profiles system wide.

The West Virginia Poison Control Center leads the Early Warning workgroup that identifies trends in substance abuse and provides alerts to educators, behavioral health providers and law enforcement. Regional Data and Planning Teams (DPT's) support the collection and translation of data at the community level and are facilitated by regional prevention grantees, with a required membership that includes: Law Enforcement, Education, Health, Mental Health and Youth.

NEEDS AND GAPS IDENTIFIED

Understanding the uniqueness of the rural Appalachian culture is fundamental to planning and implementing a successful statewide system of behavioral health care in West Virginia. There is little racial and ethnic diversity in West Virginia, with 94.1% of the population identifying as white, 3.5% of the population identifying as black, 0.7% of the population identifying as Asian, and 1.7% of the population identifying as some other race. Only 1.3% of West Virginia's population identifies as Hispanic or Latino, compared to 16.7% in the United States as a whole. Gilmer County has the most diversity, with 5.8% of its residents identifying as being of Hispanic origin and 12.7% identifying as Black. Other counties with higher rates of racial/ethnic diversity include Jefferson, Berkeley, Raleigh, Kanawha, and McDowell. West Virginia is tied with 3 other states as having the lowest percentage of adult literacy, with about 20% of the general population falling into the lowest level of literacy.

By any measure West Virginia residents are among the poorest in the country, coming in 49th, ahead only of Mississippi. As a result, the financial responsibility for health and behavioral health care, as well as associated socioeconomic supports (food, housing etc.), falls most heavily on West Virginia's State resources, which are often insufficient to meet the associated needs. Accessible transportation is especially limited in the State, with only 30 of 55 counties having public transit systems and only 33 counties with taxi services. According to the National Institutes of Health, the estimated total overall costs of substance abuse in the United States,

including productivity and health- and crime-related costs, exceeds \$600 billion annually. Approximately 7.2% of West Virginians over the age of 18 reported having a substance abuse problem in 2010-2011 (NSDUH). West Virginia (WV), located in the Appalachian Mountain range, is the 7th most rural state in the United States (US), yet has the nation's highest rate of drug deaths, more than 9 out of 10 coming from prescription drugs, with drug overdoses as the leading cause of death in 2012 among those 45 years of age or younger, killing more West Virginians than car accidents.

Barriers to Medicaid Expansion

While Medicaid expansion will likely provide first time services for younger men and some families, on the other hand, some folks who were covered by the State's charity care mechanisms may now be faced with co-pays for the first time (depending on the plan). Additionally, individuals may decide to go to the Health Insurance Marketplace and may not understand or make the best choice.

According to West Virginia providers, the three major barriers to enrollment and re-enrollment include: lack of resources, expertise, and reaching folks, as well as the whole issue of choice in the Health Insurance Exchange, now called Marketplace. Access to navigators will be a significant issue from a systems perspective. Electronic medical records may also be a barrier, as not all organizations are at the same level with the lack of/or inadequate technology contributing to billing problems. Currently, providers are hesitant to sign contracts because the contract language is vague and inconsistent and there are serious questions about covered services and the credentialing of staff.

Workforce Capacity Challenges

One of the biggest challenges facing West Virginia's behavioral health providers is building a highly qualified workforce. Through funding by the Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Prevention Enhancement Grant, the West Virginia Bureau for Behavioral Health and Health Facilities (BBHFF) set a priority to study West Virginia's behavioral health workforce. In partnership FirstChoice Health Services, Inc., a comprehensive Workforce Capacity Assessment was developed to determine the current state of the behavioral health workforce in West Virginia. This contained two parts: a web-based, multi-section survey, opened on May 2, 2012, with 205 respondents, and six regional focus groups, held in March 2012 with 59 participants. Results show that the average behavioral health worker is a 46 year old female with a Master's degree, who has worked in the field about 12 years. Most workers serve in a social work or human service role, while many others come from the counseling field. It is important to also note the diversity of West Virginia's behavioral health workforce: 7.3% of the workforce is non-white, compared to 5.9% of the West Virginia

population. West Virginia's workforce is highly educated, with 95.6% holding some level of a degree, compared to only 82% nationally. About 10% of the workforce describes themselves as "in recovery." Around half of the workforce did not choose behavioral health as their first career, with most coming from business, education, health, or non-behavioral health social services. Many workers come to behavioral health due to a personal interest or a desire to help others. Of the issues facing the field, salary was the greatest. The overall median salary for fulltime behavioral health workers in West Virginia was \$39,000, which is low compared to national data on behavioral health salaries. There is also a great shortage in the field: of the administrators surveyed, 60% reported their agency was understaffed, with an average of 12 existing vacancies. Recruiting workers has been a challenge, as many applicants are insufficiently qualified due to a lack of behavioral health experience or training and education. Retention of good workers has been hindered due to low salary and burnout: more than 4 out of 5 reported some or a lot of job related stress, with few to no stress management programs.

Providers report that the work load continues to grow because of increased demand for comprehensive prevention, crisis and residential programs. Comprehensive Behavioral Health Centers informed the Bureau for Behavioral Health and Health Facilities during a System Development Work Group that young professionals often use their agencies as a training ground. These professionals complete clinical supervision requirements, gain licensure /certification, and then move on to higher salaried positions out of state, with local schools, or private-for-profit companies. Incentives or "stay" contracts are being investigated as possible strategies for improving longevity and promotion of experience in the workforce.

In a state with a population of nearly two million people, lack of credentialed individuals and general staff shortage is far-reaching. In West Virginia that shortage includes physicians and nurses, child and adult psychiatrists, clinical psychologists, counselors, social workers and direct care staff. There are only 41 practicing licensed child psychiatrists in the State, with an average of 659 children with serious emotional disturbance per psychiatrist. This demonstrates a significant gap between need and availability of qualified child psychiatrists. Over 50% (21) of the child psychiatrists in West Virginia practice in two of the State's most populous counties and rural counties are often left without access to any child psychiatrists.

Substance Abuse in the Workplace

The annual cost of substance abuse to society is estimated to be \$510.8 billion dollars. Substance abuse can create or contribute to a variety of problems in the workplace, including injuries and fatalities, decreased worker productivity, and employee absenteeism. The 2011 National Survey on Drug Use and Health (NSDUH) revealed on a national level that 65.9% of those reporting past 30 day illicit drug use were employed full time. This translates to 8.4% of

those employed full time using illicit drugs in the past 30 days. The survey results also show that 64.8% of those employed full time reported current alcohol use.

According to the Federal Bureau of Labor only 54.7% of West Virginia's working-age residents are employed, ranking the State 50th in the nation's labor force participation. While the work force may be skilled, workers are often plagued with injuries related to high risk jobs and are at risk to become disabled or dependent on pain medication. This dependence can lead to addiction, which then results in an inability to pass required drug screens to obtain a job. According to the *Journal of Occupational Health Psychology*, job loss and the resulting financial strain can lead to depression, strain on relationships, and lowered self-esteem.

In a 2011 *Herald Dispatch* story, Governor "Tomblin said he was recently told there are 700 coal mining jobs that can't be filled in the state because people are failing the drug tests." Senator Joe Manchin added that "On my recent 'Rebuilding America' tour of West Virginia, I traveled to 20 counties throughout our state and heard the same thing time and again – drug abuse is tearing our communities apart, hurting our schools, destroying our families, and even damaging our workforce. This is more than a problem; it's an epidemic we need to eliminate right away".

In Wheeling, Chesapeake Energy, the most active natural gas driller in the State's Northern Panhandle, says that it employs more than 700 West Virginians with about 30 percent of job applicants failing drug tests. During the Governor's Regional Task Force Meetings and throughout the substance abuse strategic planning process it was noted that substance abuse was becoming a huge barrier in gaining and maintaining employment in West Virginia.

The increased morbidity and mortality rate of people with serious mental health and substance use problems– with up to 25 years of life lost – is both well-documented, and unacceptable. Nearly 60% of people with bipolar disorder and 52% of persons with schizophrenia have a co-occurring substance use disorder. Approximately 41% of individuals with an alcohol use disorder and 60% of individuals with a drug use disorder have a co-occurring mood disorder.

Data from multiple sources demonstrate that West Virginia's residents generally exhibit increased risk factors related to mental health when compared to the nation as a whole. These data also underline the fact that access to prevention, early intervention and treatment services is not meeting the needs of the State's residents. West Virginia ranked lowest among all 50 states on the Gallup Well Being Index and scored last on the Emotional Health Index portion of that poll (Mendes, 2011).

Based on 2011 U.S. Census Data and using a prevalence rate of 7.1%, there are up to 104,437 adults who have a serious mental illness and 27,262 children with serious emotional disturbances residing in West Virginia. In 2010, approximately one in four of the sheltered homeless population in West Virginia reported mental illness and/or substance use. In West

Virginia, 14.3% of children aged 12-17 are diagnosed with one or more emotional, behavioral, or developmental conditions, compared with 11.3% nationwide. Of those children, 49.1% have two or more such conditions, compared with 40.3% nationwide. Approximately 95.3% of West Virginia children served through the SMHA meet the federal definition for Severe Emotional Disturbance (SED), compared to the 73.4% U.S. Average (SAMHSA/CMHS, 2010). Youth in West Virginia reported one of the highest suicide attempt rates in the nation, at nearly 11%, in 2009.

PRIORITY POPULATIONS

Youth, Transitioning Youth and Young Adults

West Virginia has increased its partnerships across child-serving agencies, implemented clinical review teams, embraced family and youth involvement and is currently working toward improving provider readiness levels for statewide implementation of a coordinated service system. In spite of these efforts, more than 600 **youth are in out-of-state placements**. A thorough cross-systems examination of existing and new service provision was conducted by the BBHFF in January 2013, in coordination with key stake holder agencies, community providers and families, and the following recommendations were made that include specific service needs for youth, transitioning youth and young adults.

- ✓ A Single Point of Entry will improve access and referral to appropriate levels of care
- ✓ Every region will provide a full continuum of services for youth and families in-state, regardless of payer source
- ✓ Consistent Assessment / Diagnostic Tools utilizing electronic records will enhance service delivery and sharing of information between multiple systems
- ✓ Training and Technical Assistance for Youth Serving Organizations will improve clinical capacity and ensure quality services
- ✓ State and regional collaborative partnerships will increase engagement, improve referral mechanisms and access needed and appropriate community supports
- ✓ An increase in the capacity to serve transitioning youth (adolescents and young adults 17-24) will offer a “last best chance” to decrease unemployment and homelessness, and improve behavioral health and health outcomes for this population
- ✓ Youth Service Centers will be developed in an inviting location that will decrease stigma and meet the needs of youth and their families through increased hours of operation
- ✓ An increase in the number of peer/recovery support groups for youth will assist in maintaining sobriety and community and social connectedness

The chart below denotes the areas of focus by region with regard to prescription drug and under-age drinking in youth and transitioning youth aged 12-20.

Indicator	NSDUH 2008-2010							
	R1	R2	R3	R4	R5	R6	WV	US
<i>Nonmedical Use of Pain Relievers</i>	5.63	5.5	5.00	5.90	6.26	4.97	5.68	4.87

<i>Past 30 Day Alcohol Use 12-20</i>	24.00	21.75	20.81	28.10	23.46	19.17	23.36	26.54
<i>Past 30 Day Binge Ages 12-20</i>	16.81	13.98	15.17	19.88	15.82	12.48	15.94	17.47
<i>Perception Risk Binge Drinking 12+</i>	42.12	42.22	42.18	44.59	42.42	45.31	43.34	42.12

West Virginia has little available data on sexual orientation and gender identity. The Movement Advancement Project estimates that approximately 1.5% of West Virginia's population self-identifies as lesbian, gay or bisexual. National research has shown that **Lesbian, Gay, Bi-Sexual, Trans-gendered and Questioning (LGBTQ) youth** experience higher levels of risk in several areas. National studies have found that LGBTQ youth experience bullying and other traumas at a higher incidence rate than their peers. The creation of a Gay Straight Alliance within secondary school settings creates a safer school climate for LGBTQ youth and decreases the use of homophobic language. Only 23.1% of West Virginia's secondary schools have a gay/straight alliance or similar club. Not only do LGBTQ youth face tremendous challenges in school and placement, many also face rejection at home. This is especially problematic in that LGBTQ young adults who experienced high levels of rejection were more than 3 times as likely to use illegal drugs, almost 6 times as likely to have high levels of depression, and more than 8 times as likely to have attempted suicide.

Older Adults and Seniors

West Virginia has the 2nd highest prevalence of older adults in the nation, with 15% of its citizens being over the age of 65, and with over 43% of this age group having a disability. A recent SAMHSA study found a dramatic increase in illicit drug use in adults 50 and over, including an alarming incidence of non-medical use of prescription drugs among women aged 60 to 64. In part, this increase points to the aging of the baby boomer generation, and reportedly may necessitate the doubling of substance abuse treatment facilities by 2020. The report, entitled *Illicit Drug Use among Older Adults*, found that an estimated 4.7% of older adults (4.3 million) have used an illegal drug during the past year. The report further showed that men 50 and over were almost twice as likely to use marijuana over the nonmedical use of prescription drugs. In those 65 years or older, the use of non-medical prescription drugs was found to be more common than marijuana use.

Because 75 percent of adults aged 65 and older who commit suicide visit a doctor within one month before their completed suicide, there is a need to improve detection and treatment of depression by health professionals who see patients on a regular basis. Although older adults nationally and in West Virginia attempt suicide less often than those in other age groups, they have a higher suicide rate. Older Americans are more lethal in their attempts and die by suicide more often. For all ages combined, there is 1 suicide for every 20 attempts nationally, yet for people over the age of 65, there is 1 completed suicide for every 4 attempts.

Intellectual and Developmental Disabilities

The West Virginia University Center for Excellence in Disabilities states that 18.9 % of West Virginians have a disability compared to 12%, of the U.S. population, noting the highest prevalence rate in the country. The State also has a high prevalence of disabilities among its children, with the 3rd highest percentage of children in the country, aged 6-17, receiving special education services. Due to the alarming rates of in utero exposure to substances, which may result in intellectual and developmental disabilities, West Virginia must focus on this growing population. Persons with disabilities experience substance abuse rates at 2-4 times that of the general population. For example, people with conditions such as deafness, arthritis, or multiple sclerosis have shown substance abuse rates of at least double the general population estimates. The major causes for disability in the U.S. are changing from medical to social and behaviorally-related conditions, increasingly involving complications such as substance abuse, violence, and poor mental health.

According to the U.S. Department of Health and Human Services Office on Disability, recent estimates indicate that the substance abuse problem costs the American economy in excess of \$220 billion per year and it directly impacts a huge segment of the population. However, it is less understood that Americans with disabilities are at a disproportionately greater risk for encountering these problems. People with disabilities experience a number of risks that increase their chances for substance abuse to adversely impact their lives; these risks include: medication and health problems, societal enabling, a lack of identification of potential problems, and a lack of accessible and appropriate prevention and treatment services. Furthermore, in some cases the prevalence rates for substance abuse among persons with disabilities are especially alarming. For example, substance abuse prevalence rates approach or exceed 50% for persons with traumatic brain injuries, spinal cord injuries, or mental illness and persons with spinal cord injuries, orthopedic disabilities, vision impairment, and amputations can be classified as heavy drinkers in approximately 40-50% of cases.

The National Association of Dual Diagnosis (NADD) estimates the frequency of dual diagnosis vary widely, however many professionals have adopted the estimate that 30-35% of all persons with intellectual or developmental disabilities have a psychiatric disorder. The full range of psychopathology that exists in the general population also can co-exist in persons who have intellectual or developmental disabilities. The co-existence of intellectual or developmental disabilities and a psychiatric disorder can have serious effects on the person's daily functioning by interfering with educational and vocational activities, by jeopardizing residential placements, and by disrupting family and peer relationships. In short, the presence of behavioral and emotional problems can greatly reduce the quality of life of persons with intellectual or developmental disabilities. It is thus imperative that accurate diagnosis and appropriate treatment be obtained in a timely manner.

The causes of increased vulnerability to mental health problems in persons with intellectual or developmental disabilities are not well understood. Several factors have been suggested. Stress is a risk factor for mental health problems. Persons with intellectual or developmental disabilities experience negative social conditions throughout the life span that contribute to excessive stress. These negative social conditions include social rejection, stigmatization, and the lack of acceptance in general. Social support and coping skills can buffer the effect of stress on mental health. In persons with intellectual or developmental disabilities, limited coping skills associated with language difficulty, inadequate social supports, and a high frequency of central nervous system impairment, all contribute to the vulnerability of developing mental health problems. Another explanation for the increased prevalence of mental health problems in this population relates to behavioral phenotypes. In addition to the characteristic physiological signs associated with genetic syndromes, many syndromes have characteristic behavior and emotional patterns. These behavioral phenotypes may contribute to the increased rate of behavioral and mental health problems among persons with intellectual or developmental disabilities.

West Virginia spends a greater percentage of its overall Medicaid long-term care funding on institutional care than the national average. There is also generally a lack of high quality training and support for direct support personnel and the turnover rate is high. People with severe intellectual and developmental disabilities and those with serious mental health and/or behavior challenges are particularly at-risk for more restrictive and/or segregated placements and services.

Homelessness

Data from the latest West Virginia Coalition to End Homelessness Point in Time Count and Housing Inventory indicates that in 2013 chronic substance abuse among people experiencing homelessness has increased by 40% over the last year among the unsheltered population and by 33% among the sheltered population. The Bureau for Behavioral Health and Health Facilities has traditionally allocated \$900,000 annually to seven providers at ten sites to offer public inebriate services across West Virginia. Between the months of November and June, 2013 approximately 1443 individuals, mostly Caucasian middle aged men, were served without further interventions being provided based on this current model. A large portion of these so called “public inebriates” present with medical as well as co-occurring mental health and substance abuse issues and are usually considered “homeless”.

Women, Pregnant Women and Their Children

West Virginia ranks 1st in the country in tobacco use, with **smoking rates among pregnant women at 27.3%, the highest in the United States**, and nearly triple the national rate of just

under 10%, which is known to increase risks for low birth-weight, preterm deliveries, infant mortality, and Sudden Infant Death Syndrome (SIDS). In 2010 among pregnant women who smoked three months before pregnancy, an estimated 65.7% smoked during the last three months of their pregnancy. Between 2007 and 2009, the national teen birth rate declined, however, among 15-17 year olds in West Virginia, the rate increased by a substantial 17% (WV FREE, 2011). Between 2000-2009 in West Virginia, an average of 36% of pregnant teens aged 15-19 smoked, compared to an average of 28.9% of pregnant women aged 20-29 (WV FREE, 2011). Also, during the years 2005-2010, the percentage of low birth weight infants was significantly higher among those who reported smoking during the last three months of their pregnancy (PRAMS). The State also has the 7th highest percentage of low-birth weight births in the nation, at 9.5%, and ranks **1st in the country in low-birth weight births among white women (9.4%)**. Among women with known prenatal care, 83.5% of white mothers began care during the first trimester, while only 73.5% of black mothers did so.

Drinking alcohol during pregnancy can lead to miscarriage, stillbirth, and **fetal alcohol spectrum disorders (FASD)**. In 2010, 3.7% of women in West Virginia reported drinking alcohol during the last three months of pregnancy. Pregnant women aged 35 and over have the highest percentage of drinking alcohol during the last 3 months of pregnancy in the State. In 2010, West Virginia women with the lowest and highest incomes (< \$10,000 and > \$50,000) reported the highest use of alcohol during the last three months of pregnancy (PRAMS).

While **illicit drug use during pregnancy** is reported to range from 10 to 14% nationally, a 2009 West Virginia study involving the anonymous collection and assay of umbilical cord segments in as many patients as delivered in the month of August 2009 found that 19%, almost one in five babies, had evidence of alcohol or/and drug exposure. In this 2009 study, marijuana use led the way, followed by opiates, alcohol, benzodiazepines and methadone. With the State's exposure rates ranging between 19% and 80% during pregnancy, perinatal substance abuse has been identified as a critical issue in West Virginia for the health of both mothers and babies.

Neonatal abstinence syndrome (NAS), a postnatal drug withdrawal syndrome that is primarily caused by maternal opioid use, has been on the rise nationwide as well as in West Virginia, and is characterized by an increased incidence of seizures, respiratory symptoms, feeding difficulties, and low birth weight. Current 2013 data collected by individual birthing facilities range from 30-80% exposure rates. The Marshall University Medical Center Department of Obstetrics & Gynecology reported 28 NAS births per 1000 in their facility in 2009 and 80 per 1000 in 2012.

Research by SAMHSA has found that between one fourth and one half of domestic violence male abusers have a substance abuse problem. Also, **substance abuse by women increases their likelihood of becoming a victim of domestic violence**. In 2012, substance abuse was

identified as contributing to abuse in 29.9% of West Virginia Coalition Against Domestic Violence cases and yet only 0.7% of these people were referred to a community behavioral health facility or provider.

Children of Incarcerated Parents

The West Virginia Division of Corrections (WVDOC) inmate population increased by more than four times between 1991 to 2011, from 1,630 in 1991 to 6,819 in 2011. Inmates that were committed to the WVDOC but were waiting in county/regional jails for bed space in WVDOC facilities increased by a total of 1297 inmates since 1992. In fiscal year 2012, 94.2% of inmates in the WVDOC had an education level of high school diploma/GED or less. There were 7,907 drug violation arrests and 199 drug equipment arrests in 2011, a 30% increase from 2004 (WVIBRS). In a 2008 DOC data brief, 53.3% or 2,498 surveyed prisoners self-reported as parents, with a total of 4,902 children. While there is not more recent data available, the increase in the population would suggest that more children would be involved. The Regional Jail Authority provides 10 facilities and currently houses a total of 4,897 inmates, with approximately 16% being women. According to data provided by the Regional Jail Authority, there are currently 6,073 **children of parents incarcerated** in the statewide regional jail system.

Veterans

There are approximately 167,200 **veterans** living in West Virginia and over 5,100 active duty **service members and dependents** have been deployed to Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) since 9/11.

- Nearly 16% of unsheltered people experiencing homelessness in West Virginia are veterans.
- 33.2% of West Virginia veterans have a disability, compared to 26.2 of veterans nationally.
- Over 40% of unsheltered veterans reported being diagnosed with an addiction to alcohol or drugs.
- 41.2% of unsheltered veterans reported being diagnosed with a mental illness.
- In 2010, 367 of the 1,743 abusers identified through the Coalition to End Domestic Violence self-reported themselves as a veteran and/or enlisted servicemen.
- Over 20% of the servicemen in WV who received behavioral health services in 2010 were between the ages of 26-34 years old.
- 18.5% of US service members who have returned from Afghanistan and Iraq had post-traumatic stress disorder or depression.
- Approximately 86% of the servicemen and women in WV who received behavioral health services in 2010 were veterans.

- 63% of the servicemen and women who received behavioral health services reported their primary drug of choice as alcohol.
- Almost 50% of the servicemen who received behavioral health services were treated for substance abuse disorders and nearly 40% were treated for co-occurring issues.

Consumption Rates for Substances

Alcohol Consumption

Adults- West Virginia was ranked as second lowest in the nation in 2011 for current alcohol use, binge drinking, and heavy drinking among adults. Adult males had a significantly higher percentage of binge drinking than adult females in West Virginia (WVHSC, BRFSS).

Youths- 12th grade students (46%) in West Virginia are significantly more likely to have consumed alcohol within the last 30 days than 9th and 10th grade students (29.6%, 28.1%). Also, 12th grade students in West Virginia are significantly more likely to binge drink (28.4%) than 9th and 10th grade students (17.1%, 15.5%). Current research suggests that there is an association between the age of initial use of alcohol and problems with alcohol later in life. Postponing the initial use of alcohol is believed to help prevent alcohol dependency and abuse in adulthood. Male high school students in West Virginia reported a significantly higher percentage (22.8%) of first use of alcohol before the age of 13 than did females (15.6%) in 2011.

Tobacco Consumption

Adults- According to the CDC, tobacco use is the most preventable cause of death in the United States. Smoking harms nearly every organ in the body and causes many diseases, which reduce the overall health of smokers. In 2011, West Virginia had the second highest prevalence of current smoking among adults in the nation. Adults in West Virginia with less than a high school education have a significantly higher prevalence of current smoking than adults with an education beyond than high school. In 2011, the State had the fourth highest smokeless tobacco prevalence in the nation and the third highest current smokeless tobacco prevalence among males in the nation (WVHSC, BRFSS).

Youth- According to a recent U.S. Surgeon General's Report, 88% of daily adult smokers in 2012 reported initial use of tobacco by the age of 18 years. Also, from 2003-2009 high school students in West Virginia had a significantly higher percentage of initiating tobacco use before the age of 13 than the national rate (YRBS).

Drugs Consumption

Youths- Drug use is a major public health issue both in West Virginia and in the nation. In 2011 high school students in the 12th grade in West Virginia were significantly more likely to have reported using marijuana in past 30 days than 9th and 10th and 11th grade students. Also in 2011, male high school students (24.2%) in West Virginia were significantly more likely to have

used marijuana in the past 30 days than were females (15.1%). Male high school students (3.8%) in West Virginia reported a significantly higher percentage of cocaine usage in the last 30 days than did female high school students (1.2%). Male high school students in West Virginia reported a significantly higher percentage of lifetime use of cocaine, methamphetamine, ecstasy, using steroid pill or shots, and use of any drugs via injection than female high school students in 2011.

According to SAMHSA's Office of Applied Studies (OAS), those who reported that their first use of marijuana occurred before the age of 12 were twice as likely to have serious mental health illness in the past year compared to those who initiated marijuana use when they were 18 or older. Male high school students in West Virginia reported a significantly higher percentage (10.6%) of first use of marijuana before the age of 13 than did female high school students (4.3%) (YRBS).

Overall Population

West Virginia has had a higher annual per capita number of retail prescription drugs filled at pharmacies compared to the United States annual per capita numbers from 2008-2011 (State Health Facts). Opioid single ingredient became the leading drug exposure reported to the West Virginia Poison Center in 2010. The leading prescription drug reported to the West Virginia Prescription Drug Quitline in 2012 was Oxycodone (31.8%).

Consequences Resulting from Substance Use and Mental Health Disorders

Alcohol Consequences

The CDC reports that excessive alcohol consumption is the third leading preventable cause of death in the United States. The leading alcohol-attributable deaths due to excessive alcohol use for all ages in West Virginia from chronic causes are alcoholic liver disease and liver cirrhosis unspecified, and from acute causes are motor-vehicle traffic crashes and suicide (ARDI). In West Virginia males have a significantly higher age adjusted death rate from chronic liver disease and cirrhosis than females in West Virginia for each year and for the combined years 1999-2010. Males in West Virginia have a significantly higher age adjusted death rate from alcohol induced causes than do females for each year as well as for the combined years 1999-2010 (WVHSC).

Hospitalizations for an alcohol related diagnosis in 2011 have increased from a 486.8 rate per 10,000 discharges in 2007 to a 538.1 rate per 10,000 discharges in 2011. Also, hospitalization discharges with an alcohol dependence related diagnosis increased from a 203.5 rate per 10,000 discharges in 2007 to a 226.3 rate per 10,000 discharges in 2011. Males accounted for 77.4% of all of the alcohol related diagnosis discharges and 77.7% of all the alcohol dependence related diagnosis discharges in West Virginia in 2011 (HCUP).

The percentage of treatment admissions for alcohol as their primary substance of abuse in West Virginia has been nearly double the percentage of the United States as a whole from 2002-2009. However, in 2010, the percentage in West Virginia decreased by 12.2%, narrowing the gap from the national percentage (WV 28.4%, US 22.3%). Alcohol abuse in 2010 accounted for 28.4% of admissions for primary substance abuse and was the second highest reported primary substance of abuse among treatment admissions (TEDS). In 2010-2011, the rate of alcohol dependence or abuse was 5.3% among those 12 and older (NSDUH).

Those who drink and drive are a danger to everyone due to alcohol impairing their driving abilities, such as blurred vision, impaired memory, and slow reaction times. In 2011, 26.9% of persons killed in crashes in West Virginia were by drivers with a blood alcohol concentration (BAC) of 0.08 or higher, which is lower than the national rate of 30.6% (FARS). The West Virginia Department of Motor Vehicles (WVDMV) reported that there were 11,079 driving under the influence revocations in West Virginia during the 2012 fiscal year. According to the National Highway Traffic Safety Administration (NHTSA), every day almost 30 people in the United States die in a motor vehicle crash that involves an alcohol impaired driver. It is estimated that the annual cost of alcohol related crashes in the United States is more than \$51 billion.

In 2011, 12th grade students had a significantly higher percentage of driving a car after drinking alcohol than did 9th, 10th and 11th grade students. Male high school students in 2011 had a significantly higher percentage of driving after drinking alcohol than did female students (YRBS).

Tobacco Consequences

Tobacco use costs the United States billions of dollars every year in medical expenses and lost productivity. During the years 2005-2009, the estimated annual direct health care costs caused by death and illness from smoking were \$709 million. When quantified per smoker, the cost is equivalent to about \$4,600 per adult smoker (18 and older) in West Virginia. About 19% of all West Virginia deaths (among adults 35 and older in 2005-2009) were caused by cigarette smoking. Due to smoking-related premature deaths during this time, over 55,000 years of potential life (YPLL) were lost annually. This averages out to approximately 14.6 years of lost life per smoker (WVHSC, SAMMEC).

According to the US CDC, tobacco use causes thousands of deaths from related diseases every year. West Virginia had a higher age adjusted rate of death for lung/bronchus/trachea cancers, COPD, and emphysema from 1999 to 2010 than the national rate (WVHSC). Males have a significantly higher age adjusted death rate than females for lung/bronchus/trachea cancers, COPD and emphysema for the combined years for 1999-2010 (WVHSC).

Drugs Consequences

Frequent drug use can lead to hospitalizations for various drug related conditions, including but not limited to: drug-induced disorder, dependence, poisoning, and withdrawal. Discharges with a drug related diagnosis have steadily increased from 2,102.2 per 10,000 discharges in 2007 to 2,756.9 per 10,000 discharges in 2011 (HCUP). Also the rate per 100,000 population of acute hepatitis C in West Virginia has more than tripled from 2007 to 2012 (0.8 in 2007 to 3 in 2012). In 2012, 7% of reported HIV/AIDS cases in West Virginia were intravenous drug users (OEPS).

According to the US CDC more than 15,500 deaths are attributed to drug overdoses in the United States. West Virginia had a higher age adjusted death rate than the nation as a whole for drug overdoses and poisonings from 2000 to 2010. There was a significant increase in West Virginia between the age adjusted death rate from 1999 to 2010 for both genders for drug overdoses and poisonings and non-prescription drug overdoses and drug-induced causes (WVHSC). Other opiates (methadone, codeine, morphine, oxycodone, hydromorphone, meperidine, opium, and other drugs with morphine-like effects) accounted for the highest percentage of treatment admissions in West Virginia in 2010 (34.9%), which is four times higher than the national percentage of treatment admissions (8.7%) (TEDS).

Both neonatal abstinence syndrome (NAS) and fetal alcohol spectrum disorders (FASD) have been on the rise. U.S. healthcare costs associated with NAS climbed from \$39,400 in 2000 to \$53,400 in 2009, and state Medicaid programs paid for the majority of these cases. The length of stay was approximately 16 days for a newborn with perinatal substance abuse complication, compared to 3 days for other hospital births.

According to the US Bureau of Justice and Statistics, in 2004 17% of state prisoners and 18% of federal prisoners committed offenses in order to obtain funds for drugs. The number of drug violation arrests in 2011 increased 30% from 2004 (WVIBRS). There were 751 admissions to correctional facilities for drug offenses in West Virginia in 2011 (IMIS).

Factors Contributing to Substance Abuse

Alcohol Factors Contributing to Substance Abuse

Greater access to alcohol in a given community increases that community's alcohol abuse risk factor. Female high school students in West Virginia were significantly more likely to obtain alcohol by someone giving it to them in 2007-2011 (YRBS). The perception of harm from drinking excessive amounts of alcohol can influence one's decision to use alcohol. Persons aged 18 to 25 years, both in West Virginia and in the United States as a whole, reported having the lowest perceived risk of having five or more alcohol beverages once or twice a week (W.V.'s rate was 32.1% and the U.S. rate was 34.1%) compared to those 12-17 and 26 and older (NSDUH).

Tobacco Factors Contributing to Substance Abuse

Stricter enforcement of laws and understanding how youths who smoke access tobacco products can assist prevention efforts is essential in reducing the prevalence of youth using tobacco products. During 2000 to 2011, over 30% of West Virginia's underage current smokers reported obtaining cigarettes by "giving money to someone else to buy them for me," which is significantly higher than any other method (WVYTS).

Drug Factors Contributing to Substance Abuse

According to the West Virginia Prescription Drug Abuse Quitline, the most common responses for where respondent's indicated that they had obtained their prescription drugs from in 2012 were: buy on the street (86.9%), legitimate prescription (40.2%), and buying from family or friend (33.3%). The reported perception of harm from smoking marijuana is lowest among those aged 18-25, both in West Virginia and in the United States as a whole, compared to those 12-17 and 26 and older (NSDUH).

Mental Health

Mental health is a vital part of health; it is the state of well-being and ability to function in society. There is a strong correlation between mental health and substance abuse; there is a higher rate of substance abuse among those with a mental illness. From 2007-2011 female high school students in West Virginia were significantly more likely than males to feel sad or hopeless (YRBS). In 2011 the State had a **significantly higher percentage of depression** (20.1%) among adults than did the nation as a whole (16.8%) (WVHSC, BRFSS). Adults in West Virginia reported a higher rate of any mental illness and serious mental illness in the past year than did the United States as a whole between the years 2008-2011 (NSDUH).

Suicide is a serious public health issue. According to the US CDC, it is the 10th leading cause of death in the nation. Adults in West Virginia reported a higher than average prevalence of having serious thoughts of suicide in the past year from 2008-2011 (NSDUH). Female high school students were significantly more likely to report having made a suicide plan than male students in West Virginia during both 2009 and 2011 (YRBS). West Virginia had a higher age adjusted death rate for suicide than the United States did as a whole from 1999 to 2010 (WVHSC).

In 2012, 3.5% survivors served by the WV Coalition Against Domestic Violence (WVCADV) were identified as having a mental illness and 12.4% were referred to a mental health facility or provider. In 2012, substance abuse was identified as contributing to abuse in 29.9% of WVCADV cases but only 0.7% of those cases were referred to a mental health facility or provider.

STATE AND COUNTY INDICATORS AND DATA SOURCES

State Level Data Sources	
<p>Alcohol Consumption</p> <ul style="list-style-type: none"> • Current Alcohol Use: NSDUH, YRBS, WVHSC, BRFSS • Binge Drinking: NSDUH, YRBS, WVHSC, BRFSS • Heavy Drinking: WVHSC, BRFSS • Age of Initial Use: YRBS • Driving and Alcohol: YRBS, WVHSC • Alcohol Use During Pregnancy: PRAMS • Apparent per Capita Ethanol Consumption: AEDS (NIAAA) <p>Alcohol Consequences</p> <ul style="list-style-type: none"> • Alcohol-Attributable Deaths: WVHSC, ARDI • Alcohol Overdoses: WVHSC • Motor Vehicle Crashes: FARS, WVTAD • Alcohol Related Hospitalizations: HCUP • Treatment: TEDS • Crime: WVDMV; West Virginia Juvenile Justice Database (WVJJDB) • Dependence or Abuse: NSDUH <p>Alcohol Risk and Protective Factors</p> <ul style="list-style-type: none"> • Access: YRBS • Perception of Harm: NSDUH 	<p>Tobacco Consumption</p> <ul style="list-style-type: none"> • Current Use: WVHSC, BRFSS, YRBS • Frequent Use: YRBS • Age of Initial Use: YRBS • Tobacco Use during Pregnancy: PRAMS <p>Tobacco Consequences</p> <ul style="list-style-type: none"> • Economic Costs of Cigarettes: WVHSC, SAMMEC • Tobacco-Related Mortality: WVHSC <p>Tobacco Risk and Protective Factors</p> <ul style="list-style-type: none"> • Access: Synar, WVYTS • Perception of Harm: WVYTS
<p>Drug Consumption</p> <ul style="list-style-type: none"> • Current Use: YRBS, NSDUH; West Virginia Poison Center; West Virginia Prescription Drug Quitline • Lifetime Use: YRBS, NSDUH, State Health Facts • Age of Initial Use: YRBS <p>Drug Consequences</p> <ul style="list-style-type: none"> • Drug Related Morbidity: HCUP, OEPS • Drug Related Mortality: WVHSC • Treatment: TEDS • Crime: WVDMV, WVIBRS, IMIS, WVJJDB • Drug Dependence or Abuse: NSDUH <p>Drug Use Risk and Protective Factors</p> <ul style="list-style-type: none"> • Access: West Virginia Prescription Drug Quitline • Perception of Harm: NSDUH 	<p>Mental Health</p> <ul style="list-style-type: none"> • Depression and Psychological Distress: YRBS, WVHSC, BRFSS, NSDUH • Suicide: NSDUH, YRBS, WVHSC • Homelessness: WV Coalition to End Homelessness • Domestic Violence: WV Coalition Against Domestic Violence • Sexual Assault: WVIRBS

*Due to the small population size and sample size for many data sources multiple years of data must be combined (for example 5 years of vital data and BRFSS, NSDUH must combine 3 years for regional data).

County Level Data Sources	
<p>Alcohol Consumption</p> <ul style="list-style-type: none"> • Binge Drinking: WVHSC, BRFSS (combine 5 years of data for county) • Heavy Drinking: WVHSC, BRFSS (combine 5 years of data for county) • Current Use: NSDUH (combine 3 years of data for regions) • Underage drinking: NSDUH (combine 3 years of data for regions) <p>Alcohol Risk and Protective Factors</p> <ul style="list-style-type: none"> • Perception of Harm: NSDUH (combine 3 years of data for regions) <p>Alcohol Consequences</p> <ul style="list-style-type: none"> • Alcohol-Attributable Deaths: WVHSC (combine 5 years of data for county) • Motor Vehicle Crashes: FARS • Alcohol Related Hospitalizations: HCUP (will have to combine multiple years) • Crime: West Virginia State Police CIB Section • Drug Dependence or Abuse: WVHSC (combine 5 years of data for county) 	<p>Tobacco Consumption</p> <ul style="list-style-type: none"> • Current Use: WVHSC, BRFSS (combine 5 years of data for county); NSDUH (combine 3 years of data for regions) <p>Tobacco Consequences</p> <ul style="list-style-type: none"> • Economic Costs of Cigarettes: WVHSC, SAMMEC (combine 5 years of data for county) • Tobacco-Related Mortality: WVHSC (combine 5 years of data for county) <p>Tobacco Risk and Protective Factors</p> <ul style="list-style-type: none"> • Perception of Harm: NSDUH (combine 3 years of data for regions)
<p>Drug Consumption</p> <ul style="list-style-type: none"> • Current Use: NSDUH (combine 3 years of data for regions) • Lifetime Use: NSDUH (combine 3 years of data for regions) <p>Drug Consequences</p> <ul style="list-style-type: none"> • Drug Related Mortality: WVHSC (combine 5 years of data for county) • Drug Dependence or Abuse: WVHSC (combine 5 years of data for county) <p>Drug Use Risk and Protective Factors</p> <ul style="list-style-type: none"> • Perception of Harm: NSDUH (combine 3 years) 	<p>Mental Health</p> <ul style="list-style-type: none"> • Depression and Psychological Distress: NSDUH (combine 3 years of data for regions) • Suicide: NSDUH (combine 3 years of data for regions); WVHSC (combine 5 years of data for county) • Homelessness: WV Coalition to End Homelessness • Domestic Violence: WV Coalition Against Domestic Violence

BEHAVIORAL HEALTH PLAN INTEGRATION

Based on input from listening tours, review of prior planning documents, and prevailing evidence-based philosophy and practice, the overall priorities and goals that contribute to the development of person-centered, inclusive, community-based systems of care are **common across all bureau divisions**. The striking similarities in the strengths, challenges, and

recommendations for system change that emerged from planning processes, systemic review and analysis of consumption and consequence data, and significant on-going stakeholder input are reflected in West Virginia's Block Grant Plan Table 1-step 3-4.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #:	1
Priority Area:	Responsible Programmatic and Fiscal Oversight and Accountability
Priority Type:	SAP, SAT, MHP, MHS
Population (s):	SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Homeless)
Goal of the priority area:	<p>Improve the system capacity of the Bureau for Behavioral Health and Health Facilities to sustain behavioral health services in West Virginia by maximizing and leveraging resources and gathering information necessary to guide effective decision making about strategic directions and system performance.</p>
Strategies to attain the goal:	<ol style="list-style-type: none">a. Create safe and supportive environments through anti-stigma awareness and educationb. Communicate effectively with each other, local partners, the media and the publicc. Support the coordination of efforts among the West Virginia Comprehensive Behavioral Health Commission, the Governor's Advisory Council on Substance Abuse, the Governor's Regional Task Forces and the Mental Health Planning Council, in order to support an integrated advisement structured. Cultivate and maintain internal and external (State and Federal) strategic partnerships in order for individuals to have access to a good and modern service systeme. Integrate behavioral health services into mainstream health caref. Promote cross divisional professional growth and development opportunities in order to attract and retain a capable workforceg. Develop and implement policies, protocols and standards that are transparent and reflect best practiceh. Further develop and maintain a monitoring and reporting system that promotes accountability and effectivenessi. Continue realignment efforts of the youth services system to increase accessible care that meets the needs of youth and their families, with increased hours of operation that include referral and outreach, engagement and out-patient servicej. Provide a more prominent role in the administrative oversight and implementation of statewide suicide prevention, intervention and post-vention programsk. Support an infrastructure that utilizes peer and community specialist in the workforce

- l. Conduct an analysis of all Federal and State funds coming into West Virginia to promote better utilization and avoid duplication
- m. Develop cost/benefit profiles of programs and best practices
- n. Develop collaborative plans with Providers Bureau of Medical Services, APS Healthcare, Office of Health Facilities Licensure and Certification and Bureau for Children and Families for system interoperability and sharing of electronic health records (EHRs)
- o. Partner with behavioral health providers and agencies, such as criminal justice and homeless services, sharing information to enhance readiness and providing outreach and enrollment eligibility training to ensure that individuals have and maintain health insurance
- p. Create a diversified funding balance through discretionary federal grant awards and public/private partnerships
- q. Conduct quarterly monitoring of BBHMF providers for funding utilization and timely redirection of unused funds
- r. Use regional and local recommendations to help determine funding allocations
- s. Assure that research gathered from stakeholders is used to inform evidence based program selections and training topics
- t. Increase the number of opportunities for the West Virginia State Epidemiological Outcomes Workgroup and the Regional Data and Planning Teams to interface with the Governor's Advisory Council on Substance Abuse and Mental Health Planning Council to identify combined service gaps and shared outcomes
- u. Identify indicators and collect data that will enable West Virginia to better document the diversity and needs of its citizens
- v. Identify and collect the number of individuals enrolled in Medicaid expansion with a behavioral health diagnosis
- w. Partner with the Pacific Institute for Research and Evaluation (PIRE) and border States to research the effects of and promising interventions for drug exposed babies
- x. Research and provide qualitative analysis on recovery journeys to determine trends in successful treatment paths

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Implementation of a statewide health promotion campaign reducing stigma
Baseline Measurement:	There are currently 0 campaigns in WV in 2013.
First-year target/outcome measurement:	A statewide health promotion campaign will be developed by 2014.
Second-year target/outcome measurement:	A statewide health promotion campaign will be disseminated statewide by 2015.
Data Source:	

Media distribution rates.

Description of Data:

Contracted media consultant will provide the BBHMF with distribution rates.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #: 2

Indicator: Integration of behavioral health services into mainstream healthcare

Baseline Measurement: 28 FQHC's currently provide behavioral health services in 2013.

First-year target/outcome measurement: 35 Primary Care/FQHC's will provide behavioral health services in 2014.

Second-year target/outcome measurement: 40 Primary Care/FQHC's will provide behavioral health services in 2015.

Data Source:

Bureau for Public Health Office of Primary Care

Description of Data:

Number of primary care centers providing behavioral health services.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #: 3

Indicator: Behavioral Health policies, standards and protocols disseminated widely

Baseline Measurement: Standards and fiscal policies are included in grant agreements in 2013.

First-year target/outcome measurement: New and updated standards and program policies will be disseminated to all staff and providers in 2014.

Second-year target/outcome measurement: Standards and program policies will be available on the BBHMF website in 2015.

Data Source:

BBHHF website and Listserv

Description of Data:

staff and providers disseminated to and the # of standards and policies uploaded of the website.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #:

4

Indicator:

Increase in the diversification of behavioral health funding by leveraging resources through partnership and federal discretionary funds.

Baseline Measurement:

There is 0 funding analysis and cost benefit profiles completed for agency use or public dissemination.

First-year target/outcome measurement:

1 funding analysis of all state and federal funding spent on behavioral health services statewide across agencies and community programs by 2014.

Second-year target/outcome measurement:

3 new state public/ private partnerships and 1 new federal award in 2014.

Data Source:

Epidemiologista and WVSEOW
Office of Grants Management

Description of Data:

of Cost benefit analysis profiles and statewide funding analysis
federal grants applied for and received

Data issues/caveats that affect outcome measures::

No issues currently foreseen that will affect the outcomes measures.

Indicator #:

5

Indicator:

Development and improvements to existing reporting system that promotes better
OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016

accountability and effectiveness

Baseline Measurement: The existing reporting system captures prevention data in SAMHSA service areas in 2013.

First-year target/outcome measurement: 100% of continuum reporting will be captured in a web-based reporting system by 2014.

Second-year target/outcome measurement: 75% of all BBHMF providers will be reporting on time in 11 service areas by 2015.

Data Source:

Web-based reporting system

Description of Data:

served in each of SAMHSA 11 service areas

Data issues/caveats that affect outcome measures::

No problems foreseen to meeting this outcome.

Indicator #: 6

Indicator: Information gathered from WVSEOW and key stake holders will guide strategic directions and system performance

Baseline Measurement: Recommendations and priorities regarding substance abuse planning initiatives are provided to Governor through regional and state task forces in 2013.

First-year target/outcome measurement: Recommendations and priorities regarding Adult and Children's mental health will be provided to Governor through regional and state task forces in 2014.

Second-year target/outcome measurement: 100% of behavioral health recommendations will be provided collectively to Governor identifying combined service gaps and shared outcomes.

Data Source:

Community Access (Meeting Facilitators and Recorders)
Integrated Behavioral Health State Plan

Description of Data:

Integrated recommendations and shared outcomes made regarding behavioral health

Indicators added to the State behavioral health profile

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Priority #: 2

Priority Area: A Comprehensive behavioral health continuum of culturally relevant, trauma informed evidence based practices system-wide.

Priority Type: SAP, SAT, MHP, MHS

Population SMI, SED, PWWDC, IVDUs, HIV EIS, TB
(s):

Goal of the priority area:

Guide system-wide workforce development on best practice research in the integration of prevention and promotion to improve the whole health of communities, intervening early in the lives of West Virginians to decrease the prevalence of chronic health conditions to divert incarcerations and hospitalizations, supporting treatment options that promote integration and inclusion in the community and to increase the number and quality of peer and recovery support services.

Strategies to attain the goal:

- a. Provide training opportunities on the most advanced tools for screening, assessment and diagnosis
- b. Coordinate training and technical assistance to improve clinical capacity and ensure quality services system-wide
- c. Partner with West Virginia high schools, colleges and universities to ensure that individuals are recruited and prepared to meet the behavioral health service needs of its citizens
- d. Offer regularly scheduled training opportunities that are accessible in each region for individuals obtaining and maintaining peer and community certifications
- e. Partner with State and Federal experts to offer evidence based cross-training opportunities, including a yearly integrated conference with a special emphasis on priority populations
- f. Provide training and resources to employers to help create cost-effective, safe, and healthy workplaces.
- g. Offer cross-training and networking opportunities for "prevention" and "promotion" providers in each county to increase collaborative planning efforts
- h. Implement evidenced-based programs and practices shown to promote good mental health and prevent substance use/abuse
- i. Strengthen community mobilization efforts by promoting inclusion of additional sectors in existing coalitions and marketing services

- j. Support youth-led organizations to provide consistent prevention/promotion messages and create positive alternatives for youth that develop leaders
- k. Increase the number of environmental strategies applied which focus on community norms change
- l. Provide funding and training opportunities for individuals to become certified community support and prevention specialists
- m. Strengthen system of care approaches to increase consumer and family engagement and improve referral mechanisms and access to needed and appropriate community supports
- n. Expand screening, brief intervention and referral to treatment practices in schools, primary/ urgent care, homeless shelters, and non-traditional venues in order to reach priority populations, incorporating kiosk technology as appropriate
- o. Support Teen Courts and Juvenile Drug Courts to divert indicated populations from the criminal justice system
- p. Coordinate efforts among regional jails and corrections with local providers in order to expand DUI services statewide
- q. Continue collaborative meetings with the WV State Medicaid Office to discuss including and establishing Billing Code(s) for SBIRT Services within WV Medicaid
- r. Incorporate technology to engage individuals and their families in treatment
- s. Expand and integrate family support initiatives across disorder, disability and age, to increase the likelihood that there is “no wrong door” for families looking for information and support
- t. Promote the use of consistent assessment / diagnostic tools utilizing electronic records to enhance service delivery and sharing of information between multiple systems
- u. Expand telehealth/telemedicine practices statewide
- v. Expand school based behavioral health services statewide through partnerships with the West Virginia Department of Education
- w. Facilitate partnerships between behavioral health providers and drug courts, regional jails and corrections to increase the number of coordinated best practice programs
- x. Provide additional recovery residences providing safe housing as individuals transition from treatment and incarceration settings
- y. Provide 24-hour peer supported triage programs that include warm lines, holistic screening and facilitated referrals to increase motivation to treatment
- z. Identify peer/recovery support groups for youth to assist in maintaining sobriety and community and social connectedness
 - aa. Provide on-going education and certification to enhance the credibility of peer support programs
 - bb. Align all peer and recovery support programs with national standards
 - cc. Support an integrated consumer network designed to engage and recruit peers regarding workforce and leadership development
 - dd. Develop a network of peer operated “drop-in” centers to improve social inclusion
 - ee. Conduct research, draft, and disseminate a document summarizing the effectiveness of peer support to support recommendations made by the BRSS TACS team in regard to the reimbursement of Peer Support Services by funding entities
 - ff. Begin collaborative meetings with the WV State Medicaid Office to discuss including and establishing Billing Code(s) for Peer Support Services within WV Medicaid
 - gg. Begin collaborative meetings with Managed Care Organizations and other payers of healthcare services to discuss including and establishing Billing Code(s) for Peer Support Services within their reimbursement mechanisms

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator: Increase in the number of providers implementing culturally relevant, trauma informed evidenced based practices system-wide

Baseline Measurement: The number of evidence based programs provided and implemented is being captured for prevention services only in 2013.

First-year target/outcome measurement: 100 % of BBHFF providers program staff will be trained in cultural competency, motivational interviewing, suicide prevention, trauma-informed and person-centered care by 2014.

Second-year target/outcome measurement: 75% of BBHFF providers in compliance for providing culturally relevant, trauma informed evidenced based practices by 2015.

Data Source:

Grant Agreements
CACO Training Data System
Web-based provider reporting
Compliance visits by program staff

Description of Data:

Training requirements are included in all statements of work (grant agreements).
CACO will track all evidence based trainings provided.
Providers will record trainings received in monthly web-based reporting tool.
Program Director make face to face visits to providers yearly to review programs and interview administrators, front line staff and consumers.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measure.

Indicator #: 2

Indicator: Integration of prevention and promotion efforts statewide to improve whole health of WV citizens

Baseline Measurement: 100% of Prevention and Promtion providers are implementing perspective (SA, MH, Suicide, Tobacco, Pregnancy) targeted implementations in 2013.

First-year target/outcome measurement: 100% of prevention coalitions will include health, mental health, youth and law enforcement in all networking, data collection and planning efforts in 2014.

Second-year target/outcome measurement: 50% of all prevention and promotion providers will engage in cross training and networking opportunities by 2015.

Data Source:

Web-based reporting
CACO training data base

Description of Data:

Capture through coalition sector representation on web-based reporting.
of prevention and promotion providers participating in cross training opportunities.
Capture though attendance in trinings on web-based reporting

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #: 3

Indicator: Increase the number of environmental strategies which focus on community norms change

Baseline Measurement: 26% of prevention services are reported as environmental in 2013.

First-year target/outcome measurement: 100% of prevention providers trained in community norms change by 2014.

Second-year target/outcome measurement: 36% of prevention services reported as environmental by 2015.

Data Source:

Web based reporting system

Description of Data:

of trainings completed on environmental strategies
% increase reported in environmental strategies

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #: 4

Indicator: Expanding the number of certified individuals to provide behavioral health services in WV

Baseline Measurement: There are 0 professional certified as community and peer support specialist in 2013.

First-year target/outcome measurement: 50 certified community and peer support specialists in WV by 2014.

Second-year target/outcome measurement: 100 certified community and peer support specialist in WV by 2015.

Data Source:

CACO certification data base

Description of Data:

of individuals applied and received WV certification

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #: 5

Indicator: Decrease the prevalence of chronic health conditions and diverting further incarcerations and hospitalizations by intervening early

Baseline Measurement: 0 SBIRT sites in homeless and domestic violence shelters,, 1 DUI program in a correctional setting, 14 Teen Courts

First-year target/outcome measurement: 6 SBIRT sites in homeless and domestic violence shelters, 3 DUI programs in regional jails, 18 Teen Courts

Second-year target/outcome measurement: 12 SBIRT in homeless and domestic violence shelters sites, 6 DUI programs in regional jails, 22 Teen Courts

Data Source:

Web based reporting system for funded projects

Description of Data:

of SBIRT, DUI and Teen Courts

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #:

6

Indicator:

Increase in the number of school based health centers that provide behavioral health services

Baseline Measurement:

33% of school based health centers provide behavioral health services in 2013

First-year target/outcome measurement:

40% of school based health centers provide behavioral health services in 2014.

Second-year target/outcome measurement:

50% of school based health centers provide behavioral health services in 2015.

Data Source:

Web based reporting for funded services
Department of Education data base of services provided

Description of Data:

locations where behavioral health services are provided in school based health centers

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #:

7

Indicator:

Youth Services Centers located in each Region of WV offering close to home comprehensive services

Baseline Measurement:

There are 0 youth service centers located in WV in 2013.

First-year target/outcome measurement: 6 Youth service centers awarded funding to initiate programming in 2014.

Second-year target/outcome measurement: The number of youth in out of state placement will decrease from 600 to 400 by 2015.

Data Source:

BBHHF AFA and Grant Award process to fund 6 regional youth centers.
Bureau for Children and Families Data Base on Youth and Families.

Description of Data:

Statements of Work for 6 regional youth service centers.

Client level data on out of state placements.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcomes measures.

Indicator #:

8

Indicator:

Increase in the the number of effective regional suicide prevention coalitions and evidence based programs

Baseline Measurement:

There is 1 statewide coalition and 1 suicide prevention and intervention program in WV in 2013.

First-year target/outcome measurement:

6 effective regional coalitions in WV in 2014.

Second-year target/outcome measurement:

Evidenced based programs implemented for suicide prevention, intervention and postvention in 6 regions by 2015.

Data Source:

Marshall University Block Grant Evaluator

Description of Data:

of councils
of evidence based programs trained in and provided

Data issues/caveats that affect outcome measures::

There may be a change in the reporting sysem in 2014.

Indicator #: 9

Indicator: Safe and healthy workplaces created through employer education and resources

Baseline Measurement: 0 indicators collected directly from employers regarding drug testing and behavioral health problems

First-year target/outcome measurement: 6 focus groups conducted with the top 10 employers in each region to determine needs and baseline services provided by 2014.

Second-year target/outcome measurement: Drug Free Work Place and Behavioral Health Education provided to employers in 6 regions by 2015.

Data Source:

Web-based reporting on education and training.
Focus group information collected by BBHMF Research Team.

Description of Data:

Qualitative data received during regional focus groups.
Trainings provided in each region.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcomes measures.

Indicator #: 10

Indicator: Coordination between community justice programs and behavioral health providers statewide

Baseline Measurement: 2 behavioral health providers partner with drug courts and 2 providers partner with SA programming with corrections in 2013.

First-year target/outcome measurement: 6 behavioral health providers will cross train with justice programs for best practice for the population by 2014.

Second-year target/outcome measurement: 6 behavioal health providers will provide coordinated services with justice programs by 2015.

Data Source:

BBHHF Web-based reporting on trainings participated in and provided.
Supreme Court data base of service providers.
Division of Criminal Justice and Community Service data base of service providers.

Description of Data:

Partnerships and collaborations
Cross training events and participation

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #: 11

Indicator: Increased number of quality peer supported/peer-led recovery programs

Baseline Measurement: 0 recovery residences, 0 peer operated drop in centers, 0 certified peer support specialist, and 0 24-hour triage screening and referral programs aligned with national standards in 2013.

First-year target/outcome measurement: 6 Recovery Residences, 7 peer operated drop in centers, 12 peer support specialist employed, and 6 24-hour screening and referral programs aligned with national standards by 2014.

Second-year target/outcome measurement: 12 Recovery Residences, 14 peer operated drop in centers, 24 peer support specialist employed, and 12 24-hour screening and referral programs aligned with national standards by 2014.

Data Source:

BBHHF Grants Management System
CACO data base

Description of Data:

- # Recovery Residences awarded
- # Peer operated drop in centers
- # Peer Support Specialist Hired
- # 24-Hour screening and referral programs

Data issues/caveats that affect outcome measures::

Indicator #: 12

Indicator: Increased number of collaborative and integrated partnerships between youth leadership organizations

Baseline Measurement: There are 0 integrated summits and separate conferences and program initiatives for all youth leadership organizations in WV in 2013.

First-year target/outcome measurement: 1 Youth summit for all youth leadership programs to develop collaborative plans by 2014.

Second-year target/outcome measurement: Increase the number of SADD chapters from 150 to 200 by 2015.

Data Source:

- BBHMF Data System on summits/trainings
- Governor's Highway Safety Program
- SADD International Data Base

Description of Data:

- # collaborative plans
- # summits completed
- # SADD Chapters

Data issues/caveats that affect outcome measures::

Indicator #: 13

Indicator: Decrease in targeted prevalence rates of substance use/abuse and mental health

Baseline Measurement: Youth Suicide rates at 12.9%, Seniors 65+ 18.7%, Outlets selling tobacco to minors at 13.7%, Drug exposed babies at 33-80%, Prescription drug use at 5.68%, Perception of Risk in Binge Drinking at 43.34% among 12-20 year olds in 2013.

First-year target/outcome measurement: Youth Suicide rates at 11%, Seniors 65+ 17%, Outlets selling tobacco to minors at 12%, Drug exposed babies at 25%, Prescription drug use at 4%, Perception of Risk in Binge Drinking at 45% among 12-20 year olds in 2013.

Second-year target/outcome measurement: Youth Suicide rates at 10%, Seniors 65+ 15%, Outlets selling tobacco to minors at 10%, Drug exposed babies at 20%, Prescription drug use at 3%, Perception of Risk in Binge Drinking at 50% among 12-20 year olds by 2015.

Data Source:

WVSEOW
 NSDUH
 WV School Climate Survey
 Public Health Synar data base

Description of Data:

Youth suicide rates
 Senior suicide rates
 Synar rates
 Drug exposed baby rates
 Prescription drug use
 Perception of harm

Data issues/caveats that affect outcome measures:

Priority #: 3

Priority Area: Improve behavioral health outcomes for priority populations

Priority Type: SAP, SAT, MHP, MHS

Population: SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Military)

(s): Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless)

Goal of the priority area:

Target and implement evidence based programming for priority populations to include: Service Members, Veterans and Their Families, Women/Pregnant Women and their Children, Children of Incarcerated Parents, Transitioning Youth, Older Adults/Seniors, Lesbian, Gay, bi-Sexual, Transgendered and Questioning, Homeless, Individuals with Intellectual and Developmental Disabilities and IV Drug Users.

Strategies to attain the goal:

Strategies for Service Members, Veterans and their Families (SMVF)

- a. Expand Health literacy programs to all regions for SMVF
- b. Support the implementation of the Computerized Adaptive Testing Mental Health (CAT-MH) pilot project to improve screening and monitoring for Depression, Anxiety, Mania/Hypomania and suicide risk for service members and veterans
- c. Provide match funding for 6 VETCORP positions to offer community based outreach and education services
- d. Partner with the Office of Veterans Affairs, National Guard and Excalibur Services to promote regional service fairs, in coordination with VETCORP and prevention coalitions
- e. Continue to advocate and support network provisions for West Virginia providers through Tri-Care for behavioral health services
- f. Participate in Veterans Summits on Mental Health

Strategies for Women/ Pregnant Women and their Children

- a. Provide prevention, intervention of FASD and NAS training for physicians, educators, criminal justice system, and social service providers
- b. Partner with the West Virginia Perinatal Partnership to coordinate all related programs statewide
- c. Support "moms and babies programs" that improve health and recovery outcomes of mothers and children and prevent future perinatally exposed pregnancies
- d. Coordinate efforts with women's treatment and recovery programs to begin a birth mom's network

Strategies for Children of Incarcerated Parents

- a. Partner with women's prisons to support family reentry efforts
- b. Provide prevention resources to children in treatment and prison settings
- c. Provide resources for Child Welfare Agencies, Federal Prisons, and Residential Recovery Residences to improve communication and service provision
- d. Encourage inclusion into community and school based evidence based programs

Strategies for Transitioning Youth

- a. Provide transitional housing to decrease unemployment, homelessness, and improve behavioral health and health outcomes
- b. Coordinate efforts with AA and Celebrate Recovery to identify and expand the number of peer/community support groups
- c. Provide funding for a 3-year training model, Transitioning to Independence Process (TIP), to increase workforce competency

Strategies for Older Adults/Seniors

- a. Identify and implement evidenced based programs in counties with high population densities
- b. Conduct focus groups and town hall meetings in senior centers to gain insight
- c. Support "Take Back" prescription programs in senior living facilities
- d. Improve health literacy on behavioral health issues and maintaining benefits
- e. Incorporate the SBIRT screening questions into the West Virginia Bureau of Senior Services intake form for Older American Act services eligibility
- f. Conduct regional SBIRT training for front line staff at county senior service centers

Strategies for Individuals identifying as Lesbian, Gay, Bi-Sexual, Transgendered and Questioning

- a. Identify resources to support youth and others who identify as LGBTQ
- b. Provide cultural competence training with an emphasis on LGBTQ youth in all 55 counties
- c. Continue to vet all related program materials through population networks

Strategies for Homelessness

- a. Reactivate the Governor's Interagency Council on Homelessness to better coordinate agency services and supports for people experiencing, and at risk of, experiencing homelessness
- b. Partner with the West Virginia Coalition to End Homelessness to identify the number of individuals statewide during the point in time study and develop a coordinated intake and assessment
- c. Promote SBIRT and recovery support services in shelters
- d. Develop and implement best practice approaches for people seeking shelter, such as the SPDAT (Service Prioritization Decision Assistance Tool) approach being adopted by the West Virginia Coalition to End Homelessness and coordinated discharge planning
- e. Support local organizations in providing outreach, linkage and referral services for children and their families
- f. Provide support for targeted behavioral health services for the population
- g. Participate in The 100,000 Homes Campaign, a national movement of communities working together to find permanent homes for 100,000 of the country's most vulnerable

Strategies for Persons with Intellectual and Developmental Disabilities

- a. Develop and offer training on best practice for preventing substance use and promoting mental health for persons with intellectual and developmental disabilities
- b. Develop and offer training on best practice for the behavioral health workforce on serving persons with intellectual and developmental disabilities
- c. Implement the Clinical Adult Review Process (CARP) for individuals with complex support needs who have not been able to achieve stable community integration
- d. Expand the TIP model to serve youth with co-existing MI and DD, building on the work of the Co-Existing Disorders EBP Oversight Team

Strategies for IV Drug Users

- a. Identify and establish linkages with health and social services organizations to ensure wide-based knowledge of the availability of services
- b. Screening and referral services will continue to be required in all provider agreements
- c. Training on prevention, screening and referral to treatment for HIV, Hepatitis and TB will continue to be required in all provider agreements
- d. Coordinate efforts with West Virginia University's Heroin Project to improve outreach and program implementation efforts

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased number of engagement, education and referral services for service members, veterans and their families

Baseline Measurement: 3 VetCORP positions in 3 regions of WV, 0 combined service fairs, 1 health literacy program in 1 region in 2013.

First-year target/outcome measurement: 6 VetCORP positions in 6 regions and 6 combined service fairs, and health literacy programs in 3 regions in WV by 2014.

Second-year target/outcome measurement: 6 VetCORP positions in 6 regions and 6 combined service fairs sustained, and health literacy programs in 6 regions in WV by 2014

Data Source:

CADCA and WV Prevention Coalitions VetCorp Contracts
Excalibur partnership MOU for service fairs
WV State University partnership MOU for health literacy programs

Description of Data:

Vet CORPS hired
Service fairs implements by region
Health literacy programs by region

Data issues/caveats that affect outcome measures::

No issues currently foreseen that will affect the outcome measures.

Indicator #: 2

Indicator: Increased number of resources and referrals for women, pregnant women and their children

Baseline Measurement: 4 out patient moms and babies programs, 7 residential programs for women and pregnant

women, 0 birth moms/support networks for women in 2013.

First-year target/outcome measurement:

Sustain 4 moms and babies programs, 8 residential programs for women and pregnant women, 1 meeting of collaborative partners by 2014.

Second-year target/outcome measurement:

Sustain 4 moms and babies programs, sustain 8 residential programs for women and pregnant women, 1 birth moms network by 2015.

Data Source:

BBHMF Grant Agreements
Web-based reporting system

Description of Data:

programs
of facilities,
of networks

Data issues/caveats that affect outcome measures::

Indicator #:

3

Indicator:

Increase services and supports for children of incarcerated parents

Baseline Measurement:

0 evidence based programs for targeted population and 6 in 2013.

First-year target/outcome measurement:

2 Prevention programs for target in each region and 3 trainings for providers statewide by 2014.

Second-year target/outcome measurement:

6 Prevention programs for target in each region and 6 trainings for providers statewide by 2015.

Data Source:

BBHMF Web based reporting system

Description of Data:

evidence based programs for target population
trainings for providers of target population

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #: 4

Indicator: Increased services and supports for older adults and seniors at risk for behavioral health problems

Baseline Measurement: 0 SBIRT programs in senior centers, 0 focus groups and town halls in senior centers, 0 EBP's implemented for seniors in 2013.

First-year target/outcome measurement: 3 SBIRT programs in senior centers, 3 focus groups and town halls in senior centers, 3 EBP's implemented for seniors in 2013.

Second-year target/outcome measurement: 6 SBIRT services in senior centers, 6 focus groups and town halls in senior centers, 6 EBP's implemented for seniors in 2013.

Data Source:

BBHHF Web-based reporting data base
Bureau of Senior Services services

Description of Data:

SBIRT programs in senior centers
focus groups and town halls with population
EBP's implemented

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #: 5

Indicator: Increased awareness of service availability and resources for individuals identifying as Lesbian, Gay, Bi-Sexual, Transgendered and Questioning

Baseline Measurement: 6 Regional Trainings provided on cultural competency with a focus on LGBTQ, 0 Behavioral Health Web-based resources identified and disseminated in 2013.

First-year target/outcome measurement: 55 County Trainings provided on cultural competency with a focus on LGBTQ, 6 Behavioral Health Web-based resources identified and disseminated in 2013.

Second-year target/outcome measurement: 6 Regional Trainings provided to new staff on cultural competency with a focus on LGBTQ, 12 Behavioral Health Web-based resources identified and disseminated in 2013.

Data Source:

BBHMF Web-based reporting system
Fairness Network Website
BBHMF website

Description of Data:

Programs and services identified and disseminated electronically
trainings conducted on LGBTQ

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #: 6

Indicator: Improved coordination of behavioral health services for individuals and families experiencing homelessness

Baseline Measurement: Current data is not reflective of the population and consistent services are not available in 2013.

First-year target/outcome measurement: 26 county coalitions will assist in the point in time study and coordinated intake and assessment process will be activated in 3 regions by 2014.

Second-year target/outcome measurement: 55 county coalitions will assist in the point in time study and coordinated intake and assessment process will be activated in 6 regions by 2015

Data Source:

WV Coalition to End Homelessness Data Base
BBHMF Web based reporting system

Description of Data:

individuals identified during point in time study
coalitions engaged in study

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #: 7

Indicator: Best practices implemented for preventing substance use and promoting mental health for persons with intellectual and developmental disabilities

Baseline Measurement: 0 trainings are provided through BBHMF specifically for this priority population and providers serving them in 2013.

First-year target/outcome measurement: 6 trainings will be provided through BBHMF specifically for this priority population and providers serving them in 2014.

Second-year target/outcome measurement: 12 trainings will be provided through BBHMF specifically for this priority population and providers serving them in 2014.

Data Source:

BBHMF Web Based Reporting
CACO Training Data Base

Description of Data:

Trainings provided to individuals/providers

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Indicator #: 8

Indicator: Established linkages with health and social services organizations to ensure services and resources for IV drug users.

Baseline Measurement: 0 formal provider linkages with social services and health organizations for HIV, Hepatitis and TB in 2013.

First-year target/outcome measurement:

6 formal provider linkages with social services and health organizations for HIV, Hepatitis and TB by 2014.

Second-year target/outcome measurement:

13 formal provider linkages with social services and health organizations for HIV, Hepatitis and TB by 2015.

Data Source:

Letters of Intent
Memorandums of Agreement

Description of Data:

of providers with program linkage and referrals to social service and health organizations

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcome measures.

Footnotes:

Due to the inability to capture goals separately, all strategies were uploaded under each priority area and performance indicators are targeted goal areas.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	\$6,404,070		\$	\$823,639	\$28,934,698	\$	\$
a. Pregnant Women and Women with Dependent Children*	\$ 1,748,755		\$	\$	\$ 2,722,086	\$	\$
b. All Other	\$ 4,655,315		\$	\$ 823,639	\$ 26,212,612	\$	\$
2. Substance Abuse Primary Prevention	\$ 1,707,752		\$	\$	\$ 1,763,104	\$	\$
3. Tuberculosis Services	\$		\$	\$	\$	\$	\$
4. HIV Early Intervention Services	\$		\$	\$	\$	\$	\$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	\$ 426,938		\$	\$ 300,000	\$ 138,000	\$	\$
11. Total	\$8,538,760	\$	\$	\$1,123,639	\$30,835,802	\$	\$

* Prevention other than primary prevention

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
6. Other 24 Hour Care		\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
7. Ambulatory/Community Non -24 Hour Care		\$ 1,613,634	\$ 24,098,042	\$ 600,000	\$ 142,094,711	\$ <input type="text"/>	\$ <input type="text"/>
8. Mental Health Primary Prevention		\$ 130,000	\$ <input type="text"/>	\$ 200,000	\$ 336,678	\$ <input type="text"/>	\$ <input type="text"/>
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)		\$ 123,650	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
10. Administration (Excluding Program and Provider Level)		\$ 605,724	\$ <input type="text"/>	\$ <input type="text"/>	\$ 100,000	\$ <input type="text"/>	\$ <input type="text"/>
11. Total	\$	\$ 2,473,008	\$ 24,098,042	\$ 800,000	\$ 142,531,390	\$	\$

* Prevention other than primary prevention

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			\$	\$
Specialized Outpatient Medical Services			\$	\$
Acute Primary Care			\$	\$
General Health Screens, Tests and Immunizations			\$	\$
Comprehensive Care Management			\$	\$
Care coordination and Health Promotion			\$	\$
Comprehensive Transitional Care			\$	\$
Individual and Family Support			\$	\$
Referral to Community Services Dissemination			\$	\$
Prevention (Including Promotion)			\$97,688	\$130,000
Screening, Brief Intervention and Referral to Treatment			\$	\$

Brief Motivational Interviews			\$	\$
Screening and Brief Intervention for Tobacco Cessation			\$	\$
Parent Training			\$	\$50,000
Facilitated Referrals			\$97,688	\$
Relapse Prevention/Wellness Recovery Support			\$	\$80,000
Warm Line			\$	\$
Substance Abuse (Primary Prevention)			\$1,707,752	\$
Classroom and/or small group sessions (Education)			\$165,775	\$
Media campaigns (Information Dissemination)			\$248,663	\$
Systematic Planning/Coalition and Community Team Building(Community Based Process)			\$227,940	\$
Parenting and family management (Education)			\$82,888	\$
Education programs for youth groups (Education)			\$82,888	\$
Community Service Activities (Alternatives)			\$82,888	\$
Student Assistance Programs (Problem Identification and Referral)			\$41,444	\$
Employee Assistance programs (Problem Identification and Referral)			\$41,444	\$

Community Team Building (Community Based Process)			\$227,940	\$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			\$505,882	\$
Engagement Services			\$	\$829,693
Assessment			\$	\$
Specialized Evaluations (Psychological and Neurological)			\$	\$
Service Planning (including crisis planning)			\$	\$
Consumer/Family Education			\$	\$445,967
Outreach			\$	\$383,726
Outpatient Services			\$2,387,262	\$
Evidenced-based Therapies			\$1,737,771	\$
Group Therapy			\$	\$
Family Therapy			\$649,491	\$
Multi-family Therapy			\$	\$
Consultation to Caregivers			\$	\$
Medication Services			\$	\$

Medication Management			\$	\$
Pharmacotherapy (including MAT)			\$	\$
Laboratory services			\$	\$
Community Support (Rehabilitative)			\$183,900	\$76,000
Parent/Caregiver Support			\$	\$
Skill Building (social, daily living, cognitive)			\$	\$65,000
Case Management			\$	\$11,000
Behavior Management			\$	\$
Supported Employment			\$	\$
Permanent Supported Housing			\$	\$
Recovery Housing			\$183,900	\$
Therapeutic Mentoring			\$	\$
Traditional Healing Services			\$	\$
Recovery Supports			\$	\$546,820
Peer Support			\$	\$121,400
Recovery Support Coaching			\$	\$

Recovery Support Center Services			\$	\$425,420
Supports for Self-directed Care			\$	\$
Other Supports (Habilitative)			\$	\$
Personal Care			\$	\$
Homemaker			\$	\$
Respite			\$	\$
Supported Education			\$	\$
Transportation			\$	\$
Assisted Living Services			\$	\$
Recreational Services			\$	\$
Trained Behavioral Health Interpreters			\$	\$
Interactive Communication Technology Devices			\$	\$
Intensive Support Services			\$155,424	\$
Substance Abuse Intensive Outpatient (IOP)			\$155,424	\$
Partial Hospital			\$	\$

Assertive Community Treatment			\$	\$
Intensive Home-based Services			\$	\$
Multi-systemic Therapy			\$	\$
Intensive Case Management			\$	\$
Out-of-Home Residential Services			\$2,983,420	\$
Children's Mental Health Residential Services			\$	\$
Crisis Residential/Stabilization			\$	\$
Clinically Managed 24 Hour Care (SA)			\$2,983,420	\$
Clinically Managed Medium Intensity Care (SA)			\$	\$
Adult Mental Health Residential			\$	\$
Youth Substance Abuse Residential Services			\$	\$
Therapeutic Foster Care			\$	\$
Acute Intensive Services			\$	\$
Mobile Crisis			\$	\$
Peer-based Crisis Services			\$	\$

Urgent Care			\$	\$
23-hour Observation Bed			\$	\$
Medically Monitored Intensive Inpatient (SA)			\$	\$
24/7 Crisis Hotline Services			\$	\$
Other (please list)			\$596,376	\$284,771
Prevention Data Collection & Reporting (SA)			\$300,000	\$
Enrollment & Provider Business Practices			\$256,163	\$74,190
Planning Council			\$40,213	\$41,569
WV Coalition to End Homelessness			\$	\$50,000
Data Collection & Evaluation (MH)			\$	\$119,012

Footnotes:

Currently, West Virginia is working with an outside entity to create a web-based reporting system for our providers that will enable us to accurately collect the data for Unduplicated Count and Units for the 11 service areas. It is our goal to have this system in place by the beginning of the federal fiscal year starting October 1, 2014.



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III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Targeted Substances	
Alcohol	☐
Tobacco	☐
Marijuana	☐
Prescription Drugs	☐
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☐
Military Families	☐
LGBTQ	☐
American Indians/Alaska Natives	☐
African American	☐
Hispanic	☐
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☐
Underserved Racial and Ethnic Minorities	☐

Footnotes:



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III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$ <input type="text"/>
MHA Planning Council Activities	\$ <input type="text" value="41,569"/>
MHA Administration	\$ <input type="text" value="605,724"/>
MHA Data Collection/Reporting	\$ <input type="text" value="119,012"/>
Enrollment and Provider Business Practices (3 percent of total award)	\$ <input type="text" value="74,190"/>
MHA Activities Other Than Those Above	\$ <input type="text"/>
Total Non-Direct Services	\$840495
Comments on Data: <input type="text"/>	

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

C. Coverage M/SUD Services

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014.

West Virginia has elected for Medicaid Expansion. As of January 1, 2014, expanded coverage will be identical to current coverage for all Medicaid members. New member will be eligible at 138% of the FPL and will be eligible for all M/SUD services currently covered as detailed in the Medicaid Providers' Manual. Medicaid provider manuals for M/SUD can be found at:

<http://www.dhhr.wv.gov/bms/Pages/ProviderManuals.aspx>

2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid? In West Virginia if an individual or family is unable to access services offered through QHPs or Medicaid our thirteen (13) Comprehensive Behavioral Health Centers will access BBHMF's State funded charity care dollars. As the program leadership team reviews allocation on an ongoing basis, we will see where these funds are being spent. From this use of State Funding, we will know what is not being funded through the QHP and Medicaid.
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process. The Rates & Forms Commission within the Offices of the Insurance Commissioner (OIC) reviews plans when they are filed and verifies that M/SUD services are provided. The plans are certified and become QHP if they meet all of OIC's requirements. The plans must re-certify annually and again it is verified that M/SUD services are provided. At any time, if there is a complaint regarding coverage, the OIC investigates and plans risk losing their certification if M/SUD services are not provided as detailed in their submitted plan. Plans are not monitored within the year unless there is a complaint.
4. Will the SMHA and/or the SSA be involved in reviewing any complaints or possible violations of the MHPAEA? Cynthia Parsons with the Bureau of Medical Services (BMS), a sister bureau within the Department of Health and Human Resources (DHHR) typically receives complaints of this type as she handles behavioral health for BMS. Cynthia reports that she first calls the provider to investigate the complaint. If she determines there has been a violation, she notifies the provider both by phone and by letter that the violation must be remedied and must not recur. Should she then receive a subsequent complaint, an auditor will be sent out to the provider location and a formal infraction will be documented. The provider is then required to complete a plan of action for correcting the situation. Conversely, if the complaint is found to be invalid, the complaint is closed and the consumer is advised of the finding in writing. As BBHMF and BMS are sister bureaus within DHHR, while the SMHA and SSA will not be directly involved in reviewing the complaint unless their expertise is needed, both will be notified of the complaint and the resolution after the fact.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

IV: Narrative Plan

D. Health Insurance Marketplace

According to a newsletter issued by the pro-health care reform advocacy group titled, West Virginians for Affordable Health Care: “Although employees working for large employers will not see a change in their enrollment, in just [3] months (October 2013), small businesses and individuals without employer-sponsored health insurance can start applying for health coverage through the state’s new health insurance exchange. The new enrollment process for these families will be about as easy as opening a checking account. Key features of this new system will include the following: First, people will be able to fill out one simple form online, through the mail, over the phone or in person. In-person applications will be taken by a variety of community organizations that have been trained and certified by the health insurance exchange. Second, applicants will have to provide only their name, address and social security number. Everything else, such as citizenship and income, will be confirmed automatically. Eligibility will be based on income and family size. Asset tests will be eliminated for parents and the expanded population in Medicaid. Third, there will be no wrong door. Once people fill out the form and confirm their information, the new system will do one of the following: Enroll people in Medicaid who have family incomes of less than 138 percent of the Federal Poverty Level (FPL), about \$25,000 per year for a family of three; or Enroll, or at worst, refer to traditional Medicaid those who are eligible for long-term care or are disabled; or Offer a choice of private plans through the health insurance exchange to small businesses and to individuals without employer-sponsored health plans making more than 138 percent of FPL. Individuals and families earning between 138 and 400 percent of the FPL will receive generous subsidies to buy health coverage. Families earning more than 400 percent of the FPL will be given an option to enroll in one of the private insurance companies authorized to sell policies in the health insurance exchange.”

On February 15, 2013, the Governor announced, via submission of the State’s Blueprint and Declaration Letter that West Virginia would enter into a Consumer Assistance and Plan Management Partnership with the United States Department of Health and Human Services (HHS). In announcing its decision, the State decided to solely take on the In-Person Assistance (IPA) Program and removed itself from the requirement to provide Navigator Program oversight. The State also chose to not undertake a mass marketing campaign, instead relying on federal marketing efforts and localized outreach related to the IPA Program. West Virginia received Conditional approval for doing this in 2014 from the United States DHHS on March 15, 2013 in a letter signed by Secretary Sebelius.

According to February 15, 2013 article appearing in *The Charleston Gazette*, entitled W.Va. submits plans for insurance marketplace, written By Lori Kersey: “Under a state plan, West

Virginia's uninsured residents can sit down and receive one-on-one help in comparing health insurance plans. This 'in-person assistance,' meant to help uninsured people purchase health insurance, is one piece of the state's blueprint for operating a health insurance marketplace. Under the Affordable Care Act, states must submit plans to the federal government about how they plan to participate in their own health insurance marketplace, formerly called exchanges. Friday marked the deadline for states to submit a letter of declaration and a blueprint for their insurance marketplace. States had the option to run the marketplace alone or to allow the federal government to run it. As expected, WV officials submitted plans for the state and federal governments to jointly operate the Mountain State's Health Insurance Marketplace. Based on the state's blueprint, federal funding will allow WV officials to hire and train people to help residents enroll in health insurance plans. How much federal money and how many workers the state will hire is not yet certain, said Jeremiah Samples of the West Virginia Office of the Insurance Commissioner. 'We have some internal projections,' Samples said, 'but nothing has been finalized.' Cynthia Bryant, Bureau for Medical Services, said there likely would be between \$4 million and \$8 million to hire about 225 people statewide . . . He expects that some workers will be in Department of Health and Human Resources offices, some in community health centers, and -- he hopes -- some in family resource centers . . . Those workers will help enroll between 46,000 and 100,000 people. The state will have in-person assistance but it will not offer its own media campaign about the health insurance marketplace. Samples said that because the federal government will have its own mass-media campaign about the marketplace, state officials felt that a local media campaign would be a duplication of efforts. 'We'll make sure we're continuing to regulate insurance in West Virginia and providing assistance to citizens,' Samples said. 'The marketing campaign will be one the feds will undertake.'"

Deputy Secretary Samples also noted in a subsequent presentation on Medicaid Expansion that "West Virginia consumers will be able to access the Marketplace, an online portal that provides eligibility determination for Medicaid, CHIP, and premium tax credits. Consumers can also call the Federal Exchange call center, which will have ability to determine eligibility. Finally, consumers can go to a local DHHR office, access the support of in-person assisters, navigators, or certified application counselors at designated locations for help determining health coverage eligibility."

According to the Kaiser Foundation's State Health Facts website, 57% of West Virginian's have Employer-Sponsored Health Insurance, 2% have Individual health insurance, 19% have Medicaid, 5% have Other Public Insurance, and 16% are uninsured. More specifically, the NASMHPD Research Institute estimates that 15,683 people with SMI will be eligible for expanded Medicaid Coverage and that 10,747 persons with SMI will be eligible to use the State's Health Insurance Exchange.

The following table reflects the West Virginia Insurance Commission’s estimates on Marketplace usage:

Projected In Person Assistance Utilization Rates				
Category	Number of Lives	Percent Utilizing Exchange	Percent Seeking Assistance	Number of Individuals Seeking Assistance
Uninsured Below 138% FPL	132,700	50%	50%	33,175
Uninsured 138% and Above	123,000	50%	50%	30,750
Employer Sponsored Coverage	895,300	20%	20%	35,812
Individual Market	26,500	20%	20%	1,060
Total Enrollment Contacts				100,797
Anticipated Multiplier for Year				1.25
Total Yearly Contacts				125,996
Source: http://www.statehealthfacts.org/profileind.jsp?ind=126&cat=3&rgn=50 http://www.statehealthfacts.org/profileind.jsp?ind=136&cat=3&rgn=50				

The BBHFF will partner with other agencies and nonprofits to assist with education on and enrollment in both state Medicaid Expansion activities and use of the Exchange/Marketplace Call Center, Website and face to face Navigators. The BBHFF has been participating in the Health Insurance Marketplace calls targeted to West Virginia stakeholders and designated staff will use in person education and well as its website and network emails to become a *Champion for Coverage* by promoting consumer outreach material made available by its federal partners on the [marketplace@cms.gov](http://marketplace.cms.gov) website, including website widgets, network e-mails, posters and fact sheets, and educational conference calls. Staff will also facilitate in person training for groups like the Behavioral Health Planning Council and BRSS TACS Team. For example, the Office of Consumer Affairs and Community Outreach will participate in enrollment training offered for Certified Application Counselors and/or the West Virginians for Affordable Health Care and use this training to work with other stakeholders, including behavioral health providers, advocates, people in recovery and family members, to conduct outreach to people with mental health and substance use issues at peer support centers, FQHCs and CBHCs and hospital settings.

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

IV. Narrative Plan

E. Program Integrity

The BBHMF continues to develop and refine the Program Integrity efforts that are applied to all grant and contract awards. Program Integrity (PI) efforts include a clinical oversight and evaluation, as referenced in greater detail in many other sections of this application, and financial evaluation. Financial evaluations are performed at several different junctures throughout the grant award and operational processes and are tailored to each individual award and service provider. All PI efforts are applied to each grant and contract regardless of whether the award is a general revenue funded program or a sub-recipient award of Federal Substance Abuse or Mental Health Block Grant funding.

Oversight of PI Activities

The BBHMF announces all new opportunities for funding through an Announcement of Funding Availability (AFA) process which encourages all interested providers to thoroughly design and propose a service delivery model that is thorough, comprehensive, and readily tested for efficacy and success. The AFA process is overseen by individuals with clinical backgrounds, financial backgrounds, and compliance/monitoring focus to allow for a more comprehensive development of expectations and a more varied focus review of all proposals submitted. The process allows for “scoring” of all proposals to help make objective decisions of a very subjective means of communicating intentions and plans for service delivery. Once awarded each of the same groups of individuals noted above continue on with their respective PI activities which include many different facets of PI review. Technical Assistance (TA) is offered at all times through the process beginning with an AFA TA to assist any interested service providers with their development of a sound proposal and continuing through the life of the award all the way to closing out the award. TA is offered for all facets of the process including financial documentation, clinical standards, and safety standards.

Specific PI Activities Performed

The BBHMF utilizes many different PI processes including, but not limited to:

Budget reviews at the “line item” level of detail to ensure that awarded service providers are spending awarded funds in a manner consistent with the terms and conditions set forth in the Catalog for Federal Domestic Assistance, the grant or contract language establishing the award, the reporting guidelines established in the award documents, and any other special requirements for financial reporting. All grants and contracts are reimbursed on a reimbursement of costs basis to ensure that funds are only distributed after the budget has been approved and each invoice requesting reimbursement is consistent with the approved budget document.

Each request for reimbursement is thoroughly reviewed and compared to original expenditure expectations prior to payment adjudication. The majority of services are provided under CFDA and grant Statement of Work expectations and are billed as costs incurred for the provision of

services as opposed to fee for service processing for services provided. Reimbursement of costs ensures that the provider is made whole for any costs incurred that meet the allowability and acceptability established in the award documentation regardless of whether a fee for service standardized definition of service is available.

Expenditures and requests for reimbursement are monitored for amount expended in current period and whether that amount is consistent with previous requests for reimbursement, amount expended year to date and whether that amount is on pace for over or under expenditure for the year (or other period of award if less than one full year), and across multiple providers of similar services (when available) to ensure consistent costs among peer agencies. If awarded entities show a trend of under expenditure based upon annual projections, adjustments to the amount of award available to that provider is reduced to allow for redistribution to provider agencies which are showing expenses trending in excess of expectations. These mid period adjustments allow for the ability to redirect funding to the agencies who are demonstrating the greatest need and supporting the expenditures by showing successful outcomes and performance indicators. Redistribution of funds to agencies demonstrating these values is an excellent way to monitor Program Integrity across multiple agencies.

The BBHMF Monitoring and Compliance sections then uses the expenditure analysis and client services utilization data to plan a compliance and quality review of the awarded entities to verify and document the requests for reimbursement and the client specific demographic and utilization data collected and reported. Compliance for adherence to all applicable Federal, State and other relevant rules is the primary focus of the review while collection of quality measures creates documentation that can be used by the clinical staff to verify that the program is meeting all expectations of success.

Each client served in a community based or in-patient setting is reported to the BBHMF data system which allows for litmus tests of recidivism, program outcomes, and performance measures by showing which clients continue to receive services as set forth in their clinical care plans and which clients are being served in either the community or hospital setting. Each encounter is reported and tracked and is included in an episodic data set that retains the flexibility to report the client in a per-episode query or a lifetime services view.

In addition to the monitoring and oversight activities described above the BBHMF also requires all sub-recipient grantee organizations to submit an annual independent audit of financial statements and an approved indirect rate if indirect costs are requested in the budget submitted by the organization. The documentation prepared by and sent by the independent CPA allows for a basis for financial review of the BBHMF fiscal unit and the BBHMF Compliance and Quality review unit.

The state reimburses services provided at the Medicaid rate to any provider rendering services to a non-Medicaid eligible individual using state general revenue funding. Block grant funds are

used to render services that are not Medicaid eligible and for services that are not client specific but broad based in the case of prevention services.

WEST VIRGINIA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Highmark Blue Cross Blue Shield West Virginia
Product Name	Super Blue Plus 2000
Plan Name	Super Blue Plus 2000 1000 Ded
Supplemented Categories (Supplementary Plan Type)	<ul style="list-style-type: none">• Pediatric Oral (State CHIP)• Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	No

BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	Primary Care Visit to Treat an Injury or Illness	Covered	Primary Care Visit to Treat an Injury or Illness	No					All Covered Services must be Medically Necessary unless otherwise specified.	Emergency care in an Office setting will be paid as any other Office Visit.	No
2	Specialist Visit	Covered	Specialist Visit, including second surgical opinion, therapy modalities	No					All Covered Services must be Medically Necessary unless otherwise specified.	Emergency care in an Office setting will be paid as any other Office Visit.	No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Other Practitioner Office Visit (where the professional may be a Chiropractor, Nurse, Physician Assistant, podiatrist, psychologist or other professional whose services require payment under WV Code or Federal Mandate), and may include covered therapy modalities	No					All Covered Services must be Medically Necessary unless otherwise specified.	Emergency care in an Office setting will be paid as any other Office Visit.	No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient Facility Fee (e.g., Ambulatory Surgery Center but is not an office or clinic used for the private practice of a physician or other provider) and may include Therapy Services such as Radiation, Chemo, dialysis, PT, respiratory, Hyperbaric, pulmonary, speech and occupational modalities.	No					All Covered Services must be Medically Necessary unless otherwise specified.	Non-emergency visits to a Hospital based clinic are paid as an outpatient service and not as an Office Visit. Outpatient facilities may be a part of Facility Other Providers, which include Alcoholism Treatment Center, Ambulatory Medical Facility, Ambulatory Surgical Facility, Birthing Center, Day/Night Psych facility, Dialysis Facility, Drug Abuse treatment facility, Freestanding Renal Dialysis Center, Home Health Agency, Hospice facility, psychiatric facility, psychiatric hospital, Rehabilitation facility, Skilled nursing facility as may be allowed by Federal or State law.	Yes

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5	Outpatient Surgery Physician/Surgical Services	Covered	Outpatient Surgery Physician/Surgical Services performed within the scope of the provider's license.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
6	Hospice Services	Covered	Hospice Services based on an approved treatment plan when life expectancy is 6 months or less.	No					Hospice related prescription drugs are limited to a two week supply and must be for palliative or supportive care. Also excluded are physician visits, volunteer services, spiritual counseling, bereavement counseling, non-palliative chemo or radiation therapy. All Covered Services must be Medically Necessary unless otherwise specified.	Services are similar to home health and include Inpatient hospice care, Respite care, dietary guidance, DME, home health aide visits, prescription drugs.	No
7	Non-Emergency Care When Traveling Outside the U.S.	Covered	Non-Emergency Care When Traveling Outside the U.S.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
8	Routine Dental Services (Adult)	Not Covered	Routine Dental Services (Adult).								
9	Infertility Treatment	Not Covered	Infertility Treatment.						Exclusions include services related to Cloning, reversal of sterilization, In-vitro fertilization, gamete intra fallopian transfer and other ova transfer procedures.		
10	Long-Term/Custodial Nursing Home Care	Not Covered	Long-Term/Custodial Nursing Home Care.								
11	Private-Duty Nursing	Covered	Private-Duty Nursing.	Yes	5000	Other	\$ per year		Inpatient services are available when a provider's regular nursing staff cannot provide them. Non-medical and Custodial services are excluded.		No
12	Routine Eye Exam (Adult)	Not Covered	Routine Eye Exam (Adult).								
13	Urgent Care Centers or Facilities	Covered	Urgent Care Centers or Facilities per the Prudent Layperson standard.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No

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14	Home Health Care Services	Covered	Homebound patients may receive intermittent skilled care, PT, OT or speech therapy, medical supplies, Oxygen, prescription drugs, medical social services, and home health aide visits for skilled nursing or therapy services, laboratory tests, home infusion therapy.	Yes	100	Visits per year			Excluded are dietician services, homemaker services, food or home delivered meals, Custodial Care, maintenance therapy, prenatal care, private duty nursing, personal comfort items. All Covered Services must be Medically Necessary unless otherwise specified.		No
15	Emergency Room Services	Covered	Emergency Room Services per the Prudent Layperson standard	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
16	Emergency Transportation/ Ambulance	Covered	Emergency Transportation/ Ambulance	No					Trips must be to the closest facility that can provide Covered Services appropriate for your condition. All Covered Services must be Medically Necessary unless otherwise specified.		No
17	Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient Hospital Services (e.g., Hospital Stay)	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
18	Inpatient Physician and Surgical Services	Covered	Inpatient Physician and Surgical Services	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
19	Bariatric Surgery	Covered	Bariatric Surgery	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
20	Cosmetic Surgery	Covered	Cosmetic Surgery or reconstructive surgery to restore a body function or malformation caused by disease, trauma, birth defects, and growth defects, prior therapeutic processes such as mastectomy; or as a result of an act of family violence.	No					Surgery or other services primarily intended to improve appearance in the absence of disease; trauma or causes not defined as Reconstructive are excluded. All Covered Services must be Medically Necessary unless otherwise specified.		No

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21	Skilled Nursing Facility	Covered	Providing inpatient services when authorized and based on a physician's Plan of Treatment and recertified every two weeks.	No					Custodial, ambulatory, rest or part-time care and pulmonary tuberculosis treatment is excluded; Benefits expire when the patient cannot present significant improvement. All Covered Services must be Medically Necessary unless otherwise specified.		No
22	Prenatal and Postnatal Care	Covered	Prenatal and Postnatal Care, including newborn care and circumcision.	No					Services for Surrogate motherhood are not covered. Newborn care is covered when added to the plan within 30 days of birth. All Covered Services must be Medically Necessary unless otherwise specified.		No
23	Delivery and All Inpatient Services for Maternity Care	Covered	Delivery and All Inpatient Services for Maternity Care, when the newborn is added to coverage within 30 days of birth; Care for a covered newborn includes circumcision	No					Services for Surrogate motherhood are not covered. Newborn care is covered when added to the plan within 30 days of birth. All Covered Services must be Medically Necessary unless otherwise specified.		No
24	Mental/Behavioral Health Outpatient Services	Covered	Mental/Behavioral Health Outpatient Services	No					Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered, except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.		Yes

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25	Mental/Behavioral Health Inpatient Services	Covered	Mental/Behavioral Health Inpatient Services	No					Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.		No
26	Substance Abuse Disorder Outpatient Services	Covered	Substance Abuse Disorder Outpatient Services	No					Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.		No
27	Substance Abuse Disorder Inpatient Services	Covered	Substance Abuse Disorder Inpatient Services	No					Services beyond the evaluation or diagnosis of mental deficiency, retardation, autism, learning disabilities or mental retardation are not covered except as mandated by State or federal code. Mental illness that cannot be treated is not covered. All Covered Services must be Medically Necessary unless otherwise specified.		No

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28	Generic Drugs	Covered	Generic Drugs	No					Services of a Non-Network pharmacy are excluded. Other items excluded include drugs for the treatment of obesity, weight reduction or for cosmetic purposes; drugs consumed entirely at the time and place where a prescription order is issued; over the counter medications or those available without a prescription except as provided by State or Federal benefit mandates. All Covered Services must be Medically Necessary unless otherwise specified.	Insulin syringes, needles and disposable diabetic testing material are covered when dispensed in days supply corresponding to the amount of insulin dispensed.	No
29	Preferred Brand Drugs	Covered	Preferred Brand Drugs	No					Services of a Non-Network pharmacy are excluded. Other items excluded include drugs for the treatment of obesity, weight reduction or for cosmetic purposes; drugs consumed entirely at the time and place where a prescription order is issued; over the counter medications or those available without a prescription except as provided by State or Federal benefit mandates. All Covered Services must be Medically Necessary unless otherwise specified.	Insulin syringes, needles and disposable diabetic testing material are covered when dispensed in days supply corresponding to the amount of insulin dispensed.	No

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30	Non-Preferred Brand Drugs	Covered	Non-Preferred Brand Drugs	No					Services of a Non-Network pharmacy are excluded. Other items excluded include drugs for the treatment of obesity, weight reduction or for cosmetic purposes; drugs consumed entirely at the time and place where a prescription order is issued; over the counter medications or those available without a prescription except as provided by State or Federal benefit mandates. All Covered Services must be Medically Necessary unless otherwise specified.	Insulin syringes, needles and disposable diabetic testing material are covered when dispensed in days supply corresponding to the amount of insulin dispensed.	No
31	Specialty Drugs	Covered	Specialty Drugs, generally understood to be drugs not covered under the pharmacy benefit but furnished on an outpatient basis such as infusion therapy and some injectable drugs.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
32	Outpatient Rehabilitation Services	Covered	Outpatient Rehabilitation Services to treat Stroke, Spinal cord injury, Congenital deformity, Amputation, Major multiple traumas, Fracture of femur, brain injury, Polyarthritis, including rheumatoid arthritis, Neurological disorders, Cardiac disorders and Burns when there is a reasonable likelihood services will restore optimal physical, medical, psychological, social, emotional, vocational and economic status.	No					Excluded services are those associated with Mental conditions, chemical dependency, vocational rehabilitation, long term maintenance, custodial services. All Covered Services must be Medically Necessary unless otherwise specified.		Yes

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
33	Habilitation Services	Not Covered	Habilitation Services							This service is not defined by applicable State Code or in the Certificate of Coverage.	
34	Chiropractic Care	Covered	Chiropractic Care manipulations are considered same as Physical therapy	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
35	Durable Medical Equipment	Covered	Durable Medical Equipment purchase or rental at our option when prescribed by a provider practicing within the scope of their license, including orthotics, prosthetics.	No					Excluding dental appliances, elastic bandages, garter belts or similar supplies, orthopedic shoes, items not serving a medical purpose, items not able to withstand repeated use. All Covered Services must be Medically Necessary unless otherwise specified.		No
36	Hearing Aids	Not Covered	Hearing Aids								
37	Diagnostic Test (X-Ray and Lab Work)	Covered	Diagnostic Test (X-Ray and Lab Work) when ordered by a physician or qualified provider operating within the scope of their license, includes pre-admission testing	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
38	Imaging (CT/PET Scans, MRIs)	Covered	Imaging (CT/PET Scans, MRIs) ordered by a physician or other qualified provider operating within the scope of their license	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
39	Preventive Care/ Screening/ Immunization	Covered	Preventive Care/Screening/ Immunization to the extent mandated by State and Federal Code.	No							No
40	Routine Foot Care	Not Covered	Routine Foot Care								
41	Acupuncture	Not Covered	Acupuncture								
42	Weight Loss Programs	Not Covered	Weight Loss Programs								
43	Routine Eye Exam for Children	Covered	Routine eye exam	Yes	1	Visits per year					No

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44	Eye Glasses for Children	Covered	Eyeglasses for adults and children	Yes	1	Other	1 pair of glasses (lenses and frames per year)				No
45	Dental Check-Up for Children	Covered	Dental Exams	Yes	1	Other	Every 6 months			Supplemented using WV CHIP. Limitations, including dollar limits, may apply.	No

OTHER BENEFITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	Other	Covered	Abortion, elective and therapeutic	No					Partial Birth abortion.		No
2	Mental/Behavioral Health Outpatient Services	Covered	Applied Behavioral Analysis (ABA) for Autism	Yes	30000	Other	Annual \$30k limit for ABA therapy during first 3 years DX'd. \$2000/month thereafter to age 18.		All Covered Services must be Medically Necessary unless otherwise specified.		No
3	Other	Covered	Oral Surgery for boney tooth impaction	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
4	Other	Covered	Allergy tests and treatment; includes desensitization treatment	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
5	Other	Covered	Temporo and Cranio mandibular disorder treatment; "TMJ"	Yes	1	Other	Orthotics, splints and appliances are limited to one every 3 years.		Treatment to alter vertical dimension is excluded. All Covered Services must be Medically Necessary unless otherwise specified.	Exam, DX, imaging, injections, PT and physiotherapy, Surgery when needed due to physical trauma or organic disease are COVERED.	No
6	Other	Covered	Clinical Trials Coverage	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
7	Other	Covered	Sterilization surgery not subject to Medical Necessity	No					Reversal of sterilization is excluded.		No
8	Other	Covered	Human Organ Transplants including Heart, Heart/lung, Lung, Liver, pancreas	Yes	150	Other	\$150 per day for meal, transportation and lodging up to \$10,000 for recipient and one additional adult (or 2 adults if patient is a minor).		All Covered Services must be Medically Necessary unless otherwise specified.	Includes expenses of recipient, pre/post-operative care and immunosuppressant drugs.	No
9	Other	Covered	Bone Marrow procedures	Yes	150	Other	\$150 per day for meal, transportation and lodging up to \$10,000 for recipient and one additional adult (or 2 adults if patient is a minor).		Procedures to treat T-Cell leukemia virus and AIDS are excluded. All Covered Services must be Medically Necessary unless otherwise specified.	Coverage is provided for 4 listed types of transplants for 5 listed covered diseases (page 28 of benefit booklet).	No

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10	Other	Covered	Assistant at Surgery, A Physician's help to a surgeon in performing covered Surgery when no qualified house staff member, intern, or resident exists.	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
11	Other	Covered	Diabetes Education & Control	No					All Covered Services must be Medically Necessary unless otherwise specified.		No
12	Outpatient Rehabilitation Services	Covered	Speech therapy	No					Speech therapy is covered when due to a medical condition, except as otherwise specified by Federal or State mandate. All Covered Services must be Medically Necessary unless otherwise specified.		No
13	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Speech therapy	No					Speech therapy is covered when due to a medical condition, except as otherwise specified by Federal or State mandate. All Covered Services must be Medically Necessary unless otherwise specified.		No
14	Other	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
15	Other	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
16	Other	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply. Covered only if medically necessary for a WVCHIP member whose malocclusion creates a disability and impairs their physical development.	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	11
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	11
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	3
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	9
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	20
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	18
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	12
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	7
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	8
ANTIFUNGALS	NO USP CLASS	27
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	10
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	6
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	9
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	5
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	4
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	12
ANTIVIRALS	ANTIHERPETIC AGENTS	6
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5

CATEGORY	CLASS	SUBMISSION COUNT
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
BLOOD PRODUCTS/MODIFIERS VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	8
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	6
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	8
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	10
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	4
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	4
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	7
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	7
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	35
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	17
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	LAXATIVES	3
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	9
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	24
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	4
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	10
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	15
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	10
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	15
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	6
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	5
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	7
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	11

West Virginia - State Required Benefits

Benefit	Name of Required Benefit	Market Applicability	Citation Number
Emergency Room Services	Emergency Services	Individual, Group, HMO	§33-15-21, §33-16-3i, §33-25A-8d
Skilled Nursing Facility	Nursing Services	Individual, Group	§33-15-4b, §33-16-3e
Delivery and All Inpatient Services for Maternity Care	Post-partum Hospital Stay	Individual, Group, HMO	§33-15-4e, §33-16-3j
Preventive Care/Screening/Immunization	Mammograms, Pap Smears, and Human Papilloma Virus Tests	Individual, Group, HMO	§33-15-4c, §33-16-3g, §33-25A-8a
Preventive Care/Screening/Immunization	Colorectal Cancer Screening	Individual, Group, HMO	§33-15-4f, §33-16-3o, §33-25A-8e
Preventive Care/Screening/Immunization	Child Immunizations- Cost and Administration	Individual, Group, HMO	§33-15-17, §33-16-12, §33-25A-8c
Preventive Care/Screening/Immunization	Newborn Screenings	Individual, Group, HMO	§16-22-3(c)
Preventive Care/Screening/Immunization	Preventive Services (Basic Health Care Services)	HMO	§33-25A-2(1), (11)
Autism Spectrum Disorders	Autism spectrum disorders	Group (25+ employees), HMO (25+ employees)	§33-16-3v
Reconstructive Surgery	Reconstructive Surgery Following Mastectomy	Individual, Group, HMO	§33-15-4g, §33-16-3p, §33-25A-8f
Clinical Trials	Clinical Trials	Individual, Group, HMO	§33-15-4h, §33-16-3r, §33-25A-24(d)
Dental Anesthesia	Dental Anesthesia Services	Individual, Group, HMO	§33-15-4j, §33-16-3t, §33-25A-8i
Diabetes Care Management	Diabetes Coverage- cost and administration	Individual, Group	§33-15C-1, §33-16-16
Prescription Drugs Other	Contraceptive Coverage	Individual, Group, HMO	§33-16E-3
Mental Health Other	Treatment of Serious Mental Illness	Group, HMO	§33-16-3a, §33-25A-2

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

F. Use of Evidence in Purchasing Decisions

1) Does your state have specific staff that is responsible for tracking and disseminating information regarding evidence-based or promising practices? BBHMF supports a research and resources team (1 Epidemiologist, 1 Researcher, 1 Resource Specialist) which facilitates the work of the West Virginia State Epidemiological Outcomes Workgroup and also provides technical assistance and resource dissemination on best practice, fidelity and evaluation to all BBHF funded providers. The State Prevention Coordinator (NPN) provides on-going support to six (6) prevention grantees which are provided training as trainers to implement evidence based programming in all West Virginia communities.

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions? Yes, the Bureau for Behavioral Health and Health Facilities requires all providers to be trained in evidence based practices and implement evidence based programs and the requirement is included in every provider grant agreement.

a) What information did you use? NREPP, SAMHSA TIPS and training, ASAM, NiaTx, IOM Report, the BRRSS TACS Policy Academy and Knowledge Building Sessions and Literature Reviews.

b) What information was most useful? Each of the above sources has been used to help BBHF remain abreast of the latest research so that it can make fully informed decisions.

3) How have you used information regarding evidence-based practices? BBHMF has developed proposals and funding announcements which are grounded in best practice, provided funding based on research, offered educational offerings through web-based dissemination, community presentations, conferences and other more ad hoc learning opportunities.

a) Educating State Medicaid agencies and other purchasers regarding this information? Yes, BBHMF has used this information to provide cost savings analysis and general information on SBIRT and recovery supports to Medicaid and other sister agencies as well as on-going education on best practice to the Governor's Advisory Council on Substance Abuse.

b) Making decisions about what you buy with funds that are under your control? BBHMF works in coordination with regional providers in order to determine community needs and find the best fit to determine best practice.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

G. Quality

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Suicide rates in West Virginia	Reduction/No Change in substance use past 30 days	Reduction/No Change in substance use past 30 days
	Percent Babies born perinatally exposed to alcohol and other drugs	Reduction/No Change in substance use past 30 days	Reduction/No Change in substance use past 30 days
Purpose	Certified peer and community support specialist	Increase in the number certified and employed	Increase in the number certified and employed

2) Please provide information on any additional measures identified outside of the core measures and state barometer. The WV Behavioral Health Profile includes the following State and County indicators.

State Level Data Sources	
<p>Alcohol Consumption</p> <ul style="list-style-type: none"> • Current Alcohol Use: NSDUH, YRBS, WVHSC, BRFSS • Binge Drinking: NSDUH, YRBS, WVHSC, BRFSS • Heavy Drinking: WVHSC, BRFSS • Age of Initial Use: YRBS • Driving and Alcohol: YRBS, WVHSC • Alcohol Use During Pregnancy: PRAMS • Apparent per Capita Ethanol Consumption: AEDS (NIAAA) <p>Alcohol Consequences</p> <ul style="list-style-type: none"> • Alcohol-Attributable Deaths: WVHSC, ARDI • Alcohol Overdoses: WVHSC • Motor Vehicle Crashes: FARS; WVTAD • Alcohol Related Hospitalizations: HCUP • Treatment: TEDS • Crime: WVDMV, West Virginia Juvenile Justice Database (WVJJDB) • Dependence or Abuse: NSDUH <p>Alcohol Risk and Protective Factors</p> <ul style="list-style-type: none"> • Access: YRBS • Perception of Harm: NSDUH 	<p>Tobacco Consumption</p> <ul style="list-style-type: none"> • Current Use: WVHSC, BRFSS, YRBS • Frequent Use: YRBS • Age of Initial Use: YRBS • Tobacco Use during Pregnancy: PRAMS <p>Tobacco Consequences</p> <ul style="list-style-type: none"> • Economic Costs of Cigarettes: WVHSC, SAMMEC • Tobacco-Related Mortality: WVHSC <p>Tobacco Risk and Protective Factors</p> <ul style="list-style-type: none"> • Access: Synar; WVYTS • Perception of Harm: WVYTS
<p>Drug Consumption</p> <ul style="list-style-type: none"> • Current Use: YRBS, NSDUH, West Virginia Poison Center, West Virginia Prescription Drug Quitline • Lifetime Use: YRBS, NSDUH, State Health Facts • Age of Initial Use: YRBS 	<p>Mental Health</p> <ul style="list-style-type: none"> • Depression and Psychological Distress: YRBS; WVHSC, BRFSS, NSDUH • Suicide: NSDUH, YRBS; WVHSC • Homelessness: WV Coalition to End

<p>Drug Consequences</p> <ul style="list-style-type: none"> • Drug Related Morbidity: HCUP, OEPS • Drug Related Mortality: WVHSC • Treatment: TEDS • Crime: WVDMV, WVIBRS, IMIS, WVJDB • Drug Dependence or Abuse: NSDUH <p>Drug Use Risk and Protective Factors</p> <ul style="list-style-type: none"> • Access: West Virginia Prescription Drug Quitline • Perception of Harm: NSDUH 	<p>Homelessness</p> <ul style="list-style-type: none"> • Domestic Violence: West Virginia Coalition Against Domestic Violence • Sexual Assault: WVIRBS
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3) What are your states specific priority areas to address the issues identified by the data?

Please see Table 1. Section 3-4.

4) What are the milestones and plans for addressing each of your priority areas?

An extensive set of Performance Measures have been identified and included in Table 1. Section 3-4.

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

IV: Narrative Plan

H. Trauma

Although West Virginia does not currently have formal policies in place for standardized screening and connecting individuals with trauma histories, there is significant amount of best practices across the state to increase screening and referral to treatment for individuals who may have or potentially have experienced trauma. In addition, the Bureau for Behavioral Health and Health Facilities (BBHF) requires all federal and state funded grantees to be trained in trauma-informed care. This requirement is outlined in each of its grantee's statements of work.

A best practice guideline report was completed in early 2013 by the Service Delivery and Development Work Group/Trauma Best Practices, established by the Commission to Study Residential Placement of Children. As a result of the workgroup's research and recommendations and the commitment of public and private systems/agencies, significant progress has been made to improve screening and assessing trauma in children and adolescents. Some of the key strengths identified by the trauma workgroup include:

- Trauma has been incorporated into the West Virginia Child and Adolescent Needs and Strengths (WVCANS) Comprehensive Multisystem Assessment;
- The Comprehensive Assessment and Planning System (CAPS) Project for children and adolescents receiving child welfare services has been revised to trigger a specific trauma assessment;
- Strong motivation across public and private systems/agencies to improve trauma screening and treatment and trauma informed care;
- Significant expertise exists across the state in trauma treatment
- Significant training has been conducted to increase understanding, recognition and best practices for addressing trauma impacting both the children and adult service delivery system.

The types of evidence based assessments to address trauma history and/or trauma specific symptoms available across the life span include:

Children and Adolescents:

- Trauma Symptom Checklist for Children (TSCC)
- Trauma Symptom Checklist for Young Children (TSCYC)
- Child Sexual Behavior Inventory (CSBI)
- UCLA Post Traumatic Stress Disorder (PTSD) Index for DSM-IV
- Chadwick Center Trauma History Checklist

- Achenback Child Behavior Checklist
- West Virginia Trauma-Informed Child and Adolescent Needs Strengths (WVCANS) Assessment

Adults:

- Trauma Assessment for Adults (TAA)
- PTSD Checklist for Adults (PCL-A)
- Evaluation of Lifetime Stressors (ELS)
- Trauma History Screen (THS)
- UCLA Adult Post Traumatic Stress Disorder (PTSD) Scale
- Traumatic Events Screening Inventory (TESI)
- Trauma History Questionnaire (THQ).

Research was conducted to identify evidence based as well as best/promising clinical practices that can be implemented to mitigate traumatic stress reactions. The trauma specific interventions available include:

- Sanctuary Model
- Seeking Safety
- Trauma Focused Cognitive Behavior Therapy (TF-CBT)
- Parent Child Interaction Therapy (PCIT)
- Multi-Systemic Therapy
- Dialectical Behavioral Therapy
- Structured Psychotherapy for Adolescents
- Pharmacotherapy
- Alternatives for Families-CBT (AF-CBT).

There has been a significant amount of training across the state to increase capacity of providers to deliver trauma-specific interventions. The BBHMF is providing its first Comprehensive Behavioral Health Conference September 17-19, 2013. A multitude of key notes and workshops are being offered on trauma treatment and cultural competency. A consultant from the San Diego Chadwick Center for Children will be providing a keynote and two workshops, one of which is specifically addressing one of the BBHMF's priority populations: Lesbian, Bi-Sexual, Gay, Transgender and Questioning (LBGTQ) youth. Addressing trauma across the life span is a critical priority of the BBHMF. The BBHMF initiated a partnership with the National Center for Trauma Informed Care (NCTIC) in July 2013 (See Section IV. Narrative Plan, U. Technical Assistance Needs for progress and plans) and are committed to increasing training opportunities and technical assistance to increase trauma specific interventions and as well as trauma informed care. With the invaluable partnership and technical assistance of the

NCTIC, the BBHF will collaborate with the Bureau of Child and Family, Public Health, and Medical Services, the West Virginia Department of Education, the Divisions of Juvenile/Criminal Justice and community providers to develop policies and standards of care that guide not only trauma treatment but trauma informed care utilizing a public health approach for individuals across the life span.

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

I. Justice

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions? Yes, BBHFF participates on the West Virginia Justice Reinvestment teams and has recommended and provided resources to promote pre-enrollment and recovery coaches to support system navigation prior and post release in coordination with SB371. In West Virginia, this number will be substantial since a large percentage of incarcerated individuals are males with substance abuse issues who will soon be medically eligible through coverage expansion efforts.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders? West Virginia's Regional Jails include SBIRT as part of their assessment process. All counselors and nurses have been trained on using SBIRT. See also Senate Bill 371 in question 3 as it too pertains to assessments.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals? Yes, both the SMHA and SSA participate on Justice Reinvestment Teams. The BBHFF also has provided funding for adult/youth drug and adult mental health/co-occurring courts for a number of years. Specific efforts to coordinate these efforts are included in the recently passed legislation section of this grant application. Senate Bill 371, which includes among other things, revisions related to reduction of sentences for good conduct; pretrial risk assessment; the development of a cognitive behavioral program to address the needs of inmates detained in a regional jail, but committed to the custody of the Commissioner of Corrections; sentencing alternatives, such as weekend jail programs and work programs; home incarceration procedures; adding BBHFF as a member of the Community Corrections [oversight] Subcommittee; adding a person with a background in substance abuse treatment and services as a required member of [county] Community Criminal Justice Boards; standardized risk and needs assessment and day report services; probation and parole eligibility and violations; permitting the Division of Corrections to employ or contract for a director of employment and a director of housing for released inmates; creation of a community supervision committee to share information for coordinated supervision; [expansion of] drug courts; development of qualifications for provider certification to deliver a continuum of care to offenders; fee reimbursement procedures, [coordinated] by the Division of Justice and Community Services, in consultation with the Governor's Advisory Committee on Substance Abuse; and, finally, preparation of an annual report prepared by the Division of Justice and Community Services, in consultation with the Governor's Advisory Council on Substance Abuse.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems? Yes, with regard to education of criminal justice staff.

5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? The West Virginia Supreme Court of Appeals and the Division of Justice and Community Services will be providing evidence-based cross-training opportunities with Day Report Centers, Probation, Drug Courts, and Behavioral Health providers using Justice Reinvestment funds. Dr. Jennifer Peeler will also be speaker at West Virginia's Integrated Behavioral Health Conference and will discuss EBP's for this population.

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

State Education on Mental Health Parity

An advocacy piece entitled *After Parity—What’s Next Now that the federal law has passed, educational efforts are needed to ensure that mental health is viewed as central to physical health* coauthored by David L. Shern, Kirsten K. Beronio, and Henry T. Harbin, appearing in *Health Affairs* 28, no. 3 (2008): 660–662; 10.1377/hlthaff.28.3.660, states that: “The new parity law doesn’t mandate group health plans to cover MH/SA treatment, trusting that most employers will continue to cover care for these conditions. Thus, advocates must increase awareness among employers, policymakers, and the general public that behavioral health conditions are among the most prevalent and disabling chronic illnesses and that they can be prevented and effectively treated. Untreated MH/SA conditions can greatly affect employees’ productivity and attendance. Moreover, if left unaddressed, these conditions can become extremely disabling and costly. In fact, the World Health Organization has pronounced mental health disorders to be the most burdensome health conditions in the United States. World Health Organization, *World Health Report 2004: Changing History*, Annex Table 3: Burden of Disease in DALYs by Cause, Sex, and Mortality Stratum in WHO Regions, Estimates for 2002 (Geneva: WHO, 2004). Severe mental illnesses alone cost the United States \$193 billion in lost wages in 2002.” R.C. Kessler et al., “Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results from the National Comorbidity Survey Replication,” *American Journal of Psychiatry* 165, no. 6 (2008): 663–665.

A study of Mental Health Parity in California entitled *Implementation of Mental Health Parity: Lessons From California*, appearing in *PSYCHIATRIC SERVICES*, December 2009 Vol. 60 No. 12, and written by Margret L. Rosenbach, Ph.D., Timothy K. Lake, Ph.D., Susan R. Williams, M.P.P., and Jeffrey A. Buck, Ph.D., concluded that “implementation of the 2008 federal parity law should include mounting a campaign to educate consumers about their insurance benefits. . . The purpose of this study was to assess experiences with California’s parity law, and this article discusses implications for the implementation of parity at the national level . . . Lack of consumer knowledge of parity Health plans, providers, and consumer advocates all pointed to the challenge of educating consumers about the parity law, such as explaining what services are covered and to whom the law applies. Initially, health plans provided written notification to purchaser groups and individual consumers about benefit changes. Subsequently, providers played a substantial role in ongoing education efforts, usually on a one-on-one basis with individual patients. Despite these efforts, consumer awareness about parity was limited. Nearly half of the consumer focus group participants (14 of 32 consumers, or 44%) indicated that they were not familiar with the law, even though most (26 of 32 consumers, or 81%) reported that they had a diagnosis covered by the law. Providers who participated in the focus groups indicated that many consumers lacked understanding of their mental health benefits; in other words, consumers did not know that their coverage was limited before the parity law or that it was expanded after the law was implemented. Providers indicated that many consumers perceived the law as complex and said that consumers would comment that they were uncertain how the law applied to their own circumstances. When asked for their recommendations to improve the parity law, many consumers cited the need for additional education and information about parity. Some cited a role for employers and insurance companies, and others wanted providers to play a larger role. Some also recommended a concerted public information campaign: “Publicity . . . you know, signs in buses and billboards and that kind of thing. And public service announcements on television and radio.” More specifically the study found that . . . “more proactive steps are required to improve consumer knowledge about parity. The limited awareness about parity in California was attributed to the lack of a systematic effort to inform consumers about the law. Similar results were observed in parity studies in Vermont and Maryland. An orchestrated education campaign in conjunction with the implementation of the 2008 federal parity law may increase awareness of mental health benefits and open the door to mental health services, especially for first-time users who may not be aware of their mental health benefits. Enhanced public education may also lead to reduced stigma associated with mental illness.”

Given that the Mental Health Parity and Addiction Equity Act will also apply to plans offered through the exchanges, it is extremely important that BBHMF take an active role in educating its providers, consumers and families and the general public about both mental health parity, health care expansion and partner with other agencies and nonprofits to assist with education on and enrollment in both state Medicaid Expansion activities and use of the Exchange/Marketplace Call Center, Website and face to face Navigators. The BBHMF has been participating in the Health Insurance Marketplace calls targeted to West Virginia stakeholders and designated staff will use in person education and well as its website and network emails to become a Champion for Coverage by promoting consumer outreach material made available by its federal partners on both the marketplace@cms.gov website and national nonprofit advocacy organizations on <http://parityispersonal.org/>, including website widgets, network e-mails, posters and fact sheets, and educational conference calls. Staff will also facilitate in person training for groups like the West Virginia Behavioral Health Provider's Association, Behavioral Health Planning Council, the Governor's Advisory Council on Substance Abuse and the BRSS TACS Team. For example, the Office of Consumer Affairs and Community Outreach will participate in enrollment training offered for Certified Application Counselors and/or the West Virginians for Affordable Health Care and use this training to work with other stakeholders, including behavioral health providers, advocates, people in recovery and family members, to conduct outreach to people with mental health and substance use issues at peer support centers, FQHCs and CBHCs and hospital settings.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

West Virginia has behavioral health integration (behavioral health in primary care) as well as reverse integration programs (primary care in community behavioral health centers) around the state. While the two modalities have different goals, both are critical to the well-being of West Virginia citizens.

Reverse integration (so called, as it is the opposite of the original Kaiser Permanente model) establishes healthcare providers in behavioral health settings, recognizing that persons with SMI die 25 years earlier than those without SMI. Two of West Virginia's largest comprehensive behavioral health centers (CBHCs) have partnered with Federally Qualified Health Centers (FQHCs) to place medical teams in their facilities. The medical teams address the issues people with SMI are known to exhibit; namely hypertension, diabetes, obesity and cardiovascular diseases. Chronic Obstructive Pulmonary Disease (COPD) is also a serious issue in West Virginia as a whole and people with SMI are no exception. Testing and treatment for pulmonary issues are also handled by the medical team embedded in the CBHCs.

Behavioral health integration was advanced in West Virginia beginning five years ago with the West Virginia Screening Brief Intervention and Referral (SBIRT) grant. West Virginia designed the WSBIRT program to place behavioral health providers in FQHCs to focus on prevention and early intervention of both substance misuse and mental health issues. The program was also intended to strengthen collaboration between the FQHCs and the CBHCs. WV SBIRT has achieved exactly that, now boasting fifty-eight (58) sites around the state. With behavioral health providers in primary care settings, screenings for substance misuse and mental health issues, such as depression and anxiety, allow for prevention and early intervention for these critical health issues. WV SBIRT has been an enormous success and is now advocated for by the Governor's Advisory Council on Substance Abuse, with State funds now enabling expansion of this federally funded initiative.

In August of 2011, the Commissioner of the Bureau for Medical Services announced a stakeholder meeting to discuss a West Virginia State Plan Amendment to address Health Homes for Medicaid members. Now, two years later, the Bureau for Behavioral Health and Health Facilities has had two representatives well versed in mental health and substance abuse actively participating in the weekly team meetings for developing the first Health Home.

The State Plan Amendment is on schedule to be submitted in the fall of 2013, with Health Homes rolling out in the spring of 2014. The first State Plan Amendment addresses Bipolar Disorder (SMI) with a secondary focus on Hepatitis C. West Virginia has one of the highest Hepatitis C rates in the country and Bipolar Disorder often results in consumers neglecting their

health and discontinuing their medication. Both can have negative results and lead to excessive hospitalizations and unnecessary personal anguish and medical costs.

The initial State Plan Amendment will roll out Health Homes in the six (6) counties in West Virginia that have the highest rates of Bipolar Disorder as well as Hepatitis C. These 6 areas also have the most advanced CBHCs and FQHCs with existing partnerships already in place so that the Health Homes can “hit the ground running”. The Health Home team has identified other stakeholders in the six county region interested in participating in the Health Homes as providers. The payment plan has been developed and the submission should happen as scheduled this fall.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

IV: Narrative Plan

L. Health Disparities

Narrative Question:

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In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

BBHFF collects information from a large number of organizations within the behavioral health system. BBHFF receives Medicaid enrollment data from BMS and collects program eligibility data from providers. BBHFF receives authorization and encounter data from IRG/APS Healthcare, which includes relevant clinical and service information from providers, such as the thirteen Comprehensive Community Behavioral Health Centers and other community-based providers. BBHFF receives encounter data from the state's two psychiatric hospitals and five long-term care (LTC) facilities, and via the state hospitals from private acute care hospitals which provide inpatient treatment for state hospital diversion patients.

Currently, BHHF collects and reports on a variety of information relevant to the state's behavioral health system. This information includes:

- Eligibility/enrollment data, which indicates whether an individual is enrolled in a particular program and/or eligible for program services.
- Authorization data, which indicates whether an individual is authorized to receive a particular service or set of services, with supporting clinical data.
- Encounter data, which provides service episode information, such as diagnosis, treatments rendered, dates of service, etc.
- Satisfaction data, which indicates consumers' perception of services received.

The Care Connection, the Consumer Services Data Report (CSDR) and psychiatric hospital encounter data all fields on race, ethnicity, gender (including transgender), and age, though not currently on tribal connection, language or sexual orientation.

According to the West Virginia Division of Culture and History, "In West Virginia, the contemporary Native American population can best be described as a statewide community, consisting of a far-reaching network of individuals with Native American ancestry. There are approximately 3000 Native Americans in West Virginia. The community includes individuals from at least 43 different bloodlines and tribal associations. These are descendants from the regional Native Americans, including Cherokee and Shawnee, and individuals who more recently relocated to West Virginia from throughout North America. Many people in West Virginia have Native American blood, but do not have a historical tribal association, and many individuals have mixed blood, that is, ancestry of different tribes as well as different races in addition to Native American."

West Virginia has little available data on sexual orientation and gender identity. The Movement Advancement Project estimates that approximately 1.5% of West Virginia's population self-identifies as lesbian, gay or bisexual. National research has shown that Lesbian, Gay, Bi-Sexual, Trans-gender and Questioning (LGBTQ) youth experience higher levels of risk in several areas. National studies have found that LGBTQ youth experience bullying and other traumas at a higher incidence rate than their peers. The creation of a Gay Straight Alliance within secondary school settings creates a safer school climate for LGBTQ youth and decreases the use of homophobic language. Only 23.1% of West Virginia's secondary schools have a gay/straight alliance or similar club. Not only do LGBTQ youth face tremendous challenges in school and placement, many also face rejection at home. This is especially problematic in that LGBTQ young adults who experienced high levels of rejection were more than 3 times as likely to use illegal drugs, almost 6 times as likely to have high levels of depression, and more than 8 times as likely to have attempted suicide.

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care includes a section specifically addressing language needs, entitled "Communication and Language Assistance". According to a document issued by the West Virginia System of Care, entitled *Language*

Differences & Limited English Proficiency in West Virginia, “According to 2011 Census data, [only] 2.3% of West Virginians over the age of 5 (slightly over 40,000 individuals) speak a language other than English inside the home, compared to 20.3% nationally” and “with no ‘threshold populations,’ in West Virginia communities or programs, data collection translation and interpretation resources are very scarce in the state . . . A threshold population is [defined as] a linguistic group that makes up 15% or more of a program’s clients and who share a common language other than English as a primary language.” As a result, BBHMF currently works with its grant funded providers in implementing one of the four suggested CLAS approaches on an as needed basis “[o]ffer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.”

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity vulnerable subpopulations?

The process for formulating a comprehensive plan for guiding the work of the Bureau has occurred over the past two years in multiple phases. The West Virginia Behavioral Health Integrated Strategic Plan builds on the same approach used to develop the Comprehensive Substance Abuse Strategic Action Plan, which resulted in significant cross-systems leadership and commitment to address the epidemic of substance abuse in the state. This collective body of qualitative and quantitative data supports on-going planning and decision making with regard to block grant funds, in coordination with state, regional and county profiles developed by the West Virginia State Epidemiological Outcomes Workgroup (WVSEOW).

Understanding the uniqueness of the rural Appalachian culture is fundamental to planning and implementing a successful statewide system of behavioral health care in West Virginia. There is little racial and ethnic diversity in West Virginia, with 94.1% of the population identifying as white, 3.5% of the population identifying as black, 0.7% of the population identifying as Asian, and 1.7% of the population identifying as some other race. Only 1.3% of West Virginia’s population identifies as Hispanic or Latino, compared to 16.7% in the United States as a whole.

4. How will you use Block Grant funds to measure, track and respond to these disparities?

Based on input from listening tours, review of prior planning documents, and prevailing evidence-based philosophy and practice, the overall priorities and goals that contribute to the development of person-centered, inclusive, community-based systems of care are common across all bureau divisions. The striking similarities in the strengths, challenges, and recommendations for system change that emerged from planning processes, systemic review and analysis of consumption and consequence data, and significant on-going stakeholder input are reflected in West Virginia’s Block Grant Plan Table 1-step 3-4.

Footnotes:

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

M. Recovery

Please answer yes or no to the following questions:

1. Has the state developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery? Yes, the State is using the draft SAMHSA Definition.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system? Yes, the BBHMF has an office of Consumer Affairs and Community Outreach that supports hiring of individuals with lived experience, including its director and several key staff.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care? Yes, in all State and Federal planning.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Yes, including but not limited to expanding access to both traditional and non-traditional services and supports, such as peer supports, drop in centers, Wellness Recovery Action Planning, Recovery Coaches, psychiatric advance directives and other and decision support tools, and Whole Health Action Management.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others? Yes, and BBHMF is coordinating activities with the VA, National Guard and other groups on this initiative.

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Yes. BBHMF provides both funding and on-going training through the Office of Consumer Affairs and each of the clinical divisions.

7. Does the state have an accreditation program, certification program, or standards for peer-run services? Yes, a career ladder approach for peer and community support services is in the process of being finalized.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and

exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

West Virginia was awarded a Bringing Recovery Supports to Scale Technical Assistance Center (BRSS TACS) Policy Academy grant, is participating in the technical assistance provided and has submitted a draft State Action Plan and Logic Model. The State is using its Policy Academy and grant funds to help prepare people with mental health and substance use issues improve their access to integrated health care by services by taking the following steps: Developing certification guidelines for Peer Support Specialists and Recovery Coaches; Creating strategies for expanding funding and/or realigning current resources to support Peer Support Specialists, Recovery Coaches, and wellness and recovery centers; Training persons in recovery (peers) to facilitate Wellness Recovery Action Planning and advise behavioral health center staff on evidence based practices in deploying recovery supports; and, Training and use Peer Health Integrators (PHIs) to prepare peers for expanded access to insurance coverage brought about by the ACA/healthcare reform.

Involvement of Individuals and Families

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services? Listening tours statewide, regular scheduled Governor’s Task Force Meetings with communities, provider surveys, and the pending establishment of the Commissioner’s Consumer Advisory Board.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns? Yes, the West Virginia Leadership Academy, the annual Families Conference, and the Behavioral Health Advisory Council.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support? Yes, the West Virginia Leadership Academy, the annual Families Conference, and the Behavioral Health Advisory Council all promote these approaches and the BRSS TACS Team will be making additional recommendations on enhancing an ongoing feedback loop between BBHMF, its grant-funded providers and consumers and families.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services? Increase in the number of both Block Grant and State grant funded opportunities supporting recovery-oriented programs, BBHMF technical assistance made available to these programs as well as the provision of web-based and phone support in the identification and navigation of services.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary? Coordinating meetings with housing and homeless service programs and behavioral health providers, encouraging the change in mind-set that treatment does not always mean a bed, and providing more funding for recovery residences. In addition, BBHMF uses State funds to support Care Coordinators at both the CBHCs and a number of housing providers who devote a disproportionate percent of their time to helping people obtain and maintain housing of choice in the most integrated setting possible. Finally, West Virginia's Money Follows the Person program, Take Me Home, West Virginia, has carved out a pilot population of people to serve with serious mental illness who are transitioning from state hospitals for both Transition Navigator and Supported Housing Services, using the Permanent Supportive Housing toolkit fidelity scale. This model is grounded in the following principles: Choice in housing and living arrangements; Functional separation of housing and services; Decent, safe and affordable housing; Community integration and rights of tenancy; Access to housing and privacy; and, Flexible, voluntary, and recovery-focused services. Furthermore, BBHMF is actively working with the State Coalition to End Homelessness to encourage all of its partner agencies to adopt the Permanent Supportive Housing approach in the applicable circumstances.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community? Peers will be employed in recovery residences, homeless shelters, and at housing agencies. Additional drop-in centers will be added statewide and more screening and brief interventions will be provided for people experiencing homelessness.

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

N. Prevention- Substance Abuse

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

Both qualitative and quantitative data is utilized in the planning process. State, Regional, and County Profiles were developed and disseminated to the Governor's Advisory Council and at Governor's Regional Task Force Meetings in every region of the State. Each Regional Prevention Organization facilitates Data and Planning Teams that work in coordination with the WV State Epidemiological Outcomes Workgroup to support the collection and use of data at the community level. Town Hall Meetings are also conducted at county and regional levels to determine local need. Regional Task Forces prioritize regional needs and the Governor's Advisory Council makes recommendations to the Governor. Input from listening tours, review of prior planning documents, and prevailing evidence-based philosophy and practice contribute to the selection of programs and practices.

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

With the exception of discretionary funding provided by SAMHSA (drug-free communities), primary substance abuse prevention and health promotion activities are funded by BBHFF. While the same prevention strategies will continue to guide the methodology of the State's work, it is clear that priority populations are continuing to emerge due to substance abuse that will need targeted prevention services, i.e., individuals with disabilities and children of incarcerated parents. The State experienced its first decrease in prescription drug abuse since 2006, but, as often occurs, the use of other more accessible and affordable drugs increased. West Virginia will dedicate a larger percentage of its resources on implementing environmental strategies, in an effort to change perception and norms favoring use and improve its communities' ability to address all substances.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

All prevention grantees and sub-grantees have a professional development plan that focuses on the knowledge, skills and abilities needed for the position that is also in alignment with credentialing. West Virginia encourages IC & RC certification and is in the processes of

developing a community based support credential for para-professionals or those entering the field. The State Prevention Coordinator, NPN, CPSII provides training and technical assistance and works to build the capacity of the prevention network and communities. In addition to the personalized professional development plan, all grantees must participate in group learning opportunities offered during quarterly meetings and scheduled program trainings that are required through their provider contracts, including:

- Prevention Specialist Training
- Suicide Prevention Training
- Family Centered Practice
- Coalition Development
- Evidence Based Program Identification and Selection
- Professionalism
- Cultural Competency (LGBTQ, SMVF Specific)
- True Colors Personality Assessment Group Training
- FASD and Drug Exposed Babies
- Physician Engagement
- Social Marketing
- TIPS Training
- Forum Planning and Implementation
- Stress Management
- Drug- Free Workplace
- Synar Merchant Education, Programming and Protocols
- Prevention Education Trainings Specific to Substances (Prescription Drugs, Alcohol, etc.)

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

The State currently collects all required block grant fields with regard to reporting. Additionally, the State has improved its data sources at state and local levels. These charts are included in the behavioral health profile and are listed in Planning Step 2 and Section R.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

All prevention grantees must apply for funding through an Announcement of Funding Availability (AFA) process that includes the framework. Each area of the SPF is incorporated into all grant applications at BBHFF. Training is also provided on the framework at the community level by prevention grantees and the State Prevention Coordinator.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? 100% of block grant prevention set-aside funding is allocated to community based organizations.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies?

100%. List each program.

Prevention grantees report in the 6 CSAP Strategy areas. Each region is somewhat different and based on the readiness of the particular community. The State was re-configured into new sub-state planning regions in late 2011, so new partner counties and coalitions are not at the same projected percentages. Overall averages of State rates are listed below:

Strategy	%
Alternatives	3.2
Community-Based Process	46.5
Education	21.3
Environmental	23.9
Information Dissemination	4.3
Problem ID & Referral	0.8

Additional evidence based programs that are currently being implemented based on the identified community needs and supports in school based settings include:

- 1) Keep a Clear Mind
- 2) Too Good For Drugs
- 3) Too Good For Violence

- 4) STARS
- 5) STARS for Families
- 6) PREP
- 7) Celebrating families
- 8) Not On Tobacco
- 9) Strengthening Families
- 10) Active Parenting Now
- 11) Reality Tour
- 12) Second Step
- 13) Lifeskills
- 14) Alcohol EDU
- 15) Parents as Teachers
- 16) Creating Lasting Family Connections (CLFC)
- 17) Communities Mobilizing for Change on Alcohol (CMCA)

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

The Bureau for Behavioral Health and Health Facilities (BBHFF) will utilize at least 5 percent of its Mental Health Block Grant funds to implement effective evidence based prevention, promotion and early intervention. The BBHFF will continue to provide grant funding to support the statewide Family Advocacy, Support and Training (FAST) Program, the West Virginia Council for the Prevention of Suicide, the Children's Homeless Outreach Program (CHOP), Consumer Operated Services (peer-run service programs that are managed, administratively controlled, and operated by adults with mental health and/or substance use issues and emphasize self-help and wellness as their operational approach), and the West Virginia Mental Health Planning Council, including its ongoing coordination of the West Virginia Leadership Academy training. These programs provide a variety of services such as family and peer education, advocacy and support, and training, all of which address mental health promotion and early intervention.

The FAST program provides family-driven advocacy, support and training to children and adolescents with or at risk for serious emotional disturbances (SED) and their families. The goals of the program are to develop statewide/regional parent to parent/youth networks that will increase the voice of families and youth and empower them to participate not only in the planning, implementation and evaluation of their child's treatment but in the local, region and state service delivery system. The FAST Program facilitates support groups through the best practice approach referred to as "Circle of Parents. The FAST Program was approved for a West Virginia Youth Motivating Others through Voices of Experience (MOVE) Chapter in 2012 and continues to partner with the National Youth MOVE Initiative. Youth MOVE provides a unique opportunity for mental health promotion and early intervention.

The CHOP provides a secure healthy environment, case management, life skills education, brief counseling, referrals and linkage to community based services and supports for children and their families who are experiencing homelessness and are residing in a homeless shelter. The intent of the program is assist children and adolescents experiencing homelessness with or at risk for a serious emotional disturbance (SED) and their families to transition from this situation as efficiently as possible; refer and link them to behavioral health services and other community supports; and, to assist them in recovery from and prevention of future homelessness. Eight of West Virginia's 10 WV DHHR funded homeless shelters serve families and their children. The CHOP implements the following evidence based/best practice programs: Second Step; Parenting 1, 2, 3 Magic and provides screenings and assessments using the Strengths and Difficulties Questionnaire (SDQ); Question Persuade and Refer (QPR); Adolescent Suicide Assessment Protocol (ASAP-20); and, SBIRT for children twelve years and older.

Consumer operated programs are a community-based service for adults age eighteen (18) and older who have a mental illness or co-occurring disorder. The program provides activities that promote recovery, self-determination, self-advocacy, and enhancement of community living skills. These programs are an individualized, recovery-focused service, based on a relationship of mutuality that allows the individual an opportunity to learn to manage his or her own recovery; the process in which people are able to live, work, learn, and participate fully in their communities. Each person is free to define recovery in his or her terms. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Evidence based trainings that occur in consumer operated programs center around WRAP and Recovery Coach training.

The BBHMF also utilizes the mental health block grant to fund other programs that assist adult consumers in recovery and mental health promotion. The Milan Puskar Health Right (MPHR) Program provides education/promotion and support for adult consumers and families living with mental illness in north central West Virginia. The program assists low-income or uninsured individuals with case management needs in a free primary care clinic setting. The purpose of this program is to identify consumers with mental illness when they begin services at MPHR and to provide mental health case management, counseling and psychiatric services. This is one of many examples of integration of behavioral health services in primary care environments in West Virginia. The BBHMF also utilizes the Mental Health Block Grant to fund two programs in Kanawha County, the Roark Sullivan Lifeway Center (RSLC) Men's Shelter and the Young Women's Christian Association (YWCA), Sojourners Women's Shelter. The RSLC provides a comprehensive array of services to individuals experiencing homelessness, including transitional living, peer support, mental health promotion and mentoring. More specifically, Block Grant funds are used to fund the Aftercare Project, for providing follow up case management support to men and women who have moved from the Roark Sullivan and the Sojourners Shelters to permanent housing and the Peer 2 Peer program, which employs people with mental health issues at Roark Sullivan who have experienced homelessness and stayed in a shelter as support staff during evening and weekend shifts.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

O. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recover and resilience of children and youth with mental and substance abuse disorders?

In collaboration with the Bureau for Children and Families and the West Virginia System of Care Implementation Team, the BBHMF will develop a monitoring system that specifically addresses supporting recovery and resilience of children and youth with mental health and substance abuse disorders. The BBHMF is committed to improving evaluation services for the Mental Health and Substance Abuse Block Grant, as well as for other key initiatives supported with state revenue dollars. The BBHMF plans to release a Request for Proposals (RFP) in the next 3 months for Evaluation of the Mental Health and Substance Abuse Block Grant.

The BBHMF will develop standards of care which support a child and youth service system that provides individualized strength based services and that incorporates evidence based practices. An effective child and youth service system must provide for an integrated and coordinated array of community based services which promotes wellness, recovery and resilience.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

In collaboration with other governing and licensing bodies, the BBHMF will develop and disseminate standards of care, policies and protocols to guide best practices for children, youth and adults with behavioral health needs. Standards of care will address individualized care planning, as well as other best practices, to improve the child and adolescent service delivery system.

The child and adolescent service system will include a State Funded Youth Service Center (YSC) located in one region of the state that will serve as a model for the implementation of the cross-system, collaborative approach. The YSC will operate in conjunction with five (5) other Regional Youth Service Centers to create the statewide Behavioral Health Youth Services Network. The YSC will provide a variety of treatment and non-treatment options for youth with substance abuse and/or co-occurring disorders. Programming will include: Primary Prevention, Promotion & Wellness, Engagement Services, Outpatient Services, Medication Services, Community Support Services, Recovery Support Services, Intensive Support Services, and Out of Home Residential and Transitioning Young Adult Residential services. In addition, the YSC will include a statewide learning laboratory for professional development, a Referral & Outreach Center, an Engagement (Diagnostic) & Outpatient Clinic, and a Transitional Young Adult Residential Program. The Substance Abuse Mental Health Administration (SAMHSA) Block Grant will provide funding for five (5) regional coordinated programming offered to the

communities through an Announcement Funding Availability (AFA) process. The regional YSCs will be modeled after the State Youth Service Center, with the exception of the Transitioning Young Adult Residential programming, and will be responsible for receiving intakes for “close to home,” regional service placement. The regional YSCs will provide individual services, building on the strengths of youth and their families, delivered in the least restrictive environment, incorporating evidence based practices, and offer effective cross-system collaboration, including integrated management of service delivery and cost.

3. How has the state established collaboration with other child and youth serving agencies in the state to address behavioral health needs (e.g. child welfare, juvenile justice, education)?

Partnerships and collaboration among public and private systems, as well as with individuals, families, agencies and communities, are essential components of an effective system of care for children and adolescents with or at risk for serious emotional disturbances (SED), co-occurring substance abuse and/or co-occurring intellectual and developmental disabilities and their families. The role of the Bureau for Behavioral Health and Health Facilities (BBHFF) as the State Mental Health (SMHA) and Single State Authority (SSA) is to provide leadership in the administration, integration and coordination of the public behavioral health system.

In collaboration with the Bureau for Children and Families, the BBHFF’s, West Virginia System of Care (WVSOC) Initiative has created a significant cross system partnership. The WVSOC is a public /private /consumer partnership, dedicated to the mission of building the foundation for an effective coordinated and integrated service delivery system that empowers children and adolescents at risk of out of home care and their families. The WVSOC approach is a spectrum of effective, trauma informed community based services and supports for children and youth with or at risk for behavioral health challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to help them function better at home, in school and in the community.

The WVSOC began in 1999 as a federally funded (Service Administration for Mental Health and Substance Abuse), five year pilot project for a 12 county region in West Virginia. In 2005, West Virginia Lawmakers enacted legislation that established the Commission to Study the Residential Placement of Children (West Virginia Code §49-7-34). In 2010, the West Virginia Legislature passed Senate Bill 636 to reconstitute the Commission. The Bill included addressing any ancillary issues relative to foster care placement and mandated a reduction in out of state placements for children and youth. The Commission’s findings resulted in the continuation and statewide expansion of the WVSOC, as one part of the Commission’s final 13 recommendations. As a result, the West Virginia System of Care Implementation Team (SIT) was established in

2007. The SIT is a public, private, and community partnership that oversees the WVSOC initiative.

The BBHFF submitted a proposal in response to the recently released Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), for Cooperative Agreements for State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination. The purpose of this grant is to provide funding to states/territories/tribes to improve treatment for adolescents and transitional aged youth, through the development of a learning laboratory with collaborating local community-based treatment provider sites. Through the shared experience between the state and community-based treatment provider sites, an evidence-based practice (EBP) will be implemented, adolescents, transitional aged youth, and their families/primary caregivers will be provided services, and a network will be developed to enable the state and the sites to identify barriers and test solutions through a services component, operating in real time. System outcomes will include: changes to state policies and procedures; development of financing structures that work in the current environment; and, an assessment and treatment blueprint for states and providers that can be used throughout the state to widen the use of effective EBPs. Additionally, youth (ages 12-18), transitional aged youth (ages 18-24), and their families/primary caregivers will be provided services from the grant funds, which will help inform the process on systems issues needing improvement. State Youth Treatment cooperative agreements involve both state infrastructure development/improvement and direct service delivery components. All activities share a common goal of building a solid foundation for sustaining an effective, integrated adolescent and transitional aged youth treatment and recovery support services system. The BBHFF is optimistic that West Virginia will be one of the states awarded this unique funding opportunity, however, the State is committed to moving forward with a regional approach to better serving the needs of West Virginia's children and adolescents and their families either with or without the support of the SAMHSA Grant award.

4. How will the state provide training in evidence based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

The BBHFF recognizes the value of a train the trainer model, when appropriate, to effectively build and sustain regional and statewide infrastructure and workforce capacity. The BBHFF will continue to provide a variety of training opportunities on evidence based mental health and substance abuse prevention/promotion; treatment approaches, such as motivational interviewing; and, recovery services for children and adolescents. The BBHFF Regional Substance Abuse Prevention Grantees coordinate and offer a multitude of training opportunities on evidence based mental health and substance abuse prevention and promotion for children and adolescents.

The technical assistance partnership with the National Center for Trauma Informed Care (NCTIC) will greatly assist West Virginia in building workforce and service capacity for trauma informed care. The partnership with the NCTIC will provide invaluable technical assistance and training opportunities across the state, to specifically address trauma informed care for BBHHF's priority populations. The BBHHF will disseminate information on training opportunities and will promote evidence based programs and practices, SAMHSA's National Registry on Evidence Based Programs and Practices (EREPP) and web based training and best practice toolkits/curriculums available on the National Children's Traumatic Stress Network (NCTSN).

In addition, the West Virginia System of Care will offer a variety of evidence based/best practice training, including: the Family Driven Care Toolkit, Family Centered Practice, Family and Youth Engagement Strategies, Mental Health Promotion and Stigma Reduction, Youth Suicide Awareness and Prevention, Cultural and Linguistic Competency Toolkit, and Trauma Informed Care Toolkit. The Adolescent Suicide Prevention and Early Intervention (ASPEN) Program and the West Virginia Council for the Prevention of Suicide (WVCPS) also coordinate and provide a variety of training on best practices across the continuum of suicide prevention, early intervention, treatment and postvention, including: Question, Persuade and Refer (QPR) Gatekeeper Training for Suicide Prevention; Suicide Alertness for Everyone (safeTALK); Signs of Suicide (SOS) Middle School Program; Applied Suicide Intervention Skills Training (ASIST); Assessing and Managing Suicide Risk (AMSR); and, Counseling on Access to Lethal Means.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

The BBHHF is committed to improving outcomes for children and adolescents with behavioral health challenges (substance abuse, mental health, and intellectual/developmental disabilities), many of whom are primarily served through the child welfare system. The BBHHF has formalized a technical assistance partnership with the Annie E. Casey Foundation to assist the State in reviewing existing policies and practices, service array, and financing and performance management outcomes, in order to develop strategies for reducing reliance "congregate care." The BBHHF will consult with the Foundation on monitoring and service utilization tracking and costs and outcomes for children and adolescents with behavioral health needs. A priority goal of the BBHHF is to maximize and leverage resources and services to sustain behavioral health services. Two key strategies to accomplish this goal include: Conducting an analysis of all Federal and State funds coming into West Virginia to promote better utilization and avoid duplication, and developing cost/benefit profiles of programs and best practices.

The BBHHF will develop policies to ensure that the child and youth service system provides individualized strength based services, in the least restrictive environment, incorporating evidence based practices and effective cross-system collaboration, including integrated management of service delivery and cost. This approach is comprised of a spectrum of effective

community based services and supports which are organized in a coordinated network that provides meaningful partnerships with families and youth, thereby improving the youth's functioning in the home, school and community promoting recovery and resilience. Based on extensive research in the field of youth treatment services, SAMHSA has documented clinical and functional outcomes for this population, including increases in behavioral and emotional strengths, reduction in suicide attempts, improvement in school performance and attendance, fewer contacts with law enforcement, reductions in in-patient care, and more stable living situations. Outcomes have also been evaluated at the family level, including reduced caregiver strain, more adequate array of resources, fewer missed days of work due to behavioral health needs and crisis of the child, and improvement of overall family unit functioning.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

G. Consultation with Tribes

Although West Virginia does not have a formal Federal or State recognized Indian Tribe, there is an active group within the state. The Appalachian American Indians of West Virginia (AAIWV) have West Virginia State Senate acknowledgement as a tribal group since March 1, 1996 with the passage of Senate Resolution 25 followed by an identical resolution (House Resolution 23) passed by the House of Delegates on March 3, 1998.

According to an interview with Chief Wayne Appleton, Appalachian American Indians of West Virginia, Inc. is an intertribal group of Native Americans and their mixed blood lineal descendants. There are nearly 5,000 members in West Virginia and the surrounding States representing the bloodlines from 84 different Native American Tribes. Consistent with the history of this area, the majority of the members share Cherokee or Shawnee ancestry. Tribes as distant as the Ojibway, Seneca and Apache are also represented. The AAIWV is the largest group of Native Americans descendants and supporters of Native Americans in the State.

The goals of the AAIWV are to provide a "tribal home" for Native Americans in West Virginia and to save precious pieces of their heritage through education of both Native Americans and the general public about the history and culture of Native Americans in this State. Extensive teaching activities are conducted through Pow Wows and are open to the public. The AAIWV are active in holding monthly Tribal Council meetings and publishing a monthly newsletter, The Appalachian Indian Voice, which is distributed free to members. The AAIWV also provides a Food Pantry, counseling, public speaking and educational activities. The AAIWV is supported solely by member contributions. AAIWV is governed by an elected Tribal Council consisting of a Principle Chief, Chief, Tribal Officer, Tribal Liaison, Secretary, Treasurer, and 14 elected Tribal Counselors.

According to Chief Appleton, the population is concerned with alcohol and drug problems and mental illness. He specifically noted "Bipolar and Autism, poor outcomes for high school graduation, and obtaining college degrees are the greatest needs." In general, historical discrimination, lack of trust with the government and a sense of entitlement affect attitudes resulting in counterproductive outcomes for the Native American population.

General population data and prevalence numbers are needed for tribal communities with regard to substance use and abuse, mental health, education, jobs, poverty and related issues. Additional prevention might include efforts that offer connection to community and reduce historical discrimination fostering resiliency with the younger age groups to improve outcomes.

Council of Three Rivers American Indian Center's Employment and Training Program has a Workforce Investment Area (WIA) employment and training counselor located at the Workforce West Virginia Center in Charleston. The purpose of the organization is to reduce unemployment among American Indians, traditionally the least served and poorest group in the United States. Council of Three rivers American Indian Center has operated an employment and training program since 1976. The current program is funded through the U. S. Department of Labor. They assist in gaining resources and funds for job training, classroom training, job placement, and counseling. Individuals who can access these services are those that have been unemployed

at least seven days, are employed less than full time, or are a member of a low income family. Membership requirements include that you are American Indian, Alaskan Native or a Native Hawaiian.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

IV: Narrative Plan

E. Data and Information Technology

The BBHFF continues to utilize and refine its existing Information Technology (IT) system in order to meet the needs of both the State and Federal reporting requirements.

The BBHFF IT system uses Microsoft's Visual Studios as the programming language and SQL server for data storage. Community Behavioral Health Centers provide treatment data for all clients served to Innovative Resource Group, LLC, (d/b/a APS Healthcare), the Administrative Services Organization under contract with the State's Medicaid Authority for utilization management. These data include provider characteristics; client enrollment, demographics and characteristics; admission, assessment and discharge information; and, the specific services provided. The specific services provided data include the type, amount, and individual service provider. Data are collected concerning abuse or addiction to prescription or illegal drugs or alcohol. However, data regarding prescription drug distributions are not collected through the BBHFF data system but through the West Virginia Board of Pharmacy.

Data regarding activities and services of the BBHFF substance abuse prevention providers are reported to First Choice, Inc., which then reports to the BBHFF. These reports enable consistent and frequent monitoring of the prevention providers and support the creation of reports on the use of SAPT Block Grant prevention funds. It is anticipated that First Choice will begin aggregating reports of substance abuse treatment services, using data submitted to the BBHFF. The data collected by First Choice for treatment services will annotate the data provided to APS Healthcare to assist with categorizing all treatment services provided into the 11 SAMHSA defined service areas. Implementation of the additional treatment data is slated to begin before January 2014.

Data reported to APS are transmitted through an electronic data interchange and subsequently processed through a data validation routine prior to being imported into the BBHFF dataset. The BBHFF validates the data and returns daily validation reports showing all errors encountered to providers.

In addition to APS data, which includes data from the thirteen (13) comprehensive behavioral health centers, the BBHFF utilizes data from the two State-operated psychiatric hospitals and the BBHFF Driving Under the Influence (DUI) program.

The BBHFF data system utilizes a Master Consumer Index (MCI) to assign each consumer a unique identifier, enabling the BBHFF to link data from the community table(s) to Hospital and DUI tables. This allows the BBHFF to calculate a true unique count of individuals being served across all programs and collection systems and to track recidivism between all programs (and more specifically, the CBHCs and the State-operated psychiatric hospitals). Unique client level data is available as episodic data for each encounter reported through the system or as trended data showing all services received over multiple episodes.

The BBHMF system has incorporated a corporate ID (AID) and a location ID (BAID) for each provider. Data collected may be reported either as an aggregate of all service locations operated by the same agency (using AID) or broken into each specific service location throughout the state (using BAID). The Bureau also collects and tracks I-SATS numbers for all Substance Abuse service providers. All community and hospital records contain demographic, diagnosis (DSM IV for community behavioral health providers and ICD-9 for state hospitals) information and contain the corporate ID (AID). Use of APS Healthcare and First Choice data enables the ability to aggregate Medicaid and non-Medicaid provider information.

Each service program for every service provider also has a program ID based on the location ID (BAID). The service data contains the corporate ID and the Location ID, as well as the Healthcare Common Procedure Coding System (HCPCS) code for services provided and the number of unit(s) (e.g. 15 min increments). This data set also includes type of payer, including but not limited to Medicare, Medicaid, Private insurance, and self-pay. All data comply with Federal data standards in the use of ICD-9 and HCPCS codes and are updated as any revisions are released.

The BBHMF Deputy Commissioner for Administration meets twice monthly with representatives of the State's Medicaid Authority and other parties to address mutual issues concerning system interoperability and Federal IT requirements. Meetings include the BBHMF, the Bureau for Medical Services (BMS), Molina (the contracted Medicaid claims processor), and APS Healthcare (the Utilization Management contractor). These meetings are held to ensure system interoperability and compliance with Federal IT requirements.

In addition to the data collection and validation efforts being undertaken by the BBHMF, the State of West Virginia has implemented a statewide Health Information Exchange (HIE). The HIE falls under the purview of the West Virginia Health Information Network (WVHIN), a public-private partnership. The WVHIN was created by the West Virginia Legislature in 2006 to "...promote the design, implementation, operation and maintenance of a fully interoperable statewide network to facilitate public and private use of health care information in the State while ensuring the privacy and security of patient health care information." The BBHMF is in active negotiation with the HIN to become a direct participant in the HIE.

The Bureau for Medical Services, the State's Medicaid Authority, is also engaging in improvements to its IT system. BMS has issued a Request for Proposal (RFP) for operation of its Medicaid Management Information System (MMIS) and it is anticipated that the new system will meet the requirements for data interoperability, behavioral health system reform, and IT data. The BBHMF has been included in the design of the RFP.

The BBHMF has provided assistance to the 13 CBHCs to develop and use Electronic Health Records (EHR). Each of the 13 centers has been allocated a \$9,500 grant from the State's SAMHSA Data Infrastructure Grant (DIG). The DIG sub-grants are supporting infrastructure and software development to enable each of the centers to move toward EHR. All centers are moving toward full EHR system adoption and will be asked to participate in the state's HIE. The

HIN will continue to assist with education and technical assistance to all agencies implementing an EHR system.

On May 2, 2013 Governor Tomblin announced the expansion of Medicaid services to people between the ages of 19 and 64 who make from 17% to 138% of the federal poverty level. Enrollment for these individuals will begin on October 1, 2013, with coverage beginning January 1, 2014. Everyone in the expansion group will be enrolled into a Managed Care Program. At the same time there will be changes made to the current Managed Care Program, including behavioral health, personal care, pediatric dentistry, and non-emergency medical transportation. In West Virginia, all Medicaid members, current and new, who are enrolled with a Managed Care provider, will have access to the expanded services. Expansion of Medicaid eligible members and services will certainly prove to be a large investment in the State's ongoing effort to ensure that all citizens who are need of Behavioral Health services are able to receive the services needed when they need them.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

IV: Narrative Plan

F. Quality Improvement Reporting

The BBHMF is in the early stages of development and adoption of a full Continuous Quality Improvement/Total Quality Management (CQI/TQM) plan and is in the infant stages of implementation. Several of the concepts of CQI have been built into Bureau activities and functions of payers in the past and the adoption of a more formal plan will help to solidify efforts that are already in process. Several of the State's publicly funded behavioral health providers have developed their own CQI approaches and adopted recognized CQI/TQM plans for their respective operations. These endeavors provide a foundation for continued development and implementation of the statewide CQI/TQM Plan.

BBHMF Activities Related to CQI

The Bureau is in the development phase of a systemic formalized process for ensuring that CQI is stakeholder driven. The BBHMF currently has several mechanisms in place for soliciting stakeholder input for the development of quality improvement indicators. Stakeholders include consumers and their families, administration and staff of the BBHMF, the BBHMF Office of Consumer Affairs and Community Outreach, service providers, advocacy organizations, the Mental Health Planning Council, the West Virginia State Epidemiological and Outcomes Workgroup (WVSEOW), and other partners.

The BBHMF has collaborated with providers to develop standardized definitions and standardized Statements of Work for all sub-recipient and general revenue funded grant agreements for behavioral health prevention, early intervention, treatment, and recovery services, to include outcome performance, peer review, and cultural competence compliance measures. The development of these standardized documents provides for consistent assessment and evaluation of programs and processes across the State and contributes to the development of a CQI Plan. Guiding principles include the beliefs that behavioral health is an essential part of health, prevention works, treatment is effective, and people can and do recover from mental and substance use disorders.

The BBHMF Data and Technology Team capture behavioral health episodic utilization data in coordination with APS Healthcare, the State Medicaid Authority's Utilization Management contractor. Providers submit information to APS Healthcare regardless of payer source for all services provided. In addition to capturing client services data and demographic data for all consumers served, APS Healthcare uses clinical information submitted for Medicaid-eligible consumers to provide prior authorization approvals for requested services. The organization uses aggregate data and individual agency data to develop technical assistance for providers to improve outcomes and for quality improvement.

The BBHMF Data and Technology Team validate the data submitted to APS Healthcare and submit validation reports to individual providers to assure the data are accurate. The Single State Authority for substance abuse prevention and treatment (SSA) and the Mental Health

Authority (MHA) may query these data to identify trends and measure performance of individual providers. First Choice, Inc. collects and reports data provided by substance abuse prevention sub-recipient grantees. The SSA is able to use these data to identify the use of evidence based practices and types of prevention activities by provider and in the aggregate. The Marshall University School of Medicine's Center for Rural Health collects and reports data on the use of Mental Health Block Grant funds as an independent evaluator. The Center for Rural Health also provides technical assistance to Mental Health Block Grant sub-grantees in identifying outcome measures and models and tools for best practice.

The BBHFF instituted an Independent Peer Review (IPR) process several years ago for some of the publicly funded substance abuse treatment services. The IPR process in West Virginia is not designed as a measure of compliance, but as a learning venture to recognize and share best practice across the State's provider community. The goal of the IPR that has been implemented is to assess the quality and appropriateness of behavioral health services provided by Grantees using Federal SAPT Block Grant and State funds. The IPR instrument measures current use of recognized and appropriate service procedures such as those found in NIATx principles, increased availability and use of evidence based practices, and the promotion of social connectedness opportunities available to persons receiving treatment.

Provider Activity Related to CQI

At least six of the State's 13 Comprehensive Community Behavioral Health Centers have utilized NIATx principles for quality improvement. These centers utilized recommendations of stakeholders in the development of the NIATx study and changes in service delivery. The NIATx rapid cycle process of improvement model identifies issues related to decreasing wait time for services, decreasing no show rates for appointments, increasing admissions into services, and increasing continuation in treatment.

In addition to the NIATx processes, one Comprehensive Community Behavioral Health Center has a compliance council that meets monthly. The council completes monthly safety inspections for all group home facilities, analyzes and trends chart reviews and clinical supervisions, reviews trend data for incident reports, and reviews general training and documentation compliance issues. The Center utilizes information from its compliance council for continuous quality improvement.

Some of the substance abuse treatment services operated by the State's largest publicly funded Comprehensive Community Behavioral Health Center have been accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), which includes a CQI component.

Response to Critical Incidents, Complaints, and Grievances

Responsibility for overseeing consumer health and safety and responding to critical incidents in West Virginia rests with the Office of Health Facility Licensure and Certification (OHFLAC), which was recently moved into the Department of Health and Human Resources' Office of the Inspector General. In this capacity, OHFLAC has a designated Behavioral Health Program which enforces the agency's Behavioral Health Center's Licensure Rule, Title 64 Code of State Rules

Series 11 (§64CSR11). The scope of this rule includes licensed behavioral health providers (not including hospitals, long-term care facilities or private practitioners) serving people with intellectual disabilities, mental illnesses, and addictions.

§64 CSR 11, Section 7.7 requires licensed behavioral health centers to “maintain a system for critical incident reporting and demonstrate that it uses the system to improve treatment planning and services” and agency staff to “immediately notify a supervisor of any critical incident and clear other consumers from the area.”

§64 CSR 11, Section 8.2 describes the broad requirements licensed behavioral health centers must use when addressing alleged consumer rights’ violations and responding to people’s complaints. Section 8.2.a. establishes the right of consumers to file complaints and requires that a “supervisor shall report to the [agency] administrator within twenty-four (24) hours regarding all violations, or suspected violations, of a consumer's rights, except in the case of physical abuse for which immediate notification shall be made.” Section 8.2.b. requires the agency to “have evidence that all violations, or suspected violations, of a consumer’s rights are thoroughly investigated within a reasonable time period” and, subsequently, that the agency administrator “provide a written report to the [required] human rights committee of his findings and of the actions taken to prevent further occurrences.” Finally, Section 8.2.d. gives each consumer the right to “appeal to the governing body of the Center, the State licensure body, the [State Protection and Advocacy Agency] or other appropriate resource” if the “administrator’s findings and actions on behalf of a consumer regarding a violation of the consumer's rights is unfavorable, insufficient or not forthcoming within a reasonable time.” Each of the licensed behavioral health centers has, in turn, developed their own grievance policies and procedures to comply with the above requirements.

The BBHMF has established its own ancillary process to address informal complaints from consumers and families and other interested parties that begins with assistance from staff working in the Office of Consumer Affairs and Community Outreach (CACO), with support as needed from BBHMF’s clinical divisions and/or referral to an independent advocacy group, such as the State Protection and Advocacy Agency and Legal Aid of West Virginia’s grant funded Behavioral Health Advocacy project. In addition, some provider-developed grievance processes include a final appeal option to BBHMF and CACO has established a process to respond to review and respond to these formal appeals.

Each request for assistance is logged and tracked in the form of quarterly reports for the purpose of trend reporting and analysis with BBHMF’s Clinical Divisions and Monitoring Unit. Follow up calls are also made by CACO staff to assure that the more urgent requests have been appropriately and subsequently addressed by the applicable grant funded community providers. This information is also tracked by CACO and used for the purpose of reporting and analysis.

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

IV: Narrative Plan

S. Suicide Prevention

Suicide prevention has been a significant priority of the Bureau for Behavioral Health and Health Facilities (BBHFF) for over a decade. Since 2002, The BBHFF has provided federal block grant funding as well as state dollars to support the West Virginia Council for the Prevention of Suicide (WVCPS). The vision of the BBHFF and the WVCPS is that West Virginia does not lose one life to suicide. West Virginia's State Suicide Prevention Plan (WVSSPP) contains core elements, such as identifying and promoting evidence based practices and programs that address prevention, intervention and training the existing behavioral health workforce on identifying, screening, assessing and treating individuals with suicidal thoughts and behaviors. Although there has been a decrease in suicide deaths in West Virginia, the state suicide rate is still well above the national average. According to the US Centers for Disease Control (CDC), between 2001 through 2010 there were a reported 2,730 deaths in West Virginia by suicide. During that time, the reported suicide rate was 12.53 per 100,000 individuals, which is greater than the national suicide rate of 9.94 per 100,000 individuals. During that same period, all but four counties in West Virginia have a reported suicide rate higher than the national average.

The BBHFF recognizes that suicide prevention and intervention is a critical behavioral and public health priority. The BBHFF is taking a more prominent role in the administrative oversight and implementation of suicide prevention to promote changes in systems, policies, practices and environments that will support and sustain the prevention of suicide and related problems in West Virginia. In order to maximize existing resources, promote broad collaborations across systems, and monitor progress, the BBHFF will continue to work collaboratively with the WVCPC and the Adolescent Suicide Prevention and Intervention (ASPEN) Project to ensure key areas are inclusive in the WVSSPP. Adopting a regional approach is an essential component to building state infrastructure and sustaining the full continuum of suicide prevention, intervention and postvention practices.

The goals of the WVSSPP address suicide infrastructure, awareness, implementation and methodology. A tangible framework is needed for coordination of plan implementation and evaluation, and resources and technical assistance on evidence based suicide prevention practices are essential elements to achieve the goals of the state plan. Increasing public knowledge and awareness of suicide related issues, including risk and protective factors and prevention and intervention resources throughout the state, are core components of the state plan.

West Virginia's State Suicide Prevention Plan identifies high risk populations, including transitioning youth and young adults, Lesbian, Bi-Sexual, Gay, Transgender, and Questioning (LGBTQ) populations, military personnel (active, guard, reserve and veterans), and law enforcement. The WVSSPP also identifies geographic areas and settings in which risks of

suicide are high. The BBHFF is working collaboratively with the WVCPS and the Adolescent Suicide Prevention and Early Intervention Project to further develop a more comprehensive plan, that prioritizes integration and coordination activities across multiple sectors and settings which incorporate a public health approach across the life span. The goal of the BBHFF is to produce a statewide infrastructure for sustaining an effective and efficient integrated suicide prevention system, coordinating a state and regional learning, referral and early intervention approach with committed education, juvenile/criminal justice, military personnel, child welfare, behavioral and other healthcare public/private partners. Using SAMSHA's Guidance on State Suicide Prevention Leadership and Plan, the WVSSPP has been revised and is available in the attachment section of the Combined Substance Abuse and Mental Health Block Grant Application.

The BBHFF is currently in the last quarter of a no-cost extension for the Garrett Lee Smith Grant, Adolescent Suicide Prevention and Early Intervention (ASPEN). The BBHFF submitted a grant proposal on June 12, 2013 in response to SAMHSA's Request For Proposals (RFP) for Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention. The BBHFF is hopeful that West Virginia will be one of the states awarded this grant. However, in partnership with the Bureau for Public Health, the BBHFF is committed to sustaining adolescent suicide prevention and intervention and plans to move forward with or without this grant award. The BBHFF is collaborating with West Virginia's Comprehensive Behavioral Health Centers who has been the sub-recipient of the ASPEN Grant and the WVCPS to further build the state's suicide prevention infrastructure for across the life span. However, this grant opportunity would allow West Virginia to specifically 1) incorporate comprehensive evidence-based protective measures that expand universal prevention messages of hope and help at the regional level and 2) improve identification, referral and engagement interventions for youth and transitioning youth aged 10-24, living in identified high rate counties in WV. Additionally, the project will 3) build the capacity of organizations serving vulnerable sub-populations to effectively deliver coordinated care. The sub-populations recognized include: a) service members, veterans and their families; b) Lesbian Gay, Bi-Sexual, Transgendered and Questioning (LGBTQ) youth and young adults; c) individuals with mental and substance use problems; and d) suicide attempt survivors.

Preventing Suicide in West Virginia

a plan to address a silent epidemic



Prepared by the West Virginia Council
for the Prevention of Suicide for

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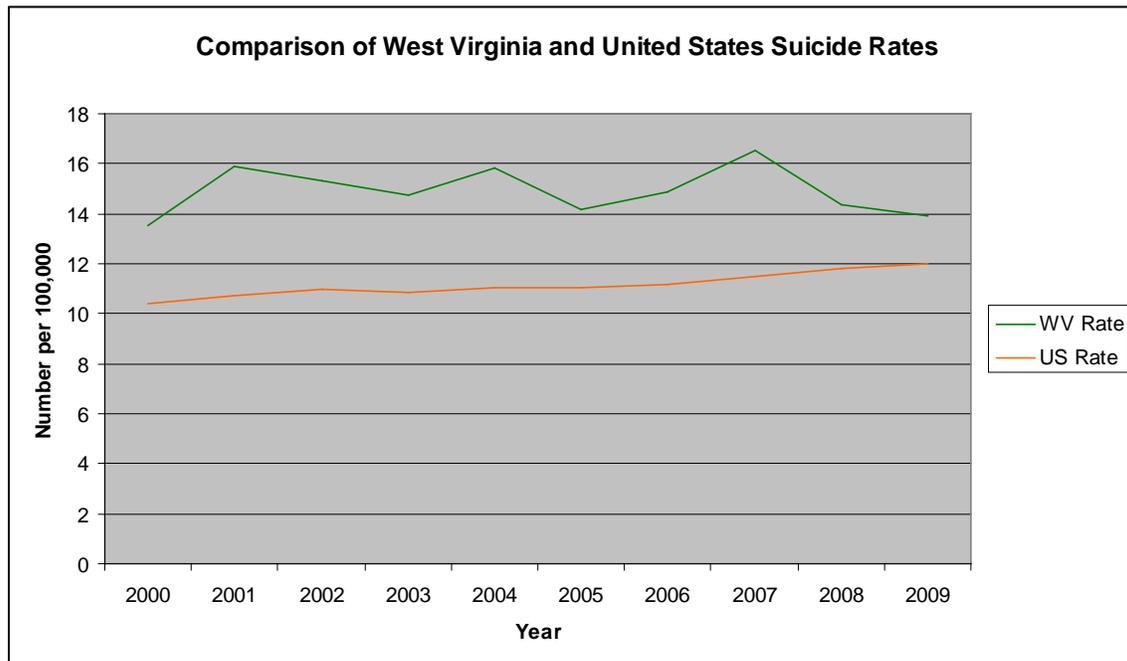
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Introduction

Suicide is a significant problem in the United States and in West Virginia. It has been called “a *silent epidemic*”¹ that “exact[s] an enormous toll from the American people.”²

On average, about 32,000 individuals in the United States died from suicide each year in the years 2000-2009. Another 650,000 receive emergency care after attempting to take their lives.³ It is estimated that one person dies every 14.2 minutes due to suicide.⁴

Data show that 2,723 individuals in West Virginia died by suicide from 2000-2009. West Virginia’s suicide rate was higher than the national average in number of persons per 100,000 population who died by suicide in that time period.⁵



“Number per 100,000” provides a statistic which enables a comparative analysis across states. Actual numbers produce a picture for the specific state, such as West Virginia. The chart below depicts the number of suicides for the years 2000 through 2009. It ranges from 246 reported

¹ See <http://www.pbs.org/thesilentepidemic/>

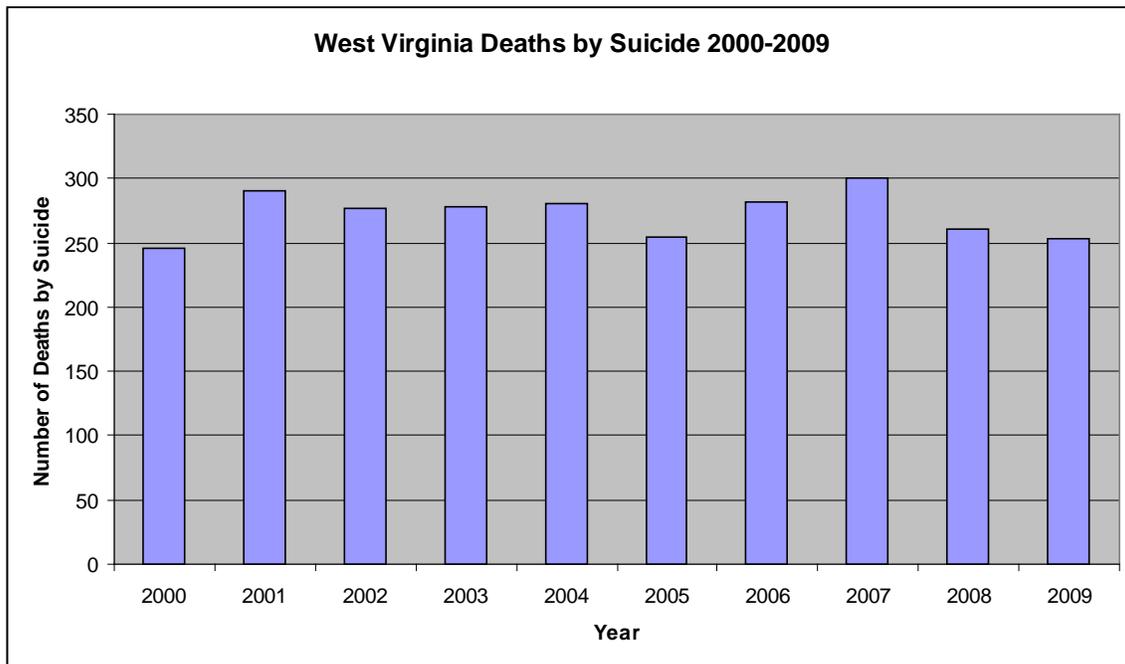
² U.S. Department of Health and Human Services, Public Health Service. 2001. *National Strategy for Suicide Prevention: Goals and Objectives for Action*.

³ Ibid.

⁴ See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf

⁵ Found at <http://www.cdc.gov/injury/wisqars/fatal.html>

deaths by suicide in 2000 to 300 deaths in 2007; more than one person died from suicide every two days in those 11 years.⁶



Intentional self-harm was the second leading cause of death among West Virginia males aged 15 to 24 in 2009, according to the Centers for Disease Control it was exceeded only by accidents.⁷ Statistics indicate that deaths by suicide affect younger West Virginians most.⁸ These data indicate that just over 1% of the deaths in 2002 and 2003 were due to intentional self-harm, but 5% of the years of potential life lost before age 65.

Young people are not the only ones who die from suicide. There were 178 deaths among West Virginians aged 25-64 in 2009 attributed to intentional self-harm, about 23% of the 789 deaths in that age group in that year. About 81% of those deaths were males.⁹

Suicide also affects older people aged 65 and older, although that is not listed by the Bureau of Public Health as a “leading cause” of death in West Virginians in that age group. Nationally in 2009, 5,858 older Americans died by suicide.¹⁰ This averages out to 1 older

People of all age groups attempt suicide, but older adults have a higher completion rate.

⁶ Ibid.
⁷ See <http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html>
⁸ See http://www.wvdhhr.org/bph/oehp/vital03/vs_30.htm
⁹ See http://www.wvdhhr.org/bph/oehp/vital03/vs_31x.htm
¹⁰ See <http://www.cdc.gov/injury/wisqars/fatal.html>

American suicide death every 1 hour and 30 minutes.

Although older adults nationally and in West Virginia attempt suicide less often than those in other age groups, they have a higher rate of suicide. Older Americans are more lethal in their attempts and die by suicide more often. For all ages combined, there is 1 suicide for every 20 attempts nationally. Among people aged 15-24 years old, there is 1 completed suicide for every 100-200 attempts. Over the age of 65, there is 1 completed suicide for every 4 attempts.¹¹

Nationally, suicide deaths consistently outnumber homicide deaths by a margin of two to one. In 2002, twice as many Americans died from suicide than from HIV / AIDS. But research has shown that 90 percent of people who die by suicide have depression or another diagnosable (and treatable) mental illness or substance abuse disorder.¹² This suggests suicide can, and is, preventable.

Efforts at preventing suicide began nearly a half-century ago, when the first suicide prevention center established in Los Angeles. This center, and many others established after it, offered community service and crisis intervention.¹³ In 1996, Gerald and Elsie Weyrauch of Marietta, Georgia began a grassroots effort to encourage public education and awareness, community action and grassroots advocacy to prevent suicide. The Weyrauch's 34-year old physician daughter died by suicide and the couple adopted a goal to create a way for people who have lost someone to suicide to transform their grief into positive action to prevent future tragedies.¹⁴

In the 10 years since that initial effort,, nearly every state has developed and implemented efforts to prevent suicide. A national hot line, to respond to individuals contemplating suicide, has been established. National and state conferences have shared information on suicide prevention, crisis intervention, and outreach methods. The country's Surgeon General has issued a report and a national strategy for suicide prevention has been developed

Suicide prevention awareness and advocacy efforts in West Virginia began in 2001, with a small grant to Valley HealthCare System in Morgantown from the West Virginia Department of Health and Human Resources to create the

**This plan has
been prepared
by the WVCPS
for the West
Virginia DHHR**

¹¹ See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf

¹² http://www.spanusa.org/index.cfm?fuseaction=home.viewPage&page_id=8A13146B-E70F-213B-95A0CE83BC5518F6

¹³ Op Cit U.S. Department of Health and Human Services, Public Health Service. 2001

¹⁴ See http://www.spanusa.org/C_about-span.html

HOTT (Helping Our Teens Thrive) Coalition. Two years later, the West Virginia Council for the Prevention of Suicide (WVCPS) was formed. The mission of the Council is to, “Reduce suicides in West Virginia and address the needs of survivors of suicide loss through evidence-based programs and practices in order to prepare communities, recognize, and support those at risk for suicide and survivors of suicide loss.” The vision of the Council is that West Virginia not lose one citizen to suicide.¹⁵

In the intervening years, the HOTT Coalition and the WVCPS have presented numerous workshops and conferences for educators, health and behavioral professionals, and social service providers. The Council has also sponsored the development of age-appropriate assessment protocols for early identification of potential suicide victims and referrals to services.

This Plan has been prepared by the WVCPS for the Department of Health and Human Resources after review and comment by several interested groups.

¹⁵ See <http://www.wvsuicidecouncil.org/>

Purpose of this Plan

The vision of the West Virginia Council on Suicide Prevention is that “West Virginia does not lose one citizen to suicide.” It is the hope that this Plan will provide guideposts to working toward that vision.

Many suicides can be prevented by developing protective factors and reducing risk factors. Protective factors include effective and assessable clinical care for mental, physical, and substance use disorders; strong connections to family and community support; skills in problem solving, conflict resolution, and nonviolent handling of dispute; and cultural and religious beliefs that discourage suicide and support self-preservation. Risk factors include mental illnesses; history of trauma or abuse; family history of suicide; job or financial loss; loss of a relationship; lack of social support; stigma associated with seeking help; and exposure to others who have died by suicide.¹⁶

No agency or organization can fully address the problem – it requires the attention, effort, and coordination of multiple organizations, groups, and individuals. These include organizations, agencies, and individuals providing mental health services; health care providers, school systems and universities, law enforcement; court officials; senior citizen organizations; faith-based organizations; and groups of families and friends of people who have died by suicide.

While representing a new and coordinated endeavor, the Suicide Prevention Plan builds on current activities and endeavors, hopefully avoiding a duplication of effort at a time when resources are limited. The work of the WVCPS has been based on this coordination of existing resources. It is believed this plan will guide further development of these efforts, leading West Virginia toward achieving the Council’s vision.

This plan builds on current activities and endeavors.

This plan has been provided for review to the West Virginia Mental Health Planning Council, the West Virginia Behavioral Healthcare Providers Association, the West Virginia Primary Care Association, and other health, social service, and education providers and organizations. It is hoped that this process will lead these organizations and individuals to considering the recommendations for addressing this *silent epidemic*.

¹⁶ U.S. Department of Health and Human Services, Public Health Service. 2001. *National Strategy for Suicide Prevention: Goals and Objectives for Action*.

Also, upon acceptance by the West Virginia Department of Health and Human Resources, the WVCPS is hopeful the recommendations will guide Department-wide and State-wide efforts to reduce suicides.

Development Process

In 2001, Valley HealthCare System responded to an Announcement of Fund Availability from the Children's Division of the Office of Behavioral Health Services in the West Virginia Department of Health and Human Resources Bureau for Behavioral Health and Health Facilities. Valley HealthCare System proposed the development and implementation of a public awareness and information project to create awareness and understanding of a *silent epidemic*: suicide among adolescents in West Virginia.

The small grant, funded through the Community-Based Mental Health Services Block Grant, enabled the creation of the Helping Our Teens Thrive Coalition (HOTT Coalition). This coalition was composed of representatives of health and behavioral health providers, educators, and interested individuals. In the beginning years, several seminars and workshops were provided to alert school personnel and the interested public in the number of children who were dying by suicide in West Virginia as well as what was needed to prevent such untimely and tragic deaths.

The workshops and seminars were well received and the HOTT Coalition was re-formed and expanded into the West Virginia Council for the Prevention of Suicide. The WVCPS understood that people of all ages die by suicide. The "target population" addressed by the WVCPS was expanded to include adults and the Council began providing bi-annual conferences which attracts several hundred health and behavioral health providers and other individuals. A Website (<http://www.wvsuicidecouncil.org/>) has been created, providing statistics and information on suicide and offering help for individuals in crisis. The Council has developed awareness curriculums covering all age groups, and currently provides workshops covering the entire lifespan.

In addition to information and education, the Council sponsored the development of protocols for suicide assessment, including the Adolescent Screening and Assessment Protocol-20 (ASAP-12), the Suicidal Adult Assessment Protocol (SAAP), and the Suicidal Older Adult Protocol (SOAP)¹⁷.

**The WVCPS has a Website:
www.wvsuicidecouncil.org**

The plan is based on the goals and objectives in the *National Strategy for Suicide Prevention Goals and Objectives for Action*. Specific goals and

¹⁷See <http://www.wvsuicidecouncil.org>

objectives, strategies, and activities for implementation were drafted by the Council membership and circulated for review and comment to stakeholder groups and individuals. Officials in the Department of Health and Human Resources have reviewed and commented on the plan and have now adopted it as the West Virginia State Plan for Suicide Prevention.

Implementation of the plan is a shared responsibility. Certainly, the Council will play a major role in coordinating efforts in achieving the plan. But all stakeholders – providers of health and behavioral health services, teachers, higher education, law enforcement, the courts, families and friends of people who have died by suicide and the general public have roles in preventing untimely and tragic deaths.

Priority Populations

This plan addresses suicide prevention for all persons in West Virginia, regardless of age, race, or gender. Data from 2009 indicates that West Virginia's 253 reported deaths by suicide were equal to 113.9 suicides per 100,000 population, the 20th highest in the United States.¹⁸ However, some population groups are more at risk than others.

The Center for Disease Control publishes data showing the number of suicides by age group. The following chart shows deaths by suicide for the years 2000 through 2009, divided into four age categories. Over the past ten years there were a reported 2,723 reported deaths by suicide in WV. This works out to an average of 272 deaths by suicides a year in WV. Over this ten year period the year with the lowest reported number of deaths by suicide was 2000 with 246 reported, the year with the highest reported number of completed suicides was 2007 with 300 reported.

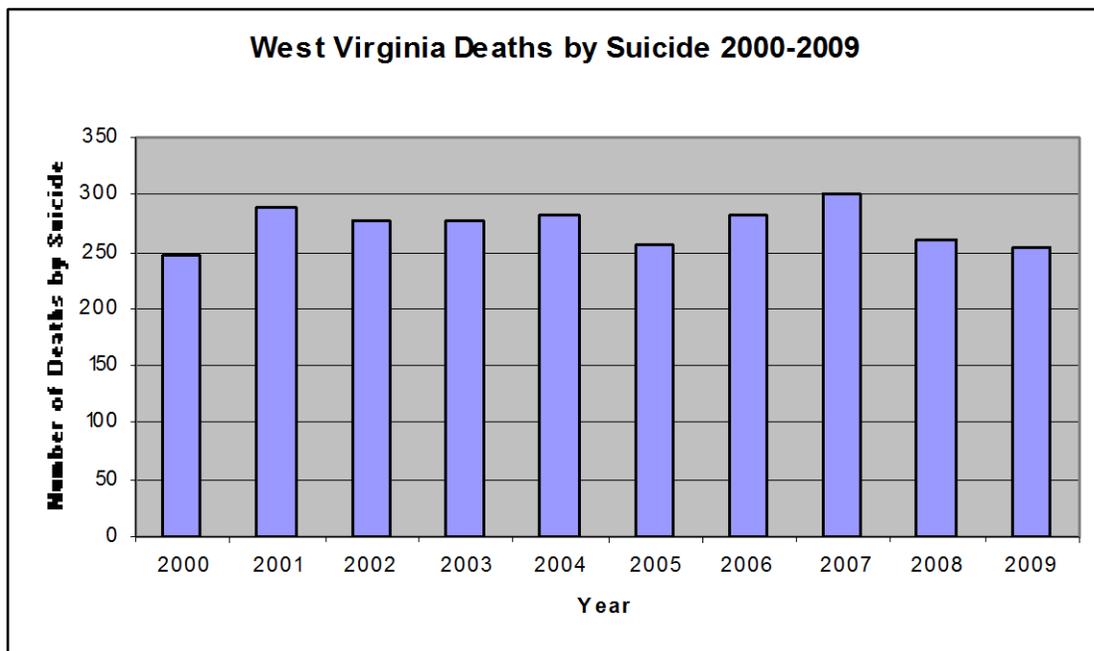


Table 1 breaks down the reported completed suicides in WV by age and gender. In 2009 there was a reported 27 deaths by suicide among the ages of 15 to 24 in WV, with a rate of 11.35, with ranked 22nd in the nation. Males accounted 93% (n=25) of deaths by suicide among this age group. The suicide rate among males of this age group for 2009 was 20.43, which ranked 15th in the nation. Among the age group of 25-64, there were a reported 178 deaths by suicide in 2009. Males accounted for 81% (n=178) of completed suicides among this age group.

¹⁸ See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf

The male suicide rate for this age group for 2009 was 29.76, which ranked 22nd nation. Males among the age group of 65+ had the highest suicide rate in WV with a reported rate of 33.30 which ranked 22ndth in the nation. Among this age group there were a reported 46 deaths by suicide in WV. Males accounted for 89% (n=41). Among all age groups WV had a consistently higher rate of suicide than the national average.

Table 1: Completed Suicide by Age

	15-24	Rate	25-64	Rate	65+	Rate
Male	25	20.43 (15 th)	144	29.76 (22 nd)	41	33.30 (22 nd)
Total	27	11.35 (22 nd)	178	18.24 (21 st)	46	16.00 (23 rd)
US Total	4,140	9.76	24,847	15.52	5,421	14.29

Table 3 breaks down the number of suicides that were completed by firearm in 2009. In WV there were 178 suicide deaths by firearm, which accounts for a rate of 9.78. This ranked 9th in nation among firearm deaths. Among the age group of 25-64, the rate of firearm death was 11.99 (n=117), which ranked 10th in the nation. Among the age group of 65+, the rate of firearm death was 13.56 (n=39), which ranked 20th in the nation. In 2009 firearms accounted for 70% of suicide deaths in WV.

Table 3: Suicide by Firearm

	15-24	Rate (Rank)	25-64	Rate (Rank)	65+	Rate (Rank)
WV Total	20	8.32 (10 th)	117	11.99 (12 th)	39	13.56 (20 th)
US Total	2,002	4.65	12,419	7.64	4,248	10.74

*All rates are per every 100,000 people

*All data was obtained from the CDC National Vital Statistics System Web-based Injury Statistics Query and Reporting System (WISQARS)

LGBT Youth

The Action Alliance for Suicide Prevention recently identified LGBT youth as a priority population for suicide prevention. LGBT youth are at a higher risk of attempting suicide than heterosexual youth. LGBT youth are 1.5 to 7 times more likely to attempt suicide than other youth.¹⁹ A

¹⁹ See http://www.sprc.org/library/SPRC_LGBT_Youth.pdf

recent study by the Suicide Prevention Resource Center found that LGBT youth are also more likely to be bullied by their peers, which increases the likelihood for attempted suicide.

Law Enforcement

Law enforcement officers are also at a heightened risk for suicide. The organization Badge of Life performed a study in 2008 that indicated that Law Enforcement officers have a suicide rate of 17.0/100,000.²⁰ This is higher than the national average of 11.2/100,000.²¹ This study also indicated that Law enforcement are three times more likely to die by suicide than they are to be killed by assailants.

Important Risk and Protective Factors

The *National Strategy for Suicide Prevention: Goals and Objectives for Action* discusses important factors that might increase the risk for suicide.

People with these risk factors may be more likely to engage in suicide behavior than people without them. Some risk factors may be reduced by interventions such as medications or social supports. Others, like previous suicide attempts, cannot be changed, but can alert others to an increased risk of suicide during periods of a recurrence of a mental illness or substance disorder or following a significantly stressful life event.

Risk factors generally fall into one of three categories. Biopsychosocial risk factors include issues that are related to health of the individuals or her or his family members. Environmental risk factors are generally situations in a person’s environment which may increase stress or support suicidal thoughts. Finally, sociocultural risk factors are those concerns within the culture that increase suicidal thoughts or behaviors.

These three sets of risk factors are listed in the table below.

Biopsychosocial	Environmental	Sociocultural
Mental illnesses, particularly mood disorders, schizophrenia, anxiety disorders, and certain	Job or financial loss	Exposure to, including through the media, and influence of others who have died by suicide

²⁰ See <http://www.badgeoflife.com/suicides.php>

²¹ See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf

personality disorders		
Alcohol and other substance use disorders		
Hopelessness	Relational or social loss	Stigma associated with help-seeking behavior
Impulsive and / or aggressive tendencies		
History of trauma or abuse	Easy access to lethal means	Barriers to accessing health care
Some major physical illnesses		
Previous suicide attempt	Local clusters of suicide that have a contagious influence	Some cultural and religious beliefs
Family history of suicide		Lack of social support and sense of isolation

Thankfully, there are protective factors for suicide – actions which can help counter suicide risks. Protective factors are varied and address individual attitudes and behaviors as well as the environment and culture of the community.

Protective factors include:

- Effective health care and clinical care for mental illnesses and substance abuse;
- Easy access to a variety of clinical interventions and supports, including peer support, for people seeking help;
- Restricted access to highly lethal means of suicide;
- Strong connections to family and community support; and
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes.

Both risk factors and protective factors are addressed in this plan.

It is essential to address and support the protective factors, as they have been helpful in preventing suicide. However, this plan cannot simply focus on protective factors alone since resistance to suicide is not permanent. The programs that support and maintain protection against suicide should be ongoing. As this plan is implemented, attention will be paid to addressing both the risk factors and the protective factors.

Plan Format

This suicide prevention plan is based on West Virginia-specific needs and resources. The format mirrors that of the *National Strategy for Suicide Prevention: Goals and Objectives for Action*. The plan identifies goals and objectives and outlines the strategies and activities to accomplish such goals.

The plan is divided into the Awareness, Implementation, and Methodology (AIM) categories of the national plan. In addition, a section is devoted to development of the infrastructure needed to oversee the plan's implementation.

The four categories are defined as follows:

- **Infrastructure** – Goals, objectives, strategies, and activities addressing the tangible framework needed to secure resources to coordinate and provide information and technical assistance to organizations, agencies, and individuals working to implement goals and objectives within the plan, and to update the plan over time.
- **Awareness** – Goals, objectives, strategies, and activities addressing increasing knowledge on a wide-scale basis.
- **Implementation** – Goals, objectives, strategies, and activities addressing the programs and activities conducted to prevent suicide.
- **Methodology** – Goals, objectives, strategies, and activities addressing program evaluation, surveillance, reporting, and research.

The final section is a document to be used to create a work plan to assure achievement.

Infrastructure

The tangible framework needed for coordination of plan implementation, providing information and technical assistance to organizations, agencies, and individuals working to implement components of the plan, and to updating the plan over time.

Goal: Develop broad-based support for suicide prevention among health care providers.

Objective: By 2015, health care providers will adopt best practices and interventions across the continuum of suicide prevention :

Activities:

- The Board of Directors of the West Virginia Council for the Prevention of Suicide will work with the executive directors and chairs of other health care organizations to develop a strategy to encourage inclusion of suicide prevention agency plans.

Goal: WVCPS will establish a foundation for the purpose of furthering and sustaining operational goals of the organization

Objective: By 2014, the Fundraising Committee of the WVCPS Board of Directors will develop a fundraising strategy.

Activities:

- ✚ The Fundraising Committee of the WVCPS will meet on a regular basis.
- ✚ Members of the WVCPS board of directors will receive training fundraising.
- ✚ Committee members will assist with development of community activities.
- ✚ Committee will engage the support of organizations and search for corporate sponsors.
- ✚ The Committee will coordinate at least one fundraising event every year.

Goal: Develop a support network for individuals who have been affected by a death of suicide

Objective: Efforts to improve services to individuals who have been affected by the death of a loved one due to a suicide will be implemented by 2012.

Activities:

- ✚ Develop and implement a training program on appropriately supporting survivors of suicide loss for first responder and health care providers.
- ✚ Utilize a train the trainers curriculum for facilitators of support groups for individuals affected by the death of a loved one due to suicide.

Objective: By 2014, The WVCPS will establish regional suicide prevention coalitions in six regions as identified by the Governor's Substance Abuse Task Force.

Activities:

- ✚ The WVCPS will identify current public and private infrastructure to collaborate in coalitions.
- ✚ The WVCPS will develop MOU detailing responsibilities of WVCPS and the regional coalition.



Awareness

Increase public knowledge of suicide-related issues in West Virginia, including risks and protective factors for suicide and available prevention and intervention resources in the local community and throughout the state.

Goal: Enhance recognition and referral of at risk individuals

Objective: By 2015, the WVCPS will work with pre-existing public and private infrastructure in order to develop formal partnerships to incorporate suicide prevention activities

Activities:

- The Marketing and Awareness Committee of the Council will meet to prioritize a strategy of engagement to include: partners, mission and vision, key responsibilities of partners, and memorandums of understanding.

Objective: By 2015, the WVCPS will act as a clearing house for suicide prevention information, education in suicide assessment, and identification and promotion of protective factors for all WV health care providers

Activities:

- The Council will provide a link to evidence based practice, programs, and interventions as well as best practices for suicide prevention.
- The council will maintain a website for suicide prevention information.

Objective: By 2013, a campaign to increase efforts to reduce access to lethal means and methods of self-harm among people who have been assessed as at risk for suicide will be developed and implemented.

Activities:

- ✦ Develop and disseminate information to providers, communities, and individuals at risk regarding use of assessments, and statistics regarding use of medications and suicide risk.
- ✦ Collaborate with the Department of Natural Resources and / or other entities to develop and implement a public education campaign concerning safely storing and securing firearms.
- ✦ Encourage health care and behavioral health professionals to counsel families and friends about preventing access to means of suicide for persons who have attempted suicide.

Implementation

Enhancing and promoting programs, services, and activities to prevent suicide by promoting protective factors and reducing risks.

Goal: Promote evidence based practices, programs, and interventions as well as best practices for suicide prevention.

Objective: By 2015, the WVCPS will disseminate and provide technical assistance for suicide prevention practices, programs, and interventions.

Activities:

- ✦ The WVCPS will identify suicide prevention needs in the community, a specific programs that will meet those needs.
- ✦ The WVCPS will identify current resources in the community.
- ✦ The WVCPS will identify stakeholders and buy in from stake holders to implament evidence based practices, programs, and interventions.
- ✦ The WVCPS will provide consultation for the implamentation of evidence based practices, programs, and interventions.
- ✦ The WVCPS will provide monitoring and evaluation of evidence based practices, programs, and interventions that are implamented.
- ✦ The WVCPS will provide monitoring of ouctomes of evidence based practices, programs and interventions that are implamented.

Goal: Provide for the enhanced follow-services for deliberate self-harm individuals

Objective: By 2015, the WVCPS will improve access to services for identified individuals receiving services from hospital emergency departments and / or primary care clinics following a suicide attempt.

Activities:

- ✚ The WVCPS will Disseminate best-practice materials to EDs throughout the state
- ✚ Advocate for Reinforced follow-up arrangements for deliberate self-harm emergency department admissions as they are identified and responded to through existing crisis response services in providing for additional education resources and recommendation of enhance follow-up care.

Methodology

Gathering data to evaluate the effectiveness of programs, activities, and clinical treatments, and conducting suicide-specific surveillance and research.

Goal: Improve the current data collect and results information system

Objective: Meet with evaluation staff to develop a system and process regarding data to be collected

Activities:

- ✦ Collect and allalyze WV county, states, and national comparable data to inform planning
- ✦ Publicly disseminate results through web-based efforts
- ✦ Participate in the state WVSEOW work group
- ✦ Evaluate all program activites and consumer satisfaction and disseminate the results

Glossary of Terms

Affected by suicide—All those who may feel the impact of suicidal behaviors, including those bereaved by suicide, as well as community members and others.

Best practices—Activities or programs that are in keeping with the best available evidence regarding what is effective.

Community—A group of individuals residing in the same locality or sharing a common interest.

Culturally appropriate—A set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures, including the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Culture—The integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith, or social group.

Deliberate self-harm—See suicidal self-directed violence.

Evidence-based programs—Programs that have undergone scientific evaluation and have proven to be effective.

Goal—A broad and high-level statement of general purpose to guide planning on an issue; it focuses on the end result of the work.

Health—The complete state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

Health Care - The care that an individual receives for physical, mental, and social wellbeing.

Intervention—A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorders, educating providers about suicide prevention, or reducing access to lethal means among individuals with suicide risk).

Lesbian, gay, bisexual, or transgender—A blanket term that refers to those who identify as lesbian, gay, bisexual, or transgender.

Means—The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs).

Means restriction—Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Outcome—A measurable change in the health of an individual or group of individuals that is attributable to an intervention.

Postvention—Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.

Prevention—A strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors.

Protective factors—Factors that make it less likely that individuals will develop a disorder. Protective factors may encompass biological, psychological, or social factors in the individual, family, and environment.

Rate—The number per unit of the population with a particular characteristic, for a given unit of time.

Resilience—Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors—Factors that make it more likely that individuals will develop a disorder. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment.

Self-directed violence (same as self-injurious behavior)—Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-directed violence can be categorized as either nonsuicidal or suicidal.

Stakeholders—Entities including organizations, groups, and individuals that are affected by and contribute to decisions, consultations, and policies.

Suicidal behaviors—Behaviors related to suicide, including preparatory acts, as well as suicide attempts and deaths.

Suicidal self-directed violence—Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.

Suicidal ideation—Thoughts of engaging in suicide-related behavior.

Suicidal intent . —There is evidence (explicit and/or implicit) that at the time of injury the individual intended to kill him or herself or wished to die and that the individual understood the probable consequences of his or her actions.

Suicidal plan—A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt; often including an organized manner of engaging in suicidal behavior such as a description of a time frame and method.

Suicide—Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Suicide attempt—A nonfatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicide crisis—A suicide crisis, suicidal crisis, or potential suicide, is a situation in which a person is attempting to kill him or herself or is seriously contemplating or planning to do so. It is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment.

Suicide attempt survivors—Individuals who have survived a prior suicide attempt.

Suicide loss survivors—See bereaved by suicide.

Achieving the Goals of the Plan

This plan has four goals and nine objectives. It includes strategies and activities which are designed to accomplish the goals and objectives. It is a five year plan – expected to be completed or modified by 2011.

Specific timelines for objectives and activities are not listed in this plan. It is expected that major responsibility and accountability to achieve the plan will be given to the West Virginia Council for the Prevention of Suicide when it is approved by the West Virginia Department of Health and Human Resources.

The grid on the following pages is provided for use by the Council in developing a work plan.

Goals and objectives are re-stated in each of one of four categories: Infrastructure, Awareness, Implementation, and Methodology. Activities planned for each of the objectives are then listed. To the right of the activities are possible dates (year) for completion. The work plan to be developed will establish target dates for completion of each activity and could be “continuous” or a specific date.

The final column is headed “Effort Required” and is an important item to consider for achieving the plan. “Effort” will consider the resources needed – human resources, funding, physical or technical resources, and activity or project management requirements.

This Achievement Plan or Work Plan should be completed by the Council within three months of the plan’s acceptance by the Department of Health and Human Resources.

INFRASTRUCTURE

Goal: Develop broad-based support for suicide prevention among health care providers.

Objective: By 2015, health care providers will adopt best practices and interventions across the continuum of suicide prevention

ACTIVITY	2011	2012	2013	2014	2015	EFFORT
The Board of Directors of the West Virginia Council for the Prevention of Suicide will work with the executive directors and chairs of other health care organizations to develop a strategy to encourage inclusion of suicide prevention agency plans.						

Goal: WVCPS will establish a foundation for the purpose of furthering and sustaining operational goals of the organization						
Objective: By 2014, the Fundraising Committee of the WVCPS Board of Directors will develop a fundraising strategy.						
ACTIVITY	2011	2012	2013	2014	2015	EFFORT
The Fundraising Committee of the WVCPS will meet on a regular basis.						
Members of the WVCPS board of directors will receive training fundraising.						
Committee members will assist with development of community activities.						
Committee will engage the support of organizations and search for corporate sponsors.						
The Committee will coordinate at least one fundraising event every year.						

Goal: Develop a support network for individuals who have been affected by a death of suicide						
Objective: Efforts to improve services to individuals who have been affected by the death of a loved one due to a suicide will be implemented by 2011.						
ACTIVITY	2011	2012	2013	2014	2015	EFFORT
Develop and implement a training program on appropriately supporting survivors of suicide loss for first responder and health care providers.						
Utilize a train the trainers curriculum for facilitators of support groups for individuals affected by the death of a loved one due to suicide.						

Objective: By 2014, The WVCPS will establish regional suicide prevention coalitions in six regions as identified by the Governor's Substance Abuse Task Force.

ACTIVITY	2011	2012	2013	2014	2015	EFFORT
The WVCPS will indentify current public and private infrastructure to collaborate in coalitions						
The WVCPS will develop MOU detailing reponsibilities of WVCPS and the regional coalition						

AWARENESS

Goal: Enhance recognition and referral of at risk individuals

Objective: By 2015, the WVCPS will work with pre-existing public and private infrastructure in order to develop formal partnerships to incorporate suicide prevention activities

ACTIVITY	2011	2012	2013	2014	2015	EFFORT
The Marketing and Awareness Committee of the Council will meet to prioritize a strategy of engagement to include: partners, mission and vision, key responsibilities of partners, and memorandums of understanding.						

Objective: By 2015, the WVCPS will act as a clearing house for suicide prevention information, education in suicide assessment, and identification and promotion of protective factors for all WV ***health care providers***

ACTIVITY	2011	2012	2013	2014	2015	EFFORT
The Council will provide a link to evidence based practice, programs, and interventions as well as best practices for suicide prevention.						
The council will maintain a website for suicide prevention information.						

Objective: By 2013, a campaign to increase efforts to reduce access to lethal means and methods of self-harm among people who have been assessed as at risk for suicide will be developed and implemented.

ACTIVITY	2011	2012	2013	2014	2015	EFFORT
Develop and disseminate information to providers, communities, and individuals at risk regarding use of assessments, and statistics regarding use of medications and suicide risk.						
Collaborate with the Department of Natural Resources and / or other entities to develop and implement a public education campaign concerning safely storing and securing firearms.						
Encourage health care and behavioral health professionals to counsel families and friends about preventing access to means of suicide for persons who have attempted suicide.						

IMPLEMENTATION

Goal: Promote evidence based practices, programs, and interventions as well as best practices for suicide prevention.

Objective: By2015, the WVCPS will disseminate and provide technical assistance for suicide prevention practices, programs, and interventions.

ACTIVITY	2011	2012	2013	2014	2015	EFFORT
The WVCPS will identify suicide prevention needs in the community, a specific programs that will meet those needs.						
The WVCPS will identify current resources in the community.						
The WVCPS will identify stakeholders and buy in from stake holders to implament evidence based practices, programs, and interventions.						
The WVCPS will provide consultation for the implamentation of evidence based						

practices, programs, and interventions.						
The WVCPS will provide monitoring and evaluation of evidence based practices, programs, and interventions that are implamented.						
The WVCPS will provide monitoring of ouctomes of evidence based practices, programs and interventions that are implamented.						

Goal: Provide for the enhanced follow-services for deliberate self-harm individuals						
Objective: By 2015, the WVCPS will improve access to services for identified individuals receiving services from hospital emergency departments and / or primary care clinics following a suicide attempt.						
ACTIVITY	2011	2012	2013	2014	2015	EFFORT
The WVCPS will Disseminate best-practice materials to EDs throughout the state						
Advocate for Reinforced follow-up arrangements for deliberate self-harm emergency department admissions as they are identified and responded to through existing crisis response services in providing for additional education resources and recommendation of						

enhance follow-up care.						
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METHODOLOGY						
Goal: Improve the current data collect and results information system						
Objective: Meet with evaluation staff to develop a system and process regarding data to be collected						
ACTIVITY						EFFORT
Collect and allalyze WV county, states, and national comparable data to inform planning						

Publicly disseminate results through web-based efforts						
Participate in the state WVSEOW work group						
Evaluate all program activities and consumer satisfaction and disseminate the results						

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

T. Use of Technology

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

What strategies the state has deployed to support recovery in ways that leverage ICT? Each of West Virginia's thirteen (13) comprehensive behavioral health providers have on site closed-circuit, HIPPA compliant, video conferencing equipment that is used regularly for internal and external meetings/trainings, as well as for some evaluation and treatment services, such as expert testimony at involuntary commitment proceedings and medication assisted treatment (MAT) services. All West Virginia behavioral health providers also use traditional telehealth mechanisms, such as automated, telephone messaging and appointment reminder, follow-up, and/or scheduling programs with consumers receiving services and supports.

West Virginia was recently awarded a Health Information Technology (HIT) grant through First Choice, a WVBBHF-funded organization, to develop and implement telehealth strategies using a smartphone application, website, and other web-based support initiatives for people in early recovery from substance use disorders. Eight (8) community behavioral health providers and college universities have been identified to partner with First Choice to pilot this project. An additional SAMHSA-funded discretionary project, called Appalachian Technology Assisted Recovery Innovations (ATARI), was awarded to WV to assist individuals in recovery via using technology to provide aftercare interventions.

The BBHFH uses video to capture "faces of hope" to interview individuals in recovery. The personal stories are captured in coordination with facilitated questions to map the journeys of people who have experienced behavioral health problems and want to share their successes.

What specific application of ICTs the State BG Plans to promote over the next two years?

The same strategies as initiated above will be promoted but expanded to statewide usage. The State also hopes to pilot additional screening kiosks, particularly by training and placing Peer Health Integrators at Wellness Recovery centers, primary care centers and behavioral health care centers to prepare peers for expanded access to insurance coverage brought about by the ACA/healthcare reform, with an emphasis on returning veteran and adolescent populations, using a combination of approaches such as Dr. Pat Deegan's Common Ground computerized decision support tool, SBIRT, Whole Health Action Management (WHAM) and Community Health Education Resource Person (CHERP) training. The Office of Community Affairs and Consumer Outreach will explore a web-based consumer portal for assessing program effectiveness.

What incentives the state is planning to put in place to encourage their use? On-going professional development to make certification more affordable and available will be provided through web-based offerings. In addition, State communication becomes more efficient with staff and providers. All applications for funding, technical assistance, reporting and fiscal

management is web-based and required. Since July 2012, all West Virginia medical prescribers must report to the PDMP system within 24 hours.

What support system the State BG Plans to provide to encourage their use? Two BBHMF team members were recently trained by the National Frontier and Rural Addictions Technology and Transfer Center (NFAR-ATTC) on Telehealth Technologies: Training of Trainers and they will be presenting lessons learned to the West Virginia Behavioral Health Providers Association, as well as to a broader group of interested parties during the State's upcoming Integrated Behavioral Health Conference in September 2013.

Whether there are barriers to implementing these strategies and how the State BG Plans to address them? Provide customized technical assistance on an as needed/requested basis.

How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine? The State currently provides SBIRT services in 38 FQHC's. Webinars have been created in coordination with hospitals and the West Virginia Nurses Association for the provision of drug diversion training mandated for prescribers in an effort to improve safe prescribing practices. West Virginia was awarded the PDMP EHR grant in 2012 and is successfully partnering across the state to ensure interoperability with prescription drug monitoring systems nationally. The State has also developed relationships with major drug store chains and emergency rooms in order to connect electronic health records with the PDMP system.

How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and what measures and data collection the state will promote to evaluate use and effectiveness of such ICTs? The State measures usage of its web-site and collects the number of web-based trainings and resources disseminated to programs. Referrals are also tracked through support lines. The State will also begin tracking program specific treatment services provided through Medicaid approved telehealth.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

IV: Narrative Plan

U. Technical Assistance Needs

The Bureau for Behavioral Health and Health Facilities (BBHFF) identified two areas for Technical Assistance: 1) trauma informed care for all populations and 2) child and adolescent behavioral health system improvements necessary to reduce reliance on residential services. Although exact prevalence estimates vary, there is a consensus in the field that most consumers of substance abuse and mental health services are trauma survivors and that their trauma experiences help shape their responses to outreach and services. Individuals with intellectual or developmental disabilities endure the trauma of isolation and devaluation, in addition to experiencing abuse and neglect at a rate at least four times that experienced by the general population. Yet the symptoms of trauma are not universally recognized or acknowledged within the behavioral health service delivery system. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

SAMHSA's National Center for Trauma-Informed Care (NCTIC) facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, developmental disabilities, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"

In June, 2013, the BBHFF initiated a technical assistance partnership with the NCTIC. Consultants from the NCTIC conducted an initial site visit to West Virginia on July 26, meeting with the BBHFF staff, members of leaders of the West Virginia Behavioral Healthcare Providers Association, and the Governor's Advisory Council on Substance Abuse. The goal of the meetings was to engage these key decision makers about the value of creating trauma informed systems of care and to generating technical assistance needs and priority training areas to be addressed during the next 12 – 18 months.

West Virginia is committed to improving outcomes for youth with behavioral health challenges (substance abuse, mental health, and intellectual/developmental disabilities), many of whom are currently served through the child welfare system. The BBHFF recognizes that the lack of quality community based behavioral health services is a significant contributor to the number of children and adolescents in state and parental custody living in out of home care, both in and outside of West Virginia. In March 2013, the BBHFF initiated a technical assistance partnership with the Annie E. Casey Foundation to assist West Virginia in reviewing existing policies and practices; service array and capacity building at the state, community and provider level; and financing and performance management outcomes in an effort to develop effective strategies for reducing reliance on institutional settings, or "congregate care."

The BBHFF continues to work collaboratively with the Bureau for Children and Families (BCF) on a daily basis, co-funding services and supports to increase access and expand service capacity for children and adolescents and their families. The two Bureaus collaborated in the planning of this technical assistance initiative and will continue to join forces throughout the entire process. The Annie E. Casey Foundation's Child Welfare Strategy Group found that helping public systems reduce reliance on congregate care for children in state custody is the most significant first step in addressing larger systems reform, including access to quality care in the community.

In April 2013, the BBHFF and BCF provided information to the Annie E. Casey Foundation about the number and demographics of youth served in out-of-home/state care as well as strengths and challenges related to West Virginia's child and adolescent service system. Two consultants from the Foundation conducted an initial site visit to West Virginia on April 16 and met with the BBHFF leadership team, to discuss the information as well as gain a better understanding of the technical assistance opportunities that could be provided by the Foundation.

A team of Annie E. Casey consultants conducted a second technical assistance site visit to West Virginia on August 6-7, to interview high level leadership personnel from the West Virginia Department of Health and Human Resources. The BBHFF is currently scheduling additional technical assistance site visits with numerous public and private agencies across child-serving systems so Foundation consultants gain as comprehensive a view as possible about West Virginia.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

⁴⁵ SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

V. Support of State Partners

West Virginia has a long history of forging strong partnerships and will continue to cultivate strategic collaborations with both public and private partners. This effort is essential to providing and sustaining services to address individual community needs. Cooperation between state and local agencies will prove necessary to maximize, leverage and coordinate financial resources. The West Virginia State Epidemiological Outcomes Workgroup (WVSEOW) includes membership from all of the suggested State Partners referenced in the Block Grant Guidance. Additionally, Governor Earl Ray Tomblin issued Executive Order No. 5-11 on September 6, 2011, which created the Governor's Advisory Council on Substance Abuse (GACSA). Appointed Council members include Cabinet level positions in the Department of Health and Human Resources, Department of Military Affairs and Public Safety, and the Department of Veterans Assistance; persons in leadership positions representing the State Police, Chiefs of Police, Sheriffs, West Virginia Supreme Court of Appeals, Department of Education, WorkForce West Virginia, Behavioral Health and Health Facilities (BBHFF); and experts from the fields of behavioral medicine, substance abuse prevention and treatment, peer and recovery supports, the faith-based and minority communities, homelessness, domestic violence prevention, and a range of health professionals, among others.

The executive order outlines the Council's duties to: provide guidance regarding implementation of the Statewide Substance Abuse Strategic Action Plan; identify planning opportunities with other interrelated systems to increase both public and private support concerning substance abuse initiatives; recommend a list of priorities for the improvement of the substance abuse continuum of care; receive input from local communities throughout West Virginia; and, provide recommendations to the Governor to improve education, data needs, employment opportunities, communication, crime prevention, and other matters related to substance abuse.

Current Partnership Focus

The Bureau for Medical Services (BMS) provided the GACSA with education on Medicaid expansion as it relates to behavioral health consumers at its recent meeting. The GACSA continues to support recommendations for SBIRT and Recovery Support Services to become covered services.

BBHFF continues to work with the Bureau for Medical Services (BMS) and the Office of Health Facility Licensure and Certification (OHFLAC) in providing coordinated oversight for public and private programs that provide medication assisted treatment. In West Virginia, BMS approved State Medicaid reimbursement for Suboxone treatment effective January 2006. Vivitrol, a time released injection of Naltrexone, received State Medicaid reimbursement approval in early

2011. In August 2011, the BMS issued a new Subutex /Suboxone /Vivitrol Policy that mandates adequate therapy services, strict documentation requirements, drug screening requirements and treatment guidelines. Legislation providing increased coordination and oversight and further regulation of Opioid Treatment Programs (OTP) will become effective October 2013.

Justice- West Virginia participated in a bipartisan and inter-governmental effort to reduce prison growth and prevent crime using a data-driven "justice reinvestment" approach. A comprehensive analysis of the criminal justice system was conducted by establishment of a working group of legislative leaders from across the political spectrum, top court officials, state agency directors, and criminal justice stakeholders to review trends in the state's criminal justice system and develop policy options. The approach resulted in the passage of SB371, the Governor's Prison Overcrowding bill, during the 2013 legislative session. The BBHFF participates at multiple levels within this initiative and has provides technical clinical support and program advisement.

Education-The BBHFF has partnered with Public Health to fund coordinated school health positions who will work collaboratively with regional prevention specialists to bridge school and community based services promoting wellness. Additional support has been provided to further develop a multi-domain, single state survey that began to be implemented during the past school year. School based mental health services are funded over multiple sites statewide in partnership with the Children's Mental Health Division. After eighteen years as a statewide initiative, it is widely accepted that School-Based Health Centers (SBHCs) provide easily accessible and cost-effective care and are strongly supported by students, parents, and school staff. The goal of the statewide initiative is to ensure primary and preventive care for youth by eliminating access barriers that children and adolescents face. Beginning August 21, 2013, there will be 89 SBHCs serving 106 schools in 32 counties, making health services available to a school-aged population of over 54,000 children. SBHCs are health clinics that bring preventive and immediate care, as well as counseling, health education, and sometimes dental care, to children and adolescents where they are much of the day – at school. Approximately one-third of the SBHCs provide behavioral health services and that number continues to increase.

Child Welfare- West Virginia is committed to improving outcomes for youth with behavioral health challenges (substance abuse, mental health, and intellectual/developmental disabilities), many of whom are currently served through the child welfare system. West Virginia recognizes that the lack of quality community based behavioral health services is a significant contributor to the number of children and adolescents in both state and parental custody living in out of home care, both in-state and outside of West Virginia. In April 2013, the BBHFF, in coordination with the Bureau for Children and Families, initiated a technical assistance partnership with the Annie E. Casey Foundation to assist the State in reviewing existing policies

and practices, the service array, and financing and performance management outcomes in order to develop strategies for reducing reliance on institutional settings or “congregate care.” The Annie E. Casey Foundation’s Child Welfare Strategy Group has found that helping public systems reduce reliance on institutional settings, or “congregate care,” for children in state custody is the most significant first step they can take in addressing larger systems reform, including access to quality care in the community.

Public Health-The Bureau for Public Health, a sister bureau located within the Department of Health and Human Resources, participates on both the GACSA and the WVSEOW, working closely with the BBHFF Resource and Research Team in the development of the State Profile. The BBHFF participates on the HIV/Infectious Disease workgroup in order to collaborate on educational opportunities that may be useful in supporting community based behavioral health providers. The SBIRT coordinator works in concert with primary care health providers and associations under the auspices of Public Health. Finally, the BBHFF maintains an on-going partnership with Public Health related to Synar compliance and tobacco prevention efforts.

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

W. State Behavioral Health Advisory Council

The Bureau for Behavioral Health and Health Facilities continues to use Mental Health Block Grant to support the operational expenses of the West Virginia Mental Health Planning Council (WVMHPC). The WVMHPC maintains at least 51% consumer membership and provides input and recommendations to the BBHF on issues facing consumers with mental health problems. The WVMHPC is comprised of consumers, families, and representatives of mental health and substance abuse providers, and key state entities including the West Virginia Department of Education, West Virginia Behavioral Health Provider Association, West Virginia Coalition to End Homelessness, the West Virginia Council for the Prevention of Suicide, Department of Juvenile Service, Department of Corrections, Bureau for Medical Services, Bureau for Children and Families, West Virginia Housing Development Authority and the Department of Rehabilitation Services. The mission of the WVMHPC is to improve the mental health service system and function as a catalyst for change. The Council is federally mandated to review and comment on the State mental health plan, monitor, review, and evaluate allocation and adequacy of mental health block grant services, and advocate for services for individuals with mental illness and co-occurring substance abuse issues.

Governor Earl Ray Tomblin issued Executive Order No. 5-11 on September 6, 2011, which created the **Governor's Advisory Council on Substance Abuse (GACSA)**. Appointed council members include Cabinet level positions in the Department of Health and Human Resources, Department of Military Affairs and Public Safety, and the Department of Veterans Assistance; persons in leadership positions representing the State Police, Chiefs of Police, Sheriffs, Supreme Court, Education, WorkForce West Virginia, Behavioral Health and Health Facilities; experts from the fields of behavioral medicine, substance abuse prevention and treatment, peer and recovery supports, the faith-based and minority communities, homelessness, domestic violence prevention; and, a range of health professionals, among others. Responsibilities of the GACSA include: provide guidance regarding implementation of the Statewide Substance Abuse Strategic Action Plan; identify planning opportunities with other interrelated systems to increase both public and private support concerning substance abuse initiatives; recommend a list of priorities for the improvement of the substance abuse continuum of care; receive input from local communities throughout West Virginia; and, provide recommendations to the Governor to improve education, data needs, employment opportunities, communication, crime prevention, and other matters related to substance abuse.

There is on-going communication and regularly scheduled meetings between the Bureau for Behavioral Health and Health Facilities and the WVMHPC and the GACSA in determining need, addressing gaps in services and promoting quality outcomes for behavioral health. All planning bodies and key stakeholders have reviewed and provided comment on the Combined

Substance Abuse and Mental Health Block Grant Plan. The Bureau continues to support the coordination of efforts among the West Virginia Comprehensive Behavioral Health Commission, the Governor's Advisory Council on Substance Abuse, the Governor's Regional Task Forces and the Mental Health Planning Council in order to support an integrated culturally diverse advisement structure.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Bob McConnell	Family Members of Individuals in Recovery (to include family members of adults with SMI)		357 View Point Lane Wheeling, WV 26003 PH: 304-281-7898	tdototh@msn.com
Phil Reed	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Rt. 7 Box 480 Fairmont, WV 26554 PH: 304-363-5205	kitcatwv@yahoo.com
Margaret Taylor	Providers		1114 Quarrier Street Charleston, WV 25301 PH: 304-340-3553	mtaylor@ywcacharleston.org
Bob Musick	Providers		256 Normandy Street Morgantown, WV 26505 PH: 304-296-1731	bmusik@valleyhealthcare.org
Ardella Cottrill	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1709 Clay Avenue Fairmont, WV 26554 PH: 304-376-4835	rdellanjr@yahoo.com
Cathy Reed	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Rt 7 Box 480 Fairmont, WV 26554 PH: 304-363-5205	kitcaatwv@yahoo.com
Joe Cunningham	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		713 Bigley Avenue Charleston, WV 25302 PH: 304-982-6217	joec@wvmhca.org
Linda Pauley	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1449 Childress Road Alum Creek, WV 25003 PH: 304-756-3734	linda-pauley@yahoo.com
Lori Byhanna	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1375 Girty's Point Road Wheeling, WV 26003 PH: 304-336-7026	thebyhannas@hotmail.com
Patrick Tenney	Family Members of Individuals in Recovery (to include family members of adults with SMI)		301 Scott Avenue Morgantown, WV 26505 PH: 304-282-1278	ptenney@valleyhealthcare.org
Earnie Jarrell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PH: 304-573-8293	ErnieMK317@aol.com
David Sanders	State Employees		1400 Virginia Street East Charleston, WV 25301 PH: 304-277-8260	iamtheevidence@gmail.com
Nancy Deming	Providers		15 Tiger Trail Fairmont, WV 26554 PH: 304-363-6844	ndeming@valleyhealthcare.org
Angie Ferrari	Family Members of Individuals in Recovery (to include family members of adults with SMI)		212 P Woodland Drive Nitro, WV 25143 PH: 304-377-9491	AFFerrari@apshealthcare.com

Nancy Schmitt	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3723 Winchester Avenue Martinsburg, WV 25405 PH: 304-676-8053	nshmitt52@gmail.com
J.K. McAtee	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		30 Cleveland Avenue Buckhannon, WV 26201 PH: 304-439-4605	peersupportsinwv@live.com
Ted Johnson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		2105 Superior Avenue South Charleston, WV 25303 PH: 304-552-3819	JonnelTJJ@aol.com
Pete Minter	Others (Not State employees or providers)	Housing	814 Virginia Street Charleston, WV 25301 PH: 304-345-6475	bobcary@wvhdf.com
Carla Cleek	State Employees	Vocational Rehabilitation	State Capitol, PO Box 50890 Charleston, WV 25305	Carla.B.Cleek@wv.gov
Cynthia Parsons	State Employees	Medicaid	350 Capitol Street, Room 251 Charleston, WV 25301 PH: 304-558-5962	Cynthia.A.Parsons@wv.gov
Debi Gillespie	State Employees	Criminal Justice	1200 Quarrier Street Charleston, WV 25301 PH: 304-558-9800	Debi.D.Gillespie@wv.gov
Susie Wilson	State Employees	Bureau for Behavioral Health and Health Facilities	350 Capitol Street, Room 350 Charleston, WV 25301	sisie.dm.wilson@wv.gov
Jennifer Ballard	State Employees		Charleston, WV 25311	Jennifer.M.Ballard@wv.gov
Merrit Moore	State Employees	Bureau for Behavioral Health and Health Facilities	350 Capitol Street, Room 350 Charleston, WV 25301	Merritt.E.Moore@wv.gov
Jane McCallister	State Employees	Social Services	350 Capitol Street, Room 691 Charleston, WV 25301	Jane.B.Mccallister@wv.gov
Jackie Payne	State Employees	Bureau for Behavioral Health and Health Facilities	350 Capitol Street, Room 350 Charleston, WV 25301 PH: 304-356-4785	jackie.f.payne@wv.gov
James Ruckle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		521 Jacob Street, Apartment 601 Charleston, WV 25301 PH: 304-542-6717	
Joyce Floyd	Family Members of Individuals in Recovery (to include family members of adults with SMI)		302 Nathan Street, Apartment 29 Elkins, WV 26241 PH: 304-637-0903	
Bill Marrs	Providers	Westbrook Health Systems	2121 7th Street Parkersburg, WV 26101 PH: 304-485-1721	
Heather Hoelscher Garcia	Others (Not State employees or providers)	Legal Aid of WV - Child Advocacy	P.O. Box 1082 Parkersburg, WV PH: 304-276-8687	

Daniel Lashley	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	91 Tavarn Road Apt. 206 Martinsburg, WV PH: 304-886-7627	Bryce365@gmail.com
Susan Kraber	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	214 East New Street, 201-6 Shepherdstown, WV 25443 PH: 614-593-2229	susankraber@gmail.com
Jessica Volz	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	357 View Point Lane Wheeling, WV 26003 PH: 304-780-9684	jessicaavolz@gmail.com
Vanessa Vangilder	Providers	326 Dutch Road Charleston, WV 25302 PH: 304-421-0915	vkvangilder@aol.com
Mark Drennan	Providers	405 Capitol Stree, Suite 900 Charleston, WV 25301 PH: 304-343-0728	mark@wvbehavioralhealth.org

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	44	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	11	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	7	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	<input type="text" value="6"/>	
Others (Not State employees or providers)	2	
Total Individuals in Recovery, Family Members & Others	26	59.09%
State Employees	9	
Providers	6	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="3"/>	
Total State Employees & Providers	18	40.91%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="6"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Representatives of the Planning Council, along with other state and community groups actively reviewed the Combined SA/MH Block Grant Plan. The Planning Council offered suggestions but did not make any recommendations to modify the application.

Footnotes:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

X. Enrollment and Provider Business Practices, Including Billing Systems

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into The state should indicate how it intends to utilize the three percent to taking into account the identified needs, including:

West Virginia will set-aside 3% of SABG and MHBG grant funds to improve the State's capacity to support enrollment for health insurance for eligible individuals served in the public mental and substance use disorder service system. The State hopes to facilitate enrollment of people with behavioral health issues and positively impact business practices across systems, both at the state and community levels.

- Partner with community providers, inter-agency staff and other agency partners, such as criminal justice services and homeless service providers, to provide outreach and enrollment eligibility training and support for individuals in need of behavioral health services.
- Support providers in their business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Ensure that the State's current design for implementation of practice management and accounts receivable systems are able to address billing, collection, risk management and compliance issues.
- Continue to partner with Bureau for Medical Services, APS Healthcare (the State's contract utilization management entity), the West Virginia health Policy Unit of the Insurance Commissioner's Office and the Office of Health Facilities, Licensure and Certification to coordinate efforts of benefits among multiple funding sources.
- Adopt health information technology that meets meaningful use standards.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

Y. Comment on the State BG Plan

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

The Bureau for Behavioral Health and Health Facilities provides on-going opportunities to solicit public input on the State's plan by: Facilitating State, Regional and County Town Hall Meetings in each region of the State; Listening Tours conducted by external consultants; and, feedback generated through the on-going dialogue between consumers and families and the Office of Consumer Affairs and Community Outreach. In addition, since September 2011, the Governor's Regional Task Forces have met 60 times in each region of the state in varied locations to ensure community voice is heard and local level priorities are made to the Governor's Advisory Council on Substance Abuse and then sent to the Governor. The Mental Health Planning Council meets quarterly and provides on-going communication with the BBHFF in sharing needs of mental health consumers families, providers, other state agencies and advocates. Priorities and recommendations from these particular groups help inform system development and improvements and are included within this year's Block Grant Plan.

A draft of this year's Block Grant Plan was made available to key stakeholders and advocates for quality behavioral health services for review and comment prior to submission that included: consumers, members of all advising bodies, education, WV Center for Excellence in Disabilities, Office of Consumer Affairs and Community Outreach and members of the WV BRSS TAC's Leadership Team. Additional opportunities will be afforded to the general public by posting on the BBHFF website.

August 26, 2013

Ms. Victoria L. Jones, Acting Commissioner
Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350
Charleston WV 25301

Dear Ms. Jones:

I am writing to express our support for the Bureau for Behavioral Health and Health Facilities' (BBHFF) combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for Federal Year 2014-2015. The BBHFF is exhibiting innovation and leadership by submitting a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The principles underlying BBHFF's integrated plan are nicely summarized by the Substance Abuse and Mental Health Services Administration (SAMHSA): Behavioral health is essential for health; prevention works; treatment is effective; and people recover from mental and substance use disorders.

West Virginia's priorities, goals and strategies in the combined Mental Health and Substance Abuse Prevention and Treatment Plan's Block Grant Programs are consistent with SAMHSA's vision to provide: a physically and emotionally healthy lifestyle (Health); a stable, safe and supportive place to live (Home); meaningful daily activities (Purpose); and relationships and social networks (Community). The BBHFF continues to demonstrate a commitment to ensuring that positive, meaningful opportunities are available for people with mental illness, chemical dependency, and intellectual/developmental disabilities.

The West Virginia Department of Education (WVDE) has a long history of working with the BBHFF. The WVDE and the BBHFF's Director of Child and Adolescent Mental Health co-chair the State Steering Team for the Expanded School Mental Health Initiative. The BBHFF provides funding support for and continues to be active members of the West Virginia Coordinated School Public Health Partnership. We intend to strengthen our collaborations and build upon the tremendous work of existing initiatives across systems to improve the behavioral health system in West Virginia.

The WVDE, Office of Healthy Schools, looks forward to continuing to partner with the BBHFF in serving the citizens of West Virginia. If you have any questions or need additional information, please feel free to contact me.

Sincerely,



Don Chapman
Office of Healthy Schools



STATE OF WEST VIRGINIA
DEPARTMENT OF MILITARY AFFAIRS & PUBLIC SAFETY
DIVISION OF CORRECTIONS



EARL RAY TOMBLIN
GOVERNOR

JIM RUBENSTEIN
COMMISSIONER

JOSEPH C. THORNTON
CABINET SECRETARY

OFFICE OF THE COMMISSIONER
1409 GREENBRIER STREET
CHARLESTON, WV 25311
(304) 558-2036 TELEPHONE - (304) 558-5934 FAX
August 26, 2013

Ms. Victoria L. Jones, Acting Commissioner
Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350
Charleston WV 25301

Dear Ms. Jones:

I am writing to express our support for the Bureau for Behavioral Health and Health Facilities' (BBHFF) combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for Federal Year 2014-2015. The BBHFF is exhibiting innovation and leadership by submitting a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The principles underlying BBHFF's integrated plan are nicely summarized by the Substance Abuse and Mental Health Services Administration (SAMHSA): Behavioral health is essential for health; prevention works; treatment is effective; and people recover from mental and substance use disorders.

West Virginia's priorities, goals and strategies in the combined Mental Health and Substance Abuse Prevention and Treatment Plan's Block Grant Programs are consistent with SAMHSA's vision to provide: a physically and emotionally healthy lifestyle (Health); a stable, safe and supportive place to live (Home); meaningful daily activities (Purpose); and relationships and social networks (Community). The BBHFF continues to demonstrate a commitment to ensuring that positive, meaningful opportunities are available for people with mental illness, chemical dependency, and intellectual/developmental disabilities. The BBHFF prioritizes support for individuals, families, and communities in assisting persons to achieve their potential and to gain greater control over their future direction.

The West Virginia Division of Corrections has a long history of working with the BBHFF. Our agency collaborates with the BBHFF State Epidemiological Outcomes Workgroup (SEOW), access to behavioral health services and a variety of activities related to the Governor's Regional Task Forces on Substance. We intend to strengthen our collaborations and build upon the tremendous work of existing cross system initiatives to improve the behavioral health system in West Virginia.

The West Virginia Division of Corrections looks forward to continuing to partner with the BBHFF in serving the citizens of West Virginia. If you have any questions or need additional information, please feel free to contact me.

Sincerely,

Jim Rubenstein, Commissioner



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH

Earl Ray Tomblin
Governor

Commissioner's Office
350 Capitol Street, Room 702
Charleston, West Virginia 25301-3712
Telephone: (304) 558-2971 Fax: (304) 558-1035

Karen L. Bowling
Cabinet Secretary

August 28, 2013

Ms. Victoria L. Jones, Acting Commissioner
Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350
Charleston WV 25301

Dear Ms. Jones:

I am writing to express our support for the Bureau for Behavioral Health and Health Facilities' (BBHFF) combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for Federal Year 2014-2015. The BBHFF is exhibiting innovation and leadership by submitting a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The principles underlying BBHFF's integrated plan are nicely summarized by the Substance Abuse and Mental Health Services Administration (SAMHSA): Behavioral health is essential for health; prevention works; treatment is effective; and people recover from mental and substance use disorders.

West Virginia's priorities, goals and strategies in the combined Mental Health and Substance Abuse Prevention and Treatment Plan's Block Grant Programs are consistent with SAMHSA's vision to provide: a physically and emotionally healthy lifestyle (Health); a stable, safe and supportive place to live (Home); meaningful daily activities (Purpose); and relationships and social networks (Community). The BBHFF continues to demonstrate a commitment to ensuring that positive, meaningful opportunities are available for people with mental illness, chemical dependency, and intellectual/developmental disabilities. The BBHFF prioritizes support for individuals, families, and communities in assisting persons to achieve their potential and to gain greater control over their future direction.

The Bureau of Public Health (BPH) has a long history of working with the BBHFF in a variety of areas targeted to improving physical and behavioral health of West Virginia residents. We intend to use the many opportunities presented by the Affordable Healthcare Act to strengthen our collaborations and build upon our existing cross system initiatives to improve the behavioral health system in West Virginia.

The Bureau of Public Health looks forward to continuing to partner with the BBHFF in serving the citizens of West Virginia. If you have any questions or need additional information, please feel free to contact me.

Sincerely,

A handwritten signature in blue ink, appearing to read "Marian L. Swinker".

Marian L. Swinker, M.D., M.P.H.
Commissioner



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Earl Ray Tomblin
Governor

350 Capitol Street, Room 251
Charleston, West Virginia 25301-7307
Telephone: (304) 558-1700 Fax: (304) 558-1451

Karen Bowling
Cabinet Secretary

August 22, 2013

Ms. Victoria L. Jones, Acting Commissioner
Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350
Charleston WV 25301

Dear Ms. Jones:

I am writing to express our support for the Bureau for Behavioral Health and Health Facilities' (BBHFF) combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for Federal Year 2014-2015. The BBHFF is exhibiting innovation and leadership by submitting a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The principles underlying BBHFF's integrated plan are nicely summarized by the Substance Abuse and Mental Health Services Administration (SAMHSA): Behavioral health is essential for health; prevention works; treatment is effective; and people recover from mental and substance use disorders.

West Virginia's priorities, goals and strategies in the combined Mental Health and Substance Abuse Prevention and Treatment Plan's Block Grant Programs are consistent with SAMHSA's vision to provide: a physically and emotionally healthy lifestyle (Health); a stable, safe and supportive place to live (Home); meaningful daily activities (Purpose); and relationships and social networks (Community). The BBHFF continues to demonstrate a commitment to ensuring that positive, meaningful opportunities are available for people with mental illness, chemical dependency, and intellectual/developmental disabilities. The BBHFF prioritizes support for individuals, families, and communities in assisting persons to achieve their potential and to gain greater control over their future direction.

The Bureau for Medical Services has a long history of working with the BBHFF. We intend to use the many opportunities presented by the Affordable Healthcare Act to strengthen our collaborations and build upon our existing cross system initiatives to improve the behavioral health system in West Virginia.

The Bureau for Medical Services looks forward to continuing to partner with the BBHFF in serving the citizens of West Virginia. If you have any questions or need additional information, please feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Nancy V. Atkins".

Nancy V. Atkins, RN, MSN, NP-BC
Commissioner

**STATE OF WEST VIRGINIA
DEPARTMENT OF MILITARY AFFAIRS & PUBLIC SAFETY
DIVISION OF JUVENILE SERVICES
STEPHANIE BOND, ACTING DIRECTOR**

**EARL RAY TOMBLIN
GOVERNOR**

**JOSEPH C. THORNTON
CABINET SECRETARY**

**OFFICE OF THE DIRECTOR
1200 QUARRIER STREET
CHARLESTON, WV 25301
TELEPHONE: (304) 558-9800 * FAX (304) 558-6032**

August 26, 2013

Ms. Victoria L. Jones, Acting Commissioner
Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350
Charleston WV 25301

Dear Ms. Jones:

I am writing to express our support for the Bureau for Behavioral Health and Health Facilities' (BBHFF) combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for Federal Year 2014-2015. The BBHFF is exhibiting innovation and leadership by submitting a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The principles underlying BBHFF's integrated plan are nicely summarized by the Substance Abuse and Mental Health Services Administration (SAMHSA): Behavioral health is essential for health; prevention works; treatment is effective; and people recover from mental and substance use disorders.

West Virginia's priorities, goals and strategies in the combined Mental Health and Substance Abuse Prevention and Treatment Plan's Block Grant Programs are consistent with SAMHSA's vision to provide: a physically and emotionally healthy lifestyle (Health); a stable, safe and supportive place to live (Home); meaningful daily activities (Purpose); and relationships and social networks (Community). The BBHFF continues to demonstrate a commitment to ensuring that positive, meaningful opportunities are available for people with mental illness, chemical dependency, and intellectual/developmental disabilities.

The Division of Juvenile Services (DJS) has a long history of working with the BBHFF. We have partnered in the realms of community-based care, treatment training and shared resources to better meet the complex needs facing adolescents in the juvenile service system. We intend to strengthen our collaborations and build upon the tremendous work of existing initiatives across systems to improve the behavioral health system in West Virginia.

The DJS looks forward to continuing to partner with the BBHFF in serving the citizens of West Virginia. If you have any questions or need additional information, please feel free to contact me.

Sincerely,



Denny Dodson
Deputy Director



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

Bureau for Children and Families
Commissioner's Office
350 Capitol Street, Room 730
Charleston, West Virginia 25301-3711
Telephone: (304) 558-0628 Fax: (304) 558-4194

Karen L. Bowling
Cabinet Secretary

August 28, 2013

Ms. Victoria L. Jones, Commissioner
Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350
Charleston WV 25301

Dear Ms. ^{Vickie}Jones:

I am writing to express our support for the Bureau for Behavioral Health and Health Facilities' (BBHFF) combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for Federal Year 2014-2015. The BBHFF is exhibiting innovation and leadership by submitting a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The principles underlying BBHFF's integrated plan are nicely summarized by the Substance Abuse and Mental Health Services Administration (SAMHSA): Behavioral health is essential for health; prevention works; treatment is effective; and people recover from mental and substance use disorders.

West Virginia's priorities, goals, and strategies in the combined Mental Health and Substance Abuse Prevention and Treatment Plan's Block Grant Programs are consistent with SAMHSA's vision to provide: a physically and emotionally healthy lifestyle (Health); a stable, safe, and supportive place to live (Home); meaningful daily activities (Purpose); and relationships and social networks (Community). The BBHFF continues to demonstrate a commitment to ensuring that positive, meaningful opportunities are available for people with mental illness, chemical dependency, and intellectual/developmental disabilities.

The Bureau for Children and Families (BCF) has a strong partnership with the BBHFF. We intend to use the many opportunities presented by the technical assistance from the Annie E. Casey Foundation initiated by the BBHFF in a collaborative effort to reduce reliance on congregate care for children and adolescents. The BCF is committed to continue its funding support for an effective system of care for children and adolescents with serious emotional disturbances and their families and build upon our existing cross system initiatives to improve the behavioral health system in West Virginia.

Ms. Victoria L. Jones, Commissioner
August 28, 2013
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The BCF looks forward to continuing to partner with the BBHFF in serving the citizens of West Virginia. If you have any questions or need additional information, please feel free to contact me.

Sincerely,



Susan C. Hage
Interim Commissioner

/sv



Offices of the Insurance Commissioner

Earl Ray Tomblin
Governor

Michael D. Riley
Insurance Commissioner

August 30, 2013

Ms. Victoria L. Jones, Commissioner
Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350
Charleston WV 25301

Dear Ms. Jones:

I am writing to express our support for the Bureau for Behavioral Health and Health Facilities' (BBHFF) Combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for Federal Year 2014-2015. It is my understanding that the BBHFF is exhibiting innovation and leadership by submitting a combined plan to address mental health and substance abuse prevention and treatment for children and adults.

It is my understanding that West Virginia's priorities, goals and strategies in the combined Mental Health and Substance Abuse Prevention and Treatment Plan's Block Grant Programs are consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA's) vision to provide: a physically and emotionally healthy lifestyle (Health); a stable, safe and supportive place to live (Home); meaningful daily activities (Purpose); and relationships and social networks (Community).

The Office of the Insurance Commissioner looks forward to the many opportunities presented by the Affordable Healthcare Act to strengthen our collaboration and build upon our existing cross system initiatives to improve the behavioral health system in West Virginia. If you have any questions or need additional information, please feel free to contact me.

Sincerely yours,

James Becker, M.D.
Medical Director
WV Offices of the Insurance Commissioner

JB/jz





PO Box 1095
Charleston, WV 25311

Ms. Vickie Jones, Acting Commissioner
Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350
Charleston, West Virginia 25301

August 28, 2013

Ms. Jones:

I am writing to offer the support of the West Virginia Mental Health Planning Council (WVMHPC) for the Bureau for Health and Health Facilities' (BBHFF) combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant application for the federal fiscal year of 2014 – 2015. BBHFF undertook submitting a combined grant proposal for the last fiscal period, exhibiting its strong belief that good behavioral health is essential for the total wellbeing of a person and that mental health and substance abuse treatment works and people can and do recover.

Representatives of the Planning Council along with other state and community groups actively reviewed and offered suggestions on this grant proposal. BBHFF is always open to the concerns of the community and invites participation in all phases of service planning. This past year members of the Planning Council participated in stakeholder meetings, community forums, and focus groups on subjects related to both fields.

The Bureau's reorganization has brought together all forms of disabilities to help remove the silos that many times limit the care given to a person. They have also added a very proficient data division to the team so that achievements and needs can readily be assessed. BBHFF is also working to bring behavioral health into primary care settings, so that more of our citizens will have access to treatment no matter where they might live. To show its desire to work toward a holistic approach of healthcare, it is holding the first statewide Behavioral Health Conference this year.

The Council looks forward to working with the Bureau on its present projects and new programs in the future. We believe that the Bureau has the ability to move behavioral health care forward to achieve progressive and positive changes in providing a full spectrum of care for the citizens of our state.

We are at present seeking new members from all of the six new regions designated by the State to insure that all communities are represented and have a voice in recommending upgrades to services in their areas. The Council also has seats for six members from the substance abuse sector and our current strategic plan mirrors many of the changes that the Bureau is working toward. Our members are ready to work side by side with BBHFF to bring recovery to our communities.

Respectfully,

A handwritten signature in black ink that reads "Linda Pauley". The signature is written in a cursive, flowing style.

Linda Pauley, Chair