

I: State Information

State Information

Plan Year

Start Year:

2012

End Year:

2013

State SAPT DUNS Number

Number

618137715

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

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

7/1/2010

To

6/30/2011

IV. Date Submitted

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

Submission Date

Revision Date

11/16/2011 11:33:44 AM

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

Assurances - 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="Michael J. Lewis, M.D., Ph.D."/>
Title	<input type="text" value="Secretary"/>
Organization	<input type="text" value="WV 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 (f) 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	Michael J. Lewis, M.D., Ph.D.
Title	Secretary
Organization	WV Department of Health and Human Resources

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [SAPT]

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

- I. FORMULA GRANTS TO STATES, SECTION 1921
- II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922
- III. INTRAVENOUS DRUG ABUSE, SECTION 1923
- IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924
- V. Group Homes for Recovering Substance Abusers, Section 1925
- VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926
- VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927
- VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928
- IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929
- X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930
- XI. Restrictions on Expenditure of Grant, Section 1931
- XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932
- XIII. Opportunity for Public Comment on State Plans, Section 1941
- XIV. Requirement of Reports and Audits by States, Section 1942
- XV. ADDITIONAL REQUIREMENTS, SECTION 1943
- XVI. Prohibitions Regarding Receipt of Funds, Section 1946
- XVII. Nondiscrimination, Section 1947
- XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that West Virginia will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as 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	<input type="text" value="Michael J. Lewis, M.D., Ph.D."/>
Title	<input type="text" value="Secretary"/>
Organization	<input type="text" value="WV Department of Health and Human Resources"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [CMHS]

Community Mental Health Services Block Grant Funding Agreements FISCAL YEAR 2012

I hereby certify that West Virginia agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

- (A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

- (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
- (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Michael J. Lewis, M.D., Ph.D.
Title	Secretary
Organization	WV Department of Health and Human Resources

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

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

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

Footnotes:

II: Planning Steps

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

Page 22 of the Application Guidance

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, intermediate 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, 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 as well as youth who are often underserved.

Footnotes:

State Information

West Virginia is the only state in the nation that falls completely within the federally designated Appalachian Region. According to the Appalachian Regional Commission, West Virginia was once highly dependent on mining, heavy industry and agriculture but is now becoming increasingly reliant on jobs in the service industry, retail and government.

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. To fully understand Appalachia, it is important to recognize the cultural diversity within the area. This culture is comprised of four distinctive groups of people: **1)** Descendants of the original pioneers who settled in the region during the westward movement. These people tend to be landowners, politicians, and business people. The characteristic traits of this group are self-reliance, independence, hard working, stable, and strong family ties. **2)** A second group is composed of the hard working coal miner, logger, or factory worker. The average worker has limited education, few skills, a large family, no wealth, and few choices of vocation. While, for example, coal mining continues to be the largest financial contributor to the economy of West Virginia, poverty in the coalfields remains a daily and depressing reality. **3)** The third group is the professional group. These are individuals and their families who have moved to Appalachia due to the profession (i.e. bankers, lawyers, teachers, ministers, etc.). Members of this group are usually not readily accepted by the Appalachians. **4)** The fourth group includes returning Appalachians. This group consists of individuals who grew up in the mountains, moved away for employment, and are now returning to Appalachia. Many of them find it difficult readjusting to the lifestyle they left as a teenager.

Geographically, the state is rural and remote. Families are often isolated from services typically provided in larger more populated areas. Compared with urban areas, rural residents have higher poverty rates, tend to be in poorer health, have fewer health resources and have more difficulty obtaining available services. Public transportation is practically non-existent throughout the State's rural areas. Accessing services may mean borrowing a car or depending on a family member or neighbor for transportation. Even the population centers in West Virginia are small in comparison with other states. The largest city in West Virginia is Charleston (population 51,400), which is home to the State Capitol. It is the only city in the State with a population that exceeds 50,000. The other most populated cities include Huntington (49,138), Parkersburg (31,492), Morgantown (29,660) and Wheeling (28,486) (*U.S. Census 2010*).

Socioeconomically, West Virginia is one of the most impoverished states in the United States. Median household income is 22% below that of the nation. Per capita income is 19% less than in the U.S. (*US Census Bureau, 2009 estimate*). Over 22% of families with children less than 18 years of age have an income below the poverty level compared to 16.6% for the U.S. Sixty-three percent of families with a female head of household (no husband present) with children less than 5 years of age have an income below the poverty level compared to 45.6% for the U.S. Over 14% of West Virginia's families access the Supplemental Nutrition Assistance Program (SNAP), compared to 10.3% in the U.S. (*U.S. Census, 2009*).

Race and Ethnicity: The composition of West Virginia's population reflects little ethnic diversity: 98.8% of the population is non-Hispanic; Caucasians account for 93.9% of the population; 3.4% of the population is African American; and 0.7% is Asian. Slightly more than one percent (1.3%) of the population is two or more races (*U.S. Census 2010*). Less than 3% of the population speaks a language other than English as their primary language compared to 20% with a primary language other than English in the nation (*U.S. Census 2009*).

Age and Gender: The median age of West Virginia's residents is 41.3 years. West Virginia has the second highest population of adults 65 and older at 20.3% of the 50 states and District of Columbia. Children and youth from birth to 21 years of age account for 25.1% of the population. Females represent 51% of the population (*U.S. Census 2010*).

Educationally, the U.S. Census Bureau reports 62% of adults in the Appalachian region have completed high school compared to the national average of 80.4%. Educational attainment beyond high school is over 10% less than that of the U.S., having a direct impact on socioeconomic wellbeing. West Virginia has an adult literacy rate of 86.6 % (*National Center for Education Statistics, 2003*). The National Institute for Literacy describes approximately 20% of West Virginia as low-level readers; defined as difficulty reading beyond a fourth grade level. Substance abuse, violence, and emotional disorders interfere with student learning. Students who are under the influence of alcohol or other drugs or battling emotional problems are not able to learn as well as students who devote their full attention to their education (*Howard Adelman and Linda Taylor, UCLA Center for Mental Health in Schools, 2003*).

Work Force: Only 54.7% of West Virginia's working-age residents are employed, ranking the State 50th in the nation's labor force participation (*Federal Bureau of Labor Statistics, 2009*). 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.

Values: West Virginians are known for being friendly, proud and helpful, but at the same time, they are realists. They know that the state's economy has been and still is one of the weakest in the nation, that incomes are low, and that their children will probably leave the State to find good-paying jobs. They often blame out-of-state business interests for these issues and complain that elected officials do little to curb the influence of out-of-state coal, timber, and natural gas firms. They have experienced widespread corruption of the public sector in years past, and question whether government is friend or foe (Barker, Bill. "A Study of West Virginia Values and Culture." Appalachian Regional Ministry, June 1, 2004).

Several authors have identified a pattern of values common to Appalachian people, and to West Virginians (*Barker, 2006; Jones, L. 1994*). Jones states that "all work in Appalachia must be based on the genuine needs as expressed by the mountain people themselves. Whatever work is done must be done with the recognition that Appalachian culture is real and functioning." The authors identify several key values: Strong Love of Tradition; Strong sense of Neighborliness and Hospitality; Love of the Home Place; Individualism Independence Self-Reliance, and Pride;

Humility and Modesty; Personalism; a Strong Sense of Solidarity; and Strong Religious Beliefs. West Virginians also have a strong sense of patriotism. In Vietnam, the national average for battle deaths was 58.9 for every 100,000 males in the 1970 Census, but for West Virginia it was 84.1. Today, residents of the State serve in all branches of the Armed Forces. The State has more members of the National Guard per capita than any other State.

II. Planning

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

Overview of the Behavioral Health System

The West Virginia Bureau for Behavioral Health and Health Facilities (BBHBF) is the State Authority for mental health, addictions, and intellectual and developmental disabilities. The BBHBF provides funding for community-based behavioral health services for persons with behavioral health needs who are either uninsured or underinsured. The BBHBF operates under the auspices of the West Virginia Department of Health and Human Resources (WVDHHR).

The WVDHHR is the State's umbrella agency for the BBHBF, Bureau of Public Health (BPH), Bureau for Medical Services (the State's Medicaid Authority - BMS), Bureau for Children and Families (Child Welfare - BCF), and Child Support Enforcement. The Department also includes other entities, such as the Deaf and Hard of Hearing, Human Rights, and Women's Commissions and several boards and councils, such as the Developmental Disabilities Council, the Health Care Authority, Office of Inspector General, Management Information Services, and the Board of Medicine.

BBHBF Mission

We ensure that positive, meaningful opportunities are available for persons with mental illness, chemical dependency, developmental disabilities and those at risk. We provide support for individuals, families, and communities in assisting persons to achieve their potential and to gain greater control over the direction of their future.

Vision

We envision a community that values and respects people and is responsive to their individual needs, wants and desires for the enrichment of their lives.

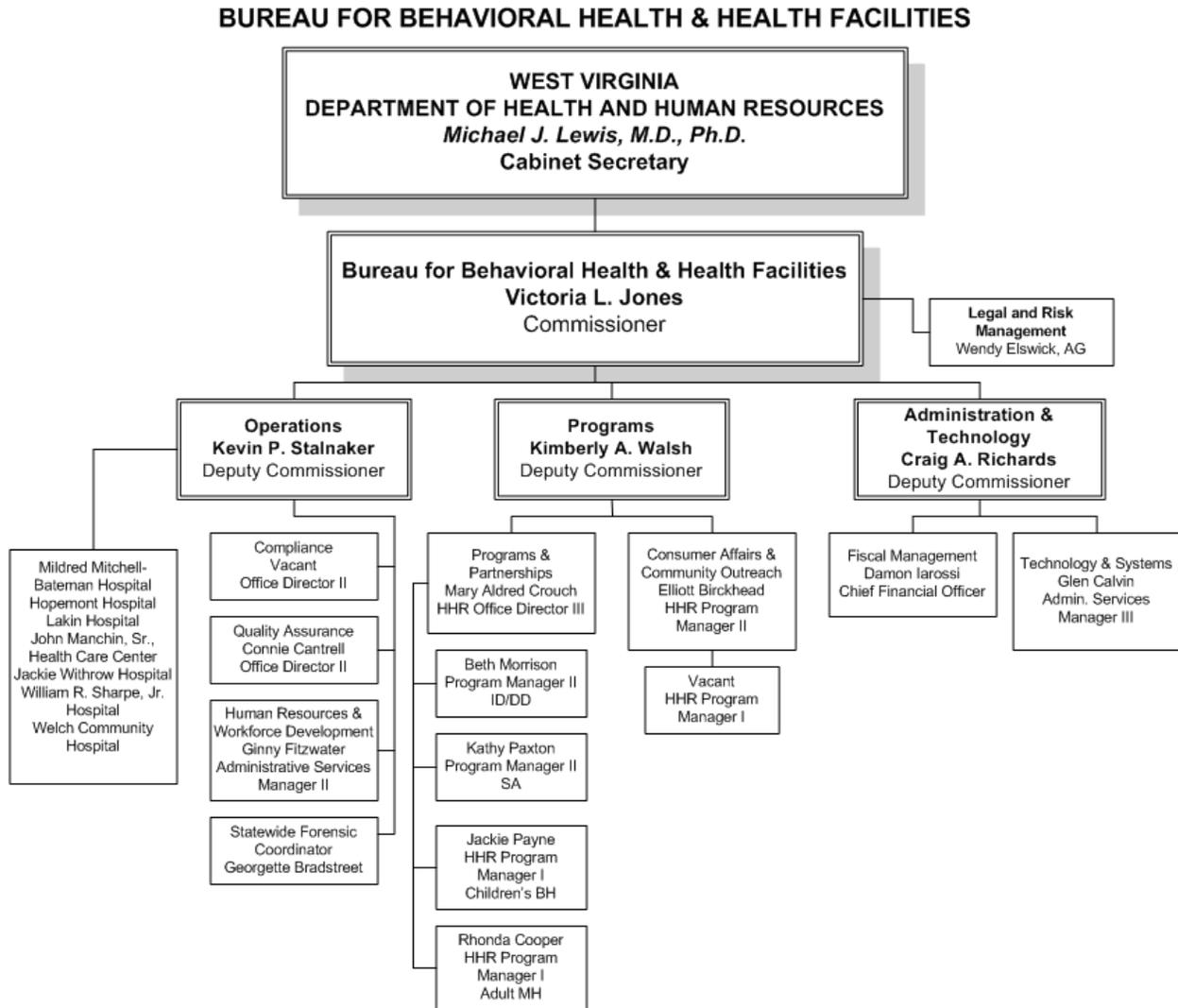
Values

We believe in integrity-based leadership that is flexible enough to respond to change that is guided by individuals, families, and communities.

Guiding Principles

- ✓ Quality in every aspect of the service system
- ✓ Collaborative, integrated and accessible services
- ✓ Culturally Competent and Consumer Driven Services without Fear of Prejudice and Discrimination
- ✓ Individualized community based services and supports meeting people where they are
- ✓ Transparent Evidence Based Practices, Programs and Policies
- ✓ Accountability through performance measures and outcomes

BBHBF Leadership includes a commissioner and three deputy commissioners who provide oversight for the interrelated sections of Operations, Programs, and Finance and Technology. The Operations Section provides oversight and coordination of planning, development, funding, and monitoring of State-operated psychiatric hospitals for adults, long-term care facilities, and an acute care facility. The Operations Section is also responsible for developing and implementing monitoring of community-based behavioral health services. The Programs and Policy Section provides oversight and coordination of planning, development, funding, and monitoring of community behavioral health services and supports. The Finance and Technology Section is responsible for fiscal management and technology and systems functions.



Organization within the Programs Section emphasizes function rather than disability. There are two new offices within the Programs Section.

The Office of Consumer Affairs and Community Outreach provides a collaborative support role to the clinical section by working closely with advocacy groups and local agencies on policy

issues. This office is also responsible for implementing the operation of a statewide behavioral health promotion and prevention network of various stakeholders, including consumers, family members, advocates, providers, the general public and service organizations. The activities of this office will help increase awareness and provide training opportunities on best practices and health promotion /risk reduction models.

The Office of Programs and Partnerships includes the Division on Alcoholism and Drug Abuse, Division of Adult Behavioral Health Services, Division of Child and Adolescent Behavioral Health, and the Division of Intellectual and Developmental Disabilities.

Behavioral Health Divisions

The ***Division on Alcoholism and Drug Abuse (DADA)*** is charged in West Virginia Code with being the Single State Authority (SSA) primarily responsible for prevention, control, treatment, rehabilitation, education research, planning and monitoring of substance abuse related services. The DADA operates with one director, an office assistant and support from three teams: Substance Abuse Technical Expert (SATE); Driver Safety and Treatment (DST), and the Epidemiological and Research (E&R) Teams. The SATE is comprised of five substance abuse specialists who provide guidance, training and technical assistance on the implementation of effective evidence-based policies, programs and practices to 13 comprehensive behavioral health centers and eight regionally based prevention grantees. The DST Team maintains a supervisor and three staff that coordinate programming for in-state and out-of-state persons whose licenses have been revoked for driving a motor vehicle under the influence of alcohol, controlled substances and/or drugs. The E&R team, consisting of an epidemiologist, researcher and student intern, was assembled to provide core support in assisting the Bureau to make data informed decisions through a systematic process of planning, implementation and monitoring services. This group also serves as staff to the West Virginia State Epidemiological Outcomes Work Group (WVSEOW).

The ***Division of Adult Mental Health*** operates with one director and additional support from clinical, planning and policy, and housing specialists to assure the implementation of community-based mental health and substance abuse services planning. Responsibilities of this division include preparing and reporting on the Community Mental Health Services Block Grant and collaborating with APS Healthcare (APS), the State's contract utilization management entity in implementation of service codes and monitoring activities. Other important activities that the Division of Adult Mental oversees include assuring Mental Health core, crisis and alternative services and supports are developed and implemented; allocation of Projects for Assistance in Transition from Homelessness (PATH); and Mental Health Block Grant dollars, target funding and monitoring, and ongoing oversight of adult services provided by the comprehensive community behavioral health center service delivery system.

The ***Division of Child and Adolescent Behavioral Health*** is responsible for facilitating, monitoring, and evaluating statewide mental health services to ensure community-based planning and service delivery for children with serious emotional disturbances. The Division operates with one director and three child and adolescent specialists. The priority of the Division is to continuously assess and evaluate the availability of quality mental health services

and to use comprehensive needs assessments to develop new services and supports as well as improve upon existing ones. A guiding priority of the Division is to improve service delivery through innovation and expansion of proven programs and best practice models. The Division works collaboratively with child-serving systems, agencies and families at the State and local levels in the planning, implementation and evaluation of the children's mental health service system to reduce duplication and strengthen program /consumer outcomes. The Division provides ongoing technical assistance to Block Grant recipients and monitors program effectiveness. Division staff also provides technical assistance to parents/caretakers, service providers and other child serving partners who request assistance in acquiring services and supports for children with mental health needs.

The ***Division of Intellectual and Developmental Disabilities*** lead by a director with support from an office assistant, program manager and three program specialists, facilitates, monitors and evaluates state-funded programs that promote independence, integration and well-being for people with intellectual and developmental disabilities. The Division oversees four grant programs that provide direct goods and services to individuals and their families or caregivers to help maintain stable, integrated, community-based service plans. Additional funding is awarded to community behavioral health agencies to provide crisis services, care coordination, residential services, and supported employment for adults, and residential living options for adults. The Division staff also partners with families, local service providers and state agencies to support individuals with co-existing developmental disabilities and mental health and/or substance abuse challenges. The Division has recently been assigned the additional responsibility of overseeing development of statewide resources for individuals with traumatic brain injury.

The Bureau takes its role seriously in being a voice, leader, convener of issues and guider of practice improvement and priorities. A communication and advisement structure has been established that will increase meaningful input from consumers and their families, State law makers, providers and the general public to better inform planning, implementation and monitoring of all behavioral health services. The BBHMF leadership receives on-going consultation from the communication and advisement structure put in place that includes consumer panels, commissions, cross planning teams, providers and community members to insure community voice.

State System Development and Support for Behavioral Health Integration

With almost three years' experience in state level behavioral health integration, West Virginia will serve as a model for other states in eliminating treatment silos of substance use and mental disorders while championing the Federal focus of integrating mental health and substance abuse treatment in primary health care. Although this integration has focused on reorganization of the BBHMF, the Bureau is encouraging its Grantees to do likewise.

The Affordable Care Act (ACA) encourages, supports, and provides funding for the integration of healthcare and behavioral healthcare. Regulations are being written and funds provided in West Virginia to end treatment of physical, mental, and substance abuse problems in disconnected systems. West Virginia has also taken steps to integrate behavioral health and primary care. Ten of the State's Federally Qualified Health Centers (FQHCs) employ a

behavioral health provider. These health centers offer behavioral health services coordinated with medical services. Because these healthcare teams are able to treat healthcare and behavioral health issues earlier, better healthcare outcomes can be achieved.

The federally funded West Virginia Screening, Brief Intervention and Referral to Treatment (SBIRT) project is also an example of integrated behavioral health, having established services in 69 sites statewide. Current venues include primary care (32), Trauma Centers (2), Hospital emergency departments (5), school based health sites (16), workforce development centers (2), Health Department (1), Colleges/Universities (1), Mental Health Agencies (7) and free clinics (3). The BBHMF is currently planning inclusion of SBIRT services in an additional free clinic in Morgantown that will become operational in the September, 2011. Additionally, the project is collaborating with the West Virginia Perinatal Partnership to extend SBIRT services to four obstetric practices statewide.

Further implementation of the ACA will aid in accessible service delivery by increasing the number of persons who will be eligible for Medicaid or low-cost health insurance. The Office of the Insurance Commissioner recently stated that West Virginia will provide several consumer quality and efficacy studies to ensure an efficient and value driven market transition into the Exchange, including further funding for actuarial services and economic modeling as envisioned under the Planning Exchange Grant. West Virginia will also create tools for successful risk adjustment; undertake an Exchange issuer initiative and complete a Producer and Navigator strategic plan; allow for continued policy integration with constituent State agencies; and develop a business and operational plan that will ensure financial sustainability by January 2015.

West Virginia Behavioral Health Commission

With the behavioral health system in West Virginia rapidly moving toward a state of crisis, and with substance misuse, abuse and addiction growing annually, involuntary commitments to State-operated psychiatric hospitals growing, and an increasing number of children being placed in other states, the West Virginia Legislature enacted HB 4488, creating the Comprehensive Behavioral Health Commission (Commission) in 2006. The Commission members and its Advisory Board were charged, in part, with bringing together key stakeholders to review, assess, and make recommendations to improve the current behavioral health system of care. During initial years of work, the Commission members, its Advisory Board and over 300 stakeholders discussed, prioritized and finalized a shared vision with over 100 recommendations for various system improvements to the behavioral health system of care. These recommendations were narrowed to include six overarching goals focusing on the development of a model of care, quality of care, cost and perception of care as well as workforce development and incorporating technology into practice.

E. H. v. Matin (“Hartley”)

Beginning in 2009, the WVDHHR and the BBHMF have undertaken systemic changes in response to Court orders in *E.H. v. Matin*, typically known as “Hartley.” The agreements reached under Hartley mirrored the recommendations made by key stakeholders of the Behavioral Health Commission members and its Advisory Board and resulted in an investment of over \$24 million

into the behavioral health system of care. The changes brought about by this investment are achieving an improved community based support system, an enhanced community based infrastructure, improved inpatient programs and improved policies and procedures for the entire behavioral health care system.

Making Data Informed Decisions and Performance Monitoring

During the last year the BBHMF, Division of Compliance has hired two qualified and experienced staff members. Each person brings extensive knowledge in different aspects of behavioral health programs and/or monitoring and technical assistance reviews. During the current State fiscal year, it is expected that the Division of Compliance will develop multiple tools and instruments to assist program staff in monitoring grants as well as providing a specialized and independent resource to perform onsite monitoring reviews.

WVDHHR's current sub-recipient monitoring plan provides both a centralized and decentralized approach to monitoring. While multiple aspects are mandated at a Department and Bureau level, the plan also permits and requires programs to use discretion and experience to develop unique monitoring tools and methods. In accordance with this framework, the Division of Compliance will expand the capabilities and range of techniques used to monitor sub-recipient grantees.

The BBHMF, through its Division of Data and Technology, continues to collect and store a very robust and comprehensive data set pertaining to the services rendered to the citizens of West Virginia. The data set collects not only an extensive and elaborate list of key demographics of each consumer for whom services are provided, but also an extensive set of descriptors that describe the types of services provided, location of service provision, and any other key service identifiers determined to be relevant and helpful. The BBHMF continually performs edit checks, data validation studies, and system enhancements to ensure that only accurate and timely information is being stored and reported. The system being utilized allows for the receipt of data from all BBHMF-funded community based service providers regardless of the type of system or operating environment the provider may be using. With such a robust data system and the compliment of full time directly employed staff that are available to host the system, data driven decisions regarding service provision and the funding thereof will be inherent in the BBHMF process.

The data and information available in the BBHMF data system allows for intricately detailed summaries of types of services utilized, the location of the service delivery (both geographic location and actual setting of service delivery), escalation or de-escalation of primary diagnosis, and a host of demographic attributes of the consumer population. The system in its current configuration does not track utilization in a manner that allows for the subjective or objective application of outcome measures to ensure that the system is operating effectively and efficiently. Merely quantifying the types of services rendered and identifying the demographics of those to whom the services are delivered is not an effective means of system monitoring. The integration of outcomes into the BBHMF overall system design and monitoring is imperative if the behavioral health system in West Virginia is to be successful. The BBHMF is fully cognizant of the need to integrate successes and outcome tracking into the data system and is actively working toward the establishment of such a means of measure. Understanding the needs of each

geographic area of the state as well as identifying which service delivery models achieve the greatest successes will allow for an opportunity of re-assessing the funding made available to each provider throughout the state to ensure the most cost efficient service delivery model that will still achieve the outcome goals established by the BBHFF.

As outcomes and efficiency standards are more accurately tracked, the BBHFF will be able to make decisions in a timely manner regarding the funding of programs throughout every geographic area of the state, thus ensuring that consumers are able to leverage any and all services required within a reasonable travel distance from their home in an appropriate service delivery location. Real time adjustment of the funding made available to each provider will allow the BBHFF to make adjustments to the service delivery system as needs arise.

All of this depends upon the ability of the BBHFF to establish the next tier of utilization of the data and information that are currently available, or will be made available, and to utilize the data in a manner that establishes objective measures of the service delivery system. The measures established will be applied to the location of services funded as well as the level of funding allocated to each service provider and location.

See also: Attachment – BBHFF Data Quality Improvement Plan.

Evidence Based Practices

West Virginia's publicly funded prevention /promotion, early intervention, treatment and recovery initiatives are data driven and grounded in a public health foundation to respond to the toll substance abuse, poor emotional health, and mental illnesses have. Prochaska's theory of change is used in addressing readiness with regard to any step within the continuum of services in West Virginia. Theoretical frameworks that include risk and protection, asset and resiliency models are embedded within services to determine levels of need from prevention /promotion to recovery.

All publicly funded Comprehensive Behavioral Health Centers with Grant Agreements with the BBHFF are encouraged to embrace NiaTx Principles. Levels of service are determined through assessments that encourage motivational interviewing. Diagnosis is determined by credentialed staff utilizing Diagnostic and Statistical Manual IV (DSM IV) and American Society of Addiction Medicine (ASAM) criteria constituting the most comprehensive framework and specific descriptors for matching the patient's multidimensional clinical severity to a referral into the most appropriate level of care. They embody important concepts that promote individualized, cost-effective, trauma informed care. These concepts include the need for a broad continuum of care and for comprehensive assessment and treatment to address patients' physical, psychological, and social needs. Cultural competence, care coordination and family centered practice are included as tenants of effective service delivery. These best practice criteria are included in all Grant Agreements as well as required participation in the independent peer review process promoting continuous quality improvement.

West Virginia System of Care

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 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 reflect the cultural, racial, ethnic, and linguistic differences of the population served to facilitate access to and utilization of appropriate services and support to eliminate disparities in care. Services must be family driven and youth guided.

The West Virginia System of Care began as a federally funded pilot project in 1999. The Legislature adopted legislation in 2005 to establish the Commission to Study the Residential Placement of Children (§49-7-34). This Commission studied the systemic barriers to keeping West Virginia children in their homes and communities. Cross system stakeholders met often with the Commission. 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 WVSIT team 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 WVSIT serves as the State Steering Team for the State's Service Array statewide needs and gaps assessment process.

The SIT has focused on the integration of the WVSOC values and principles across all child-serving agencies across systems. A subcommittee of the SIT was established to operationalize the values and principles of the System of Care in an effort to assist behavioral providers to enact best practices.

Each of West Virginia's counties established a cross-system team of local public, private and community partners to address seven child welfare capacities that included safety, permanency and well-being. 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 Community Collaboratives has resulted in the development of a three-year strategic plan to address the continuum of services and supports for West Virginia children and their families.

Advocacy and consumer rights have long been a priority for the community and State behavioral health care system and are based on State Code (§27-5-9) and licensing regulations (§64 CSR 11). The BBHCF promotes treatment and services for all West Virginians with behavioral health needs who rely on the publicly funded behavioral health system. In addition to State law, people are protected by agency-based grievance procedures which are provided to each consumer served by a licensed behavioral health facility. Consumers and families may take their concerns to a Human Rights Committee located within each behavioral health center. A grievance is reviewed by a committee composed of family members, consumers, faith-based representatives, agency representatives, and various other community members. Most Human Rights Committees have between five and eleven individuals who are required to address grievances within two weeks of the filing date. Grievance procedures are established by a Center's Code of Ethics. If the consumer or family member does not receive an acceptable

determination, the person may appeal the complaint first to the agency's Board of Directors and ultimately to the Commissioner of the BBHFF.

Medicaid Coverage Expansion

The Center for Medicare and Medicaid (CMS) approved an amendment to West Virginia's State Medicaid Plan describing ACT. The **ACT State Plan** Amendment allows people with mental health and co-occurring ID/DD issues to access ACT services. BMS has formed an ad hoc group to revise and update its ACT Program Instruction.

HealthCheck is West Virginia's Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). This program provides periodic, comprehensive health examinations; vision, dental and hearing assessments; immunizations; and treatment for follow-up of conditions found through the health examination as covered by the Plan. HealthCheck requires standard health screening forms to be completed by providers at well-child exams. West Virginia Child Health Insurance Plan (WVCHIP) recommends that all providers use the HealthCheck form or an equivalent form at well-child exam visits. Healthcare providers of parents of children ages 3 to 5 a copy of the HealthCheck exam form to present to school authorities for public Preschool and Kindergarten entry.

WVCHIP covers children from birth through age 18. It pays for a full range of health care services for children including: doctor visits, check-ups, vision and dental visits, immunizations, prescriptions, hospital stays, mental health and special needs services. Approximately 5%-6.3% of West Virginia children are estimated to be uninsured. It is estimated that 7 out of 10 of these children may have qualified for CHIP or Medicaid. A total of 37,758 children enrolled in WVCHIP in 2010.

According to the 2010 WVCHIP Annual Report, "Healthcare reform will impact WVCHIP significantly. While the bill extends CHIP reauthorization through 2015, it also increases the federal share for the program from 2016 through 2019. WVCHIP will be virtually 100% federally funded during this time. One major impact of healthcare reform is the increase in the income eligibility limit for the state Medicaid program. Effective January 1, 2014, the upper income limit for Medicaid will increase to 133% of the Federal Poverty Level (FPL). This increase means many children that are now income eligible for WVCHIP will move to Medicaid. The estimate is that WVCHIP will lose around 12,000 kids on this date. Other impacts of the ACA are still being determined.

WVCHIP is partnering with other state Agencies to plan and implement healthcare reform program staff regularly participate in meetings coordinated by the Governor's Office on Health Enhancement and Lifestyle Planning (GOHELP), the State Agency responsible for coordinating healthcare reform work among state agencies. WVCHIP also partnered with Oregon and Alaska CHIP to form the Tri-State Health Improvement Consortium (T-CHIC) and was awarded a Quality Demonstration grant funded by the Children's Health Insurance Reauthorization Act (CHIPRA). Work under this five-year grant focuses on improvement of children's health care quality by demonstrating the unique and combined impact of patient-centered care delivery models and health information technology (HIT) on the quality of children's healthcare as

measured by a variety of indicators being assessed simultaneously for their validity and utility in driving quality improvement. The goal of the project is to identify a set of dynamic and robust child health quality measures and the identification of the features of patient-centered care models – including their incorporation of HIT and electronic information exchange – that produce the greatest improvements in quality across a range of provider types, delivery systems, and geographic settings. The project should also create momentum and infrastructure for long-term quality improvement in each State. WVCHIP is partnering with the West Virginia Health Improvement Institute (WVHII) to conduct work on this grant.”

Medication Assisted Treatment

Methadone was first used in the 1960’s for “maintenance treatment” of Opiate addiction. Within 10 years, the use of Methadone was widespread. In October of 2002, Buprenorphine received FDA approval for use with detoxification and maintenance of heroine and other narcotic addictions. Buprenorphine is a “partial-agonist” that in low doses can mimic the effects of narcotics. This new medication was intended for office-based treatment of addiction which allowed for an explosion in the number of treatment providers available to public. Also in October of 2002, Subutex and Suboxone received FDA approval for the treatment of opiate addiction. Subutex contains only Buprenorphine, the opiate agonist, while Suboxone contains both Buprenorphine and the opiate antagonist Naloxone.

Growing acceptance of Opioid addiction as a brain disease has led to significant advances in medication assisted treatment. These advances have created greater acceptance of the use of medications in the treatment of addiction. The American Society of Addiction Medicine (ASAM) in Mid-August of 2011 released a new definition that clearly described addiction as is a chronic brain disorder and a primary disease. The use of medication assisted treatment is predicted to continue to increase exponentially.

In West Virginia, the Bureau of Medical Services (BMS) approved State Medicaid reimbursement for Suboxone treatment with prior authorization in 2005 that went into effect in January of 2006. Vivitrol, a time-released injection of Naltrexone received State Medicaid reimbursement approval in early 2011. Naltrexone, an opiate antagonist, blocks the effects of narcotic medications and alcohol. In August 2011, following the approval of Suboxone treatment by four Opioid Treatment Clinics in the State, the Bureau of Medical Services issued a new Subutex /Suboxone /Vivitrol Policy that mandates adequate therapy services, strict documentation requirements, drug screening requirements and treatment guidelines. The BBHMF will continue to work with BMS relative to best practices with all medication assisted treatment services.

The BBHMF, recognizing the need for guidance and oversight of medication assisted treatment programs, organized a Medication Assisted Treatment Advisory Group in July 2011. This advisory group consists of physicians, pharmacists, and addiction treatment specialists in addition to staff from the BBHMF. This group is charged with developing best practice dosing recommendations, titration protocols, and provider review protocols. The BBHMF has also designated a new State Methadone Authority who will work with this advisory group and other

oversight agencies to assure evidence-based practices and best practices are followed in all medication assisted treatment programs in the State.

Money Follows the Person Grant

According to the Bureau for Medical Services (BMS), West Virginia spent \$536,736,503 in SFY 2010 on institutional long term care services (nursing facilities and ICF/MR facilities), or 53.5% of Medicaid long term expenditures. In the same fiscal year, West Virginia spent \$466,645,341 on community-based services (HCBS waivers, personal care and home health), or 46.5% of Medicaid long term expenditures. West Virginia currently ranks 21st among the states in percent of total Medicaid expenditures for home and community-based services compared to institutional services.

The ***Money Follows the Person (MFP) Rebalancing Demonstration, Take Me Home, West Virginia***, will significantly improve opportunities for individuals who are elderly or who have disabilities to receive the supports and services needed to sustain them in community settings. The successful, sustainable transition of 520 of these individuals from residence in a long term care facility to a qualified home setting is a goal of the Take Me Home program. In addition, over the five year demonstration period, West Virginia intends to use the increased resources, experience gained, and lessons learned to strengthen its long term care system and its ability to support the use of home and community-based services in lieu of those provided in an institutional setting.

The Take Me Home, West Virginia program, will target older West Virginians and/or individuals who are physically disabled and who are eligible for the State's existing Aged and Disabled Waiver, the pending Traumatic Brain Injury Waiver, or State Plan Personal Care services. The MFP will also serve persons with severe mental illness who reside in an Institution for Mental Diseases (IMD) but require a service that makes them eligible for Medicaid and therefore eligible for MFP inclusion. West Virginia will seek eligible individuals from throughout the State and from a variety of institutional settings, although most individuals are expected to transition from a Medicaid-certified nursing facility. Other facilities that may be involved include hospital rehabilitation units, and rehabilitation hospitals. Identification of potential participants who are in a nursing facility will take three forms: Direct referral to the Take Me Home program by a staff member or other service provider; Self or family referral to the program resulting from awareness of the program generated by the state's marketing and outreach efforts; and, Screening based on the Minimum Data Set (MDS) information collected during the nursing facility stay.

If an individual meets the basic criteria for inclusion in the Take Me Home program, a Transition Navigator will meet with him/her to explain the program including the eligibility criteria, available services, the option for self-direction of services, and what happens at the end of the MFP demonstration period. It is not anticipated that any participant cost-sharing will be required, and this will be made clear as services and options are discussed. Should the member express an interest in the program, the Navigator will proceed with the informed consent processes and to ensure the individual's eligibility for the program. The information sharing on the part of the Transition Navigator will be critical to the potential participant's ability to make

an informed decision about the Take Me Home program versus other options for transitioning. Also critical to this discussion is information concerning the option for self-directing all or a portion of his/her service delivery.

An application for a ***Traumatic Brain Injury (TBI) Medicaid Waiver*** was submitted by the Bureau for Medical Services (BMS) to the Centers for Medicare and Medicaid Services (CMS) for review January 1, 2011. The Waiver will serve up to 75 members during the first year and up to 125 members during by the third year. BMS has issued a RFP seeking an Administrative Services Organization to certify prospective TBI Waiver providers using established criteria in the Waiver application and to provide ongoing support for the provider network; provide day-to-day operations and oversight of the TBI Waiver Program; determine medical eligibility for initial TBI Waiver applicants and annual re-evaluations of medical eligibility for Waiver members; and, implement a Quality Improvement System consistent with CMS expectations. The bid opening date for the RFP is scheduled for September 20, 2011. It is anticipated that assuming CMS approval, enrollment could begin for this waiver as early as January 2012.

Medical Health Homes

West Virginia is the first state in the nation to win approval from the U.S. Department of Health and Human Services (HHS) for a redesigned health care program for people with disabilities and/or who are economically disadvantaged that contains an emphasis on personal responsibility. Medicaid recipients have been asked to sign ***“personal responsibility contracts”***. The state had initially sought a waiver from program rules to address costs, but when that was determined to be administratively cumbersome, a state plan amendment was pursued under section 6044 of the Deficit Reduction Act of 2005. This provision allows states to provide alternative benefit packages for Medicaid eligible people except those exempted under section 1937 of the Social Security Act. West Virginia’s plan amendment was approved and became effective on April 1, 2006.

Mountain Health Choices (MHC) is designed to ensure that members receive the right care, at the right time and by the right provider through care coordination. It encourages the selection of ***a medical home*** (a designated primary care physician), where primary health care is provided and records are kept, for every Medicaid member. Mountain Health Choices gives members a choice of benefit plans (basic or enhanced packages), requires responsibility, sets expectations for behavior and rewards success. It is designed to encourage healthy habits for all West Virginia Medicaid members.

Medicaid members who sign the Member Responsibility Agreement have access to services not provided in traditional Medicaid Benefits. By visiting their medical home for a check-up and working with their healthcare providers to set goals for health improvement, members qualify for the Enhanced Benefit Package. This package provides the opportunity for members to participate in weight management, physical activity and other educational opportunities for health improvement. Members who choose not to sign the Member Responsibility Agreement will have the Basic Benefit Package. This package covers all healthcare services which are mandated by Federal and State laws. Medicaid members have the opportunity to enroll in the

Enhanced Benefit Package each year upon their date of re-determination and for 90 days after that date.

The medical home partners with Medicaid to monitor and report compliance with the member agreement, which outlines the responsibilities of the patient to maintain a healthy lifestyle, and to which they have agreed. This qualifies the member to receive the Enhanced Benefit Plan under Medicaid. If the member fulfills the responsibilities agreed to, he/she will remain in the Enhanced Benefit Plan. If the member does not fulfill the responsibilities agreed to he/she will be moved to the Basic Benefit Plan, with some exceptions. Members will receive advanced notification if their benefits are to be reduced and have the right to appeal the decision. After twelve months in the Basic Plan, and again at re-determination, members have the opportunity to sign the Member Agreement and be re-enrolled in the Enhanced Plan. Visits to psychologists and psychiatrists are covered and there are no limits on the number of visits allowed in the Enhanced Plan. The Enhanced Medicaid benefit package also provides for coverage of emergency dental situations, specifically palliative treatment for relief of pain.

In theory the redesign could be a positive development because people with mental illness could undoubtedly benefit by using this holistic approach of preventative physical health care to enhance their mental health, which is a key goal of the Presidents New Freedom Commission on Mental Health – physical health is essential to improved mental health – especially given the recent National Association of State Mental Health Program Directors (NASMHPD) finding that people with serious mental illness die on average 25 years earlier than does the general population in the United States.

Community Based Behavioral Health Services

Substance and mental disorders must be treated in an integrated fashion. The Bureau has used target funding to promote integrated service approaches at multiple levels, including but not limited to the West Virginia System of Care; Expanded School Based Mental Health services and supports; transitioning youth; crisis intervention; disaster planning and response; cross-training of service providers in motivational interviewing and trauma informed care; Wellness Recovery Action Planning (WRAP); peer advocacy and support; suicide prevention; and residential services and supports such as step down programs, Non-Treatment Recovery Homes and Consumer-Operated Independent Living Services (COILS).

Two State-owned and operated inpatient psychiatric hospitals, located in Weston and Huntington, serve individuals with co-occurring mental health and substance abuse disorders from all 55 counties in West Virginia. In addition, the Bureau partners with and provides funding for care of involuntarily committed clients with substance abuse and co-occurring disorders to two community based inpatient psychiatric hospitals and a number of inpatient acute care hospitals with psychiatric units.

Community based behavioral health services for adults and children are being implemented that involve the collaboration of systems, bureaus, families and consumers. Additionally, people who are experiencing homelessness, co-occurring disorders, and individuals with serious substance and mental health disorders and children with serious emotional disturbances who have been

involved with the criminal/juvenile justice system need recovery and resiliency-oriented services. Statewide there are many creative and impactful initiatives along the continuum of care (*prevention/promotion, early intervention, treatment and recovery*) that are positively impacting behavioral health services in West Virginia.

Prevention/ Promotion

In 2010, with the restructuring of substance abuse block grant prevention dollars, prevention services were expanded to insure access to all 55 West Virginia counties. Prevention funding was allocated to ***eight community based organizations*** representing four different service areas with an emphasis placed on the collection of local needs assessment data and use of evidence based strategies. Significant outcomes have been achieved by the grantees. Grantees report providing 2,253,598 services (duplicate count) to West Virginia communities, implementing 48 universal, selected and indicated evidence based programs; collecting more than 16,000 pounds of prescription drugs during prescription drug take back days in coordination with national initiatives; offered safe storage containers for prescription drugs in communities across West Virginia; allocated funding for synthetic drug analysis to provide community /law enforcement /retailer education geared to positively guide strategies for managing a growing bath salts abuse problem; and partnered with CADCA in a pilot project to develop a National Youth Leadership Initiative.

All prevention providers are currently targeting BBHMF priorities such as the prevention of prescription drug misuse and/or abuse, underage drinking, drug exposed pregnancy, and physician engagement. Prevention providers also target other issues prevalent or unique to a particular service area, such as sales of tobacco to youth and sales of synthetic drugs.

The federally funded ***Adolescent Suicide Prevention and Education Network*** (ASPEN) and the State funded West Virginia Council for the Prevention of Suicide has demonstrated the value of providing prevention information and assessment tools in integrated settings, involving education systems, behavioral health providers, and healthcare providers. The BBHMF has taken several steps to respond to the need to create data-driven systems for behavioral health services. Grant Agreements with CBHC's provide an opportunity for data-based monitoring and decision making, and the WVSEOW will provide an opportunity to use data from a variety of sources for planning and for measuring change.

In rural areas, hospital emergency rooms may not be readily accessible. Valley HealthCare's link to the National Suicide Prevention Lifeline connects people to the closest place to receive help, which may be the satellite office of the regional behavioral health center. In the event of an emergency, the regional CBHC crisis line may also be called to access mental health services or 911 is available to access transportation to the nearest hospital. The Department of Health and Human Resources has provided financial assistance for a 211 telephone number that connects people to community-based social services.

West Virginia Prescription Drug Abuse Quitline (WVPDAQ)

The WVPDAQ has been in operation since 2008 as a response to the developing prescription drug abuse crisis in the state. With the mission of service, outreach and research, the WVPDAQ is a telephone Quitline that provides psycho-educational resources, support with follow-up and assistance and treatment referral to community based services for prescription drug abuse.

Problem Gamblers Network of West Virginia

Callers to the problem gamblers help-line are provided general counseling assistance and offered free treatment opportunities with professional counselors and programs in their local communities. The Problem Gamblers Help Network of West Virginia, the group that operates the 1-800-GAMBLER help-line, has released a compilation of data on all of the callers to the help-line in the nine years since it started. According to the FY 2009 report, between August 1, 2000 and December 31, 2009 8,045 people have called the 1-800-Gambler help-line asking for help for a gambling problem, or to ask about getting help for a family member or friend with a gambling problem (5,556 of these 8,045 calls were from the gamblers themselves). The report shows that most people in West Virginia who call the help-line are addicted to electronic gaming machines, either in local bars and restaurants, or at one of the state's four tracks. Most are in debt due to their gambling, and many admit to committing illegal acts, including writing bad checks, to finance their gambling. The majority of these 5,556 gamblers are either employed full-time, 4083, or not working due to a disability, 844. The rest work part-time, are unemployed or are retired.

The BBHMF coordinated ***medical provider training*** on prescription drug abuse. There have been 14 opioid dependency trainings for physicians with an estimated 980 doctors statewide that were trained in total. There are now 90 physicians in West Virginia who are listed on the CSAT website as Buprenorphine prescribers, as well as 17 treatment programs. Additional training on Medication Assisted Treatment (MAT) was held at the West Virginia Alcohol and Drug Abuse Counselors (WVAADC) fall conference last year and was attended by more than 70 addiction professionals. A BBHMF Medical Education Team has been developed to determine and disseminate best practice guidance documents on medication assisted treatment, adolescent substance abuse, adult substance abuse, drug exposed pregnancy and suicide prevention.

Prevention Resource Officer (PRO) Program

The Prevention Resource Officer (PRO) program is a cooperative effort between schools and law enforcement. The three main components of the PRO program are prevention, mentoring and safety. The officers facilitate classes on non-traditional education topics such as juvenile law, domestic violence, underage drinking, drug and alcohol prevention and child abuse and neglect. Officers are also trained on how to be a positive mentor to students and to recognize potential danger, prevent violence and to respond to dangerous school situations.

West Virginia Adolescent Health Initiative

West Virginia's Adolescent Health Initiative is a project developed and coordinated by the Office of Maternal, Child and Family Health (OMCFH) within the Bureau for Public Health. OMCFH funds a dedicated network of eight regional Adolescent Health Coordinators across the

State. The Initiative is designed to introduce, develop, train, and provide needed technical assistance to youth, parents, teachers, health care professionals, other regional networks, and civic groups with focused attention on improving adolescent health indicators while building asset-rich communities.

Family Smoking Prevention

The BBHMF submitted a response to solicitation FDA-11-Tobacco announced by the Food and Drug Administration earlier this year. This solicitation specifically focused on State compliance with the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act). The Act provides FDA the authority to regulate the manufacture, marketing, and distribution of tobacco products to protect the public health generally and to reduce tobacco use by minors. The FDA will contract with West Virginia to carry out the necessary enforcement activities to comply fully with this Act. For many years pursuant to receipt of Federal Block Grant funds, State Synar regulation compliance, for which the SAMHSA is responsible, has been implemented. Synar compliance activities regarding underage tobacco sales target underage sales and distribution with an annual non-compliance rate not to exceed 20%. The BBHMF has recently completed contract negotiations with FDA regarding the additional compliance activities pursuant to the Tobacco Control Act and implementation of this effort is now underway.

Early Intervention

The federally funded West Virginia Screening, Brief Intervention and Referral to Treatment (SBIRT) is a demonstration of the effectiveness of early intervention in addition to demonstrating the integration of primary care and behavioral health. SBIRT staff are trained in motivational interviewing and are skilled in obtaining histories of the use of alcohol or other drugs. Since its inception, SBIRT has served 105,000 persons, identifying and intervening with 5,000 individuals for treatment.

Teen Courts emerged in West Virginia in 1997. There are currently 17 active teen courts throughout West Virginia. Teen courts offer a unique “second chance” justice program for youth between the ages of 11 and 18 who are alleged to have committed a status offense or an act of delinquency which would be a misdemeanor if committed by an adult. Upon successful completion of the program charges against the defendant are dismissed. In addition to the obvious benefit of interrupting a developing pattern of inappropriate behavior, the Teen Court program helps to reinforce self-esteem, provide motivation for self-improvement and promote a healthy attitude toward authority. In July 2006 the West Virginia Teen Court Association launched, linking new and existing programs together to help share information and collect data on how to effectively deliver justice to youth in West Virginia communities.

Treatment

West Virginia’s publicly funded community-based behavioral health system is comprised of 13 regional ***Comprehensive Behavioral Health Centers*** (CBHCs) which serve all 55 counties. The 13 CBHCs operate 38 satellite offices. Services are provided through Grant Agreements with the BBHMF. In addition to Federal and State allocations from the BBHMF, the CBHCs bill

Medicaid, other insurance, and have a sliding fee private pay schedule. CBHCs provide services to children with serious emotional disturbances, adults with serious mental illnesses, individuals with substance use disorders, and persons with intellectual and developmental disabilities. The focus of service delivery is a system that meets the needs of consumers and supports the concepts of timely access to care and high quality mental health services. By law or Grant Agreement, CBHCS are to provide five core services: crisis services; linkage with inpatient and residential treatment facilities; diagnostic and assessment services; treatment services; and recovery support services.

The CBHCs are non-profit organizations with a board of directors whose members are selected from a variety of community stakeholders. The executive director /chief executive officer reports directly to the board. While other smaller, private agencies receive grant funds from BHCF to deliver treatment, prevention, or support services, the regional comprehensive behavioral health centers are designated by Grant Agreement and State law to provide essential community behavioral health care services.

There are 53 hospitals in West Virginia, 31 of which are located in rural areas. The state has 18 hospitals currently identified as Critical Access Hospitals. Rural health /mental /dental health care is accessed through primary care clinics (Federally Qualified Health Clinics or FQHCs). There are 53 Rural Health Clinics in West Virginia, and 28 FQHCs provide services at 188 sites in the State. These primary care centers house 17 Black Lungs clinic sites and operate 46 School-Based Health Centers. Many of these clinics offer pharmaceutical services. One such pharmacy is located on site at the CBHC in Huntington, and some offer mental health services utilizing either licensed clinicians or staff from the regional CBHC. The primary care centers provide medical services for approximately 20% of the state's population. The state's 10 free clinics and their approximately 2,100 volunteers served 54,925 patients during 229,844 patient visits and filled 496,930 prescriptions in SFY 10. Each year grants totaling nearly \$3,000,000 provide comprehensive medical care to more than 75,000 enrolled patients with approximately 250,000 office visits each year. These clinics have traditionally developed strong collaborative partnerships with the community through individuals, organizations, businesses, churches and civic groups in an effort to maximize limited resources.

Expanded Men's Substance Abuse Treatment Services

A men's substance abuse treatment program serving the State's Northern Panhandle, "Miracles Happen" has addressed its waiting list by partnering with the faith-based, peer-run Lazarus House, a halfway house. Miracles Happen is operated by one of the State's Comprehensive Community Behavioral Health Centers, Healthways. The halfway house provides safe housing for additional clients served in an after-hours Intensive Outpatient substance abuse treatment program. Miracles Happen has more than doubled the number of individuals it is able to serve.

Pinecrest Campus Expansion

Pretera Center for Mental Health Services, one of the State's 13 Comprehensive Community Behavioral Health Centers, recently opened its new Pinecrest substance abuse treatment campus and is about to expand its medically managed detoxification program from 10 beds to 16 beds,

supporting increased capacity to serve those in need and specifically individuals with co-occurring substance use and mental disorders. Co-occurring enhanced detoxification beds in West Virginia is currently a non-existent service, while the need continues to increase. The program expansion includes adding LPNs, behavioral rehabilitation specialists and a part-time staff psychiatrist. Clients with uncontrolled behavioral health symptoms will be able to receive psychiatric services at the same time they complete their detoxification. In the short-term residential treatment program at Pinecrest, co-occurring clients will continue with psychiatry and will attend special groups designed to meet the needs of persons with co-occurring behavioral health and addiction problems. In addition to adding the new co-occurring detoxification beds, placing substance abuse services together in one campus will allow this publicly funded provider to double current capacity of residential treatment beds from 24 to 48.

DUI Treatment Collaborative

Another of the 13 Comprehensive Community Behavioral Health Centers in the State, Westbrook Health Services in Parkersburg, has formed a partnership with the West Virginia Division of Corrections to proactively provide DUI Safety and Treatment classes while people are still incarcerated. Westbrook addiction treatment staff provides classes in St. Mary's Correctional Facility in St. Mary's twice yearly to inmates who need to clear their driver's licenses of current DUI offenses. This allows DUI offenders to leave prison with their driver's licenses already reinstated, thus removing a barrier to successful reintegration into the community.

Pregnant and Post Partum Women's Treatment

Turning Pointe for Families proposes to serve women who are pregnant or postpartum and who have co-occurring substance use and mental disorders in a new, culturally responsive, trauma-informed sixteen bed residential unit located on the grounds of Jackie Withrow Hospital in Beckley, West Virginia. Referrals will come primarily from 14 counties in southern West Virginia where prescription pain pill abuse is referred to as epidemic. Turning Pointe will be operated by FMRS, a comprehensive behavioral health center with current specialized residential programs for men and for women, and will implement evidence-based treatment for 208 residents, their minor children, the fathers of the children and other significant extended family members. The program will serve 330 children or other family members women in treatment with developmentally and culturally appropriate assessments, prevention and intervention services, counseling interventions and linkages to needed medical, educational, economic and housing services. Linkages have been made for developmental assessments of infants and young children.

Women's Treatment

Southern Highlands, a Comprehensive Behavioral Health Center, is currently collaborating with the BBHFF to develop a ten bed residential substance abuse treatment unit for women located in McDowell County. The program will be based on a model developed by the BBHFF, commonly known as Support to Addiction Recovery (STAR). The program will follow the ASAM criteria for Level III: Residential/Inpatient treatment. Women will receive up to ninety

days of residential treatment including intensive group therapy, supportive group counseling, intensive individual therapy and supportive individual counseling. The facility will have the capacity to meet the needs of individuals with co-occurring substance use and mental disorders. Individuals served will be supported throughout the phases of treatment and support to their transition back into the community through employment, housing, after care and other needed supports to aid in maintain recovery upon discharge.

Recovery

The Healing Place of Huntington opened in 2011 to provide a unique approach to substance abuse recovery within the community. This program, coupled with residential resources currently available, offers an alternative to professionally managed clinical services provided in a treatment program. It is a program of peer support and recovery where residents help one another and hold one another accountable for recovery in a program modeled after the Healing Place in Louisville, KY. That program reports has a success rate of 65 percent, or about five times greater than traditional recovery centers. The Healing Place serves adult men in a residential therapeutic community level of care on a long-term basis.

Rea of Hope is a recovery fellowship home in Charleston, West Virginia for 10 women or women and their children. Program goals are to further assist women in their recovery by becoming independent and positioning themselves to provide a safe living environment for themselves and their children. Recently, Rea of Hope obtained new funding from the West Virginia Affordable Home Trust Fund, The Federal Home Loan Bank and the BBHFF for expansion. The expansion will include another property to provide housing for four more women or women and their children. Rea's New Life Apartments currently offer seven apartments exclusively for Rea of Hope graduates and their minor children. The new funding plans to offer another property with four additional apartments.

The Federal Anti-Drug Abuse Act of 1988, P.L. 100-690, required each State to establish a revolving fund to make loans to six or more recovering individuals to rent houses to use as self-run, self-supported group homes that are alcohol and drug free. The law was based on the then thirteen- year experience of the national network of self-help Oxford Houses. Today, after 34 years experience there are more than 1,300 Oxford Houses throughout the United States. In West Virginia, Oxford House operates eight recovery houses with 59 beds. Oxford House and the BBHFF are closely partnered to assure that safe housing is provided to all residents and that the houses are closely affiliated with substance abuse treatment providers in West Virginia. BBHFF is also working the administration of Oxford House at their corporate offices to determine areas of greatest need for transitional, non-treatment housing for recovering men and women.

Linkages with Judicial System

The first and only ***Mental Health Court*** began in 2003. Mental Health Courts are now active in four counties with two Circuit Judges and four Magistrates participating. Counties of operation include Hancock, Brooke, Ohio, and Marshall. The BBHFF is collaborating with the Supreme Court of Appeals to further expand court options, with emphasis placed on co-occurring and behavioral health court development.

The BBHMF provided funding in 2005 to support the development of *Adult Drug Courts*. This funding supports Drug Coordinator positions and assessment and treatment costs. There are now 11 regional courts serving 29 counties. Additional funding support has been secured through various resources including funds from the Supreme Court of Appeals and grant funding through the Bureau of Justice Assistance (BJA). Funding has also supported Drug Court trainings through collaboration with the Supreme Court of Appeals.

Addiction-related commitments are a significant factor in the rise of involuntary admissions to the State-operated psychiatric hospitals. The BBHMF has collaborated with the Supreme Court of Appeals to train Mental Hygiene Commissioners on substance use disorders and alternatives to involuntary treatment.

The state also supports and promotes using *Juvenile Drug Courts*. Courts currently exist regionally in Brooke, Hancock, Lincoln, Boone and Logan Counties and in Cabell, Mercer, Monongalia, Putnam, Randolph, Wayne and Wood counties (Attachment 10). These Courts divert youth aged 10 to 17 who are charged with non-violent substance related offenses into intensive programs. These programs often include outpatient treatment, probation case management, compliance monitoring and parental education. The Courts encourage family involvement in these programs, as this may improve success rates.

Beginning in 1997 *Teen Courts* emerged in West Virginia. There are currently seven active teen courts throughout the State. Teen courts offer a unique “second chance” justice program for youth between the ages of 11 and 18 who are alleged to have committed a status offense or an act of delinquency which would be a misdemeanor if committed by an adult. Upon successful completion of the program, charges against the defendant are dismissed. In addition to the obvious benefit of interrupting a developing pattern of inappropriate behavior, the Teen Court program helps to reinforce self-esteem, provide motivation for self-improvement and promote a healthy attitude toward authority. The West Virginia Teen Court Association was launched in 2006, linking new and existing programs together to help share information and collect data on how to effectively deliver justice to youth in West Virginia communities.

The BBHMF is pursuing partnerships to support initiatives for Family Treatment and Family Court. Such initiatives are being developed through partnerships with our legal system, Division of Justice and Community Services, and others.

Children’s Clinical Outreach Services Liaisons

The BBHMF formally announced the availability of funding for the 13 CBHCs in FY08 for the employment of an individual to work directly within their agency as an administrator of children’s services to develop new services and improve access to current services for ***children and adolescents with serious emotional disturbances and their families***. The intent of this support was to assist the CBHCs in re-engaging community partners using a more collaborative approach to meeting the needs of West Virginia’s children and families. Each of the 13 CBHCs receive funds for the position, known as the Children’s Clinical Outreach Services Liaison (CCOSL).

The overall purpose of the program is to provide children and adolescents with serious emotional disturbances and their families with comprehensive services in their home community, reducing the need for out of home or out of state placement for intensive behavioral health treatments. The program is intended to develop, improve and maintain collaborative relationships within the communities served; increase visibility and awareness of the agency's programs and services; and improve the overall capacity to serve children with behavioral health needs and their families.

Each CCOSL has four overarching responsibilities within the CBHC service area: integration and collaboration of behavioral health clinical services and the community continuum of care for children; provide leadership in the development of new services that contribute to an improved capacity to serve children; provide leadership in developing improved access to out-patient services within the community mental health environment; and to provide community education /awareness outreach services to stakeholders within the CBHC service area.

The CCOSLs have had a positive impact on the children's mental health system. The use of Trauma-Focused Cognitive Behavioral Therapy, recognized as an evidence based treatment, has increased. CCOSLs have taken active roles within their own agencies to improve internal policies and processes that affect access and capacity to serve children and families effectively. More children are remaining in West Virginia when placed in residential treatment according to data available to the BBHFF. The CCOSLs participated in the full Service Array process organized by the Bureau for Children and Families, guaranteeing input from every CBHC. CCOSLs have developed new cross-systems formal agreements or partnerships with more agencies /organizations in their regions. The CCOSL's link with other child serving systems has increased child and family access to services and supports.

The impact of the CCOSLs is evident in the results of a brief survey of the 13 Comprehensive Community Behavioral Health Services. Respondents described an array of services available to children and adolescents, including mentoring, outpatient, intensive outpatient, school-based, and in-home services. Children's Liaisons participate in community functions relative to children's services to educate the public about services available and to identify gaps in services. A major focus of the CCOSLs reported is to collaborate with other providers of services.

Comprehensive Community Behavioral Health Centers report suicide prevention activities geared to youth, the use of SBIRT in school-based settings, and participation in community organizations to address issues of underage drinking and safe schools. One Center has obtained foundation funding to initiate a program to provide information to students in middle school.

School Based Mental Health Services

One of the more notable strengths supporting the provision of community-based services is the priority initiative of Expanded School Mental Health (ESMH). West Virginia's ESMH Initiative is a 3-tiered framework that includes the full continuum of prevention, early intervention and treatment; serves all students; and emphasizes shared responsibility between schools and community mental health providers.

The BBHBF partners with the West Virginia Department of Education (WVDE) to develop, improve, and increase school-based mental health services for all students. BBHBF staff co-chairs a statewide Steering Team with WVDE. This effort is supported with a Memorandum of Understanding between the Secretary of Health and Human Resources and the State Superintendent of Schools. The ESMH Steering Team includes State and local child-serving agencies, education agencies, parents, and faith-based organizations. The ESMH has made significant accomplishments since its inception. As a result of the cross-systems collaboration, the WVDE is developing new school counseling protocols that will include facilitating ESMH services and supports as a part of the school counselor performance standard. In addition, the WVDE has reviewed its policies concerning student behavior /discipline and has recently developed a “Manual for Expected Behavior in Safe and Supportive Schools,” which is still in draft form and available for public comment.

The BBHBF has provided financial and technical support to the development of School Based Mental Health (SBMH) services since 2000. The concept of SBMH services was in its infancy across the country in the late 1990s to early 2000. Over the past 10 years research has been conducted on the progress and outcomes of state’s efforts, and more recently, even more has been written detailing the many benefits of integrating behavioral health into the educational system. The need for this integration is well documented in the final report of the President’s New Freedom Commission on Mental Health (*Transforming Mental Health Care in America, New Freedom Commission, 2003*).

The BBHBF funds seven agencies providing ESMH Services in 27 schools in nine counties. Services are provided in elementary, middle, and high schools. ESMH programs help to reduce the ongoing battle of stigma and avoidance behaviors associated with mental and substance use disorders. ESMH programs provide access to services that might not otherwise be provided. Additional school-based mental health programs and supports in various pockets of West Virginia receive funding from public and private resources. Funding is provided through Medicaid, WVCHIP, private insurance, the WVDE, State and Federal grants, foundations, and other community organizations. The ESMH programs funded by the BBHBF provide a combination of mental health promotion and education, prevention, early identification, and treatment.

Core services of the ESMH Programs include but are not limited to the following:

- Individual counseling/therapy;
- Group counseling/therapy;
- Family counseling;
- Classroom education on mental health issues;
- School-wide prevention programs;
- Screening and assessment for mental health problems;
- Case management services; and
- Consultation services for school personnel and parents

During SFY 10 ESMH programs served 441 youth with 6,982 hours of individualized mental health treatment. In addition, they provided 1,670 hours of prevention activities, screening,

classroom presentations, and consultations. Caucasian youth comprised 93% of the youth served across all 27 sites; African American youth represented 4% of those served; and multiracial youth were 2% of those served. The majority (83%) of the youth who received individualized services were receiving benefits from Medicaid or CHIP while 10% of the youth had private insurance company and 6.3% had no medical coverage. Providers administered the CAFAS to all youth at intake and three-month intervals. Comparison data indicates that 71% of youth demonstrated an improvement in their overall score and 17% maintained it.

The Substance Abuse Early Intervention Programs (EIP) in Mercer and Logan counties are the first of their kind in West Virginia. The programs target youth, ages 12 to 17, who are in the onset stages of substance abuse. They are designed to provide increased understanding of substance abuse consequences and coping skills to resist pressures to engage in substance abuse.

Quit Line

The West Virginia Prescription Drug Abuse Quit Line launched in 2008 with funding support derived from the Purdue Pharma settlement. The Quit Line has pursued its mission to provide service, outreach and research with the aim of educating those abusing prescription drugs and their families about such abuse, resources available and services that can support their recovery. Since its inception the Quit Line has served over 1,500 callers.

Telemedicine

West Virginia is a primarily rural State with limited numbers of behavioral health professionals. The BBHMF and CBHCs have identified telemedicine approaches as a partial resolution. Telemedicine offers opportunities for behavioral health professionals to interact with individuals in the rural areas without consideration of transportation and access issues. The availability of telemedicine is currently limited due to limitations on reimbursements for services provided through telemedicine. Even with these limitations, there has been an increase in the number of consumers served through telemedicine, from 456 individuals in 2009 to an estimated 2,836 to be seen in 2011.

The BBHMF is collaborating with the State Medicaid Authority to expand the use of telemedicine based on model policies developed by the American Psychiatric Association. Several CBHCs are actively using telemedicine for service provision when and where reimbursable. Examples include Assertive Community Treatment team meetings, psychiatric evaluations, and testifying for the purpose of commitment hearings.

The BBHMF is facilitating the use of telemedicine technology to enable State employed psychiatrists at the two State-operated psychiatric hospitals to consult with staff and consumers in rural areas. Telemedicine technology is available in the State facilities and all CBHCs. Several CBHCs are currently using this consultation and treatment option and others plan to add it in the near future. The BBHMF is considering using telemedicine services for SBIRT and forensic evaluations.

Telemedicine services have also been used to increase the availability of medication assisted treatment in coordination with an onsite Suboxone clinic.

Specialized Services for Priority Populations

Pregnant Women and Women with Children who have a Mental or Substance Use Disorder

There are four CBHCs in West Virginia with a full continuum of services for women, pregnant women or women and their children. These CBHCs provide outpatient and intensive outpatient services for women with mental and substance use disorders. Additionally, each of these providers offers detoxification services for women with substance abuse problems or co-occurring disorders. The four also offer short-term and long-term residential substance abuse services with a total of 84 residential beds. West Virginia has another seven CBHCs that offer outpatient services, both mental health and substance abuse, to both women and men. Crisis Stabilization services are also available for women in five different locations around the State. These units serve women who have serious mental illness, substance abuse or co-occurring issues that do not require involuntary treatment, but do require intensive inpatient services.

The BBHMF partially funds several non-treatment recovery housing providers. These peer-operated and supervised programs may serve up to 22 individuals in three locations. These recovery homes offer women the opportunity to live in safe housing after treatment while they work on their early recovery. Additionally, there are two transitional non-treatment houses for women in recovery that are peer operated. These locations provide housing for 13 women.

There are two notable pockets of excellence in women's treatment in West Virginia. A CBHC in the southwestern region offers a complete continuum of services for women. They provide all services from outpatient to transitional living for women and women with children and partner with a local obstetric practice through a local acute care hospital to offer high risk pregnancy services for substance abusing women. The second provider with comprehensive services is a residential recovery house that provides safe housing for women and their children in recovery as they rebuild their lives. This provider now has services for 10 women, but has recently received several grants to expand and plans to purchase two additional houses and add services for an additional seven women and/or women with their children.

Older Adults

The Office of the Olmstead Coordinator uses funds allocated by BBHMF to contract with two agencies to assist West Virginia citizens with disabilities, including psychiatric disabilities, and seniors who reside in nursing homes to live and be supported in integrated community settings. The Transition Navigator Program is part of the West Virginia Transition Initiative. The Transition Initiative is managed by the Olmstead Office in collaboration with the Bureau for Medical Services and the Bureau of Senior Services. During SFY 2010, the two Transition Navigator programs relocated to the community 35 people from nursing facilities and diverted 84 people from nursing facilities.

In recognition of the extremely high suicide rate among older adults in the State, the West Virginia Council for the Prevention of Suicide contracted with a professor in the psychology department at West Virginia University to develop, pilot and train community-based clinicians on the use of the Suicide Older Adult Protocol (SOAP). SOAP is an empirically supported guided clinical interview for use by mental health professionals. It is a risk assessment model to determine level of suicide risk among older adults. Specific response guidelines are offered for each level of risk.

Military Personnel

The West Virginia Council of Churches uses State and local funds to coordinate *Care-Net: Beyond the Yellow Ribbon* which provides services and supports to ***military personnel and their families*** through all phases of the deployment cycle including pre- and post-deployment. The project targets all prior and current military members who claim West Virginia as home. The West Virginia Council of Churches collaborates with the West Virginia Mental Health Consumers' Association to implement Wellness Recovery Action Planning (WRAP) for veterans with mental health and addiction issues as one component of peer support at Veteran's Centers.

The BBHMF collaborates with the Inter-Service Family Assistance Committee (ISFAC). The primary goal of ISFAC is to develop and strengthen family assistance delivery systems and increase awareness of networks within civilian and military communities. The ISFAC assists in coordinating and extending community resources to empower, mentor and build resilience for military personnel, especially in the event of mobilization, deployment, or natural disaster.

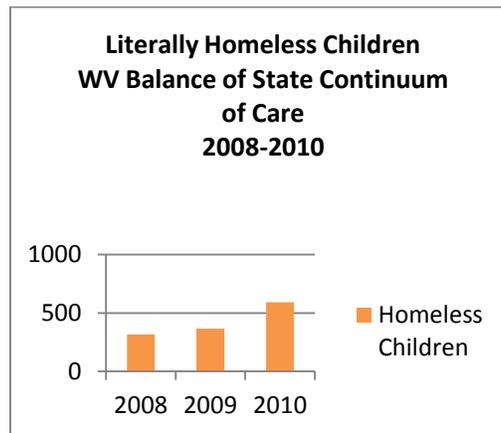
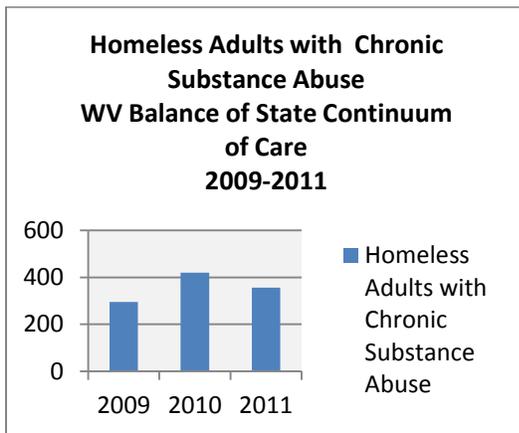
The Peer Recovery Network provides outreach to veterans experiencing homelessness in the metro-Charleston. They locate these veterans, offer clothing and food, encourage them to move into shelters, assist in finding permanent housing, and offer assistance with recovery.

One provider of services to individuals who are homeless, the Roarke-Sullivan Lifeway Center (RSLC) in Charleston, provides services specifically directed to veterans. The RSLC services to veterans include individuals and group therapy, case management, transportation, mental health and substance abuse support services. The Veterans Administration provides on-site benefit assistance for any veteran in the community in need of services. Several other community organizations provide on-site services to veterans. The RSLC operates a 12-bed transitional living program combined with intensive case management support for male veterans.

Homeless

West Virginia is working to create and implement a seamless system to meet the comprehensive needs of people who are experiencing homelessness and/or are at risk of becoming homeless. There are many facets of homelessness, including issues unique to domestic violence, women with children, veterans, older adults and temporary job loss. Five years ago WVDHHR and the U.S. Department of Housing and Urban Development (HUD) organized the Interagency Council on Homelessness to impact services for people experiencing homelessness or who are at risk of becoming homeless. Members of the Interagency Council are representatives of organizations across the State.

Forty-one counties have joined again to complete a HUD Balance of State Continuum of Care (COC) application. This grant funds housing and supportive services for people who are experiencing homelessness in areas of the state which had previously not received HUD COC funding. Rural areas of the state have especially benefited from these additional funding resources; several projects specifically target support services to people with a serious mental illness and/or co-occurring addiction. Projects include the Shelter-Plus-Care model of permanent housing providing rental assistance to individuals and families experiencing homelessness, along with supportive services. One shelter also offers non-medical detoxification services and works closely with the local community behavioral health center. Individuals served by homeless shelters in West Virginia have access to this program.



People who are experiencing homelessness and who are located in the deep, rural areas of West Virginia often live with family members, especially during the winter months. The culture of West Virginia involves families taking responsibility for their own, so many times people “double up” under one roof. However, some do not, and, for this reason, outreach services are necessary in rural areas. Projects for Assistance in Transition from Homelessness (PATH) programs are located in strategic areas across the state and serve people with mental illness and/or co-existing disorders in rural areas by providing outreach and assigning staff to spend time in counties where there is limited access to services. People in these counties are referred to shelters as needed. Those regions were brought under the umbrella of the Balance of State which leveraged additional funding resources for homeless services. This has been a successful endeavor which has been facilitated by the West Virginia Coalition to End Homelessness. Peer transportation by the Mental Health Services Block Grant assists with transportation issues in these rural areas.

Although the plight of people experiencing homelessness is partially addressed by Projects for Assistance in Transition from Homelessness (PATH) and regional and local homeless providers around the state, an increasing number of people experience of not having permanent residency. Accessing services can be a tremendous challenge without a fixed address, identification and health insurance. The BBHMF is an active member of the West Virginia Housing Development Fund’s (the state housing agency) Interagency Housing Coalition and has identified housing for people with serious mental illness as a priority in the agency’s five-year plan. In addition, one of

the regional CBHCs, Pretera Center, has received several significant HUD 811 grants in the Charleston and Huntington areas which provide services and supports for people with mental health and co-occurring substance abuse issues.

For example, utilizing \$60,000 in Affordable Housing Program (AHP) funds as leverage, Pretera's Assaley Place Apartments project added eight units for people experiencing homelessness with serious mental illness. New and rehabilitated units were created on three vacant and blighted properties within two blocks of each other in Charleston's East End neighborhood. Two new units were constructed on a donated vacant lot; four apartments in an existing 2½-story brick building were rehabilitated; and two apartments were rehabilitated in an existing 1½-story wood-frame residential building. All of these buildings preserved the neighborhood's housing architecture and met the Environmental Protection Agency's energy-star ratings for electrical systems, plumbing, windows, doors, appliances and heating units. A Section 811 rental housing program, Assaley Place supports Charleston's approved Bridges to Tomorrow Comprehensive Plan and the East End Neighborhood Revitalization Plan.

Recovery and Peer Supports

West Virginia has a long history of encouraging and funding peer organizations and services. The West Virginia Mental Health Consumers Association used a Federal grant to provide technical assistance and training throughout the nation, focusing on the Leadership Academy approach to empowerment and advocacy. The BBHMF has supported this organization to enable the development of a variety of peer-operated and services and supports. Many individuals in the State have been trained in WRAP and WRAP facilitation.

West Virginians in recovery from mental illness and substance abuse are assisting in transforming the system with strong consumer advocates located throughout the State. The BBHMF sought new partnerships with consumers and peer-operated programs and services in SFY 12. The BBHMF recently announced funding availability totaling \$920,000 for recovery oriented peer education, peer support development and training, peer mentorship and recovery supports, peer transportation, supported employment, and drop-in centers.

Care Coordination Program

A State funded Care Coordination Program was initiated in SFY 2006 with funding totaling \$3 million. Care coordination was created to decrease the number of involuntary commitments resulting in diversions to private hospitals and to increase community support for individuals discharged from facilities and individuals at risk for hospitalization who are currently in community settings. Current data do not suggest that care coordination is decreasing commitments and diversions. However, the data suggest that Care Coordination impacts recidivism, community tenure, and the quality of life of individuals. Consumers and family members interviewed at regional programs praised the quality of this program.

The BBHMF allocated additional funding in SFY 10 to CBHCs for an additional 19 care coordinators. To date, there are 123 funded Care Coordinators in the 13 CBHCs. In SFY 11, independent agencies in West Virginia were funded for 16 Care Coordinators. The funding has

enabled care coordination throughout the State for preventive and individualized, intensive follow up services for people with serious mental illness, substance use disorders and/or intellectual and developmental disabilities who are in crisis and at risk of being involuntarily committed, or leaving inpatient settings that resulted from involuntary commitments.

Employment services

The Divisions of Intellectual and Developmental Disabilities and Adult Behavioral Health collaborate to provide funding, support and training for supportive employment programs modeled on job coaching and job development guidelines established by the Association for Persons in Supported Employment (APSE). This endeavor is an efficient use of State dollars for the BBHMF and capitalizes on the strengths of each division. The West Virginia Mental Health Consumers Association (WVMHCA) and Pretera Center for Mental Health Services collaborate in using BBHMF funding to help adults with serious mental illness and co-occurring addictions find competitive employment in integrated work settings. Additional employment opportunities are provided by Job Squad and Goodwill.

Housing services

According to second-quarter 2010 U.S. Census data, West Virginia has an extremely high (74.4%) owner-occupied housing rate. While this is a positive statistic in many respects, it also results in a shortage of safe and affordable housing for people who do not have the means to purchase and maintain their own residence. The BBHMF supports efforts of publicly funded behavioral health providers to increase the availability of safe and affordable housing.

The Department of Housing and Urban Development (HUD) Continuum of Care, Balance of State, has been fully funded and additional housing and supportive services continue to expand. In SFY 09, West Virginia's three regional Continuums and the Balance of State Continuum received \$2,278,201 from HUD in new Continuum of Care dollars and \$3,152,079 to renew funding for 27 existing local programs. Of the new funding, \$455,100 was for new Shelter Plus Care programs and \$950,064 for Shelter Plus Care renewal projects. Another \$320,097 was set aside for a new Supportive Housing Program for two Housing First projects in Charleston, \$101,343 for a new substance abuse recovery program for men experiencing homelessness in Huntington, and \$113,071 for new transitional housing in Parkersburg for people with serious mental illness.

Education Services

West Virginia continues to invest in educational services for adults with serious mental illness. The Comprehensive Behavioral Health Commission includes representatives from higher education. Resources available include the West Virginia One Stop Centers and services available through the Division of Rehabilitation Services (DRS). One Stop Centers offer a variety of services for both consumers and employers in the areas of training and employment. These services include assessment of skills, abilities, aptitudes and needs; assistance with unemployment insurance; access to Wagner-Peyser Act funded employment services, such as the

State's public labor exchange and labor market information; career counseling; job search and job placement assistance; and information on training, education and related supportive services.

DRS offer other educational assistance through community based supports. In SFY 10, DRS provided school transitional services to 6,197 students with disabilities aged 16 to 21. In addition, DRS provided \$6.6 million for tuition and other college expenses for 2,474 students with disabilities.

The BBHMF uses Mental Health Block Grant funds to support the Recovery Education Center to train adults with serious mental illness or co-occurring disorders as Peer Support Specialists. The training has been accepted by the Kanawha Valley Community and Technical College (KVCTC) for a Certificate program.

The Recovery Education Center offers a unique blend of Peer Support Specialist certification from WVMHCA and college credit towards an Associate's Degree in Applied Science from KVCTC Community Behavioral Health Technology. The training is frequently linked to supported employment and job placement with local behavioral health and peer support providers. This initiative simultaneously enables recovery and employment and helps address the state's workforce development.

Dental Services

The West Virginia Dental Association has a Donated Dental Services program providing free dental care to people with disabilities. The latest available data reports \$63,361 in donated dental services, 29 patients treated, 95 volunteer dentists; and 41 volunteer dental labs. The West Virginia University School of Dentistry is available to provide free comprehensive dental care to adults and children of all ages. The clinics offer 24 hour emergency treatment. The West Virginia University Institute of Technology Dental Hygiene Program offers free cleanings and other dental services at certain times during the spring and fall semesters. There are no eligibility or income requirements.

Seven of West Virginia's primary care centers and satellite clinics offer dental care in nine counties. Three of the free clinics offer dental services. Adult pre-employment dental care is available on an as needed basis to eligible people who receive cash assistance from the State Temporary Assistance for Needy Families (TANF) program, West Virginia WORKS. This service is intended to help TANF recipients become more self-sufficient.

Faith Based Support Services

The BBHMF provides funding to three faith based organizations.

Burlington United Methodist, a charitable human services organization, provides residential care and a variety of community-based services. Residential services are provided for 30 youth aged 8 to 18. Both Level II and Level III services are provided. Level II targets youth with diagnoses that manifest in moderate to severe adjustment difficulties. Level III services provide a highly structured, intensively staffed 24-hour setting for youth with severe conduct and emotional

disorders that prevent them from functioning in multiple areas of their lives. The organization also manages a Youth Services Program for youth who are experiencing behavioral difficulties and are at risk for court intervention. Services are provided to both the youth and his or her family.

The Religious Coalition for Community Renewal (RCCR) collaborates with other community organizations to develop projects and programs to help renew communities by identifying, addressing, and overcoming obstacles which keep people from accessing safe and affordable housing. The RCCR is a membership organization with over 30 religious interfaith congregations making up its membership. The RCCR is supported by a volunteer board. It receives funding from its members, individuals, businesses, state, local and federal government, foundations and trusts. Programs include Jubilee Housing, a program developed to encourage and support safe and affordable housing; Smith Street Station, a 29-unit furnished apartment facility for one- and two-person families; and the Samaritan Inn for men with co-occurring disorders.

The BBHMF also provides funding to the Partnership for African American Churches (PAAC). The PAAC uses an African American Faith Based, Community Based Participatory /Empowerment model to implement selective prevention measures among African Americans in Kanawha, Logan and Mingo counties in West Virginia. The PAAC continues to empower and provide support for established groups of communities of color and build additional coalitions in West Virginia communities. Once these coalitions are functional they are provided training contained in the African American Faith-Based Tool Kit developed by Central Center for the Application of Prevention Technologies (CAPT). The training focuses on Substance Abuse Prevention Specialist Training and implementation of the Strategic Prevention Framework (SPF) in the Faith Based environment. Once community members are trained and reach the implementation stage of the SPF, they will select and implement SAMSHA approved environmental and program solutions. These solutions are expected to be effective as they will be driven by locally specific data, will be science based, and will be implemented, monitored and evaluated by local community based residents.

The BBHMF collaborated with SAMHSA's Coordinator for Faith Based and Neighborhood Partnership Initiative to co-sponsor a three-day Capacity Building Technical Assistance meeting that included topics of sustaining and expanding treatment capacity, building collaborative relationships and partnerships, evidence-based practice, outcomes and results oriented evaluation, fundamentals of a marketing plan, and fundraising strategies. Twelve non-profit agencies participated in this two-and-a-half day event. Agencies represented faith-based organizations, CBHC staff, peer organizations, prevention coalitions, and long-term care providers.

Faith-based organizations with Grant Agreements with the BBHMF are required to comply with the provisions of 42 U.S.C. 300x-65 and 42 C.F.R. part 54. Individuals receiving services from faith-based organizations partially funded by the BBHMF are required to inform individuals of their right to alternative services.

Disaster Preparedness for Special Populations

The BBHFF employs a full-time Disaster Coordinator who collaborates with first responders, hospitals, local health departments, and others to develop disaster response plans, continuance of operations plans and to conduct table top and other exercises across the State. The BBHFF uses \$183,500 in Health Resources and Services Administration (HRSA) funds from the Bureau of Public Health (BPH) to support regional provider preparation and response activities across the State, including a 24/7 hotline, an annual disaster mental health conference and disaster mental health training for designated staff at each of the CBHCS. The BBHFF 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.

Physician Leadership in Public Policy Recommendations

In August 2011 the West Virginia State Medical Association published a report offering recommendations on prescription drug diversion. The report is the culmination of collaborative efforts of physicians committed to finding solutions to the growing epidemic of the illicit use of controlled substances. The report speaks to the development and evolution of a prescription monitoring program (PMP), including advisory support, information management and reporting including enhanced Methadone reporting, funding for enhanced PMP development, penalties related to PMP information handling, improved control of scheduled drugs, heightened regulation of pain clinics, and limitations on dispensing of controlled substances and other drugs. In addition, the report emphasizes improved PMP education, training and certification for law enforcement, and equipping first responders with the ability to effectively treat drug overdoses, thus offering increased capacity to save lives. This report offers thoughtful consideration of the substance abuse issues impacting West Virginians and sets forth clear and concise guidance regarding short term and long term strategies that are essential to implementing effective prescription drug diversion efforts.

Improved Practice Guidelines, Protocols and Mandated Requirements

Reviewing and revising or updating practice guidelines, protocols, and legislative requirements set forth in West Virginia State Code continues to be a focus related to system improvement. The Office of the (Hartley) Court Monitor has been asked to facilitate the development of updated behavioral health and Certificate of Need standards for the State. This activity began in May 2011 and will culminate in the Legislative session of 2013. Stakeholders from all aspects of behavioral health service and support communities are participating in the process. A primary objective of the revisions will be to address the relatively dramatic changes that have occurred in the areas of community based behavioral health services, particularly those affecting the populations of consumers with co-occurring mental health and substance abuse issues. Homeless outreach services have been incorporated, as have fellowship homes and transitional addictions programs. Additionally, the changing nature of in-home supportive services, such as those provided under Federal Medicaid Waiver programs through Medicaid, require amendment of the more traditional definitions and regulations of behavioral health treatment services.

II: Planning Steps

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

Page 22 of the Application Guidance

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: Unmet Service Needs and Critical Gaps

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide by 2020. West Virginia is no exception to this crisis. Data reviewed to assess the needs and critical service gaps of West Virginia are categorized as epidemiological/empirical data, community qualitative (anecdotal) data, and system or administrative data. Such data guided decisions to determine the State's priorities, goals and strategies.

The *2011 Behavioral Health in West Virginia State Epidemiological Profile* includes a variety of data sources available that are related to substance consumption, related consequences, and critical mental health indicators. This type of epidemiological analysis and summary forms the basis for the State's monitoring system for substance use and mental health prevention/promotion efforts. These efforts may also inform stakeholders of the needs of the State, the planning, and the approach West Virginia is taking to address these issues relevant to Treatment/Monitoring/Evaluation.

Community Qualitative Data

The BBHMF has collaborated with others in obtaining significant information related to behavioral health system needs. The BBHMF facilitated regional stakeholder meetings throughout West Virginia regarding substance abuse prevention and treatment. The BBHMF continues significant partnerships with the Bureau for Children and Families on the West Virginia System of Care and the West Virginia Service Array Initiative. Both of these priority partnerships have involved significant stakeholder input to identify gaps and needs for children and adolescents and their families. The BBHMF collaborated with the West Virginia Mental Health Planning Council as they conducted community forums regarding services for adults with serious mental illness.

In June 2010, the BBHMF launched meetings with key stakeholders, Federal consultants and State representatives in an effort to seek input regarding local concerns, priorities, solutions and strategies to improve the behavioral health service delivery system. The BBHMF conducted eight focus groups, six community forums, 10 special interest sessions, and numerous individual meetings to assess stakeholder perception about substance use and abuse, prevention efforts, treatment availability, and what currently works to positively impact communities across the State. Participants included the general public, prevention and treatment service providers, first responders, law enforcement, physicians, educators and youth leaders. The BBHMF's priority throughout this stakeholder input process was to seek comment on current prevention and treatment needs of West Virginia communities; however, valuable input was provided in the needs for mental health promotion and treatment services as well. With more than 450 representatives from various stakeholder groups, ongoing collaborative relationships were developed to address the State's substance abuse epidemic.

Comments and concerns expressed during this process included:

- Substance abuse is a real concern and is directly related to other concerns in the community like unemployment, crime, and poverty

- There is a sense of hopelessness when it comes to addressing the states substance abuse problem
- There is increased accessibility and availability of synthetic drugs like “bath salts”
- People are dying (from the use or abuse of substances)
- More young kids are using substances
- Pregnant women are using prescription drugs without knowing what the harm will be
- Schools have less time to support non-academic initiatives
- Youth need to be part of the solution, working with caring adults
- There is a need for local data to be able to obtain funding and help people realize that there is a problem
- In the past, Safe and Drug- Free Schools dollars were used to conduct school surveys and support youth initiatives in schools, but those funds are no longer available
- There is a loss in work force capacity
- Treatment isn’t long enough and people relapse upon discharge
- Treatment facilities won’t admit you if you have private insurance
- Law Enforcement does not respond when you call; dealers don’t spend any time in jail even if they are arrested
- There seems to be a disconnect between prevention and service providers
- There is a lack of physicians who know about substance abuse prevention

(West Virginia Communities Respond: A Synthesis of Qualitative Forum Discussions)

The West Virginia Mental Health Planning Council (WVMHPC) has been a community voice for the behavioral health system in the State. The WVMHPC added provider and consumer seats representing substance abuse three years ago. The WVMHPC prepared and presented to the BBHFF a document, “Synopsis of Current Recommendations for Mental Health and Substance Abuse Services in West Virginia: With a Blueprint for Transformation.” The document focused on the system of care in the State relative to the New Freedom Commission on Mental Health. It recognized a number of good and modern services in the State and described gaps and needs. The WVMHPC also undertook a mystery shopper survey of crisis services in the State and made recommendations for improvement. Several sparsely attended community forums sponsored by the Council have indicated the need for transportation to and from services as well as the need to expand recovery-oriented services.

With the technical assistance of the National Child Welfare Resource Center for Organization Improvement, the WVDHHR began a statewide gaps and needs assessment referred to as the West Virginia Service Array (WVSA) Initiative. The WVSA is an established process to identify service needs of children and their families across all domains. The WVSA process was completed by the 13 Community Collaboratives covering every county in West Virginia. The Community Collaborative members included representatives of local behavioral health and primary care providers; family resource networks (FRNs); and juvenile services. The Collaboratives had little success engaging families and local education representatives.

Each of the 13 Community Collaboratives assessed their current capacity to meet the needs of children and families and created a comprehensive service directory for their counties. In addition, they developed and are implementing Resource Development Plans (RDP) to address the needs of their communities. All 13 Community Collaboratives concurred that there are critical service gaps in substance abuse prevention services; treatment services for adults, adolescents and women with dependent children; and the presence of school-based family resource workers (defined as social service workers stationed in schools to provide family support and other preventive services).

Critical Gaps in Collection, Analysis, Interpretation and Use of Data

Data systems for West Virginia’s publicly funded behavioral health system are fragmented and insufficient for the BBHMF make informed decisions. Current collection methods do not guarantee data integrity or quality control. Additionally, data collection methods available to the BBHMF do not meet the minimum standardized categories for race and Hispanic ethnicity, nor do they provide information regarding sexual orientation and gender identity. Efforts will be taken in the next year to assure data is complete, timely, accurate, valid, reliable, and accessible.

Grant Agreements with First Choice enable collection and reporting of substance abuse prevention activities provided. The CBHCs submit treatment data on individuals served and services provided and the BBHMF is able to compare that data with service data provided by APS Healthcare, the State’s Utilization Management contractor for Medicaid. Services funded by the Mental Health Services Block Grant are reported through a Grant Agreement with Marshall University. These data sources are used to provide the State’s reports for SAMHSA’s Treatment Episode Data Set (TEDS) and SAMHSA’s National Outcome Measures (NOMS). They are also used to assist the BBHMF in its planning.

The BBHMF data collection and reporting process will be improved using the tools of the Division of Compliance and the West Virginia State Epidemiological Outcomes Work group (WVSEOW). The BBHMF recently obtained funding to employ an Epidemiologist. The Epidemiologist facilitates the work of the WVSEOW, which includes representatives of State agencies, providers and associations. The WVSEOW will collaborate in data sharing, early warning monitoring systems, and State and community profile development. Data will be used to produce useful interpretation reports so that the BBHMF can make informed decisions relative to continuum planning, allocation, implementation and monitoring.

West Virginia State Epidemiological Work Group Membership		
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		Charleston, WV 25301 (304) 558-8814
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In addition to the membership listed above, staff of the BBHMF participate in the SEOW. These include Kimberly Walsh, Deputy Commissioner and co-Project Director; Craig Richards, Deputy Commissioner and co-Project Director; Kathy Paxton, Project Manager; Shannon McBee, Epidemiologist; Wendy Elswick, Assistant Attorney General; Glen Calvin, Data and Technology; and a Research Assistant yet to be named.

The BBHMF Division of Compliance has employed two qualified, experienced staff members. Each brings extensive knowledge in various aspects of behavioral health programming, monitoring and technical assistance reviews. During the current State fiscal year, it is expected that the Division of Compliance will develop multiple tools and instruments to assist program staff in monitoring grants as well as providing a specialized and independent resource to perform onsite monitoring reviews.

WVDHHR's current sub-recipient monitoring plan provides both a centralized and decentralized approach to monitoring. While multiple aspects are mandated at a Department and Bureau level, the plan also permits and requires programs to use discretion and experience to develop unique monitoring tools and methods. In accordance with this framework, the Division of Compliance will expand the capabilities and range of techniques used to monitor sub-recipient grantees.

Youth survey data can be a useful tool in planning services for children and adolescents. However, comprehensive youth survey data covering multiple domains has never been available in West Virginia. Some county school districts have used Safe and Drug-Free Schools funds to implement surveys in the past. This funding is no longer available. The last statewide school survey was conducted in 2005. The BBHMF is collaborating with the Department of Education to develop a statewide approach to using the Youth Risk Behavior Survey.

Critically important healthcare data are often fragmented and reside in silos that do not communicate with each other. The West Virginia Health Information Network (WVHIN) was established in 2006 to design a statewide interoperable health information technology network. The WVHIN is charged with building a secure electronic health information system for the exchange of patient data among physicians, hospitals, diagnostic laboratories, other care providers, and other stakeholders.

The WVHIN's Health Information Exchange (HIE) will connect providers and others electronically to enable clinical information and administrative data to be shared between organizations. The WVHIN will provide the interoperability necessary to enable secure exchange of information.

Critical Gaps in Access to Comprehensive Services

Parity in Serving Individuals with Mental Health Disorders

The Vocational Rehabilitation agency in West Virginia, the Division of Rehabilitation Services (DRS), has not been as aggressive in conducting outreach to and providing services for people

who are not working because of a mental illness as opposed to people who are not working due to a physical disability. According to its FY 2010 Annual Report, only about 12% of its 15,592 customers were categorized as having a “psychosocial impairment.” In addition, DRS has historically had a policy about not providing service to people who have been hospitalized until at least six months after they have returned to the community.

Consumer/Family Engagement

The BBHMF has long recognized the significant need for and lack of consumer /family outreach and engagement in planning, implementation and evaluation of the behavioral health system. Poverty, caregiver trauma, access, stigma, and poor prior health care system experience can be significant barriers for children and adults. Families may not feel welcomed, supported and heard by service agency staff. Service providers often express frustration with the lack of consumer follow up for treatment and family participation in all aspects of their child’s treatment. Significant barriers often frequently identified in West Virginia culture include concerns about privacy and sharing details of experiences or treatment in more public venues.

Research describes the numerous benefits of consumer-centered /family-driven treatment, but the State’s behavioral health providers have yet to put the findings of this research fully into practice. Family participation can improve the way children and adults are served by increasing focus on families, provision of services in natural settings, greater cultural sensitivity, and result in a more effective community-based system of care. It is essential for service providers to be ever mindful that seeking consumer and family input is a key to increasing engagement and improving behavioral health outcomes. As Jones states, “... all work in Appalachia must be based on the genuine needs as expressed by the mountain people themselves” (1994).

Service providers often express frustration with the lack of consumer follow up for treatment and family participation in all aspects of their child’s treatment. Poverty, caregiver trauma, access, stigma, and poor prior health care system experience can be significant barriers for children and adults. Families may not feel welcomed, supported and heard by service agency staff. The Family Advocacy, Support and Training (FAST) Program of Legal Aid of West Virginia has found that families sometimes lack the skills or confidence to participate in their child’s treatment and service agency activities. Additionally, West Virginia culture may present a barrier because people are often concerned about privacy and independence.

Substance Abuse Services

As part of the West Virginia Service Array Needs/Gaps Assessment, 10 of the 13 Community Collaboratives indicated that there is a gap in Substance Abuse Services in their areas. All 13 indicated that substance abuse prevention services were available to at least 25% of their population, but none reported these services were available to the total population. The average reported availability was 48.5%. When assessing needs/gaps in outpatient substance abuse treatment services, 12 counties reported there was little to no accessibility to these services. Of the remaining responses, the average availability reported was 32.1%. The quality of outpatient substance abuse services was rated as “poor” to “occasionally good” in 11 of the 13 Children’s Community Collaboratives.

Data from multiple sources reveal that West Virginia's substance use/abuse related indicators are often above the national norms, and that access to prevention, early intervention and treatment services is not meeting the estimated need. In 2009, West Virginians filled more prescription drugs at pharmacies than residents of any other state. In West Virginia, the per capita rate was 18.9 prescriptions, while the national norm was 12 (*Kaiser Family Foundation, 2010*). Nationally, only 2.8% of all individuals admitted to behavioral health services sought treatment for opioid dependence; in West Virginia, these individuals accounted for 12.2% of admissions (*Hall, 2008*). As reported by the American Association of Poison Control Centers, West Virginia leads the nation in "bath salt" poisoning cases, and the number has grown dramatically over the last year. In 2010, there were three such cases reported to the West Virginia Poison Control Center. There have already been 204 cases reported thus far in 2011.

According to the *2007-2008 West Virginia Behavioral Risk Factor Survey Report*, approximately 152,000 residents over the age of 18 have a substance abuse disorder. However, in 2009, West Virginia served only 8,970 individuals through substance abuse treatment admissions (*TEDS, 2009*). This implies that more than 143,000 individuals needed treatment but did not receive it. This gap in services has resulted in dire consequences for West Virginia, affecting residents of all ages and socio-economic classes.

West Virginia places a strong priority on the early identification of substance "misuse" which involves approximately 25% of the general population. This segment of the population is often overlooked by traditional medical, criminal justice, and social service systems due to the lack of explicit evidence associated with individuals who meet the diagnostic criteria for abuse or dependence. The West Virginia SBIRT project uses a public health, population based approach and universal screening in various settings to promote substance use as a health issue. The project provides screening in seven venues, including Primary Care Centers, Hospital Emergency Departments, School Based Health Sites, Colleges/University Health Centers, Workforce Development Centers, Homeless Shelters, Mental Health Units and Free Clinics (Health Right). The project promotes a flexible approach to implementation to avoid disruption of the flow in established sites. This flexible approach accounts for the success of SBIRT in West Virginia and has led to substantial buy-in from the 67 implementation sites. West Virginia SBIRT is well on the way to sustainability and has been endorsed by several significant stakeholders, including the West Virginia Primary Care Association, the West Virginia Perinatal Partnership, the Expanded School Based Health Initiative, the Governor's Office of Health Enhancement and Lifestyle Program (GOHELP) and the West Virginia Medical Association.

Interventions are based on the evidence based models of Stages of Change and Motivational Interviewing. Individuals who screen positive for binge drinking, misuse of prescription medication or who are in the experimental phase of illicit substance use are provided feedback in a non-confrontational manner about how their substance use may negatively impact their health. Individuals are given the opportunity to address this issue by using strategies that are provided by trained SBIRT clinicians. Patients are tracked for follow-up and provided additional support and clinical services as appropriate.

SBIRT has proved to be a much needed addition to the system of care for substance use in the State. Since being awarded in September, 2008, West Virginia's SBIRT project has screened 108,380 individuals for substance use and provided interventions to 6,184 people. The project's interventions have led to impressive positive outcomes in several life areas such as emotional health, physical health and family/social connectedness.

Substance-related Deaths: Unfortunately, many individuals with substance use disorders are unsuccessful in obtaining the services they need, and eventually die of overdose or illness related to chronic addictions. The State experienced a 550% increase in drug overdose deaths between 1999 and 2004 (Hall, 2008). Drug overdose is the leading cause of death for West Virginians under age 45 (*West Virginia Prescription Drug Abuse Quiltline, 2010*), with a rate that is nearly double that of the U.S. Opioids are the number one cause of drug overdoses in the State (*West Virginia Bureau for Public Health*), contributing to 93.2% of deaths associated with unintentional pharmaceutical overdose fatalities. Only 44% of the deceased had a prescription for the opioids contributing to the death (*Hall, 2008*).

Alcohol is responsible for many deaths in the State. The rate of alcohol related overdoses in West Virginia has doubled since 2001 (*Centers for Disease Control and Prevention, 2008*). Approximately 40% of all fatal motor vehicle accidents were alcohol-related in 2009 (*National Highway Traffic Safety Administration, 2011*). According to the West Virginia Bureau for Public Health, chronic liver disease and cirrhosis account for 241 per 10,000 deaths in West Virginia, which is higher than the national average.

Behavioral Health Services

Data from multiple sources reveal that West Virginia's residents generally exhibit increased risk factors related to mental health when compared to the nation. These data also reveal 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 Sub-Index* of that poll (*Mendes, 2011*).

According to the *2009 Youth Risk Behavior Survey*, West Virginia youth are more likely than their peers across the nation to live in fear of and to experience violence. Nearly 8% avoid going to school because they feel unsafe at school or on their way to or from school on at least one day per month. Over 23% have been bullied on school property at least once in a year. More than 24% had carried a weapon, and just over 10% had carried a gun on at least one day in the 30 days before being surveyed. Nearly 14% reported that they have been hit, slapped or physically hurt on purpose by their boyfriend or girlfriend. Over 11% have been physically forced to have sexual intercourse at least once in their lives (*Centers for Disease Control and Prevention 2009*).

According to the *2007-2008 West Virginia Behavioral Risk Factor Survey Report*, it is estimated that 182,000 West Virginians over the age of 18 have a diagnosable mental illness. Based on 2009 U.S. Census data, and using prevalence rates of 7.1%, there are up to 101,646 adults who have a serious mental illness, and 25,357 children with serious emotional disturbances residing in West Virginia. During SFY 2009, the State's CBHCs served 42,247 adults with serious mental illness, and 16,563 children with serious emotional disturbances.

Trauma Exposure: Research shows that "...repeated trauma exposure tends to produce a cumulative detrimental effect with loss of resilience and increased vulnerability to future trauma exposure" (Shaw, Espinel and Shultz 2007). The youth of West Virginia face a variety of primary and secondary traumatic experiences, often at higher rates when compared with other youth in the nation. About 19% of our state's children have experienced abuse or neglect, nearly double the nationwide rate of just over 10%. As reported previously, over 11% of our youth have been physically forced to have sexual intercourse at least once in their lives, and nearly 14% have been hit, slapped or physically hurt by their boyfriend or girlfriend (Centers for Disease Control and Prevention 2009). In 2006, there were 996 West Virginia youth who were victims of domestic violence (National Coalition Against Domestic Violence 2008).

Suicide: According to the West Virginia Bureau for Public Health, the suicide rate in West Virginia is 15.6% per 100,000 people. Over two-thirds of all suicide deaths were firearm related. Although suicide was the 12th leading cause of death overall, it was the second leading cause of death for individuals aged 15-34. According to the 2009 Youth Risk Behavior Survey, 18% of West Virginia's youth had seriously considered attempting suicide in the last 12 months. Almost 14% actually made a plan about how they would attempt suicide during that year. Alarming, more than 10% report they had attempted suicide one or more times in the last year, and almost 5% made a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse. In 2008, self-inflicted injuries accounted for 1,643 hospital admissions for youth age 24 and under, making it the 4th leading cause of injuries resulting in hospitalization (Children's Safety Network 2011).

ASPEN has trained 1,275 individuals from a variety of disciplines, such as school personnel, mental health professionals, youth services workers, faith-based professionals, juvenile justice workers and other individuals serving and interacting with at-risk youth. The focus of the training was on awareness, screening, and protective factors.

Services for Priority Populations

Children and Adolescents with serious emotional disturbances: In West Virginia, 14.3% of children aged 2-17 have one or more emotional, behavioral, or developmental conditions, compared with 11.3% nationwide. Of those children, 49.1% have two or more of such conditions, compared with 40.3% nationwide (National Survey of Children's Health 2007). Over 9% of West Virginia's youth aged 12 to 17 years report having at least one major depressive episode, exceeding the national average (SAMHSA, 2007). According to the 2009 Youth Risk Behavior Survey, nearly 30% of our state's youth reported that they had felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities at least once over the course of the previous year.

Adults with serious mental illness: One statistical analysis reported there were 92 commitments per 100,000 in West Virginia in 1995. Eight years later, between April 2003 and March 2004, there were 256 commitments per 100,000 people, a net increase of 178%.

Accessible transportation is an identified weakness in the overall healthcare system. Public transportation is nearly non-existent in rural areas of the State. A benefit which allowed people

with disabilities to purchase discounted public transportation passes has been discontinued. West Virginia has attempted to resolve this through flexible services such as Assertive Community Treatment (ACT) and Care Coordination. These services are not sufficiently widespread to enable adequate access to services.

Although there are a number of strong, recovery-oriented peer support programs available in West Virginia, gaps remain. The east and central regions do not have non-traditional resources available beyond 12 step programs like Alcoholics Anonymous and Narcotics Anonymous.

Development of a system of care for adult behavioral health is necessary to address the wide range of issues for people with serious mental illness. The BBHMF vision is to create a System of Care for the adult behavioral health population to address the identified needs for adults with serious mental illness. The ideal system would incorporate primary health care with behavioral health services and support services such as housing, jobs, education and social experiences. The BBHMF plans to embark on the development of such a System of Care for adults.

Persons who are intravenous drug users: West Virginia ranks low in the total number of HIV/AIDS cases (40 out of 50 states). Only 8.7% of those cases reporting injection drug exposure. Although these numbers are not significant, West Virginia students in grades 9-12 report a steady increase in heroin use on at least one or more times during their lifetime since 2005. These students also report a steady increase in the use of needles to inject any illegal drug into their body on at least one or more times during their lifetime.

Adolescents with substance abuse problems: West Virginia's youth exhibit higher risk related to the use of several substances when compared to their peers in the nation. According to the 2009 *Youth Risk Behavior Survey*, more West Virginia high school students reported: binge drinking; alcohol and marijuana use before age 13; riding in a car with someone who had been drinking (25.6%); using cocaine (8%), methamphetamine (6.5%), chemical inhalants (15%), heroin (4%), or steroids (6%) at least one time in their lives; and, using a needle to inject drugs at least once (4%). Additionally, West Virginia high school students are demonstrating a trend toward increased risk behaviors associated with substance use. Youth's use of heroin and intravenous drug use has steadily inclined since 2005 in West Virginia (SAMHSA, 2006).

Pregnant women who have a substance use and/or mental disorder: Research shows that women of childbearing age, particularly 18-34, show the highest use of alcohol (Savage, 2006). Umbilical cord studies indicate that as each year passes, more babies born in West Virginia have been exposed to drugs. In 2009, nearly 20% of West Virginia newborns tested positive for alcohol and/or drugs; in 2010, the incidence rate had increased to 33%. The national norm for this indicator is 4%, which reveals the State's elevated risk (Stitely, et al., 2010). Women aged 35 and older, as well as women who had an annual income of \$50,000 or more, reported the highest use of alcohol during the last 3 months of their pregnancy (Centers for Disease Control and Prevention, 2010).

Many West Virginia providers find that it can be challenging to address substance use behaviors with pregnant women. Because pregnant women often experience shame or denial regarding their substance use, they may minimize the extent of the use or deny it completely. This

behavior can interfere with a provider's ability to accurately diagnose and treat the substance use disorder.

Military Personnel and their Families: Years of war have significantly stressed West Virginia's military personnel and their families. According to the 2010 West Virginia National Guard Annual Report, 1,000 Guard personnel deployed during 2010, and approximately 11,000 have deployed since September 11th, 2001. These individuals exhibit increased rates of combat stress, substance abuse, divorce and suicide. Of the 1.6 million U.S. soldiers who have been deployed in Iraq and Afghanistan, 18%-20% show symptoms of post-traumatic stress disorder (PTSD), depression, or both. Only slightly more than half of these veterans have sought treatment (Seal, et al., 2009). According to the Department of Veterans Affairs (VA), about 47% of the men and women leaving military service associated with the conflicts in Iraq and Afghanistan have sought VA health care. In 2009, there were 29,211 West Virginia veterans who received disability compensation or pension payments, and nearly 600 participated in VA vocational rehabilitation programs. Thirty-five West Virginia service members have lost their lives while serving in Iraq and Afghanistan.

Individuals with or at risk of contracting communicable diseases: WVBPH data indicate that 8.7% of HIV/AIDS cases in West Virginia reported injection drug use exposure. West Virginia reported 1,718 AIDS cases to CDC, cumulatively, from the beginning of the epidemic through December 2008. West Virginia ranked 40th highest among the 50 states in the total number of AIDS cases reported (*Centers for Disease Control and Prevention, 2010*).

In 2007, West Virginia ranked the second highest of the States in the rate of Acute Hepatitis B in the country. The Acute Hepatitis B rate in West Virginia in 2010 was 4.7 per 100,000. In 2008 WV reported the 41st highest rate of tuberculosis among states in the U.S. The incidence of tuberculosis in West Virginia was 0.8 per 100,000 in 2010 (WVBPH, 2011).

Individuals with mental and/or substance use disorders who are homeless: During SFY 2010, more than 54,000 individuals in West Virginia experienced some form of homelessness; children represented nearly 5,000 of that number (*Bureau for Medical Services data; National Center on Family Homelessness, 2009*). Of these individuals, more than 4,000 reported living in a homeless shelter or an unspecified place. The 2009 HUD report indicated that there were 1,003 individuals who were "literally homeless" (living in a shelter or outdoors).

West Virginia's 2011 Point in Time count indicated that 714 sheltered individuals were "literally" homeless in the Charleston and Huntington surrounding areas. PATH providers in the Charleston-Huntington area served 568 adults in SFY 2010. Based on these estimates, nearly 150 adults who experienced homelessness that year did not receive services they needed.

According to the Marshall University Technical Assistance and Evaluation Project, West Virginia's PATH programs served more than 1,500 adults who were experiencing some form of homelessness in SFY 2010. Of those individuals served, approximately 84% (or about 1,260) were deemed "literally" homeless.

Individuals who experience homelessness are at an elevated risk for developing a number of health problems. More than twice as many children in homeless families (16%) in the State were reported as having moderate to severe difficulties with emotions, concentration, behavior, and getting along with other people when compared to their peers from middle income families.

Individuals with mental and/or substance use disorders who are involved in the criminal or juvenile justice system: Individuals charged with substance related offenses represent a large percentage of people served by West Virginia's criminal justice system. A 2005 NIDA study reported 35% of all West Virginia arrests were related to alcohol and 15% were related to drugs. The West Virginia Division of Justice and Community Services reports that in 2009 there were nearly 8,000 arrests related to illicit drugs and 6,000 individuals were charged with driving under the influence (DUI). In 2010, individuals charged with drug offenses accounted for 699 of the State's incarcerated population.

In February 2011, the Criminal Justice Statistical Analysis Center's Office of Research and Strategic Planning released a report, "West Virginia Correctional Population Forecast, 2010-2020." According to this report, West Virginia has the second fastest growing prison population in the nation. The prison population grew by 5.1% in 2009 and by 4.9% in 2010. The corrections population is projected to grow over the next decade at an average rate of 4.6% each year. Over the next decade, the State prison system can expect to receive approximately 305 additional inmates per year. In 2008, 539 parole violators were returned to prison, resulting in a 152% increase in returns between 2004 and 2008.

In 2008, the arrest rate per 100,000 youth age 10-17 in West Virginia for violent crimes was 72; for property crimes, 577; for drug abuse 204; and for weapons possession 25 (*Puzzanchera 2009*). In the same year, there were 565 juvenile offenders in residential placement (*Hockenberry, Sickmund and Sladky 2011*). Many West Virginia children and adolescents arrested for minor offenses are placed under court supervision until they become adults. Often, these individuals are involved in the system through pre-petition diversion programs or improvement periods, but end up deep in the system because of technical violations while under court supervision. These juveniles are eventually taken into custody and housed in detention facilities far from their homes, so that their family, community, school, and other positive relationships are interrupted (*Puritz and Sterling 2010*).

Numerous studies demonstrate that contact with the justice system can cause harm to youth. Juvenile justice intervention decreases the odds that youth will graduate from high school or obtain meaningful employment, and increases the odds that they will engage in criminal behavior again (*Bernburg and Krohn 2003*). Approximately 12% of youth in juvenile facilities experience one or more incidents of sexual victimization by another youth or facility staff (*Beck, Harrison and Guerino 2010*).

Providing all youth with easy access to a diverse array of supports and opportunities would allow West Virginia communities to intervene during the beginning stages of delinquent behavior without prematurely drawing youth into the justice system (*Butts 2008*). However, due to resource limitations, it has been difficult to provide juveniles with local programs that address their individual needs and strengths.

Individuals with mental and/or substance use disorders who live in rural areas: The rural nature of West Virginia presents very unique challenges to accessing behavioral health care. A wide array of behavioral health services exist in more heavily populated areas, but inconsistencies may be found in the delivery of core services in rural areas, especially in regard to psychiatric and psychological services. Although substance abuse prevention services are available in all areas of the State, mental health promotion is limited. Mental health promotion has not always been a priority for the State's mental health system, so many people are not even aware of the need for intervention, or become aware only when a crisis develops. Rural areas are quite remote and access to even basic necessities may require considerable driving time, assuming people have access to transportation.

Many West Virginians reside in predominantly rural areas with limited or no access to primary or behavioral health care services. According to the latest statistics available from DHHR's Office of Community Health Systems and Health Promotion, Division of Rural Health and Recruitment, as of January 2010 all or parts of 18 of 55 counties are designated as Primary Care Health Professional Shortage Areas and all or parts of 15 counties are designated as Dental Health Professional Shortage Areas. West Virginia also has broad geographic areas (16 of the State's 55) counties that have been designated as Mental Health Professional Shortage Areas by the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services (DHHS).

The residents of these rural communities often rely heavily on local coal mining operations for employment. Recent research suggests that residents of mountaintop mining counties experience significantly more days of poor physical, mental, and activity limitation as well as poorer self-rated health compared with other counties. These mining areas are associated with the greatest reductions in health-related quality of life (*Zullig and Hendryx 2011*). In addition, West Virginians are intimately familiar with the dangers of mining. Mining deaths and disasters cause both primary and secondary traumas to laborers, their families, and friends. Many times these incidents are televised, furthering the effects of the trauma.

Underserved racial and ethnic minority and LGBTQ populations: Although they represent only a fraction of the State's population, West Virginia's minority populations often experience risk factors and behavioral health issues at a higher rate than do white, non-Hispanic individuals. It is estimated that in 2007, 14.4% of Hispanic children, and 13% of black children age 0-17 had emotional, developmental, and/or behavioral health special needs compared to 7.4% of their white, non-Hispanic peers (*National Survey of Children's Health 2007*).

According to data collected by Marshall University in SFY 2010 for State block grant-funded initiatives for children with serious emotional disturbance and adults with serious mental illness, minority populations are over-represented in most programs.

African American children with serious emotional disturbances represent 9.4% of those served; nearly triple the population rate (3.4%) for the State. Grouped together, all minorities (African American, Hispanic, Multi-racial, Asian, Native American, and "other") represent 20.5% of

children with serious emotional disturbance served by publicly funded programs; more than triple the population rate for the State (6.1%).

According to WVBMS data, 8.7% of the individuals who stayed in homeless shelters during SFY 2010 were racial or ethnic minorities. Among adults with serious mental illness and/or co-occurring disorders receiving intensive community-based services, African Americans represent 15% of those served. This disparity is even more pronounced in transitional living programs for adults with serious mental illness and/or co-occurring disorders, where African Americans represent 20% of the total population served.

The *Movement Advancement Project* estimates that approximately 1.5% (about 28,000) of West Virginia's population self-identifies as lesbian, gay or bisexual. Social inequality is often associated with poorer health status, and sexual orientation has been associated with multiple health threats. Men who have sex with men are at increased risk for suicide symptoms and accounted for 53% of the estimated new HIV infections in 2006 (*Wolitski et al., 2008*). Lesbians and bisexual women have a higher rate of obesity, smoking, depression, anxiety, heavy drinking and drug abuse than do heterosexual women.

LGBTQ youth face many challenges at school and at home. According to a national study, many experience verbal (80%) or physical (40%) harassment at school to such an extent that over 25% miss school because they feel unsafe. LGBTQ youth are twice as likely to attempt suicide than their heterosexual peers, and are more likely to report high levels of substance abuse (*Centers for Disease Control and Prevention, 2011*). While the creation of a Gay Straight Alliance within secondary school settings creates a safer school climate for LGBTQ youth and decreases the occurrence of homophobic language (*Ray, 2006*), only 23.1% of West Virginia's secondary schools have such a club (*Brener, et al. 2009*).

Not only do LGBTQ youth face tremendous challenges in school, many face rejection in their homes. West Virginia ranks above the national average in religiosity (*Pew Research Center 2009*), which correlates negatively with attitudes toward the LGBTQ population (*Winter 2011*). For this reason, many parents of LGBTQ youth in West Virginia have difficulty accepting their child's sexual orientation. Nationally, 50% of gay teens experience a negative reaction from their parents when they come out and 26% are kicked out of their home (*Battle 2002*). In addition, LGBTQ young adults who experience high levels of rejection are more than three times as likely to use illegal drugs, almost six times as likely to have high levels of depression, and more than eight times as likely to have attempted suicide (*Centers for Disease Control and Prevention 2011*).

The State has collected little data on this population, reflecting the State's delayed response to address the needs of this population. West Virginia has yet to address this issue effectively, primarily due to the lack of information about LGBTQ health needs and LGBTQ-specific training for primary and behavioral health care providers.

Persons with disabilities:

It is estimated that approximately 34, 000 West Virginian's have a disability, the highest percentage of people with disabilities among U.S. states, according to the *Cornell University Employment and Disability Institute*. Public and private organizations provide special education, rehabilitation, and personal assistance to individuals with disabilities. There is a relatively robust system of resources for the approximately 4,500 individuals with significant intellectual and developmental disabilities who qualify for Federal funding (Medicaid Home and Community Based Waiver program), including housing, personal support services, and employment and day programming.

Significant gaps in service exist, particularly for children and adults with mild intellectual disabilities (IQ between 50 and 70), with co-existing intellectual disabilities and mental illness or history of trauma, and individuals with autism spectrum disorder and disabilities resulting from traumatic brain injury. Services gaps range from appropriate assessment to housing to specialized behavioral interventions and supports. West Virginia is fortunate to have a social and cultural bias toward "caring for our own," and the vast majority of individuals with developmental disabilities live with family members. However, caregiver age is increasing and family income in West Virginia is generally decreasing, suggesting the service delivery system will be further challenged to serve middle-aged adults with disabilities over the next 10 years.

A trained competent workforce continues to be a significant gap for this population, including a lack of expertise in mental health issues for individuals with developmental disabilities and a lack of choice in providers. Access to services is often limited, due to the geography and rural nature of the State's population, and individuals who do not qualify for Medicaid or other third party insurance struggle to pay for services. These service gaps are demonstrated in the system's inability to respond with reasonable promptness to individuals with developmental disabilities receiving services in State-operated psychiatric hospitals, creating significantly longer lengths of stay; in the number of youth with co-existing intellectual disabilities and serious emotional disturbances who are referred to out-of-state residential treatment programs because West Virginia providers are not sufficiently trained, and the number of mildly impaired adults who drift through homeless shelters without permanent housing, employment or social supports.

The BBHMF is addressing these gaps through coordination with other public and private initiatives. For instance, the BBHMF Division of Intellectual and Developmental Disabilities is partnering with the well-established Children's System of Care to integrate functional assessment and Positive Behavioral Support consultation into residential treatment and foster care programs that serve children with co-existing disorders. The Division's Adult Clinical Assessment and Consultation project employs a nationally recognized assessment for individuals with multiple diagnoses and convenes specialized, multidisciplinary consultation teams to reduce inappropriate admissions to state institutions. The Division is also seeking to improve data collection and tracking of people with developmental disabilities who are un-served or under served in the behavioral health system, and who do not qualify for, or are not receiving State or community supports.

Transitioning Youth/Young Adults: The BBHMF has identified significant needs among transitioning youth that have been in the foster care system, residential care, and/or juvenile detention. Many individuals age out of those systems lacking the needed skills, supports and

tools necessary for successful independence. It is essential for the youth and adult systems to partner in order to bridge the gaps and create a seamless transition to adult independence.

West Virginians between the ages of 18 and 24 face a unique set of challenges. These individuals are at a greater risk of developing a behavioral health or substance use disorder, and of experiencing added difficulties related to such a disorder. According to the *2007-2008 West Virginia Behavioral Risk Factor Survey Report*, 13.8% of young adults reported binge drinking within the previous 30 days, while just 8.8% of adults age 25 and over reported this behavior. In 2010, the rate for young adult binge drinking increased to 18.2% (*Centers for Disease Control and Prevention, 2010*). Nearly 14% of young adults reported they had a disability that limited their activity because of physical, mental, or emotional problems; 32% had no health insurance (19.8% of other West Virginia adults reported the same); and 46.8% had no personal doctor or health care provider while only 22% of all other adults faced the same difficulty.

National data suggest that approximately 33% of youth in foster care are diagnosed with a behavioral or substance related disorder (*Zima et al., 2000*). According to the National Coalition for the Homeless, youth aging out of foster care lack support and are often more vulnerable to homelessness, higher rates of unemployment, poor educational achievement, hospitalization, incarceration, mental illness and unplanned pregnancy. Youth transitioning from foster care to adulthood are twice as likely as same age peers to be unable to pay rent and utilities and four times as likely to be evicted (*Courtney, et al., 2004*). Approximately 25% of youth experiencing foster care do not receive a diploma or GED by age 23 or 24. When youth are allowed to stay in state supported care past the age of 18 they are more likely to pursue higher education, have increased earnings, and delay pregnancy (*Choice, et al., 2001*). Many youth transitioning to adulthood in West Virginia do not choose to remain in the State's care.

Forensic populations: West Virginia does not have a free-standing forensic hospital. There has been a 142% increase in the forensic population, from 45 forensic patients at Sharpe Hospital in 1999 to 109 at Sharpe and Bateman Hospitals in 2010. In addition, forensic patients are currently housed in the regional jail system awaiting a forensic bed at one of the State-operated facilities. Maximum bed capacity at the two State facilities is 260, with 109 beds currently designated for the forensic population. The West Virginia Legislature recently appropriated funds to add 50 forensic beds to Sharpe Hospital.

Circuit Court Judges in West Virginia are elected rather than appointed and may be reluctant to release individuals who remain under their jurisdiction and have served less time than the maximum sentence they were charged with out of concern that they may re-offend. In addition, some attorneys in the criminal defense bar may be advising their clients to plead not guilty by reason of mental illness without fully explaining the possible outcomes. In some cases, individuals return to the community faster when found guilty, are sentenced, and serve time in prison rather than when found not guilty by reason of mental illness.

Older Adults: West Virginia has one of the "oldest" populations in the nation. Individuals over the age of 65 need specialized care due to the age-related health needs and limited supports. An integrated approach to physical and behavioral health is essential to improving quality of life. According to 2011 Block Grant Reporting, 2.81% of those receiving mental health services are

seniors. Of that number, 2.6% received services from community mental health programs. In FY 2010, 59 seniors were admitted to state hospitals. According to the Marshall University Evaluation Project, 2% (69) of the 3,467 individuals served by programs funded by the Mental Health Services Block Grant were seniors.

According to a recent report issued by the *National Institute on Drug Abuse*, persons 65 years of age and above comprise only 13% of the population, yet account for approximately one-third of all medications prescribed in the United States. Older patients are more likely to be prescribed long-term and multiple medications. Because these individuals have the poorest compliance rates relating to directions for taking medications, they could unintentionally misuse them. Approximately 18% of adults 60 years and older may abuse prescription drugs. Older adults tend to use prescription medication three times as frequently as the general population.

Collaborative Planning & Service Integration

Although West Virginia has taken great strides toward integrating State offices, divisions and planning models, system silos still exist. Distinct funding streams with diverse objectives and inconsistent strategies have segregated community service systems. Effective collaboration between behavioral health and primary care is needed to fully integrate prevention and early intervention services. Implementation has been stalled due to a number of issues such as competitive mindsets among and between primary care and behavioral health providers, resistance to/or fear of change, and differences in reimbursement mechanisms. Some bi-directional integration has been undertaken. The SBIRT initiative is an example of locating a behavioral health professional in a primary care setting. Several primary care centers and free clinics offer a full complement of services in the more urban areas. Two CBHCs have integrated a primary care physician within the center.

Uninsured Consumers & Payment for Services

According to the West Virginia Bureau for Medical Services, approximately 238,000 adult West Virginians are uninsured. That number is expected to gradually shrink as the Affordable Care Act is implemented and more people become eligible for either Medicaid, private insurance, or the Health Insurance Exchange.

Medicaid funding for ongoing community support has been substantially reduced due to previous federal disallowances, utilization management, decreased state provider tax, and other factors. Data in West Virginia has indicated for several years that the rate of hospitalization and re-hospitalization for people with mental illness and co-occurring disorders has risen dramatically. That trend continues, with State-operated facilities operating at or above capacity. The 260 licensed State-operated beds are not sufficient to meet current demand. Because of this, between 70 and 100 individuals are diverted to 13 private hospitals daily. These diversions cost the State \$8 million and to \$9 million annually. Data suggests that the practice of BBHFF-funded diversions has had an unintentional side effect. Some private hospitals refuse to accept voluntary admissions with questionable funding sources in favor of taking involuntary admissions with a guaranteed payment source.

Critical Gaps in the Capacity & Competency of the Workforce

West Virginia is fortunate in the level of caring and competent individuals providing behavioral health services across the State. Healthcare professional shortages, retention of staff, and skills development for existing staff are often challenges.

Workforce Capacity Issues

One of the biggest challenges facing West Virginia's providers is building a highly qualified workforce. Providers report that the work load continues to grow because of increased demand for comprehensive prevention services, crisis services, and residential programs. CBHCs informed the BBHMF during in 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.

West Virginia wages are low compared to neighboring states. According to the May 2010 data from the Bureau of Labor Statistics, the mean wage for mental health counselors in the state of West Virginia was \$30,500 per year and averaged \$40,930 in four surrounding states with comparable costs of living (Ohio, Kentucky, Pennsylvania and Virginia). Similarly, wages for mental health and substance abuse social workers averaged \$32,350 in West Virginia but \$40,150 in the same four neighboring states. This wage disparity makes it increasingly difficult for West Virginia providers to hire and retain qualified applicants.

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, for 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. Rural counties are often left without access to child psychiatrists.

There is a gap between persons needing behavioral health counseling services and personnel qualified to provide these services. Licensing and Certification Boards report 743 Licensed Professional Counselors, 599 Clinical Psychologists, 321 Certified Social Workers, and 283 Licensed Independent Social Workers. Addictions certifications span a wide range of educational achievement and often overlap other licenses and general human service degrees. Advanced Alcohol and Drug Counselor (AADC) is a master's level addictions credential and denotes lengthy, specialized experience and training in the provision of addictions counseling. There are currently 109 AADCs registered in the state of West Virginia. There are only 45 Certified Clinical Supervisors in the state at this time, which makes it difficult for additional professionals to obtain the AADC credential.

There are several licenses and credentials at the BA or MA level that cannot independently provide counseling but may provide supportive counseling or case management services. These include Licensed Graduate Social Workers, Licensed Social Workers, Temporary Social Work permits and certificates, Certified Criminal Justice Professionals, Counselors in Service and Certified Prevention Specialists. These licenses and certifications tend to overlap as well. Many community mental health providers employ master's level unlicensed and noncertified individuals to provide therapy and/or supportive counseling.

Competency Issues

There is evidence that while the BBHMF provides substantial training opportunities, skill building within the publicly funded behavioral health system is lacking. Information provided during community forums and subsequent meetings with providers suggest the fundamentals of prevention and promotion have been diluted and in some areas of the State, lost entirely. The Family Resource Networks who provided these services were well versed in collaboration, planning and facilitation processes but did not possess best practice knowledge and were not certified prevention specialists. These findings are anecdotal. A formal assessment will be undertaken to determine the capacity of the existing workforce and to better determine reasons for staff failure to maintain skills after training.

The BBHMF promotes training in and the use of evidence-based practices. The BBHMF has provided training in Eco-Systemic Family Therapy and encourages clinicians to participate in other trainings such as Trauma-Focused Cognitive Behavioral Therapy. However, because CBHCs struggle financially and have so few experienced clinical staff on hand, they can be reluctant to release staff for training, even when free and/or fully funded by the State. Unfortunately, this reluctance has limited the number of clinicians trained in evidence-based practices in West Virginia.

The BBHMF requires that all Grantees provide culturally and linguistically competent services. Grantees are directed to Georgetown University Center for Cultural and Linguistic Competence for guidance. The BBHMF also offers training in cultural competence.

Although the BBHMF requires culturally and linguistically competent services, a recent survey found that only one Comprehensive Community Behavioral Health Center routinely provided cultural competence training. That provider requires training in cultural competency and diversity through its online Essential Learning program. All employees of that provider are required to be familiar with the organization's Statement of Affirmative Action and Code of Conduct.

Allied Health and Primary Care Training in Behavioral Health and Substance Abuse

West Virginia, like other states, is working diligently to integrate behavioral health and primary care. To this end, it is essential that providers are cross-trained to recognize and intervene when applicable. However, accomplishing this task has proven to be a challenge. There are a number of reasons for this difficulty. Research suggests that primary care providers may be reluctant to broach behavioral health topics, especially with regard to substance use among pregnant women

(*West Virginia Physician Survey; Join Together*). This reluctance may dissuade health professionals from seeking additional training.

This is unfortunate because as Dr. Nora Volkow (NIDA Director) stated, “doctors can intervene before substance abuse becomes a full-blown addiction, making them the first line of defense against substance abuse and addiction. We tell our doctor a lot of things we wouldn’t tell our relatives or spouses.” Staff education and training regarding identification and management of mental illness can help primary care providers overcome the perceived limitations of the setting that influence timely and comprehensive evaluation. In addition, primary care providers can inform and advocate for policy changes at local, state, and national levels that are needed to ensure comprehensive care of children with mental health illnesses.

Gaps in Resource Management

The publicly funded behavioral health system in West Virginia currently does not track utilization in a manner that allows for the subjective or objective application of outcome measures to ensure that the system is operating effectively and efficiently. Merely quantifying the types of services rendered and identifying the demographics of those to whom the services are delivered is not an effective means of system monitoring. The integration of outcomes into the BBHMF system design and monitoring is imperative if the behavioral health system in West Virginia can be successful. The BBHMF is working toward the establishment of such a means of measure.

When outcomes and efficiency standards are accurately tracked, the BBHMF can make timely decisions regarding the funding of programs dispersed throughout the State. This will ensure that consumers can access services required within a reasonable travel distance from their home. Real time adjustment of the funding allocated to each provider will allow the BBHMF to make adjustments to the service delivery system as needs arise.

Lack of Policies and Procedures

The BBHMF has focused on improving the overall structure of the organization in the past few years. Employment of qualified staff and reorganization of the Bureau has created a sustainable structure to achieve systemic improvement. One challenge facing the BBHMF is to develop and publish detailed policies and procedures to guide Grant Agreements in addition to overall Bureau functioning.

West Virginia’s System of Care for Children and Youth and their Families is a public /private /consumer cross-systems State implementation team that provides collaborative planning, but lacks policy making authority. West Virginia is currently applying for a Mental Health System of Care Planning Grant to institutionalize this framework which is consistent with the Strategic Prevention Framework to further best practice in collaborative service planning. It is hoped that both initiatives will complement a holistic integrated behavioral health delivery system at the State and local levels.

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

Page 23 of the Application Guidance

Start Year:

2012

End Year:

2013

Number	State Priority Title	State Priority Detailed Description
1	Assessment and Planning	Data-informed decision making.
2	Capacity	System-wide infrastructure development.
3	Implementation	Building a comprehensive and competent continuum of care targeting services to the following populations: a) children with SED and their families, b) adults with SMI, c) persons with or at risk of developing substance use or mental health disorders, and d) at risk populations and those requiring targeted services.
4	Sustainability	Fiscal accountability and program sustainability.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

Page 23 of the Application Guidance

Start Year:

2011

End Year:

2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
No Data Available				

Footnotes:

Please refer to Attachment, "Step 4: Goals, Strategies and Performance Indicators"

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 CMHS - Services Purchased Using Reimbursement Strategy

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Start Year:

2011

End Year:

2013

Reimbursement Strategy	Services Purchased Using the Strategy	Other
Grant/contract reimbursement	Prevention /Promotion, early intervention, treatment, and recovery management	

Footnotes:

The BBHMF utilizes the grant/contract reimbursement methodology to contract with providers for services supported by the Substance Abuse Prevention and Treatment Block Grant and by the Mental Health Services Block Grant. This process consists of performing an analysis of historic funding and expenditure reimbursement information which is then utilized in the allocation of funds for services to the community based service providers, which include 13 comprehensive behavioral health centers. Once allocation amounts are determined, sub-recipient Grant Agreements are prepared by BBHMF staff and sent to the individual provider agencies for their review, acceptance, and signature. The Grant Agreements include a Statement of Work which outlines the services to be provided, a budget document which conveys the amount of funding awarded for the provision of said services, and the expected outcomes of the services being provided. Once the Grant Agreement is approved, the service provider can begin requesting reimbursement of costs for services provided. Grant invoices are delivered, reviewed, and paid, generally on a monthly basis.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SAPT - Services Purchased Using Reimbursement Strategy

Page 29 of the Application Guidance

Start Year:

End Year:

Reimbursement Strategy	Services Purchased Using the Strategy	Other
Grant/contract reimbursement	Prevention /Promotion, early intervention, treatment, and recovery management	

Footnotes:

The BBHMF utilizes the grant/contract reimbursement methodology to contract with providers for services supported by the Substance Abuse Prevention and Treatment Block Grant and by the Mental Health Services Block Grant. This process consists of performing an analysis of historic funding and expenditure reimbursement information which is then utilized in the allocation of funds for services to the community based service providers, which include 13 comprehensive behavioral health centers. Once allocation amounts are determined, sub-recipient Grant Agreements are prepared by BBHMF staff and sent to the individual provider agencies for their review, acceptance, and signature. The Grant Agreements include a Statement of Work which outlines the services to be provided, a budget document which conveys the amount of funding awarded for the provision of said services, and the expected outcomes of the services being provided. Once the Grant Agreement is approved, the service provider can begin requesting reimbursement of costs for services provided. Grant invoices are delivered, reviewed, and paid, generally on a monthly basis.

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 CMHS - Projected Expenditures for Treatment and Recovery Supports

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Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	<ul style="list-style-type: none"> • General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services 	<10% <input type="text" value="6"/>
Engagement Services	<ul style="list-style-type: none"> • Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach 	10-25% <input type="text" value="6"/>
Outpatient Services	<ul style="list-style-type: none"> • Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers 	10-25% <input type="text" value="6"/>
Medication Services	<ul style="list-style-type: none"> • Medication management • Pharmacotherapy (including MAT) • Laboratory services 	10-25% <input type="text" value="6"/>
Community Support (Rehabilitative)	<ul style="list-style-type: none"> • Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services 	<10% <input type="text" value="6"/>
Recovery Supports	<ul style="list-style-type: none"> • Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care 	<10% <input type="text" value="6"/>
Other Supports (Habilitative)	<ul style="list-style-type: none"> • Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services 	10-25% <input type="text" value="6"/>

- Recreational services
- Interactive Communication Technology Devices
- Trained behavioral health interpreters

Intensive Support Services

- Substance abuse intensive outpatient services
- Partial hospitalization
- Assertive community treatment
- Intensive home based treatment
- Multi-systemic therapy
- Intensive case management

<10% 

Out-of-Home Residential Services

- Crisis residential/stabilization
- Clinically Managed 24-Hour Care
- Clinically Managed Medium Intensity Care
- Adult Mental Health Residential
- Adult Substance Abuse Residential
- Children's Mental Health Residential Services
- Youth Substance Abuse Residential Services
- Therapeutic Foster Care

<10% 

Acute Intensive Services

- Mobile crisis services
- Medically Monitored Intensive Inpatient
- Peer based crisis services
- Urgent care services
- 23 hour crisis stabilization services
- 24/7 crisis hotline services

<10% 

Prevention (Including Promotion)

- Screening, Brief Intervention and Referral to Treatment
- Brief Motivational Interviews
- Screening and Brief Intervention for Tobacco Cessation
- Parent Training
- Facilitated Referrals
- Relapse Prevention /Wellness Recovery Support
- Warm line

10-25% 

System improvement activities

N/A 

Other

N/A 

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 SAPT - Projected Expenditures for Treatment and Recovery Supports

Page 30 of the Application Guidance

Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	<ul style="list-style-type: none"> • General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services 	<10% <input type="text" value="6"/>
Engagement Services	<ul style="list-style-type: none"> • Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach 	10-25% <input type="text" value="6"/>
Outpatient Services	<ul style="list-style-type: none"> • Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers 	26-50% <input type="text" value="6"/>
Medication Services	<ul style="list-style-type: none"> • Medication management • Pharmacotherapy (including MAT) • Laboratory services 	<10% <input type="text" value="6"/>
Community Support (Rehabilitative)	<ul style="list-style-type: none"> • Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services 	<10% <input type="text" value="6"/>
Recovery Supports	<ul style="list-style-type: none"> • Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care 	<10% <input type="text" value="6"/>
Other Supports (Habilitative)	<ul style="list-style-type: none"> • Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services 	<10% <input type="text" value="6"/>

- Recreational services
- Interactive Communication Technology Devices
- Trained behavioral health interpreters

Intensive Support Services

- Substance abuse intensive outpatient services
- Partial hospitalization
- Assertive community treatment
- Intensive home based treatment
- Multi-systemic therapy
- Intensive case management

N/A 

Out-of-Home Residential Services

- Crisis residential/stabilization
- Clinically Managed 24-Hour Care
- Clinically Managed Medium Intensity Care
- Adult Mental Health Residential
- Adult Substance Abuse Residential
- Children's Mental Health Residential Services
- Youth Substance Abuse Residential Services
- Therapeutic Foster Care

<10% 

Acute Intensive Services

- Mobile crisis services
- Medically Monitored Intensive Inpatient
- Peer based crisis services
- Urgent care services
- 23 hour crisis stabilization services
- 24/7 crisis hotline services

N/A 

Prevention (Including Promotion)

- Screening, Brief Intervention and Referral to Treatment
- Brief Motivational Interviews
- Screening and Brief Intervention for Tobacco Cessation
- Parent Training
- Facilitated Referrals
- Relapse Prevention /Wellness Recovery Support
- Warm line

10-25% 

System improvement activities

N/A 

Other

N/A 

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 CMHS - Primary Prevention Planned Expenditures Checklist

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Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Information Dissemination	Selective	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Information Dissemination	Indicated	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Information Dissemination	Unspecified	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Information Dissemination	Total	\$	\$	\$	\$	\$
Education	Universal	\$ <input type="text" value="130,260"/>	\$ <input type="text" value="378,939"/>	\$ <input type="text" value="172,755"/>	\$ <input type="text"/>	\$ <input type="text"/>
Education	Selective	\$ <input type="text" value="65,130"/>	\$ <input type="text" value="126,313"/>	\$ <input type="text" value="57,585"/>	\$ <input type="text"/>	\$ <input type="text"/>
Education	Indicated	\$ <input type="text" value="26,052"/>	\$ <input type="text" value="126,313"/>	\$ <input type="text" value="57,585"/>	\$ <input type="text"/>	\$ <input type="text"/>
Education	Unspecified	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text"/>	\$ <input type="text"/>
Education	Total	\$221,442	\$631,565	\$287,925	\$	\$
Alternatives	Universal	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Alternatives	Selective	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Alternatives	Indicated	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Alternatives	Unspecified	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Alternatives	Total	\$	\$	\$	\$	\$
Problem Identification and Referral	Universal	\$ <input type="text" value="26,052"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Problem Identification and Referral	Selective	\$ <input type="text" value="0"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Problem Identification and Referral	Indicated	\$ <input type="text" value="0"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Problem Identification and Referral	Unspecified	\$ <input type="text" value="0"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Problem Identification and Referral	Total	\$26,052	\$	\$	\$	\$

Community-Based Process	Universal	\$ 13,026	\$	\$	\$	\$
Community-Based Process	Selective	\$ 0	\$	\$	\$	\$
Community-Based Process	Indicated	\$ 0	\$	\$	\$	\$
Community-Based Process	Unspecified	\$ 0	\$	\$	\$	\$
Community-Based Process	Total	\$ 13,026	\$	\$	\$	\$
Environmental	Universal	\$	\$	\$	\$	\$
Environmental	Selective	\$	\$	\$	\$	\$
Environmental	Indicated	\$	\$	\$	\$	\$
Environmental	Unspecified	\$	\$	\$	\$	\$
Environmental	Total	\$	\$	\$	\$	\$
Section 1926 Tobacco	Universal	\$	\$	\$	\$	\$
Section 1926 Tobacco	Selective	\$	\$	\$	\$	\$
Section 1926 Tobacco	Indicated	\$	\$	\$	\$	\$
Section 1926 Tobacco	Unspecified	\$	\$	\$	\$	\$
Section 1926 Tobacco	Total	\$	\$	\$	\$	\$
Other	Universal	\$	\$	\$	\$	\$
Other	Selective	\$	\$	\$	\$	\$
Other	Indicated	\$	\$	\$	\$	\$
Other	Unspecified	\$	\$	\$	\$	\$
Other	Total	\$	\$	\$	\$	\$

Footnotes:

Note: "Other Federal" is Adolescent Suicide Prevention and Early Intervention Grant

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 SAPT - Primary Prevention Planned Expenditures Checklist

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Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	\$51,978	\$	\$	\$	\$
Information Dissemination	Selective	\$	\$	\$	\$	\$
Information Dissemination	Indicated	\$	\$	\$	\$	\$
Information Dissemination	Unspecified	\$	\$	\$	\$	\$
Information Dissemination	Total	\$51,978	\$	\$	\$	\$
Education	Universal	\$693,040	\$	\$60,000	\$	\$
Education	Selective	\$173,260	\$	\$0	\$	\$
Education	Indicated	\$86,630	\$	\$0	\$	\$
Education	Unspecified	\$0	\$	\$0	\$	\$
Education	Total	\$952,930	\$	\$60,000	\$	\$
Alternatives	Universal	\$86,630	\$	\$	\$	\$
Alternatives	Selective	\$0	\$	\$	\$	\$
Alternatives	Indicated	\$0	\$	\$	\$	\$
Alternatives	Unspecified	\$0	\$	\$	\$	\$
Alternatives	Total	\$86,630	\$	\$	\$	\$
Problem Identification and Referral	Universal	\$86,630	\$	\$	\$	\$
Problem Identification and Referral	Selective	\$0	\$	\$	\$	\$
Problem Identification and Referral	Indicated	\$0	\$	\$	\$	\$
Problem Identification and Referral	Unspecified	\$	\$	\$	\$	\$
Problem Identification and Referral	Total	\$86,630	\$	\$	\$	\$

Community-Based Process	Universal	\$0	\$	\$	\$	\$
Community-Based Process	Selective	\$0	\$	\$	\$	\$
Community-Based Process	Indicated	\$0	\$	\$	\$	\$
Community-Based Process	Unspecified	\$0	\$	\$	\$	\$
Community-Based Process	Total	\$0	\$	\$	\$	\$
Environmental	Universal	\$519,780	\$	\$	\$	\$
Environmental	Selective	\$0	\$	\$	\$	\$
Environmental	Indicated	\$0	\$	\$	\$	\$
Environmental	Unspecified	\$0	\$	\$	\$	\$
Environmental	Total	\$519,780	\$	\$	\$	\$
Section 1926 Tobacco	Universal	\$34,652	\$	\$	\$	\$
Section 1926 Tobacco	Selective	\$0	\$	\$	\$	\$
Section 1926 Tobacco	Indicated	\$0	\$	\$	\$	\$
Section 1926 Tobacco	Unspecified	\$0	\$	\$	\$	\$
Section 1926 Tobacco	Total	\$34,652	\$	\$	\$	\$
Other	Universal	\$	\$	\$300,000	\$	\$
Other	Selective	\$	\$	\$	\$	\$
Other	Indicated	\$	\$	\$	\$	\$
Other	Unspecified	\$	\$	\$	\$	\$
Other	Total	\$	\$	\$300,000	\$	\$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 CMHS - Projected State Agency Expenditure Report

Page 38 of the Application Guidance

Start Year:

End Year:

Date of State Expenditure Period From:

Date of State Expenditure Period To:

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
2. Primary Prevention	\$ <input type="text" value="260,519"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="1,105,239"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>
3. Tuberculosis Services	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
4. HIV Early Intervention Services	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
5. State Hospital		\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>
6. Other 24 Hour Care	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>
7. Ambulatory/Community Non-24 Hour Care	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>
8. Administration (Excluding Program and Provider Level)	\$ <input type="text" value="894,803"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="164,392"/>	\$ <input type="text" value="0"/>	\$ <input type="text" value="0"/>
9. Subtotal (Rows 1, 2, 3, 4, and 8)	\$1,155,322	\$0	\$1,105,239	\$164,392	\$0	\$0
10. Subtotal (Rows 5, 6, 7, and 8)	\$894,803	\$0	\$0	\$164,392	\$0	\$0
11. Total	\$1,155,322	\$0	\$1,105,239	\$164,392	\$0	\$0

Footnotes:

Other funds - column C - from ASPEN Grant and PATH Grant.

State funds - column D - includes Charity Care.

NOTE: ROW 1 HAS BEEN BLOCKED, BUT WEST VIRGINIA ASSUMES THIS WAS MEANT FOR MENTAL HEALTH PREVENTION (NOT PRIMARY PREVENTION) AND TREATMENT. THE FOLLOWING AMOJNTS WOULD HAVE BEEN ENTERED IF IT HAD BEEN POSSIBLE:

Column A: \$1,213,032

Column B: \$0

Column C: \$525,000

Column D: \$67,540,935

Column E: \$0

Column F: \$0

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 SAPT - Projected State Agency Expenditure Report

Page 38 of the Application Guidance

Start Year:

End Year:

Date of State Expenditure Period From:

Date of State Expenditure Period To:

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	\$6,595,802	\$0	\$3,752,210	\$15,139,639	\$0	\$74,776
2. Primary Prevention	\$1,732,600	\$0	\$0	\$0	\$0	\$0
3. Tuberculosis Services	\$0	\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0	\$0	\$0	\$0	\$0	\$0
5. State Hospital		\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care	\$0	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care	\$0	\$0	\$0	\$0	\$0	\$0
8. Administration (Excluding Program and Provider Level)	\$334,598	\$0	\$255,089	\$211,423	\$0	\$0
9. Subtotal (Rows 1, 2, 3, 4, and 8)	\$8,663,000	\$0	\$4,007,299	\$15,351,062	\$0	\$74,776
10. Subtotal (Rows 5, 6, 7, and 8)	\$334,598	\$0	\$255,089	\$211,423	\$0	\$0
11. Total	\$8,663,000	\$0	\$4,007,299	\$15,351,062	\$0	\$74,776

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist

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Start Year:

End Year:

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	\$ <input type="text" value="20,000"/>	\$ <input type="text" value="20,000"/>	\$ <input type="text" value="161,664"/>	\$ <input type="text" value="80,303"/>		\$281,967
2. Quality Assurance	\$ <input type="text" value="20,000"/>	\$ <input type="text" value="7,000"/>	\$ <input type="text" value="161,664"/>	\$ <input type="text" value="28,106"/>		\$216,770
3. Training (Post-Employment)	\$ <input type="text" value="13,428"/>	\$ <input type="text" value="9,920"/>	\$ <input type="text" value="111,493"/>	\$ <input type="text" value="39,616"/>		\$174,457
4. Education (Pre-Employment)	\$ <input type="text" value="5,000"/>	\$ <input type="text" value="5,000"/>	\$ <input type="text" value="40,615"/>	\$ <input type="text" value="19,808"/>		\$70,423
5. Program Development	\$ <input type="text" value="20,000"/>	\$ <input type="text" value="10,000"/>	\$ <input type="text" value="161,664"/>	\$ <input type="text" value="39,884"/>		\$231,548
6. Research and Evaluation	\$ <input type="text" value="10,000"/>	\$ <input type="text" value="7,500"/>	\$ <input type="text" value="79,638"/>	\$ <input type="text" value="29,980"/>		\$127,118
7. Information Systems	\$ <input type="text" value="10,000"/>	\$ <input type="text" value="7,500"/>	\$ <input type="text" value="79,638"/>	\$ <input type="text" value="29,980"/>		\$127,118
8. Total	\$98,428	\$66,920	\$796,376	\$267,677	\$	\$1,229,401

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

D. Activities that Support Individuals in Directing the Services

The BBHMF does not have a policy concerning participant-directed services. However, several initiatives are directly related to participant-directed services.

The Centers for Medicare and Medicaid Services (CMS) recently awarded a Money Follows the Person Rebalancing Demonstration, "Take Me Home, West Virginia" to the State's Medicaid Authority. This program builds on the successful Transition Navigator Pilot Program initiated through the State's Olmstead Office. The recently funded program has a goal of successfully transitioning 520 individuals from residence in a long-term care facility to a qualified home setting over five years. It is anticipated that at least 58 of these 520 individuals will be people with a serious mental illness.

Priority for services from this program will be given to individuals who choose to self-direct their home and community-based services through an Aged and Disabled Waiver Program. Participant-directed care should be increased from an estimated 11% in the first year of the grant to 16% or more in the fifth and final year of the grant.

The inclusion of a participant-directed option in this demonstration project follows a history of providing his option through Medicaid Waivers in West Virginia. Participant-directed care options were added to the Aged and Disabled Waiver in 2007. By October 2010, the 1,000th person was enrolled in participant-directed care through the Aged and Disabled Waiver program.

A proposal for a Medicaid Waiver for Medicaid-reimbursed services for individuals with traumatic brain injuries recommends a participant-directed option. The proposal for this option is to provide a monthly budget based on indentified needs.

The BBHMF has provided funding for several years to enable a consumer organization to train other consumers in Wellness Recovery Action Planning (WRAP). Funding has enabled training in WRAP as well as development of facilitators for WRAP training. WRAP is an evidence-based program that enables an individual to identify what is helpful in their recovery. In State Fiscal Year 2010, 333 individuals received WRAP training. WRAP training and Peer Support training has been incorporated into the Community Behavioral Health Technician (CBHT) training at the Kanawha Valley Community and Technical College. The CBHT program provides two-year associate degrees with special foci on mental illness, substance abuse, and autism.

West Virginia's Advance Directive /Medical Power of Attorney law specifically notes the potential to have a Psychiatric Advance Directive (PAD). The BBHMF Website provides a tool kit for a PAD which includes information for consumers, family members, and providers. The Protection and Advocacy for Individuals with Mental Illness (PAIMI) project of West Virginia Advocates has provided training in PADs for the PAIMI Advisory Council. Council members have trained other individuals in the development and use of PADs. Training and instruction on the use of PADs has also been provided through by Legal Aid of West Virginia.

One of West Virginia's Comprehensive Community Behavioral Health Centers has implemented a Recovery Management model in which the consumer is viewed as having the right and responsibility for managing his or her own recovery process. Self-directed care in this model is intended to enable consumers to assess their own needs, determine what and how much is needed, and monitor quantity and quality of care. Several of the Comprehensive Community Behavioral Health Centers have engaged Recovery Coaches to work directly with consumers in developing recovery plans and assist them in monitoring care.

As the Website for the BBHCF is updated, it is planned that a section for the Office of Consumer Affairs and Community Outreach will include information and links for Decision Aids for healthcare and for behavioral health care. The International Patient Decision Aids Standards recommend availability of such aids via the Internet "to promote wide access to them and to ensure they may be easily updated if the evidence base changes."

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
 - Provider characteristics
 - Client enrollment, demographics, and characteristics
 - Admission, assessment, and discharge
 - Services provided, including type, amount, and individual service provider
 - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
 - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
 - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
 - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
 - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
 - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
 - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
 - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
 - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
 - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
 - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

Please also see attachment, "BBHFF Data Action Plan."

E. Data and Information Technology

The BHHF uses a robust Information Technology (IT) system that is ever changing to meet the needs of the State and Federal reporting requirements.

The BBHHF 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 APS Healthcare, the Administrative Services Organization which contracts with the State's Medicaid Authority for utilization management. These data include provider characteristics; client enrollment, demographics and characteristics; admission, assessment and discharge, and services provided. Services provided data include the type, amount, and individual service provider. Data on prescription drug usage are not currently collected, although data are collected concerning abuse or addiction to prescription to illegal drugs or alcohol.

Data regarding activities and services of the BBHHF substance abuse prevention providers are reported to First Choice, Inc., which then reports to the BBHHF. These reports enable consistent and frequent monitoring of the prevention providers and support 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 BBHHF.

Data reported to APS are imported to the BBHHF. The BBHHF validates the data and returns validation reports to providers on a daily.

In addition to APS data, which includes data from the thirteen (13) comprehensive behavioral health centers, the BBHHF utilizes data from the two State-operated psychiatric hospitals and the BBHHF DUI program. Some data are provided by private service providers.

This system utilizes a Master Consumer Index (MCI) to assign each consumer a unique identifier, enabling the BBHHF to link data from the community table(s) to Hospital and DUI tables. This allows the BBHHF to calculate a true unique count of individuals being served across all tables and to track recidivism between the community behavioral health providers and the State-operated psychiatric hospitals.

The BBHHF system has incorporated corporate ID (AID) and a location ID (BAID) for each provider. The Bureau also collects and uses I-SATS numbers for 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 and First Choice data enables the ability to aggregate Medicaid and non-Medicaid provider information.

These data enable the BBHHF to produce reports of services provided to Medicaid-eligible and other clients served in West Virginia. Reports may be produced indicating services provided to individual clients and services provided by a provider.

Each service program for each 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 HCPCS code for services provided and the number of unit(s) (usually in 15 min increments). This data set also includes Type of payer as in Medicare, Medicaid, Private insurance, self pay, etc and if it

is targeted (for a unique service) or Non-targeted (e.g., charity care) funded. All data comply with Federal data standards in the use of ICD-9 and HCPCS codes.

This process enables the BBHMF to aggregate service data by agency, program, location, services being provided, payer type, and target and non-targeted fund types.

The BBHMF Deputy Commissioner for Administration and Technology meets twice weekly with representatives of the State's Medicaid Authority and other parties to address mutual issues concerning system interoperability and Federal IT requirements. One meeting includes the BBHMF; the Bureau for Medical Services (BMS); Molina, an entity which processes Medicaid claims; and APS Healthcare, Medicaid's Utilization Management contractor. This meeting is to assure system interoperability and compliance with Federal IT requirements. The other meeting includes the BBHMF; representatives of the Bureau for Children and Families (BCF), which reimburses providers for services to foster children; and APS Healthcare, which provides Utilization Management for BCF. This meeting is also held to assure system interoperability and Federal IT requirements.

West Virginia is implementing a Federal grant to create a statewide Health Information Exchange (HIE). The grant has been awarded to 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 not a direct participant in the development of the HIE, but is able to provide review and comment on proposals through the office of the Secretary of the Department of Health and Human Resources.

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

The BBHMF has provided assistance to the 13 Comprehensive Community Behavioral Health Centers to develop and use Electronic Health Records (EHR). Each of the 13 centers has been provided 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.

The BBHMF surveyed the 13 Comprehensive Community Behavioral Health Centers to determine each center's status in converting to electronic records. Three centers report total conversion. Two centers report partial conversion and report they are running dual systems. Other centers report plans to convert to HER in early 2012. One of the centers reported plans to implement E-prescribing in 2012.

IV: Narrative Plan

F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects 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 that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their 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 critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

F. Quality Improvement Reporting

The BBHHF does not have a Continuous Quality Improvement (CQI) Plan. Several of the concepts of CQI are built into Bureau activities and functions of payers such as Medicaid. In addition, several of the State's publicly funded behavioral health providers have developed their own CQI approaches. These endeavors provide a foundation for the future development of a CQI Plan.

BBHF Activities Related to CQI

The Bureau is in the development phase of a systemic formalized process for ensuring that CQI is stakeholder driven. The BBHHF 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 BBHHF, the BBHHF Office of Consumer Services 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 BBHHF has collaborated with providers to develop standardized definitions and Grant Agreement Statements of Work 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 BBHHF Data and Technology Team capture behavioral health episode and utilization data in coordination with APS Healthcare, the State Medicaid Authority's Utilization Management contractor. Providers submit information to APS Healthcare regardless of source of payment for services. APS Healthcare uses information submitted for Medicaid-eligible consumers to approve 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 BBHHF Data and Technology Team validate the data submitted by 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 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. 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 in the past year 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

Four 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

G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to 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 opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, 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 include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description 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.

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

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

H. Service Management Strategies

The data and program staff at the BBHMF will review not only the service utilization and financial data captured internally through the submission of data reporting, but also through the quarterly reports prepared by its grant funded data collection agencies, First Choice Health Systems (for SAPT Block Grant funded services) and the Technical Assistance and Evaluation Office, Robert C. Byrd Center for Rural Health, Marshall University Research Corporation (for Mental Health Block Grant funded services), with an emphasis on analysis of trends in over/underutilization of services. When individual service issues are identified the assigned program staff will communicate the detected issue(s) and request clarification and justification of trends noted. The BBHMF will then meet with the applicable grantee directors to discuss whatever issues have been identified and attempt to solve any problems noted or to help eliminate any barriers discovered. These data reviews will occur quarterly throughout the grant period with final reports generated by the close of State Fiscal Year 2013.

By issuing periodic Announcements of Funding Availability (AFA) for Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant services, the BBHMF will have the ability to annually address programs that continue to struggle and/or are unable to correct problems. The BBHMF believes that a competitive grant process leads to better service outcomes by strongly encouraging grantee agencies to develop and monitor their own quality assurance mechanisms. AFAs are issued on an as-needed basis, with need determined through a combination of needs assessment and current performance of sub-grantees.

Finally, the Mental Health Planning Council, the Substance Abuse Advisory Council, and the state SEOW group will use the reports submitted by the BBHMF data division, First Choice Health Systems and Marshall University Research Corporation to assist with regular reassessment of West Virginia's service priorities that will subsequently be reflected in AFAs issued for SAPT and Community Mental Health Services Block Grant services. The Mental Health Planning Council and the Substance Abuse Advisory will report to the BBHMF quarterly following reports submitted by the BBHMF and/or First Choice and Marshall University.

In summary, the BBHMF will utilize all data resources in a manner that will allow for the proper application of data driven decisions as related to the proper allocation of both fiscal resources and service delivery locations. Providers will be measured for both effective and efficient service delivery.

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
No Data Available		

Footnotes:

I. State Dashboards

The State of West Virginia desires to create a dashboard related to a goal of increasing access to behavioral health and substance abuse treatment services. Using strategies outlined under this goal, West Virginia believes this increased access will decrease the number of involuntary commitments and the number of out of home placements and will increase the number of persons served, programs serving re-entry populations, and veterans accessing services. Another performance indicator under this goal is an increase in the number of trauma-informed providers. Dashboard items include:

Increase access to behavioral health and substance abuse treatment services.

Performance Indicators (PI)

- #Involuntary commitments
- #Out of home placements (both in and out of state)
- #Hospitalizations
- #Programs serving re-entry populations
- #Served
- #Veterans accessing services

The second dashboard to be created is related to the goal of increasing consumer, family and community voice in planning, implementation, and evaluation of services. This goal is directly related to the State's Technical Assistance request for the development of a System of Care for Adults with Serious Mental Illness. Dashboard items will measure the State's progress toward the goal and, more specifically, progress toward obtaining information for the enhancement of services for individuals with serious mental illness. Dashboard items include:

Increase consumer, family and community voice in planning, implementation and evaluation of services.

Performance Indicators (PI)

- #Consumer/community forums, focus groups, town hall meetings, interviews
- #Consumers, youth and stakeholder groups represented on panels and advisory boards
- #Technologies employed
- #Comments/blogs/etc. received

These dashboard items were selected to meet West Virginia's unique needs. The first set of dashboard items is directly related to the current over-use of involuntary commitments and the increase in the forensic population. Strategies to increase access to community-based services should impact both involuntary commitments and the forensic population. The second set of dashboard items is designed West Virginia's progress toward addressing the needs of individuals with serious mental illness. West Virginia has had experience in developing a System of Care for children and adolescents and their families and developing a strategic plan for substance abuse prevention and treatment.

IV: Narrative Plan

J. Suicide Prevention

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Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

J. Suicide Prevention

The West Virginia Council for the Prevention of Suicide (WVCPS) sponsored a one day retreat to highlight its accomplishments over the past three years and to discuss potential goals and objectives to accomplish in the next four years. With the assistance of a facilitator, group members brainstormed and discussed a number of priority areas that could lend community input into the WVCPS's Strategic Plan. Group members also discussed several ideas and offered suggestions for future activities to further support the goals of the WVCPS. The Strategic Plan is a work in progress and the WVCPS will continue to meet quarterly and discuss and monitor progress. The vision of the West Virginia Council for the Prevention of Suicide is that "West Virginia does not lose one citizen to suicide." It is the hope that this Plan will provide guideposts for working towards that vision.

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 behavioral 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.

The WVCPS Strategic Five Year Plan was provided to a variety of stakeholders for review, including the BBHMF, 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 the hope of the WVCPS that this collaborative process will assist these organizations and individuals to consider the recommendations of the Strategic Plan into their own plans for addressing this "silent epidemic."

The WVCPS Strategic Four Year Plan has six goals and eight objectives. The WVCPS has the primary responsibility and accountability to monitor the implementation of the plan. The plan contains four priority areas: Infrastructure, Awareness, Implementation, and Methodology. The goals and objectives are outlined below:

INFRASTRUCTURE:

Goal: Develop broad-based support for suicide prevention among providers of behavioral health and health care services.

Objective: By 2015, all professional behavioral health and health care organizations in West Virginia will include suicide prevention activities in goals and objectives within their organization.

Goal: WVCPS will establish an "endowment fund" for the purpose of furthering and sustaining operational goals of the organization.

Objective: By 2015, the WVCPS will develop and establish an endowment fund in order to further sustainability.

AWARENESS:

Goal: WVCPS programs and services will target West Virginia highest risk populations and their families. Such services will entail a continuum from preventive to supportive linkage leading to appropriate treatment and post-vention services as needed.

Objective: By 2015, Cooperative agreements with West Virginia identified high risk populations will be established that detail products, services, activities and materials to be available and provided by both parties.

Objective: By 2015, the WVCPS will ensure availability of education in suicide assessment, management of risk behaviors, and identification and promotion of protective factors for all West Virginia health care providers.

IMPLEMENTATION:

Goal: Promote mental wellness

Objective: Decrease stigma with media-based approach.

Objective: By 2015, the Council will have developed media materials presentations and conducted community roundtables in West Virginia counties.

Objective: 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 by 2015.

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

Objective: Increase post-vention efforts and resources individuals affected by the death of a loved one due to suicide, including procedures for marketing such support groups.

METHODOLOGY:

Goal: Utilize data to inform planning and decision-making.

Objective: Improve the current data collection and results information system comparable data to inform planning.

IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. 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.

Footnotes:

K. Technical Assistance Needs

The State of West Virginia has made great strides in creating an organizational structure at the State level to address the behavioral health needs of the State. Reorganization of the Bureau for Behavioral Health and Health Facilities has followed function in place of continuation of silos for mental health and substance abuse. The opportunity to develop and submit a unified behavioral health plan in response to the Substance Abuse Prevention and Treatment Block Grant and the Mental Health Services Block Grant has emboldened the Bureau's approach to integrating substance abuse and mental health services.

The BBHFF is also fortunate in the expertise among staff to provide impetus in further implementation of bi-directional integration of primary care and behavioral health services. SBIRT implementation has identified strengths of integrating behavioral health into primary care and other health settings. Experiences of community behavioral health centers in integrating healthcare into behavioral health settings will be shared with other providers to encourage further development of this approach to integration. Development of a sustainability plan for SBIRT will seek to ensure continuation of that approach.

The Bureau's development of the State Epidemiological Outcome Workgroup and other activities to enhance data collection, interpretation, and reporting will be important in developing and implementing a data-driven decision making process.

The State has moved forward with the development of a System of Care for children and adolescents and their families. The foundation of the System of Care is permeating all child-serving agencies and services in West Virginia.

West Virginia has undertaken and accomplished the development of a comprehensive strategic plan for substance abuse prevention and treatment. This strategic plan was developed with technical assistance supported by the Center for Substance Abuse Prevention and the Center for Substance Abuse Treatment.

A solid plan for adults with serious mental illness needs to be developed. The foundation for a plan which emphasizes self-direction, a recovery orientation, and the essentials of supports to complement treatment has been built. Impediments to full plan development and implementation include resources to support this approach and training of providers.

Thus, the State of West Virginia requests **technical assistance to fully develop and implement a System of Care for adults with serious mental illness**. It is anticipated this technical assistance would assist the State in:

- Completing an inventory of practices and approaches which have been successful in the State in integrating individuals with serious mental illness into the community;
 - Identifying practices which could be replicated using the State's current reimbursement strategies;
 - Identifying desired practices which need acceptable and valid changes in current reimbursement strategies;

- Identifying training and technical assistance needed for local providers to implement desired practices;
- Obtaining needs assessment information from a large group of stakeholders: consumers, ex-patients, persons in recovery, families of such persons, providers, and the general public;
- Creating and implementing a survey of the causes leading to extended hospital stays and excessive use of the commitment process; and
- Identifying the elements of a System of Care for Adults with Serious Mental Illness with recommendations on reimbursement strategies

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State 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:

- How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)?
- Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

L. Involvement of Individuals and Families

West Virginia's Single State Authority (SSA) for substance abuse prevention and treatment and Mental Health Authority believe deeply in supporting and helping to strengthen consumer and family networks, recovery organizations and community peer advocacy organizations. This support is reflected in directly funding peer-operated services, involvement of consumers and families in advisory roles, and direct solicitation of consumer and family voice in planning.

The BBHMF has a strong relationship with the West Virginia Mental Health Planning Council (WVMHPC). Consumer and family representation on the WVMHPC is always at least 51% of the membership. BBHMF consults with the WVMHPC on a regular basis regarding the current system and considers strategies to increase the availability of recovery oriented services. Recently, the WVMHPC assisted in the development of an announcement for funding availability (AFA) for consumer-operated services. The WVMHPC also assists in reviewing responses to AFAs and evaluates existing consumer-operated services.

The SSA has developed a comprehensive strategic plan for substance abuse prevention and treatment with technical assistance from SAMHSA. The plan has been endorsed by the Governor, who has appointed a Statewide Substance Abuse Advisory Council. In addition to this Council, the BBHMF is hosting regional task force meetings to seek and obtain broad stakeholder input into regional and State needs for improved substance abuse prevention and treatment services. The BBHMF focuses on assuring consumer and family voice in these regional meetings.

A Behavioral Health Council, composed of representatives of the Mental Health Planning Council and the Substance Abuse Advisory Council, will also be formed to assure collaborative efforts between the two councils.

In addition to these planning and advisory councils, the BBHMF Office of Consumer Affairs and Community Outreach is developing a Consumer Advisory Panel to assure continued focus on recovery oriented services.

The BBHMF is currently developing a network of consumer-operated drop-in centers in the State. The BBHMF intends to establish at least one drop-in center in each of six identified regions. Each drop-in center will be a hub of consumer-operated services and will focus on the identified needs of local consumers and their families. Each site will indicate a designee to participate on a State-wide advisory board, to maintain cohesion in programming, outcome measures, and reporting protocols as well as sharing ideas and resource information.

The Kanawha Institute for Social Research and Action (KISRA) offers Compeer in Kanawha County, the location of West Virginia's largest city and capitol. Compeer is also offered at the Northern West Virginia Center for Independent Living near Morgantown. Compeer programs provide one-to-one volunteer supportive friendships and mentoring relationships to adults and youth in mental health recovery. Compeer community-based programs and services achieve positive outcomes such as reduced social isolation and greater community integration for individuals on their recovery journey.

The BBHMF continues to collaborate with Kanawha Valley Community and Technical College to offer Peer Support Specialist (PSS) certifications. The BBHMF is currently exploring ways to

increase the availability of training and support the ability of consumers to further their education. BBHMF is also working to continue the West Virginia Leadership Academy, a nationally recognized best practice. The Leadership Academy equips consumers with the skills and knowledge necessary to positively impact the behavioral health system and advocate for consumers and families. Finally, the BBHMF is working to ensure that Wellness Recovery Action Planning (WRAP) is available across the state through consumer-operated drop-in centers and through facilitators who can facilitate WRAP in community settings.

The Office of Consumer Affairs and Community Outreach (CACO) located within BBHMF is responsible for several initiatives including the development and implementation of an advisory committee comprised of individuals in recovery and family members. The office is staffed by individuals in recovery and family members with expertise in various systems. The office is also responsible for coordinating BBHMF trainings and ensuring they are culturally competent and recovery-oriented.

The Division of Adult Mental Health and the CACO are collaborating to develop a minimum of four regional mental health forums to obtain consumer and family recommendations to enhance mental health services. These forums will provide opportunity to describe and engage individuals in recovery-oriented services.

At least one Comprehensive Community Mental Health Center has trained and deployed Recovery Coaches to provide supports to individuals in treatment for substance abuse. Recovery Coaches can be effective in relapse prevention.

Traditionally, there has been a lack of youth voice in planning, development and implementation of behavioral health services in the State. While youth are, as a rule, intimately involved in the development of their personal treatment planning, few agencies have moved forward to include them in planning on a broader scale. During FY 2011, the Youth Coordination program of Family Advocacy, Support and Training (FAST) partnered with Putnam County schools to elicit the voices of high school students concerning drop-out issues. FAST hosted a series of youth forums in the schools at which the students completed survey instruments and participated in discussions facilitated by the Youth Coordinator. As a result, the students formed a youth council, which presented the findings first to their local school officials, and then at West Virginia Student Success Summit. In response to the students' input, Putnam County schools made several changes to its operations and policies.

This year, FAST plans to expand these efforts geographically, topically, and technologically. The Youth Coordinator will host forums in eight additional school districts dispersed throughout the State, again seeking student input concerning drop-out issues. In addition, the Youth Coordinator will seek the voices of youth who are engaged in school based mental health treatment, again using survey instruments and facilitated discussion. FAST has secured thirty new touchpad devices for the purposes of administering surveys. Using this technology in the place of paper instruments should increase the likelihood of honest responses from participants and ensure accurate analysis. Once the data are compiled, a youth council with representatives from all sites and from both issues will present its findings to school and behavioral health professionals in at least one public venue.

FAST's Youth Coordination program has long-range plans to found a State-wide youth council that will tackle a variety of issues that concern the youth members, including child welfare, substance use and mental health issues. Currently, FAST is considering the formation of a Youth Move chapter in an effort to formalize the council and have access to guidance and support from a national organization. All youth council activities will be supported by the West Virginia System of Care initiative (WVSOC), which will also seek youth input concerning WVSOC planning.

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

- a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
- b. What specific applications of ICTs does the State plan to promote over the next two years?
- c. What incentives is the State planning to put in place to encourage their use?
- d. What support systems does the State plan to provide to encourage their use?
- e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
- f. How does the State plan 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?
- g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
- h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

M. Use of Technology

West Virginia has used telemedicine in community-based behavioral health services for several years. Each Community Behavioral Health Center, the State-operated psychiatric hospitals, and medical schools at West Virginia University and Marshall University have the capacity for behavioral health professionals and consumers of services to interact via telemedicine connections.

Telemedicine is used to provide behavioral health expertise in rural areas of the State. Behavioral health professionals provide technical assistance and consultation to rural-based behavioral health staff. Telemedicine is also used in some hearings relative to probable cause for involuntary treatment.

The BBHMF has established a Web-based site for comments regarding perception of care and practice improvement. The Office of Consumer Affairs and Outreach reviews comments received and maintains a database of information from that Website as well as calls received. The database is used to identify trends, suggest needed technical assistance, and identify issues for resolution.

The BBHMF is studying the experience of other States in developing and implementing various approaches to Interactive Communication Technologies (ICT) in addition to telemedicine. Of concern to BBHMF leadership is the ability to secure protected health information using ICT. The BBHMF will determine steps other States have taken in this regard and provide that information to the West Virginia Office of Technology which will assist in developing additional ICT approaches.

IV: Narrative Plan

N. Support of State Partners

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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, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. 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; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State 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. 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 Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into 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.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local 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 child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

N. Support of State Partners

Strategic partnerships are important to the BBHMF. Collaboration and partnerships are evident in several arenas of planning and development for behavioral health services.

At the Commissioner level, the BBHMF Commissioner meets regularly with commissioners of bureaus in the Department of Health and Human Resources (DHHR): Public Health, Medical Services, Children and Families, and Child Support. These meetings are chaired by the Secretary of the DHHR and aid in coordinating Department-wide initiatives.

A strong partnership exists between the BBHMF and all other child-serving agencies and organization in the State through the System of Care initiative for children and adolescents and their families. The System of Care Implementation Team 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. It is the State Steering Team for the State's Service Array statewide needs and gaps assessment process. A subcommittee of the team was established to operationalize the values and principles of the System of Care to assist behavioral providers to enact best practices.

The BBHMF engaged its partners in the development of a strategic plan for substance abuse prevention and treatment. All stakeholders, including State agencies such as the Medicaid authority, the judicial system, education, and Children and Families, were included in obtaining information for the development of that plan. Other State agencies were also represented, such as corrections and highways. Information for the plan was also obtained from substance abuse prevention and treatment professionals and persons in recovery.

Another forum for partners is the West Virginia Mental Health Planning Council. The Council has active membership from the State Medicaid Authority, corrections, vocational rehabilitation, and education.

Letters of support from a number of partners are included as attachments to this application.

IV: Narrative Plan

O. State Behavioral Health Advisory Council

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Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

O. State Behavioral Health Advisory Council

The BBHMF is fortunate to have direct communication with and receive advisement from numerous work groups, panels and councils.

West Virginia Comprehensive Behavioral Health Commission

With the behavioral health system in West Virginia rapidly moving toward a state of crisis, the West Virginia Legislature enacted legislation creating the Comprehensive Behavioral Health Commission (Commission) in SFY06. The Commission members and its Advisory Board were charged, in part, with bringing together key stakeholders to review, assess, and make recommendations to improve the current prevention, treatment, education, and workforce development for the behavioral health system of care, with emphases on substance abuse and domestic violence. During the first few years of work, the Commission members, its Advisory Board and over 300 stakeholders came together to discuss, prioritize and finalize a shared vision with over 100 recommendations for various system improvements to the behavioral health system of care. These recommendations were narrowed to include six (6) overarching goals and objectives, but remained in existence for specific ideas generated. Recently the Commission was extended for two more years to support work and efforts initiated and essential to continued system wide improvement.

Commissioner Panels

As part of the comprehensive Bureau re-organization that was launched in 2008 three advisory boards were recommended for development to support and guide the Bureau for Behavioral Health and Health Facilities work. The Commissioner's Consumer Advisory Panel is comprised of a volunteer group of individuals who are in some capacity consumers of behavioral health services. This may be through direct care or someone who supports a person accessing behavioral health services. This panel offers to the Commissioner during listening sessions what is working well and what needs attention within the current system(s). In addition, the panel will be a forum for the Commissioner where he/she can discuss new proposals, policies or system improvement ideas being considered. A second advisory group is the Clinical Advisory Group, led by the Medical Director and comprised of clinical staff from BHMF facilities, clinical representatives from providers and others engaged in clinical work within the system. The focus of this group is to bring together professionals with clinical expertise on a regular basis to discuss clinical issues impacting the behavioral health system. Finally, the Providers Advisory Committee is a group comprised of behavioral health and other providers affiliated with the Bureau. This group is coordinated and led by the Deputy Commissioner for Programs and Planning and addresses topics regarding the behavioral health system from the providers perspective.

Work Groups

The BBHMF partnered with Comprehensive Behavioral Health Service providers to determine areas of common need and establish work groups to share ideas and plan for the implementation of a full continuum of behavioral health services. Each work group is co-facilitated by Bureau staff and a local provider of services. Additional representation of the group is made up of provider-selected staff. Collectively, these groups offer guidance and support in the areas of

planning for a comprehensive service continuum, compliance and continuous quality improvement. Current work groups include: Behavioral Health Systems Development; Community Supports; Grant /Statement of Work; Funding and Allocation; and Intellectual and Developmental Disabilities.

WV Mental Health Planning Council

The West Virginia Mental Health Planning Council (WVMHPC) is one of the oldest Planning Councils in the country, having been established in 1989 pursuant to the passage of Federal law 99-660 in 1986, continuing through Public Law 101-639 and Public Law 102-321 in 1992.

The WVMHPC developed a process to monitor and evaluate services and programs funded by the Mental Health Services Block Grant, which was reported in a monograph published by the National Association of Mental Health Planning and Advisory Councils (NAMHPAC) (“Promoting Collaboration: An Exploration of Successful Partnerships Between Mental Health Planning and Advisory Councils and State Mental Health Agencies”).

Two members of the WVMPC have served as trainers and consultants for the NAMHPAC. One member is current chair of the Board of Directors of NAMHPAC.

In addition to the membership required by statute, the WVMHPC has reserved two seats for youth representation. One member is also the Chair of the Advisory Council for Protection and Advocacy for Individuals with Mental Illness (PAIMI) and provides reports from the advocacy organization at each meeting. The membership of the WVMHPC has included providers of substance abuse treatment and recovery services and individuals in recovery for the past three years.

Because of the increasing concerns of substance misuse and abuse in the State, the development of a separate substance abuse planning council structure has been discussed. To insure there is adequate support and objective review and input relative to the mental health and substance abuse continuums of support, a substance abuse planning council is being formed utilizing the structure in place for the mental health equivalent. Given that today’s consumer population is characterized proportionately as co-occurring (both a mental health and substance abuse diagnosis) it is essential that continuous capacity to focus on issues common to each area be maintained. In furthering the efforts for the BBHMF to pursue integration and a focus on treating the whole person it is essential that a planning body that bridges mental health and substance abuse discussions be formed. The BBHMF will develop a “Cross – Planning” Council that will support such efforts during SFY 12.

State Fiscal Year 2011 has been a transitional year for the WVMHPC. Restructuring of the BBHMF, development of new Statements of Work for entities funded by the Bureau and the development of a monitoring and compliance unit within the BBHMF were considered by the WVMHCA as important processes which needed to be understood and integrated into the Council’s work. In addition, it was essential for the Council to learn about plans of the State’s Medicaid Authority to expand its managed care coverage to individuals who are Medicaid-eligible due to being recipients of SSI. Another important issue in the environment was plans for the State’s response to the Affordable Care Act. Thus, the year’s agenda focused on educating

the Council on new developments and advocating for individuals with serious mental illness, children and youth with serious emotional disturbance, and individuals with substance use disorders.

The Deputy Commissioner of the BBHMF presented at one meeting of the WVMHPC to describe and discuss plans for Bureau reorganization. The Council membership was appreciative of the plans to integrate mental health services and substance abuse services within the Bureau. Council members also applauded announced plans for filling vacant positions and the Bureau's plans to focus on accountability through expansion of the monitoring and compliance unit and improved Statements of Work for grantees.

The WVMHPC thought it significant that the Bureau reorganization included creating the Office of Consumer Affairs and Community Outreach. Council members were assured that creating this office secured a consumer voice in all Bureau endeavors. The office will also be responsible for coordinating training, focusing on evidence based practices.

The Planning Council hosted presentations by all managed care organizations contracting with the Medicaid Authority. They provided information concerning coverage for mental illness and procedures for enrolling. The Council participated with other advocacy organizations in learning about the plans for expanding managed care approaches for the Medicaid population and expressed concerns. The Bureau for Medicaid has since tabled expansion plans.

The WVMHPC hosted a presentation on the Creating Homes Initiative (CHI) sponsored by the Tennessee Department of Mental Health. The CHI has successfully expanded opportunities for safe and affordable housing for individuals with serious mental illness. The Planning Council's Housing Committee has utilized the information from the CHI to develop objectives for increasing the availability of safe and affordable housing. The committee is focusing on one area of the State at the present time.

Another presentation to the Planning Council provided information on the State's Screening, Brief Intervention, Referral and Treatment (SBIRT) program. The Council is supportive of this program and its potential impact on early identification of misuse or abuse of alcohol or other drugs. The Council suggested SBIRT is an excellent model of primary care and behavioral health integration and recommends continuation following Federal funding. The Council chair is a member of the SBIRT sustainability committee.

The BBHMF Director of Programs and Partnerships provided information to the WVMHPC concerning bi-directional integration of behavioral health and healthcare. The Director was able to share information from her experiences in providing integrated care. The WVMHPC supports bi-directional integration and is encouraged that a person with direct experience is working within the BBHMF to provide leadership. This should be a significant advantage as implementation of the Affordable Care Act moves forward.

A portion of one meeting of the WVMHCA was dedicated to providing information to a consultant engaged by the Court Monitor in the *Hartley v. Matin* consent decree. The Court had ordered the Court Monitor to engage a consultant to study and report on the effects of utilization

management for Medicaid-reimbursed behavioral health services. The consultant utilized a meeting of the WVMHCA to gather information from a variety of stakeholders concerning Medicaid-reimbursed behavioral health services. The consultant also utilized the Planning Council's 2008 report, "Synopsis of Current Recommendations for Mental Health and Substance Abuse Services in West Virginia: With a Blueprint for Transformation" in the final report.

A member of the WVMHPC regularly updates Council members via Email concerning legislative activities when the Legislature is in session. The Council received a comprehensive report concerning legislation related to behavioral health services at the completion of the regular Legislative session.

Once a year, the WVMHPC conducts a "PLUS" meeting. This meeting is designed to encourage non-members, specifically consumers and family members. In SFY 2011, the meeting focused on children and their families. Two days of activities and educational presentations were provided for the children and adolescents in attendance and presentations during the Council meeting focused on behavioral health services for children and adolescents. The WVMHPC received information on the State's ASPEN project, which seeks to decrease suicides among children and adolescents; a police department prevention resource located in a local high school; the West Virginia Service Array organized by the Bureau for Children and Family; plans for the Expanded School Mental Health Initiative, and an update on implementation of the Affordable Care Act. The presentation on the Service Array included a hands-on review of the Beehive (www.beehive.org), a resource for locating services.

The WVMHPC also continued partial sponsorship of the annual Blues Fest in Charleston, with a theme of "Listening to the Blues is Fun; Having the Blues is no Fun." The WVMHPC logo was included on a banner over the main stage and attendees had the opportunity to obtain literature based on the theme and providing information on obtaining assistance for depression.

Expert Panels

In addition to local, State, and Federal efforts, individuals involved in the various efforts outlined above and the many consumer and provider stakeholders there are a number of groups that have developed to address substance misuse and abuse statewide. These groups offer a collective expertise and are relied upon as advisory groups. Through education, consultation, advocacy and promotion of good mental health and the prevention of substance use and abuse, the groups work collaboratively with one another and the BBHFF to provide input for improvements to the behavioral health system of care.

Controlled Substances Advisory Board

The West Virginia Controlled Substances Advisory Board supports access to legitimate medical use of controlled substances but helps educate the public with regard to use, abuse, diversion and addiction. The group promotes the use of the Prescription Drug Monitoring Program for pharmacists and informs West Virginia communities about use and abuse trends.

Underage Drinking Prevention Work Group

The purpose of the Underage Drinking Prevention Workgroup (UDP Workgroup) is coordination of a comprehensive statewide network for the prevention of underage drinking. This group includes State agency, university and community representation.

Medical Education Team

The Medical Education Team plans for and develops best practice prevention guidelines and treatment protocols and works to improve medical professional competencies in the area of substance use and mental health disorders. The team will target Suicide, Prescription Drug Abuse, Drug Exposed Pregnancies (Alcohol and Prescription Drugs), Alcohol Use in Youth and Alcohol Abuse in Adults. The West Virginia Medical Professionals Health Program will facilitate the work of the Medical Education teams, which will be a physician-led initiative. Partners will include Rural Health Education Centers, the West Virginia Perinatal Partnership, (a consortium of over 100 health care professional and public and private organizations), Primary Health Care Facilities, and universities. The group serves as an expert advisory panel on all medical professional substance abuse prevention and mental health promotion related issues.

Prevention Partnership Network

The partnership is made up of both state agency field staff and community based prevention specialists. The network is comprised of eight grantees in all service areas of West Virginia, covering all 55 counties and include the Partnership of African American Churches, Community Connections, Barbour County Family Resource Network (FRN), Marshall County FRN, Randolph FRN, FRN of the Panhandle, Presteria-Region 2 Collaborative, and Potomac Highlands Guild.

West Virginia SBIRT Policy Steering Committee

The West Virginia SBIRT Policy Steering Committee is a freestanding policy steering committee to provide strategic policy and operational advice on the SBIRT project to the BBHFF, as well as provide advice on integrating SBIRT into the existing system of care and on policies, as appropriate. The Policy Steering Committee has created a committee to recommend sustainability for the SBIRT project.

West Virginia Perinatal Partnership

The West Virginia Perinatal Partnership is statewide partnership of health care professionals and public and private organizations working to improve perinatal health in West Virginia. The focus of the Partnership includes supporting health care providers to be able to best care for pregnant women and their babies; encouraging new laws that promote better health for pregnant women and their babies; creating opportunities for perinatal professionals to share their expertise with each other; spreading the latest knowledge about perinatal health through educational programs; working to reduce tobacco and drug use among pregnant women; fostering oral health care in pregnant women and infants; and studying research and trends in mother /child health and working to distribute that information.

Partnership of African American Churches

The Partnership of African American Churches (PAAC) is a faith based community development corporation. The PAAC is a specific initiative driven organization focusing on holistic health which encompasses, education, physical health, absence from disease, economic, crime

prevention and integrating comprehensive youth development intrinsic to its core programmatic solutions.

The West Virginia System of Care Implementation Team (SIT)

One of the primary recommendations from the Commission to Study Residential Placements is to develop an integrated and comprehensive System of Care approach for all out-of-home children, with the adoption of the values and principles of a system of care as a guidepost. The leadership, planning, assessment, collaboration and communication involved in building a System of Care depends on the full involvement of West Virginia's child-serving bureaus, divisions, agencies, service providers, and representatives of those youth and families who receive services. A System of Care Implementation Team (SIT) was created to represent all stakeholders to direct and monitor all related activities in building the West Virginia System of Care.

The West Virginia Council for the Prevention of Suicide

The mission of the West Virginia Council for the Prevention of Suicide (WVCPS) is to reduce the number of suicides in West Virginia and provide workshops throughout the state to educate individuals on the early signs of depression and suicide and how to obtain services.

Commission to Study Residential Placement of Children

A statute created the Commission to Study Residential Placement of Children included “strategies and methods to reduce the number of children who must be placed in out-of-state facilities and to return children from existing out-of-state placements, initially targeting older youth who have been adjudicated delinquent.” The Commission recognized that the total environment in which out-of-home children are a part of needs to be addressed to make the long-term changes that will dramatically reduce the amount and degree of many of the required interventions now in place. With this in mind, the Commission agreed to broaden the scope of its oversight. Since publishing its first summary report, “Advancing New Outcomes” in May 2006, the Commission has continued to meet on a voluntary basis to ensure that work is being done to implement their recommendations. In 2010, the Legislature enacted SB 636 to reconstitute the Commission. This legislation includes addressing any ancillary issues relative to foster care placement and requires the reduction of out-of-state placements by 10% for the first two years and 50% by the third year of the Commission’s existence.

Expanded School Mental Health (ESMH) Steering Team

The mission of West Virginia's Expanded School Mental Health Initiative is to develop and strengthen policies, practices and services that promote learning and social-emotional well-being for all of West Virginia's youth through a collaborative process that engages schools, families and community-based agencies. It is a joint initiative of the BBHMF and the West Virginia Department of Education. A state steering team was established 2007 and is comprised of State, local, and community partners working to develop and oversee implementation in an effort to increase and enhance school based mental health services.

West Virginia Behavioral Health Providers Association

Members of the West Virginia Behavioral Health Providers Association are behavioral health care provider organizations serving recipients in each of the 55 counties in the State. They are

committed to creating and sustaining healthy and secure communities. They are a network of committed organizations and advocates promoting services of unparalleled value.

West Virginia Association of Alcoholism and Drug Abuse Counselors

West Virginia Association of Alcoholism & Drug Abuse Counselors, Inc. is the state affiliate of NAADAC, The Association for Addiction Professionals. Their mission is to lead, unify, and empower addiction focused professionals to achieve excellence through education, advocacy, knowledge, and standards of practice, ethics, professional development and research.

IV: Narrative Plan

Table 11 List of Advisory Council Members

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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 (from Mental Illness and Addictions)		357 View Point Lane Wheeling, WV 26003 PH: 304-281-7898	tdototh@msn.com
Cindy Thompson	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		PO Box 3154 Elkins, WV 26241 PH: 304-591-1225	cat_2502@yahoo.com
Phil Reed	Individuals in Recovery (from Mental Illness and Addictions)		Rt. 7 Box 480 Fairmont, WV 26554 PH: 304-363-5205	kitcatwv@yahoo.com
Beth Dortch	Others (Not State employees or providers)		5109 Rockdale Cross Lanes, WV 25313 PH: 304-410-4835	Beth@wvdawg.org
Steve Mason	Providers		Rt 6 Box 211 Charleston, WV 25311 PH: 304-343-9410	ssckm@yahoo.com
Carolyn Nelson	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		2105 Superior Avenue South Charleston, WV 25303 PH: 304-746-1155	watchpigsflying@aol.com
Margaret Taylor	Providers		1114 Quarrier Street Charleston, WV 25301 PH: 304-340-3553	mtaylor@ywcacharleston.org

256 Normandy Street

Bob Musick	Providers	Morgantown, WV 26505 PH: 304-296-1731	bmusik@valleyhealthcare.org
Ardella Cottrill	Individuals in Recovery (from Mental Illness and Addictions)	1709 Clay Avenue Fairmont, WV 26554 PH: 304-376-4835	rdellanjr@yahoo.com
Cathy Reed	Individuals in Recovery (from Mental Illness and Addictions)	Rt 7 Box 480 Fairmont, WV 26554 PH: 304-363-5205	kitcaatwv@yahoo.com
Dianna Bailey-Miller	Providers	110 S. Third Street Clarksburg, WV 26301 PH: 304-695-1155	Diannabadvocate@aol.com
Rita Herod	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Rt. 6, Box 38 Clarksburg, WV 26301 PH: 301-709-2680	
Linda Leasure	Individuals in Recovery (from Mental Illness and Addictions)	713 Bigley Avenue Charleston, WV 25302 PH: 304-345-7312	lindaleasure@wvmhca.org
Jamie Doty	Others (Not State employees or providers)	950 Valley View Avenue, Apt. 306 Morgantown, WV 26505 PH: 304-650-0268	jdoty314@gmail.com
Joe Cunningham	Individuals in Recovery (from Mental Illness and Addictions)	713 Bigley Avenue Charleston, WV 25302 PH: 304-982-6217	joec@wvmhca.org
Linda Pauley	Providers	1449 Childress Road Alum Creek, WV 25003 PH: 304-756-3734	linda-pauley@yahoo.com
Lori Byhanna	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	1375 Girty's Point Road Wheeling, WV 26003 PH: 304-336-7026	thebyhannas@hotmail.com
Debra Hansen	Individuals in Recovery (from Mental Illness and Addictions)	900 5th Avenue Huntington, WV 25704 PH: 304-544-9570	deborahhansen@wvmhca.org

Patrick Tenney	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	301 Scott Avenue Morgantown, WV 26505 PH: 304-282-1278	ptenney@valleyhealthcare.org
Bob Hansen	Providers	PO Box 8069 Huntington, WV 25705 PH: 304-399-1133	BobH@Prestera.org
Earnie Jarrell	Individuals in Recovery (from Mental Illness and Addictions)	PH: 304-573-8293	ErnieMK317@aol.com
Jackie Hensley	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	57 Elm Street Davisville, WV 26142 PH: 304-588-2009	jdolphins68@yahoo.com
David Sanders	Individuals in Recovery (from Mental Illness and Addictions)	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 (from Mental Illness and Addictions)	212 P Woodland Drive Nitro, WV 25143 PH: 304-377-9491	AFFerrari@apshealthcare.com
Shelia Hicks	Individuals in Recovery (from Mental Illness and Addictions)	625 8th Street Huntington, WV 25701 PH: 304-521-6817	sheilahicks@wvmhca.org
Nancy Schmitt	Individuals in Recovery (from Mental Illness and Addictions)	3723 Winchester Avenue Martinsburg, WV 25405 PH: 304-676-8053	nschmitt52@gmail.com
J.K. McAtee	Individuals in Recovery (from Mental Illness and Addictions)	30 Cleveland Avenue Buckhannon, WV 26201 PH: 304-439-4605	peersupportsinwv@live.com

Ted Johnson	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		2105 Superior Avenue South Charleston, WV 25303 PH: 304-552-3819	JonneITJJ@aol.com
Bob Carey	State Employees	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
Francie Clark	State Employees	Education	Capitol Complex, Building 6, Room 360 Charleston, WV 25305	fclark@access.k12.wv.us
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		1409 Greenbrier Street 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
Rhonda Cooper	State Employees	Bureau for Behavioral Health and Health Facilities	350 Capitol Street, Room 350 Charleston, WV 25301	Rhonda.E.Cooper@wv.gov

Footnotes:

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

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Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	44	
Individuals in Recovery (from Mental Illness and Addictions)	11	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	9	
Vacancies (Individuals and Family Members)	<input type="text" value="3"/>	
Others (Not State employees or providers)	2	
Total Individuals in Recovery, Family Members & Others	25	56.82%
State Employees	10	
Providers	7	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="2"/>	
Total State Employees & Providers	19	43.18%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

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Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

P. Comment on the State Plan

West Virginia's State plans for the Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant were made available for review and comment by the West Virginia Mental Health Planning Council (WVMHPC) throughout the preparation process. The timeframe between finalizing the Guidance for the Block Grants and submission date for the 2012-2013 application has prevented pre-application review and comment. The Chair of the WVMHPC has had an opportunity to review the final document and share information with members of Council's Executive Committee. The Planning Council has submitted a letter endorsing the plan, which is attached.

The completed plan was submitted for review and comment to the entire Planning Council in October. The plan has been placed on the BBHMF Website for review and stakeholders have been notified of its placement, utilizing an extensive listserv. As revisions are made, updated documents will be posted, replacing the original documents.

In addition to these efforts to obtain public comment, the West Virginia Legislature annually hosts a public hearing on all Federal Block Grants for the State. The Legislature provides public notice of the hearings. State agencies responsible for each Block Grant provide a summary of relevant Block Grants, which is followed by comments from Legislators and/or the general public.

Step 4: Goals, Strategies and Performance Indicators

<p>State System Priority 1: Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the West Virginia behavioral health service delivery system.</p>
<p>Goal 1: Improve the State's data collection methods.</p>
<p>Strategies</p> <ol style="list-style-type: none">1. The West Virginia State Epidemiological Work Group (WVSEOW) will identify, prioritize and document key policy /program questions and decisions regarding needs, inputs, processes and outcomes.2. The BBHMF leadership will define the data or indicators necessary to respond to programmatic and/or policy priorities.3. The WVSEOW will conduct a review of existing datasets and determine what (if any) new datasets are required to address the programmatic /policy priorities.4. Develop cross-system data retrieval and sharing protocols for existing datasets housed by external agencies or organizations.
<p>Performance Indicators (PI)</p> <ul style="list-style-type: none">• Priority questions /decisions documented.• Datasets clearly defined and linked with priority questions /decisions.• Catalog of all existing datasets identified for possible use with evaluative statements. Written rationale for creating any new datasets.• Data protocol developed.• #Agencies /Organizations providing /sharing data.
<p>Description of Collecting and Measuring Changes in PI</p> <ul style="list-style-type: none">• Facilitate brainstorming sessions organized around BBHMF strategic objectives to identify priority decisions.• Documentation produced during meetings.• The WVSEOW will identify and review all sources of useful data (TEDS, YRBS, APS, etc.).• The BBHMF Epidemiologist will submit recommended protocol to leadership for submission to other agencies and web site.

State System Priority 1: Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the West Virginia behavioral health service delivery system.
Goal 2: Implement sophisticated data analysis and interpretation practices that promote informed decision-making.
Strategies <ol style="list-style-type: none"> 1. The WVSEOW will produce and review State and local behavioral health profiles. 2. Produce cost analysis reports. 3. Produce reliable utilization and encounter reports that can be accessed via the web. 4. Produce outcomes reports (descriptive and inferential analyses). 5. Collaborate with BMS, ASO and other Insurers to analyze provider data.
Performance Indicators (PI) <ul style="list-style-type: none"> • Profile, cost analysis, utilization, encounter, outcomes and provider data reports • Web based real time utilization reports posted
Description of Collecting and Measuring Changes in PI Data and technology staff will use available datasets for analysis and report generation

State System Priority 1: Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the West Virginia behavioral health service delivery system.
Goal 3: Use data interpretation to improve the access, quality and outcomes of West Virginia behavioral health services.
Strategies <ol style="list-style-type: none"> 1. The SEOW and Data and Research Team will produce reports that make connections and comparisons, and explore both causes and consequences. 2. Develop an early warning network by partnering with local law enforcement, DEA and poison center to track current trends in substance use and abuse. 3. Create common standards and service definitions related to performance measures. 4. Define measures to assess cross system effectiveness. 5. Create uniform standards and reporting for the administration and operation of the DUI Safety and Treatment Program.
Performance Indicators (PI) <ul style="list-style-type: none"> • Data Interpretation Reports produced • #Early Warning Alerts deployed • Service definitions and treatment standards documented and disseminated • Measures defined on all grantee Statements of Work • Implementation of uniform standards and reporting
Description of Collecting and Measuring Changes in PI <ul style="list-style-type: none"> • Alerts completed by Data and Research Team and disseminated • Leadership will work with monitoring and compliance to complete and post • Statements of Work signed and implemented • Data submitted to the BBHFF

State System Priority 2: Build the capacity and competency of West Virginia’s behavioral health workforce and other stakeholders to effectively plan, implement, and sustain comprehensive, culturally relevant services.

Goal 1: Increase the capacity of the behavioral health workforce.

Strategies

1. In coordination with System Development Work Group, conduct a statewide survey to assess workforce capacity, factors correlated with staff turnover, and use of evidence-based practices.
2. Collaborate with the Governor’s office on Work Force, the U.S. Bureau of Labor Statistics, Employee Assistance Programs and Major Employers to determine employment profiles.
3. Support innovative efforts to attract and retain qualified staff (e.g., tuition reimbursement, internships, and stay contracts).
4. Implement a West Virginia Peer Training and Certification Program.
5. Promote certification of counselors through Tri-Care to support veterans receiving services.
6. Increase the number of certified / licensed professional’s delivering services.

Performance Indicators (PI)

- Capacity Survey and employment profiles completed and analyzed
- # Qualified behavioral health /substance abuse personnel
- # Meetings held & # in attendance
- # Organizations/individuals engaged in internships, tuition reimbursements, stay contracts
- # Resources developed and disseminated

Description of Collecting and Measuring Changes in PI

- Data and technology team will analyze and report findings related to the Capacity Survey and employment profiles
- Obtain data from applicable licensing/certification boards and compare to workforce capacity survey
- Documentation of meetings (agendas, minutes, attendance records, etc.)
- Data submitted to First Choice, Inc. /Marshall University then analyzed and forwarded to BBHMF quarterly
- Peer Recovery Support numbers recorded

State System Priority 2: Build the capacity and competency of West Virginia’s behavioral health workforce and other stakeholders to effectively plan, implement, and sustain comprehensive, culturally relevant services.

Goal 2: Increase the awareness, knowledge, and skills among behavioral health professionals and other stakeholders.

Strategies

1. Promote cross training opportunities for all BBHMF program staff with an emphasis on evidence based programs, practices and policies.
2. Support grantees’ staff development efforts and stakeholder education via training, resources, and technical assistance (TA) using traditional and innovative methods (e.g., conferences, workshops, white papers, e-based modules, pod casts and YouTube mini-lessons) that focus on best practice and high-risk populations.
3. Maintain CEU provider status for Social Work and Nursing. Gain approval to provide CEUs for Counseling, IC&RC, Law Enforcement, Medical and Psychology.
4. Provide funding and assistance for a behavioral health conference as well as a consumer /family-lead learning opportunity.
5. Partner with higher education to promote the integration of behavioral health topics in curricula and practical experiences (practicum, internship, residency) within primary care professional preparation.
6. Partner with higher education to establish standards for curriculum and practical experience (practicum, internships) to promote competence and eligibility for licensure /certification in behavioral health and substance abuse treatment.
7. Develop and disseminate survey instruments for use following all trainings offered and/or funded by the BBHMF.

Performance Indicators (PI)

- #Training/Learning Opportunities /Conferences offered
- #Participants from various systems (e.g., primary care, corrections, faith-based, education)
- #TA contacts
- #Resources developed and disseminated
- #CEUS provided yearly
- #Completed surveys with Documentation of findings
- #Meetings with higher education
- Standards for student practical experience
- # Residents participating in behavioral health integration settings

Description of Collecting and Measuring Changes in PI

- Attendance recorded at each learning opportunity
- Data submitted to First Choice, Inc. /Marshall University, analyzed and forwarded to BBHMF quarterly
- Recorded by Consumer Affairs and Community Outreach and reported quarterly
- Obtain conference report 30 days after event including all evaluation analysis.

<p>State System Priority 3: Increase access to a continuum of culturally and linguistically competent, integrated behavioral health prevention/ promotion, early identification, treatment and recovery management services that are high quality and person-centered.</p>
<p>Goal 1: Integrate behavioral health prevention/promotion, early identification, treatment and recovery support services with other health and social services.</p>
<p>Strategies</p> <ol style="list-style-type: none"> 1. Collaborate with the West Virginia Medical Professional Health Program /State Medical Association and other stakeholders to promote the integration of primary and behavioral health care through training and resource development. 2. Partner with other state agencies to support integrated projects involving other systems.
<p>Performance Indicators (PI)</p> <ul style="list-style-type: none"> • #Meetings with primary health care sites • #Trainings provided on BHI • #Resources (protocols, physician guidance, and best practice documents) developed and disseminated • #Partnerships and Memoranda of Understanding
<p>Description of Collecting and Measuring Changes in PI</p> <ul style="list-style-type: none"> • Medical education teams establish best practice protocols for behavioral health prevention /promotion, early intervention and treatment • Meeting agendas, minutes, attendance recorded

<p>State System Priority 3: Increase access to a continuum of culturally and linguistically competent, integrated behavioral health prevention/ promotion, early identification, treatment and recovery management services that are high quality and person-centered.</p>
<p>Goal 2: Increase access to substance abuse prevention and mental health promotion activities.</p>
<p>Strategies</p> <ol style="list-style-type: none"> 1. Prevent substance abuse by supporting prevention efforts with funding, training, and conferences. 2. Prevent suicides by supporting prevention efforts with funding, training and conferences. 3. Promote mental health through partnerships with WVDE to strengthen the implementation of social-emotional learning curriculum and coordinate local efforts between prevention grantees and school wellness specialists.
<p>Performance Indicators (PI)</p> <ul style="list-style-type: none"> • #Suicides • Incidence rate of prescription drug abuse, under-age drinking, and drug exposed pregnancies • #of buys during SYNAR inspections • #Community based coalitions • #Prevention training events held • #Conferences held • #Memoranda of Understanding
<p>Description of Collecting and Measuring Changes in PI</p> <ul style="list-style-type: none"> • Data submitted to First Choice, Inc. /Marshall University then analyzed and forwarded to BBHMF quarterly

- The BBHMF Epidemiologist will access datasets to analyze trends in suicide, substance abuse, and mental health.

State System Priority 3: Increase access to a continuum of culturally and linguistically competent, integrated behavioral health prevention/ promotion, early identification, treatment and recovery management services that are high quality and person-centered.

Goal 3: Increase access to early intervention strategies /programs that mitigate further substance use and mental disorders.

Strategies

1. Expand the continuum of care for youth in foster care transitioning to adulthood.
2. Increase the number of SBIRT integrated sites in West Virginia.
3. Provide funding for a prescription help line to provide psycho-educational resources and referral information.
4. Improve sustainability of suicide prevention and early intervention programming.
5. Promote the expansion of Teen and/or Juvenile Drug Courts.
6. Expand ESMH services and supports across West Virginia.
7. Support statewide family advocacy efforts for children and youth with SED.
8. Support children’s homeless outreach programs.

Performance Indicators (PI)

- #Transitioning youth programs
- #SBIRT sites
- # Prescription Help Line Calls reported
- # Referrals provided/made
- # Teen Courts and Juvenile Drug Courts
- # ESMH sites
- # Family/youth support groups
- # Parent volunteers
- # Peer to peer support trainings conducted
- # Children served

Description of Collecting and Measuring Changes in PI

- Data submitted to First Choice, Inc. /Marshall University then analyzed and forwarded to BBHMF quarterly

<p>State System Priority 3: Increase access to a continuum of culturally and linguistically competent, integrated behavioral health prevention /promotion, early identification, treatment and recovery management services that are high quality and person-centered.</p>
<p>Goal 4: Increase access to behavioral health and substance abuse treatment services.</p>
<p>Strategies</p> <ol style="list-style-type: none"> 1. Increase and market community based services to reduce acute and residential care. 2. Develop programs that serve re-entry populations using effective treatment models. 3. Encourage veterans and their families to access services through the West Virginia Veteran's Home and Military One Source. 4. Increase the availability of trauma-informed care and related assistance for families.
<p>Performance Indicators (PI)</p> <ul style="list-style-type: none"> • #Involuntary commitments • #Out of home placements (both in and out of state) • #Hospitalizations • #Programs serving re-entry populations • #Served • #Veterans accessing services • #Trauma-informed providers
<p>Description of Collecting and Measuring Changes in PI</p> <ul style="list-style-type: none"> • Data submitted to First Choice, Inc. /Marshall University then analyzed and forwarded to BBHMF quarterly • Recorded by Consumer Affairs and Community outreach and reported quarterly

<p>State System Priority 3: Increase access to a continuum of culturally and linguistically competent, integrated behavioral health prevention/ promotion, early identification, treatment and recovery management services that are high quality and person-centered.</p>
<p>Goal 5: Increase access to community supports that provide recovery, resiliency and social integration.</p>
<p>Strategies</p> <ol style="list-style-type: none"> 1. Inform providers and consumers regarding the locations of 12-Step programs and resources. 2. Fund community based organizations that promote recovery and are consumer operated. 3. Collaborate with the Department of Transportation and community organizations to increase consumer transportation options.
<p>Performance Indicators (PI)</p> <ul style="list-style-type: none"> • #Resources developed and disseminated • #People served and # services provided • #EBP's Implemented • #Meetings • #Transportation options available
<p>Description of Collecting and Measuring Changes in PI</p> <ul style="list-style-type: none"> • Data submitted to First Choice, Inc. /Marshall University then analyzed and forwarded to BBHMF quarterly • Recorded by Consumer Affairs and Community outreach and reported quarterly

<p>State System Priority 3: Increase access to a continuum of culturally and linguistically competent, integrated behavioral health prevention /promotion, early identification, treatment and recovery management services that are high quality and person-centered.</p>
<p>Goal 6: Increase consumer, family and community voice in planning, implementation and evaluation of services.</p>
<p>Strategies</p> <ol style="list-style-type: none"> 1. Incorporate consumer input into the development of the BBHFF website. 2. Formalize and maintain SA and MH Planning and Cross Planning Advisory Groups. 3. Implement the use of internet technology to solicit consumer and family input. 4. Consumer Affairs and Community Outreach will monitor discharged cases to ensure positive consumer outcomes. 5. Consumer Affairs and Community Outreach will log all calls to determine trends of needs and service provision. 6. Facilitate the collection of meaningful community input. 7. Require youth membership on all community-based coalitions.
<p>Performance Indicators (PI)</p> <ul style="list-style-type: none"> • #Consumer/community forums, focus groups, town hall meetings, interviews • #Consumers, youth and stakeholder groups represented on panels and advisory boards • #Technologies employed • #Comments/blogs/etc. received • #Discharged cases reviewed • #Calls logged
<p>Description of Collecting and Measuring Changes in PI</p> <ul style="list-style-type: none"> • Quarterly report regarding consumer calls, comments, blogs, feedback and discharge interviews presented by Consumer Affairs and Community Outreach • Meeting agendas, minutes, and participation logs

State System Priority 3: Increase access to a continuum of culturally and linguistically competent, integrated behavioral health prevention /promotion, early identification, treatment and recovery management services that are high quality and person-centered.

Goal 7: Improve the quality of treatment services system wide.

Strategies

1. Require grantees to implement evidence-based practices with clinical supervision to maintain fidelity.
2. Adopt and promote uniform best practice client assessments and intake protocols to improve access to care.
3. Utilize provider networks as a mechanism to strengthen implementation of peer-to-peer technical assistance on best practice.
4. Develop medication assisted treatment protocols and disseminate to providers.
5. Identify and promote treatment models that serve the whole family.
6. Develop standards for Non-Treatment Residential Facilities.

Performance Indicators (PI)

- Defined on Statements of Work
- #EBPs used
- Clinical Supervision records
- #Technical Assistance Provided
- Medication Assisted Treatment Protocols published
- #Resources developed and disseminated
- Non-Treatment Residential Facilities Standards published

Description of Collecting and Measuring Changes in PI

- Data submitted to Marshall University then analyzed and forwarded to BBHMF quarterly
- Monitoring and compliance reviews quarterly
- Website and listserv dissemination

State System Priority 4: Manage resources effectively by promoting good stewardship and further development of the West Virginia behavioral health service delivery system.

Goal 1: Maximize and leverage financial resources to sustain behavioral health prevention /promotion, early intervention, treatment, and recovery services in West Virginia.

Strategies

1. Use data interpretation regarding the effectiveness and efficiency of grantee activities to inform future funding decisions.
2. Develop formal relationships with critical partners (e.g., local foundations, EPSDT, Medicaid, private insurers and faith based organizations).
3. Collaborate with public and private insurers to eliminate service/reimbursement requirements that are contraindicated to effective practice.
4. Collaborate with Medicaid and other partners to assure the availability of covered services upon implementation of the Affordable Care Act.
5. Develop a sustainability plan for SBIRT and promote sustainability planning among grantees.
6. Cross-behavioral health planning teams and work groups will review State and Federal plans regularly and amended as necessary to meet the needs of West Virginia.
7. Diversify funding by applying for other discretionary federal and private funding opportunities.
8. Promote legislative action to support funding for prevention, early intervention and treatment services by providing cost analyses that demonstrate effectiveness and taxpayer savings to legislators.

Performance Indicators (PI)

- #MOU's and Partnerships
- #Meetings
- #Eliminated/amended requirements
- Sustainability Plan completion, inclusion of sustainability language in Statements of Work
- Documentation of plan review and updates
- #Grants submitted and awarded

Description of Collecting and Measuring Changes in PI

- Each staff will complete a monthly report to be submitted to Deputy Commissioner

<p>State System Priority 4: Manage resources effectively by promoting good stewardship and further development of the West Virginia behavioral health service delivery system.</p>
<p>Goal 2: Cultivate and maintain partnerships that promote the sustainability of prevention /promotion, early intervention, treatment and recovery services in West Virginia.</p>
<p>Strategies</p> <ol style="list-style-type: none"> 1. Partner with and receive technical assistance with other states regionally and nationally, such as SAMHSA, CMS, NASADA, CRET, NASHB, NTSN, MIDATTC 2. Partner with contiguous states for implementing consistent, practices, policies and enforcement 3. Partner with the Department of Education and Public Health to strengthen community and prevention /promotion efforts through the Consolidated School Health Project.
<p>Performance Indicators (PI)</p> <ul style="list-style-type: none"> • # Shared learning opportunities • # Technical assistance requested/received • # Meetings • # Protocols established • # Memoranda of understanding and partnerships
<p>Description of Collecting and Measuring Changes in PI</p> <ul style="list-style-type: none"> • Data submitted to First Choice, Inc. /Marshall University then analyzed and forwarded to BBHMF quarterly • Each staff will complete a monthly report to be submitted to Deputy Commissioner



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 31, 2011

Ms. Victoria L. Jones
Bureau for Behavioral Health and Health Facilities
350 Capitol St. Room 350
Charleston, WV 25301

Dear Ms. Jones:

I am writing to support 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 2012-2013. The BBHFF is exhibiting innovation and leadership by being one of the first states to submit a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The underlying principles of the BBHFF 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.

The goals of West Virginia'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 ensure that positive, meaningful opportunities are available for persons 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 cooperates with the WV Department of Health and Human Resources in the following areas: State Epidemiological Outcomes Workgroup (SEOW), Adult Behavioral Health, Oxford Houses, and Bureau for Child Support Enforcement. 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 West Virginia Division of Corrections looks forward to collaboration with BBHFF to serve the citizens of West Virginia. If you have 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

Earl Ray Tomblin
Governor

Bureau for Children and Families
Commissioner's Office
350 Capitol Street, Room 730
Charleston, West Virginia 25301-3711
Telephone: (304) 356-4521 Fax: (304) 558-4194

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

August 31, 2011

Ms. Victoria L. Jones
Bureau for Behavioral Health and Health Facilities
350 Capitol St. Room 350
Charleston, WV 25301

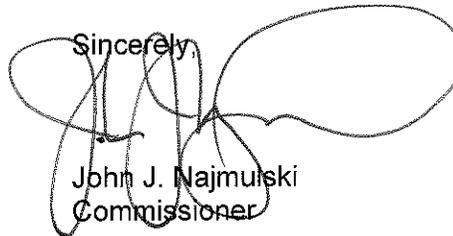
Dear Ms. Jones:

I am writing to support 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 2012-2013. The BBHFF is exhibiting innovation and leadership by being one of the first states to submit a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The underlying principles of the BBHFF 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.

The goals of West Virginia'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 ensure that positive, meaningful opportunities are available for persons 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 Children and Families (BCF) has a long history of working with the BBHFF. 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.

Sincerely,



John J. Najmowski
Commissioner

JJN:KW:dlr

STATE OF WEST VIRGINIA



WEST VIRGINIA REGIONAL JAIL AND CORRECTIONAL FACILITY AUTHORITY

1325 VIRGINIA STREET, EAST
CHARLESTON, WV 25301-3011
(304) 558-2110
FAX: (304) 558-2115

EARL RAY TOMBLIN
Governor

JOSEPH C. THORNTON
Cabinet Secretary

August 31, 2011

Ms. Victoria L. Jones
Bureau for Behavioral Health and Health Facilities
350 Capitol St. Room 350
Charleston, WV 25301

Dear Ms. Jones:

I am writing to support 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 2012-2013. The BBHFF is exhibiting innovation and leadership by being one of the first states to submit a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The underlying principles of the BBHFF 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.

The goals of West Virginia'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 ensure that positive, meaningful opportunities are available for persons 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 WV Regional Jail and Correctional Facility Authority has a long history of working with the BBHFF. 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.

WVRJA looks forward to collaboration with BBHFF to serve the citizens of West Virginia. If you have questions or need additional information, please feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Larry F. Parsons".

Larry F. Parsons,
Executive Director



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

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

August 31, 2011

Ms. Victoria L. Jones
Bureau for Behavioral Health and Health Facilities
350 Capitol St., Room 350
Charleston, West Virginia 25301

Dear Ms. Jones:

I am writing to support 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 2012-2013. As we are both aware, substance abuse is rampant in West Virginia—with tremendous burden in both medical and social aspects. The West Virginia BBHFF is exhibiting innovation and leadership by being one of the first states to submit a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The underlying principles of the BBHFF 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.

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The Bureau for Public Health (BPH) has a long history of working with the BBHFF in a number of areas targeted toward improving the physical and behavioral health of West Virginia residents. We look forward to strengthening our collaborations and to build upon the tremendous work of existing initiatives across systems to improve the behavioral health system in West Virginia.

The BPH looks forward to collaboration with BBHFF to serve the citizens of West Virginia. If you have questions or need additional information, please feel free to contact me.

Sincerely,


Chris H. Curtis, M.P.H.
Acting Commissioner



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

350 Capitol Street, Room 251

Charleston, West Virginia 25301-7307

Telephone: (304) 558-1700 Fax: (304) 558-1451

Earl Ray Tomblin
Governor

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

August 31, 2011

Ms. Victoria L. Jones
Bureau for Behavioral Health and Health Facilities
350 Capitol St. Room 350
Charleston, WV 25301

Dear Ms. Jones:

I am writing to support 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 2012-2013. The BBHFF is exhibiting innovation and leadership by being one of the first states to submit a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The underlying principles of the BBHFF 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.

The goals of West Virginia'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 ensure that positive, meaningful opportunities are available for persons 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 strengthen our collaborations and build upon the tremendous work of existing initiatives across systems to improve the behavioral health system in West Virginia.

The Bureau for Medical Services looks forward to collaboration with BBHFF to serve the citizens of West Virginia. If you have 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

August 31, 2011

<http://wvde.state.wv.us>

Ms. Victoria L. Jones
Bureau for Behavioral Health and Health Facilities
350 Capitol St. Room 350
Charleston, WV 25301

Dear Ms. Jones:

I am writing to support 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 2012-2013. The BBHFF is exhibiting innovation and leadership by being one of the first states to submit a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The underlying principles of the BBHFF 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.

The goals of West Virginia'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 ensure that positive, meaningful opportunities are available for persons 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 Department of Education has a long history of working with the BBHFF. In particular, we co-chair the State Steering Team for Expanded School Mental Health and both agencies are 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 West Virginia Department of Education looks forward to collaboration with BBHFF to serve the citizens of West Virginia. If you have questions or need additional information, please feel free to contact me.

Sincerely,



Melane B. Purkey Executive Director
Office of Healthy Schools

**WEST VIRGINIA
MENTAL HEALTH PLANNING COUNCIL**

PO Box 1095
Charleston, WV 25324-1095

Phone: 304-552-3819
Fax: 304-746-1155

www.wvmhpc.org



August 29, 2011

Ms. Vickie Jones
Commissioner
Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350
Charleston, West Virginia 25301

Dear Vickie:

The West Virginia Mental Health Planning Council has had an opportunity to review and comment on the application for the Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant. Some of our members have participated in the development of the document to be submitted to SAMHSA.

The Council is excited about the many positive changes taking place at the Bureau for Behavioral Health and Health Facilities. We believe the Bureau is more poised than ever for progressive, positive changes that will translate into improved, community-based services for people with mental and substance use disorders. The Council is aware of plans to create a Substance Abuse Planning Council. We look forward to working with that new organization and coordinating efforts through the planned Behavioral Health Advisory Council.

Many changes in healthcare and behavioral healthcare will be undertaken nationally and in West Virginia in the next few years due to budgetary constraints and the implementation of the Affordable Care Act. Reorganization to better integrate substance abuse and mental health services, the SBIRT demonstration which integrates behavioral health and healthcare, statewide implementation of the System of Care for children and adolescents and their families, and Expanded School Based Mental Health are examples of creating the foundation to accept and adapt to these changes. We are also appreciative of the intensive work undertaken to expand substance abuse prevention efforts, the expansion of substance abuse treatment, and the development of the State's strategic plan for substance abuse prevention and treatment.

This has been an exciting year. We look forward to even more progress and want to assure you of our availability to assist in implementing your plans.

Sincerely,



Ted J. Johnson, Chair

Recovery

Resilience

Reimbursement

STATE OF WEST VIRGINIA
DEPARTMENT OF MILITARY AFFAIRS & PUBLIC SAFETY
DIVISION OF JUVENILE SERVICES
DALE HUMPHREYS, 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 31, 2011

Ms. Victoria L. Jones
Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350
Charleston, WV 25301

Dear Ms. Jones:

I am writing to support 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 2012-2013. The BBHFF is exhibiting innovation and leadership by being one of the first states to submit a combined plan to address mental health and substance abuse prevention and treatment for children and adults. The underlying principles of the BBHFF 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.

The goals of West Virginia'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 ensure that positive, meaningful opportunities are available for persons 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 Division of Juvenile Services has a long history of working with the BBHFF. We have partnered in the realms of community-based care, treatment training and shared resources. 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.

Ms. Victoria L. Jones
Page 2
August 31, 2011

The Division of Juvenile Services looks forward to collaboration with BBHF to serve the citizens of West Virginia. If you have questions or need additional information, please feel free to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Denny Dodson". The signature is fluid and cursive, with a large initial "D" and "D".

Denny Dodson, Deputy Director

DD: RR



State of West Virginia
Earl Ray Tomblin
Governor

Office of the Governor
State Capitol
1900 Kanawha Boulevard, East
Charleston, WV 25305

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Toll Free: 1-888-438-2731
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www.wvgov.org

August 30, 2011

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary
One Davis Square, Suite 100, East
Charleston, West Virginia 25301

Dear Cabinet Secretary Lewis:

This letter is to authorize you in your position as 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 request, etc.

This authorization will remain in effect until further notice.

With warmest regards,

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

Earl Ray Tomblin
Governor



State of West Virginia
Earl Ray Tomblin
Governor

Office of the Governor
State Capitol
1900 Kanawha Boulevard, East
Charleston, WV 25305

Telephone: (304) 558-2000
Toll Free: 1-888-438-2731
FAX: (304) 342-7025
www.wv.gov

August 30, 2011

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary
One Davis Square, Suite 100, East
Charleston, West Virginia 25301

Dear Cabinet Secretary Lewis:

This letter is to authorize you in your position as 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 request, etc.

This authorization will remain in effect until further notice.

With warmest regards,

A handwritten signature in cursive script that reads "Earl Ray Tomblin".

Earl Ray Tomblin
Governor

Step 4: Goals, Strategies and Performance Indicators

State System Priority 1: Data-informed decision making.
Goal 1: Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the West Virginia behavioral health service delivery system.
Strategies <ol style="list-style-type: none">1. Identify, prioritize and document key policy /program questions and decisions regarding needs, inputs, processes and outcomes.2. Define the data or indicators necessary to respond to programmatic and/or policy priorities.3. Conduct a review of existing datasets and determine what (if any) new datasets are required to address the programmatic /policy priorities.4. Develop cross-system data retrieval and sharing protocols for existing datasets housed by external agencies or organizations.5. Produce and review State and local behavioral health profiles.6. Produce population specific profiles to include: <i>Pregnant Women Having a SUD and or MHD, Drug Exposed Children in WV</i>, Unemployable West Virginians, <i>Returning West Virginia Military Personnel</i>7. Produce cost analysis reports.8. Produce reliable utilization and encounter reports that can be accessed via the web.9. Produce outcomes reports (descriptive and inferential analyses).10. Collaborate with BMS, ASO, Tri-Care and other Insurers to analyze provider data.11. Produce reports that make connections and comparisons, and explore both causes and consequences.12. Develop an early warning network by partnering with local law enforcement, DEA and poison center to track current trends such as increases in <i>intravenous drug use</i> in substance use and abuse.13. Create common standards and service definitions related to performance measures.14. Define measures to assess cross system effectiveness.15. Create uniform standards and reporting for the administration and operation of the DUI Safety and Treatment Program.16. In coordination with System Development Work Group, conduct a statewide survey to assess workforce capacity, factors correlated with staff turnover, and use of evidence-based practices.17. Collaborate with the Governor's office on Work Force, the U.S. Bureau of Labor Statistics, Employee Assistance Programs and Major Employers to determine employment profiles.18. Provide inclusion of qualitative stakeholder input into planning and evaluation of services to include but not limited to: Consumers of Services, Providers of Services, First Responders, Youth Leaders, Youth, Community at Large19. Develop and disseminate survey instruments for use following all trainings offered and/or funded by the BBHFF.20. Implement an Independent Peer Review Process (IPR) by service and specialty areas.
Performance Indicators (PI) <ul style="list-style-type: none">• Priority questions /decisions documented.• Datasets clearly defined and linked with priority questions /decisions.• Catalog of all existing datasets identified for possible use with evaluative statements.

Written rationale for creating any new datasets.

- Data plan with protocols developed.
- #Agencies /Organizations providing /sharing data.
- Profiles, cost analysis, utilization, encounter, outcomes and provider data reports
- Web based real time utilization reports posted
- Data Interpretation Reports produced
- #Early Warning Alerts deployed
- Service definitions and treatment standards documented and disseminated
- Measures defined on all grantee Statements of Work
- Implementation of uniform standards and reporting
- Capacity Survey and employment profiles completed, analyzed and disseminated
- # Qualified behavioral health /substance abuse personnel
- # Community forums, stakeholder and town hall meetings
- # Regional Task Force Meetings
- # Peer reviews completed

Description of Collecting and Measuring Changes in PI

- Facilitate brainstorming sessions organized around BBHMF strategic objectives to identify priority decisions.
- Documentation produced during meetings.
- BBHMF will work in coordination with the WVSEOW to identify and review all sources of useful data (TEDS, YRBS, APS, etc.).
- The BBHMF Epidemiologist will submit recommended protocol to leadership for submission to other agencies and web site.
- Data and technology staff will use available datasets for analysis and report generation
- Alerts completed by Data and Research Team and disseminated
- Leadership will work with monitoring and compliance to complete and post
- Statements of Work signed and implemented
- Data submitted to the BBHMF
- Qualitative reports submitted to BBHMF
- Peer reviews conducted (IPR Template) by provider organizations and submitted to BBHMF and statewide results disseminated

State System Priority 2: System-wide infrastructure development.

Goal 1: Build the capacity and competency of West Virginia's behavioral health workforce and other stakeholders to effectively plan, implement, and sustain comprehensive, culturally relevant services.

Strategies

1. Support innovative efforts to attract and retain qualified staff (e.g., tuition reimbursement, internships, and stay contracts).
2. Implement a West Virginia Peer Training and Certification Program.
3. Promote certification of counselors through Tri-Care to support *military personnel and their families* receiving services.
4. Increase the number of certified / licensed professional's delivering services.
5. Promote cross training opportunities for all BBHMF program staff with an emphasis on *culturally and linguistically competent and gender appropriate* behavioral health integration, evidence based programs, practices and policies.
6. Support grantees' staff development efforts and stakeholder education via training, resources, and technical assistance (TA) using traditional and innovative methods (e.g., conferences, workshops, white papers, e-based modules, pod casts and YouTube mini-lessons) that focus on best practice and high-risk populations.
7. Provide training opportunities for grantees that emphasize improved *services for persons with or at risk of having substance use or mental health disorders or who are at risk of contracting communicable diseases*.
8. Maintain CEU provider status for Social Work and Nursing. Gain approval to provide CEUs for Counseling, IC&RC, Law Enforcement, Medical and Psychology.
9. Provide funding and assistance for a behavioral health conference as well as a consumer /family-lead learning opportunities.
10. Partner with higher education to promote the integration of behavioral health topics in curricula and practical experiences (practicum, internship, and residency) within primary care professional preparation.
11. Provide and/or support external training opportunities for related disciplines to strengthen the community workforce (e.g., physicians, criminal justice, educators, first responders, home visitors)
12. Partner with higher education to establish standards for curriculum and practical experience (practicum, internships) to promote competence and eligibility for licensure /certification in behavioral health and substance abuse treatment.

Performance Indicators (PI)

- # Meetings held & # in attendance
- # Organizations/individuals engaged in internships, tuition reimbursements, stay contracts
- # Resources developed and disseminated
- #Training/Learning Opportunities /Conferences offered
- #Participants from various systems (e.g., primary care, corrections, faith-based, education)
- #TA contacts
- #Resources developed and disseminated
- #CEUS provided yearly
- #Completed surveys with Documentation of findings
- #Meetings with higher education

- Standards for student practical experience
- # Residents participating in behavioral health integration settings

Description of Collecting and Measuring Changes in PI

- Data and technology team will analyze and report findings related to the Capacity Survey and employment profiles
- Obtain data from applicable licensing/certification boards and compare to workforce capacity survey
- Documentation of meetings (agendas, minutes, attendance records, etc.)
- Data submitted to First Choice, Inc. /Marshall University then analyzed and forwarded to BBHMF quarterly
- Peer Recovery Support numbers recorded
- Attendance recorded at each learning opportunity
- Recorded by Consumer Affairs and Community Outreach and reported quarterly
- Obtain conference report 30 days after event including all evaluation analysis.

State System Priority 3: Building a comprehensive and competent continuum of care targeting services to the following populations: a) *children with SED* and their families, b) *adults with SMI*, c) *persons with or at risk of developing substance use or mental health disorders*, and d) *at risk populations and those requiring targeted services*.

Goal 1: Increase access to a continuum of culturally and linguistically competent, integrated behavioral health prevention/ promotion, early identification, treatment and recovery management services that are high quality and person-centered.

Strategies

1. Develop a strategic plan for an expanded West Virginia System of Care (WVSOC) that includes all children, youth, adults and families.
2. Promote the adoption and operationalization of the core values and principles of the WVSOC across systems/providers through organizational readiness assessments, WVSOC orientations and skill-building trainings, and external reviews.
3. Create and/or strengthen cross-systems partnerships to *integrate* behavioral health, social and health care services in order to achieve improved outcomes with a particular emphasis on primary care, *integrated recovery for pregnant women and access to services for military personnel*.
4. Promote the expansion and implementation of community-based services and supports (e.g., Expanded School Mental Health, Care Coordination) that use evidence-based services and community supports to keep individuals in their communities and prevent hospitalizations of *adults with SMI or individuals with substance use disorders* and residential placement of *children with SED*.
5. Promote and provide funding for *substance use prevention* and *mental health promotion* efforts that are both *universal* and that target *individuals at risk* of developing disorders with strategic partnerships, funding, education and training.
6. Support community based prevention and promotion efforts that utilize *environmental approaches* that change norms through the implementation of laws, policies and enforcement with particular emphasis on youth access to tobacco and under age drinking.
7. Support the implementation of a statewide Women's Service Network that includes a Birth Mom's Initiative to offer resources and system consistency in the provision of *gender specific supported recovery services*.
8. Collaborate with agencies and organizations (e.g., West Virginia Development Disabilities Council, Centers for Independence, American Association of Retired Persons-WV, Fairness West Virginia, Veterans Administration, West Virginia Coalition for Minority Health, Partnership of African American Churches, and Appalachian Regional Commission) that represent *marginalized and/or underserved populations* to identify and address systemic barriers to access, develop and provide specialized training, and formulate plans for outreach efforts.
9. Provide outreach, funding, and/or technical assistance to marginalized and/or underserved populations and their families (*homeless* shelters, *high-risk offender* re-entry programs, *LGBTQ* individuals, *rural* services, *military* services, *transitioning youth* services, and problem-solving courts).
10. Collaborate with the Department of Transportation and community organizations to increase consumer transportation options for individuals living in rural areas and those with limited access to transportation assistance.
11. Promote the use of best practices to prevent, intervene and treat *trauma*, crisis and *suicidality*

through cross-systems partnerships, education and training.

12. Increase the number of SBIRT approaches integrated into existing systems.
13. Promote and support help lines that provide psycho-educational resources and referral information.
14. Support statewide advocacy efforts for *children with SED, adults with SMI, individuals with substance use disorders*, and their families.
15. Promote the development of a statewide network of *consumer-operated recovery* services and supports through funding, training and technical assistance.
16. Implement the use of innovative technology (e.g., online forums, surveys, and social media), in-person meetings, existing community coalitions and advisory councils to solicit *consumer and family input*.
17. Establish two-way communication with the public by sharing state-level data and information using a variety of media, and solicit feedback.
18. Assure *consumer and family participation*/representation in policy-making teams and workgroups.
19. Using cross-systems representation, identify/develop and promote models, protocols and/or standards that are grounded in *best practice*, serve the whole family, and result in better outcomes.

Performance Indicators (PI)

- # Memoranda of Understanding (WVDE, DJS, DOC, BCF, etc.)
- # Cross-system priorities/goals/strategies documented in action plans and implemented
- # Meetings held with cross-system representation (primary care, corrections, education, etc.)
- Strategic Plan for the West Virginia System of Care (expanded to include all populations)
- # WVSOC organizational readiness assessments and external reviews completed
- Increased number of community-based programs (ESMH, Care Coordination)
- Increased number of individuals/families served
- Decreased psychiatric hospitalizations
- Decreased number of children receiving residential care, especially in out of state facilities
- Increased positive outcomes among individuals/families receiving services
- Increased number of programs serving marginalized and/or underserved populations (problem-solving courts, re-entry programs, transitioning youth programs)
- Decreased number of suicides and non-accidental self-injuries
- Decreased incidence of prescription drug abuse, under-age drinking and tobacco use, and drug exposed pregnancies
- Increased number of SBIRT sites
- Increased use of evidence-based practices
- Increased transportation options
- # Conferences/trainings/workshops/technical assistance activities
- # Events soliciting consumer/youth and family input
- #Media employed to share and receive information
- #Respondents/participants and role
- Defined on Statements of Work
- # Best Practice models/protocols/standards/guides identified/developed & published

Description of Collecting and Measuring Changes in PI

- Medical education teams establish best practice protocols for behavioral health prevention

/promotion, early intervention and treatment

- Meeting agendas, minutes, attendance recorded
- Data submitted to First Choice, Inc. /Marshall University then analyzed and forwarded to BBHMF quarterly
- The BBHMF Epidemiologist will access datasets to analyze trends in suicide, substance abuse, and mental health.
- Recorded by Consumer Affairs and Community outreach and reported quarterly
- Quarterly report regarding consumer calls, comments, blogs, feedback and discharge interviews presented by Consumer Affairs and Community Outreach
- Meeting agendas, minutes, and participation logs
- Website and listserv dissemination
- Consumer Affairs and Community Outreach will monitor discharged cases to ensure positive consumer outcomes.
- Consumer Affairs and Community Outreach will log all calls to determine trends of needs and service provision.

State System Priority 4: Fiscal accountability and program sustainability.

Goal 1: Manage resources effectively by promoting good stewardship and further development of the West Virginia behavioral health service delivery system.

Strategies

1. Use data interpretation regarding the effectiveness and efficiency of grantee activities to inform future funding decisions.
2. Develop formal relationships with critical partners (e.g., local foundations, EPSDT, Medicaid, private insurers and faith based organizations).
3. Provide support to facilitate the Governor’s Advisory Council on Substance Abuse, Governor’s Regional Task Force Meetings, Mental Health Planning Council and the Behavioral Health Planning and Advisory Council.
4. Collaborate with public and private insurers to eliminate service/reimbursement requirements that are contraindicated to effective practice.
5. Collaborate with Medicaid and other partners to assure the availability of covered services upon implementation of the Affordable Care Act.
6. Develop a sustainability plan for SBIRT and promote sustainability planning among grantees.
7. Cross-behavioral health planning teams and work groups will review State and Federal plans regularly and amend as necessary to meet the needs of West Virginia.
8. Diversify funding by applying for other discretionary federal and private funding opportunities.
9. Promote legislative action to support funding for prevention /promotion, early intervention and treatment services by providing cost analyses that demonstrate to legislators effectiveness and taxpayer savings.
10. Partner with, provide and receive technical assistance with other states and national organizations; such as, SAMHSA, CMS, NASADAD, EDC, CDC, NASMHPD, NASHB, NTSN, MIDATTC and NCTIC
11. Partner with contiguous states for implementing consistent, practices, policies and enforcement
12. Partner with the Department of Education and Public Health to strengthen community and prevention /promotion efforts through the Consolidated School Health Project.

Performance Indicators (PI)

- #MOU’s and Partnerships
- #Meetings
- #Eliminated/amended requirements
- Sustainability Plan completion, inclusion of sustainability language in Statements of Work
- Documentation of plan review and updates
- #Grants submitted and awarded
- # Shared learning opportunities
- # Technical assistance requested/received
- # Protocols established

Description of Collecting and Measuring Changes in PI

- Each staff will complete a monthly report to be submitted to Deputy Commissioner
- Data submitted to First Choice, Inc. /Marshall University then analyzed and forwarded to BBHFF quarterly

- Each staff will complete a monthly report to be submitted to Deputy Commissioner

BBHHF Data Quality Improvement Plan

Section 1: Description

The Bureau for Behavioral Health and Health Facilities (BBHHF) Data Quality Improvement Plan articulates an approach for satisfying selected goals and priorities for the states' Substance Abuse Priorities and Implementation Plan which are aligned with federal initiatives to meet Substance Abuse Strategic Goals. The following plan sets a strategy to systematically assess, improve and document data quality within the Bureau. Quality improvement is an ongoing and evolving process. BBHHF activities shall consist of monitoring and reporting outcomes and results using: Instructional coding manuals, standard operating procedures, data edits, data quality and completeness audits, and education and training activities. This action plan will outline tasks needing to be completed in order to enhance data the data quality within the bureau. This plan will describe in successive order: 1) The goals 2) Justification for the goal 3) Description of how the goal will be accomplished, and 4) Who is responsible for the goal.

The following plan should be implemented in order to address the following dimensions that make up a data quality:

1. **Accuracy**-How well the information from the data reflects the reality it was designed to measure.
2. **Timeliness**-How up-to-date is the data, what gaps are there in reporting, and what can be implemented to ensure timeliness.
3. **Comparability**- The extent to which the database is consistent over time with the use of uniform definitions, standardized queries, and reporting mechanisms.
4. **Usability**-the ease with which data may be understood and accessed.
5. **Relevance**-the degree to which the data meets the needs of the Bureau and stakeholders current and potential future needs.

Section 2: Plan

Goal	Justification	Description	Responsibility
Process Review	To clarify processes and policies surrounding provider reporting, Care Connection, and APS	A review of the process policies shall be conducted in order to determine the historic implication of providers reporting behavioral health data, fields within the Care Connection, and the role and responsibility that APS has for behavioral health data. A clear understanding of the process will allow the Bureau to streamline the reporting process, create a sense of accountability, and determine the necessity and feasibility of data fields being collected.	BBHHF Leadership
Procedure Manual	To provide a standardized instructional procedure manual	A procedure manual shall be developed to include: information about existing types of data collection system, participation in database, capabilities and limitations, standard operating procedures, how to query, produce reports, confidentiality, change data, etc.	Data & Technology Team
Instructional Code Manual	To define and describe the organization of the database and the fields within the database	Create a spreadsheet for the data fields within the database. Provide a description of the fields including: useful information about the field, content means, expected values, definition of values, code definitions, format, etc. Include a description for each table to include useful information about the type of information that is stored the table, its relationship to other tables, service descriptions, etc.	Data & Technology Team
Internal Data Review	To streamline data collection and reporting to comply with state and federal reporting requirements	Assemble a team to review data on a continual basis to review: fields currently being collecting, assess outcome measures being collected, identify gaps in the data, and determine necessity and feasibility of data fields. Data team will provide recommendations to enhance data quality and to ensure federal reporting requirements are met; while reducing the work load on providers.	Epidemiologist & Data and Technology Team & BBHHF Leadership

<p>Data Submission Validity Reports</p>	<p>To determine the timeliness of data being received by BBHHF</p>	<p>Develop a process to track data submissions on a daily basis. Accuracy of a database depends on many factors. The process should capture and document: coverage-who should be submitting data to BBHHF, frequency-what timeframe intervals should the data be reported, unit non response-have all the records been submitted, Item non-response- are the submitted records complete. A report should be generated for each facility to provide feedback to providers, for tracking purposes, and for accountability.</p>	<p>Data & Technology Team</p>
<p>Data Accountability Process</p>	<p>To establish responsibility of those entities mandated to report to BBHHF</p>	<p>Through utilization of the data submission validity reports develop and implement a means to hold providers accountable for their data submission. Leadership should discuss and agree upon a notification schedule and develop a penalty timetable to address providers failing to submit data within a timely matter. Document contact with entity for tracking purposes.</p>	<p>Data & Technology Team and BBHHF Leadership</p>
<p>Data Request Policy</p>	<p>To ensure BBHHF releases data for appropriate purposes, that the data is as accurate and complete as possible, and that data releases are documented and consistent across BBHHF</p>	<p>Develop a data request policy for BBHHF that describes the purpose of the policy, data covered, data not covered, guidance for release of data, and documentation of data released. Data released from the Bureau shall confirm to high standards of objectivity. This means the information released is accurate, reliable, unbiased, and is presented in an accurate, clear, and unbiased manner. Documents should be reviewed by assistant attorney general for legality purposes. Once the policy has been reviewed the policy should be disseminated to all BBHHF employees.</p>	<p>Epidemiologist</p>

<p>Data Cleansing Process</p>	<p>To assure data is useful and functional to meet the needs of the Bureau</p>	<p>Develop and implement a cleaning process and schedule that will serve in delivering useful end-user data. Cleaning data eliminates errors and redundancy, increases data accuracy and reliability, assures consistency and completeness, and allows for improvement feedback. A typical data cleaning routine includes:</p> <ul style="list-style-type: none"> • Identifying invalid or inaccurate data • Investigating the reasons for the bad data, this allows you the understanding to take the necessary actions to correct the data. • Determine how the dirty data should be cleaned or corrected. • Perform accuracy tests to ensure the data were properly cleaned. • Make adjustments to application design so that bad or incomplete data can be rejected. 	<p>Data & Technology Team</p>
<p>Query System</p>	<p>To develop standardized queries for regular data queries for state and federal reporting</p>	<p>A standardized set of queries shall be developed using established parameters for state and federal reporting purposes. A standardized query system will eliminate variances within data reporting and standardize outcome measures. Queries shall also be developed to address policies and cost savings within the Bureau. Ideally a web-based system to query data frequently accessed for state and federal reporting is recommended to be developed.</p>	<p>Data & Technology Team</p>
<p>Data Reviews</p>	<p>Provide leadership team with information to make data informed decisions surrounding policy, outcome measures, and use of resources.</p>	<p>Monthly reports shall be developed to communicate surveillance measures of the behavioral health system and discussed at program leadership meetings.</p>	<p>Epidemiologist</p>

Training

To increase knowledge, skills, and abilities within the scope of data.

A series of standardized continuing education training courses shall be developed for staff and stakeholders for BBHFF.

Suggested Courses:

- Educate new staff on the Bureau's data capabilities.
- Epidemiology 101-of basic data elements, key terms, core concepts, and standard definitions.
- Data resources available.
- Provider training of reporting requirements and rational.

Epidemiologist and Data & Technology Team