West Virginia

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT
AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/03/2017 10.26.42 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development
State Information

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: James
   
   Last Name: Matney
   
   Agency Name: West Virginia Department of Health and Human Resources
   
   Mailing Address: 350 Capitol Street, Room 350
   
   City: Charleston
   
   Zip Code: 25301
   
   Telephone: 304-356-4773
   
   Fax: 304-558-1008
   
   Email Address: James.A.Matney@wv.gov

State CMHS DUNS Number

Number: 618137715

Expiration Date: 2/9/2018

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: Nancy

   Last Name: Sullivan

   Agency Name: West Virginia Department of Health and Human Resources

   Mailing Address: 350 Capitol Street, Room 350
III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name  Rebecca

Last Name  Roth

Telephone  304-356-4791

Fax  304-558-1008

Email Address  Rebecca.E.Roth@wv.gov

Footnotes:
State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

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

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 (24 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 nondiscrimination 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.


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 Costal 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.); (a)


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.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
LIST of CERTIFICATIONS

1. CERTIFICATION 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). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children’s services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Bill J. Crouch

Signature of CEO or Designee: _________________________________

Title: Cabinet Secretary

Date Signed: ________________

mm/dd/yyyy

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

## Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

### Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
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The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Bill J. Crouch

Signature of CEO or Designee: __________________________

Title: Cabinet Secretary

Date Signed: mm/dd/yyyy

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

#### Disclosure of Lobbying Activities

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

**Standard Form LLL (click here)**

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<th>Bill J. Crouch</th>
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<tr>
<td>Title</td>
<td>Cabinet Secretary</td>
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<tr>
<td>Organization</td>
<td>West Virginia Department of Health and Human Resources</td>
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**Signature:**

**Date:**

**Footnotes:**
Planning Steps

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

Narrative Question:

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

Footnotes:
Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Organizational Overview of Public M/SUD system at State Level

The West Virginia Bureau for Behavioral Health & Health Facilities (BBHHF) is the federally designated Single State Authority (SSA) and State Mental Health Authority (SMHA) for mental health, substance abuse, and intellectual and developmental disabilities responsible for administering the Substance Abuse Prevention and Treatment and Community Mental Health Block Grant. With the Block Grant and a combination of other federal grants and state funding, BBHHF supports comprehensive behavioral health prevention, promotion, early intervention, treatment, and recovery programs statewide. BBHHF provides funding for community-based behavioral health services for persons with behavioral health needs, including those who are uninsured or underinsured, as well as operational support for seven State-owned facilities with long-term or acute care psychiatric functions for adults. BBHHF operates under the auspices of the West Virginia Department of Health and Human Resources (WVDHHR) which also includes the State Bureaus for Public Health, Children and Families (Child Welfare), Child Support Enforcement, and Medical Services (Medicaid). The overall role of BBHHF is to provide leadership, oversight and coordination of policy, planning, development, funding and monitoring of the public behavioral health system.

The principles that guide the work of the BBHHF are aligned with SAMHSA principles in understanding that the evidence base behind behavioral health prevention and promotion, treatment, and recovery services continues to grow and promises better outcomes for people with or at risk for mental and substance use disorders.

The mission of BBHHF is to ensure that West Virginians with mental health or substance use disorders, intellectual/developmental disabilities, chronic health conditions, or long-term care needs experience services that are comprehensive, readily accessible, and tailored to meet individual, family, and community needs. The Bureau recognizes that participant-centered planning, family-centered care, and community involvement are critical to develop and improve services in West Virginia. We support partnerships, data-informed decision-making, and evidence-based practice as key to every aspect of behavioral health.

Organizational Structure

The Commissioner’s Office provides direction to the Bureau and communicates the goals of the Bureau/Department to the community to ensure continuity of services. Underneath the Commissioner’s Office are three integrated sections (Programs and Policy; Administration; and Operations), each overseen by a Deputy Commissioner.

Staff within the Programs and Policy section are charged with the development, implementation, and oversight of the statewide community-based behavioral health system of
care and must ensure that individuals with mental health, substance use, and/or developmental disorders have meaningful treatment and support services to maximize their abilities to function as productive and stable citizens of West Virginia within the least restrictive environments suitable to their needs. Funding is provided to comprehensive community behavioral health centers and other providers to provide for a statewide continuum of care and supports for individuals in need of prevention, intervention, treatment and recovery, as well as related supports and services.

The Programs and Policy section underwent a reorganization in 2016 to reflect and support the integrated nature of behavioral health programs, after BBHHF’s 2015 Integrated Block Grant application. The new structure includes the main programmatic divisions of the Bureau:

- Office of Adult Services;
- Office of Children, Youth, and Family Services; and
- Office of Policy, Research, Planning and Compliance.

The Office of Adult Services ensures and provides access to services and supports to meet the mental health and co-occurring needs of adults and transitional age youth, enabling them to live, learn, work, and participate actively in their communities. The Office of Adult Services also establishes standards to ensure effective and culturally competent care to promote recovery. In addition, the Office of Adult Services sets policy, promotes self-determination, protects human rights, and supports mental health training and research.

The Office’s priorities include development and expansion of peer and family supports, the West Virginia Leadership Academy, recovery education, housing and homeless outreach to people with mental health issues and co-occurring substance use disorders (SUDs), coordination and delivery of services for returning veterans and their families, integrated primary care and mental health services, and operational support for the West Virginia Mental Health Planning Council. As the Single State Authority (SSA), along with the other programs offices, the Office of Adult Services oversees prevention, treatment, recovery, educational research and planning for SUD-related services. The Office’s SUD priorities include reducing prescription drug misuse, reducing the number of substance-exposed pregnancies, supporting pregnant and postpartum women and their families, reducing the number of substance-related deaths, reducing the number of repeat Driving Under the Influence (DUI) offenses, increasing the number of substance treatment services to meet the need of communities, and increasing the number of recovering individuals living and working in safe and supportive environments. The Office provides leadership, facilitation, technical assistance, and funding to support children and adults who have intellectual/developmental disabilities, prioritizing self-advocate/family/provider awareness of and access to community services and supports, and developing services and supports for individuals with complex support needs.
The **Office of Children, Youth and Families** administers programs to promote the behavioral health of children and youths in West Virginia communities through universal prevention and individualized services for mental health, substance use, and intellectual and developmental disabilities. The Office provides leadership, technical assistance and funding to support children and youths with serious emotional disturbances (SED), young adults transitioning to adulthood with serious mental illness (SMI), children and youths with intellectual or developmental disabilities (I/DD), and their families. Key initiatives to build capacity include the West Virginia System of Care (WVSOC); Statewide Family Advocacy, Support, and Training (FAST) Program; Expanded School Mental Health (ESMH); Children’s Clinical Outreach Liaisons; Children’s Mental Health Wraparound pilot project; Children’s Mobile Crisis Response services; adolescent suicide prevention and early intervention; and support for young adults transitioning to adulthood.

The **Office of Policy, Planning, Research, & Compliance** oversees the cross-Bureau functions of the Programs and Policy section of BBHHF. This office includes strategic planning, behavioral health workforce development; system engagement; access and consumer affairs, primarily through statewide and intermediary organizations such as the WV Behavioral Health Planning Council (WVBHPC), WV Interagency Council on Homelessness (WVICH), the Helpline (844-HELP4WV), and the Governor’s Advisory Council on Substance Abuse; program monitoring and compliance functions; program data and research analysis and dissemination; legislative and policy analysis; training and technical assistance; and communication, including website development and stigma reduction.

Staff within the **Administration** section are responsible for fiscal and general administrative duties for the Bureau including budgeting, reporting, and administrative policy. The **Fiscal Division** staff provides financial oversight and guidance to the seven State-owned hospitals and are responsible for allocation of grant funds to the community behavioral health centers and other community-based service providers.

The Bureau’s data and technology needs are administered through the WV Department of Health and Human Resources’ Office of Management Information Services (MIS). In collaboration with the MIS, BBHHF collects and stores a comprehensive data set pertaining to Bureau-supported services rendered to the citizens of West Virginia. The data sets collected include 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.

Staff within the **Operations** section provides operational support to the Bureau and is responsible for the direct oversight of the seven State-owned hospitals (i.e., two psychiatric hospitals, four nursing homes, and one acute care hospital with a long-term care unit). Those seven facilities are as follows:
- Hopemont Hospital (Long-Term Care)
- Jackie Withrow Hospital (Long-Term Care)
- John Manchin, Sr. Health Care Center (Long-Term Care)
- Lakin Hospital (Long-Term Care)
- Mildred Mitchell-Bateman Hospital (Acute Inpatient Psychiatric Facility)
- William R. Sharpe Jr. Hospital (Acute Inpatient Psychiatric Facility)
- Welch Community Hospital (Acute Hospital and Long-Term Care Facility).

For regional planning purposes, BBHHF uses the following configuration of six regions:

Region 1: Brooke, Hancock, Marshall, Ohio, and Wetzel Counties
Region 2: Berkeley, Grant, Hampshire, Hardy, Jefferson, Mineral, Morgan, and Pendleton Counties
Region 3: Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt, and Wood Counties
Region 4: Barbour, Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, and Upshur Counties
Region 5: Boone, Cabell, Clay, Kanawha, Lincoln, Logan, Mason, Mingo, Putnam, and Wayne Counties
Region 6: Fayette, Greenbrier, McDowell, Mercer, Monroe, Nicholas, Pocahontas, Raleigh, Summers, Webster, and Wyoming Counties.
SSA/SMHA Roles and Responsibilities

- Comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care;
- Integration and coordination of the public behavioral health system;
- State-level program funding decisions based on behavioral health indicators and program evaluation data;
- Prioritization and approval of all expenditures of funds received and administered by the BBHHF, including the establishment of rates, reimbursement methodologies, and fees;
- Oversight of the implementation of the agreed upon Hartley Consent Decree order related to community support activities, including but not limited to, expansion of Care Coordination services, expansion of group homes and residential services, and the development of additional day supports;
- Partnership with DHHR Bureaus for Children and Families, Medical Services, and Public Health on evidence-based supports for children and families and community issues, including licensure and regulation of behavioral health professionals, programs, and facilities;
- Promotion of activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services;
- Implementation of the responsibilities related to behavioral health required by state law, as referenced in West Virginia Code, Chapter 27, Article 1A et seq., and all applicable legislative rules.

Behavioral Health Provider System

West Virginia’s publicly-funded community based behavioral health system is anchored by thirteen (13) Comprehensive Behavioral Health Centers (CBHC’s), operating full service and/or satellite offices in each of the counties located in the center’s catchment area. Public behavioral health services provided by a CBHC are for all populations and all ages at risk for, or have a diagnosis of, mental illness, substance abuse, intellectual/developmental disability, or a co-occurring/co-existing disorder. The Comprehensive Behavioral Health Centers are charged with ensuring the following “essential services” are available and accessible in each county: Screening, Assessment, Crisis Response, Outpatient services (with referral for Intensive Outpatient Services (IS) as may be assessed/needed), Information and Referral capacity, and Medication Management.

Most of the “essential services” are billable through third-party payors, but additional funding may be needed to ensure availability of these services at the county level. Continuum Enhancement Funds are provided by BBHHF to meet this need. Charity Care State general revenue funds are also provided so that no one is turned away for inability to pay. The BBHHF provided $8,175,960.06 to pay for uncompensated care in FY 2017. The funding supports the development and provision of services and activities that are not otherwise billable through other funding streams or that exceed any approved service limits or caps. These funds may not be used for costs covered by an organization’s administrative or indirect cost plan.
There are more than 80 additional BHHF service grants awarded to six regional prevention agencies, nonprofit organizations, schools, and other state agencies to decrease substance use and promote mental health and wellness, through the building of effective coalitions and implementing evidence based services in the state’s 55 Counties. Examples include the following:

- Treatment and recovery system maintenance and expansion throughout WV and particularly in high-need areas;
- Advocacy services and discharge planning supports for individuals who can transition to less restrictive community-based services;
- Six Prevention Lead Organizations, one for each BBHHF region of the state, promote positive mental health and substance use prevention for adults and youths through evidence-based programs, public awareness campaigns, toolkits, and support county prevention coalitions;
- Juvenile diversion programs, Children’s Homeless Outreach Programs, Prevent Suicide WV, and WV Students Against Destructive Behavior (SADD);
- Education and training related to behavioral health, including participant-led services, Recovery Coach Academy, Mental Health First Aid, and statewide Addiction Awareness training for Adult and Child Protective Service workers and their supervisors.

PREVENTION AND PROMOTION SERVICES

The Bureau for Behavioral Health and Health Facilities allocates funding to six regional Prevention Lead Organizations that provide technical support to local Prevention Coalitions in all 55 counties in West Virginia (WV). All prevention grantees implement the following strategies: information dissemination, prevention education, community mobilization, environmental strategies, alternatives for youth, and problem identification and referral. All counties are required to complete the strategic prevention framework (SPF) planning model to identify needs and match evidence-based programs and practices.

As part of on-going prevention efforts, and to maintain block grant funding, the Bureau is responsible for the coordination and implementation of Synar inspections in accordance with guidelines set forth by the Center for Substance Abuse Prevention and the U.S. Food and Drug Administration. West Virginia continues to be in compliance in limiting retail sales of tobacco to minor youths. In fact, the Retailer Violation Rate (RVR) was down to 10 percent in 2016. The inspections are conducted in cooperation with the West Virginia State Police and community partners. Since 2003, BBHHF has trained merchants on the See Red? initiative, which emphasizes not selling tobacco products to anyone whose driver’s license or state I.D. has the telltale color red that indicates he or she is a minor.

Over the past year, substance abuse coalitions have provided in-depth evidence-based education programs to thousands of youths and young adults in schools and universities. Aside from youth education, proven community trainings have been attended by nearly 14,000 adults. Various media campaigns – educating communities about substance abuse, offering resources for help, and encouraging parents to talk to their kids about drugs – have reached
nearly 1 million West Virginians through newspaper, radio, TV, print, and digital promotions. For the past few years, BBHHF has supported the youth-led SADD (Students Against Destructive Decisions) through prevention leads’ statements of work and funding for the statewide SADD conference, which had more than 400 youths and 650 overall attendees in 2016. The next SADD conference will be November 3-5, 2017, at Camp Dawson in Preston County. BBHHF received an award in 2016 for outstanding partnership from WV SADD, which in turn received national recognition. There are currently more than 280 SADD chapters in the state with 10,000-plus student leaders. West Virginia has other youth groups, including RAZE crews, the Harrison County Dream Team, and ten county Teen Summits and Teen Institutes. Cabell County, one of the state’s more populous counties, has Youth Prevention Teams in all middle and high schools.

In addition to the Block Grant, West Virginia supports prevention through the following discretionary SAMHSA grants:
- Partnerships for Success (PFS), which focuses on the reduction of underage drinking and non-medical use of prescription opiates in 12 high-need counties in the state;
- Prescription Drug Overdose Prevention (PDO), which is establishing a naloxone distribution strategy in high risk counties/regions and a “take-home” naloxone program directed as high-risk individuals, family members, friends, and caregivers;
- Strategic Prevention Framework for Prescription Drugs (SPF-Rx), will enhance the infrastructure to address prescription drug misuse with youths aged 12-17 and adults; and
- Opioid State Targeted Response (STR), which includes funding for Harm Reduction services, prescriber education and community Prevention Coalition education funding.

Theses regional prevention and wellness initiatives will be even more critical in light of elimination of state funding for the Regional Wellness Specialists and Tobacco Prevention initiatives by the 2017 West Virginia Legislature.

Not funded by BBHHF from the Block Grant, but part of the current prevention landscape in WV, is the work of the Center for Health and Safety Culture, Western Transportation Institute, Montana State University. Research staff from this Center have assisted the State with the SPF-PFS grant; they also provide TA support to WV’s prevention sub-grantee Prevention Lead Organizations and 55 county coalitions, with:
- onsite and online training;
- monthly learning and information disseminating calls;
- an online Community of Practice site for community prevention staff and BBHHF staff;
- prevention-related surveys, including, for example, a health care provider survey for WV’s PFS and PDO grants, a survey on beliefs and attitudes of school staff, and support for local implementation of the WV School Climate Survey at the county level as well as reporting on its analysis when it is completed;
- toolkits for school personnel and key leaders and community adults to change perceptions of substance use, video for community leaders about how to influence students in their community around substance use prevention, and creating and delivering a community dialog guide specific to WV.
Toolkits include background materials, survey results, speaking points, messaging resources, and specific actions local coordinators can take to promote best-practices among different layers of the social ecology.

EARLY INTERVENTION, TREATMENT AND RECOVERY

In addition to providing prevention services, the SAPT Block Grant is a major source of continuum funding, allocating $6.5 million for substance abuse early intervention, treatment and recovery services in West Virginia. The Bureau continues to provide funding to support West Virginia Juvenile Drug Courts. Block grant funding is also utilized to purchase evidence-based Driving Under the Influence Program curriculum to promote best practice and consistency statewide. BBHHF provides funding support to a continuum of treatment options, including outpatient and intensive services, and short and long term residential treatment that are not otherwise covered by Medicaid, Medicare, or private insurance. Block grant funds provide for community based recovery support services that included the expansion of best practice in peer supports, having trained over 240 recovery coaches statewide in every region with 29 trained as trainers and expanded recovery residences that provide focused short and long-term housing access for people who need safe and supportive housing to live drug and/or alcohol free. MTM has been awarded a contract to be the state of West Virginia’s non-emergency medical transportation (NEMT) manager. The organization provides rides free of charge for eligible Medicaid Members throughout the state for covered medical services. The program was put in place to alleviate transportation barriers to treatment in a rural State.

West Virginia is one of the 32 states that have adopted the Medicaid expansion under the Affordable Care Act, with nearly 220,000 additional residents enrolled in Medicaid since October 2013. West Virginia Medicaid provides health coverage to more than one third of West Virginia’s population, and Medicaid expansion led to an increased percentage who received behavioral health coverage as a result. According to former Secretary of HHS, West Virginia Medicaid paid for 45 percent of all MAT [Medication Assisted Treatment] provided in 2016. There are nine licensed social work (LICSW) practices, 164 psychiatric practices, and 219 psychological practices that provide assessments, testing, individual, group, family, and crisis intervention services to West Virginia Medicaid members across the state.

Integrating behavioral health with primary care. Federally Qualified Health Centers (FQHCs) have increased their role in providing SUD services—19 of the state’s 34 FQHCs across 108 sites employ a behavioral health provider. Five of the state’s largest CBHCs provide coordinated primary health care services in a community mental health setting and share behavioral health staff with rural primary care centers through colocation and integration agreements. BBHHF supports Screening and Early Intervention around the state, with promotion of SBIRT and training with more than 3500 trained statewide.

ADDRESSING CULTURAL COMPETENCE

West Virginia requires training for all providers to be able to implement culturally competent evidence-based programming statewide with a special emphasis on priority populations that include: pregnant women, service members, veterans and their families, transitioning-aged
youth, persons who inject drugs (PWID), individuals experiencing homelessness and individuals identifying as lesbian, gay, bi-sexual and transgendered. Courses in health disparities and special population engagement are included during the statewide integrated behavioral health conference and regional training and technical assistance efforts. Examples of specific efforts to reach priority populations are listed below.

- **Drug-Free Moms and Babies (DFMB) initiative** is an integrated obstetrics service currently available at five birthing centers in WV that promotes early screening, intervention, behavioral health support, treatment and recovery supports (partnership with the WV Bureau for Public Health and the Claude Worthington Benedum Foundation) for pregnant and postpartum women. West Virginia’s Opioid STR grant provides additional opportunities to build on the work of the DFMB initiative and support for West Virginia’s Perinatal Partnership.

- **Residential Treatment Facilities** are prioritized for people who inject drugs, women who are pregnant, transitioning aged youth, and individuals transitioning from a higher level of care. These facilities currently provide clinically-managed, high-intensity services that feature a planned regimen of care in a safe, structured, and stable environment. Residential programming is gender specific, trauma-informed, and in coordination with day habilitation, rehabilitation and peer supports.

- **All BBHHF grantees’ Statements of Work (SOW) include** the requirement for provision of or arrangement for *Tuberculosis (TB) services* including testing to determine presence of TB and needed treatment, including referral to another source if a person is not admitted for services.

WV BBHHF has supported *increased access to treatment* through support since September 2015 for the WV Call-line (1-844-HELP4WV) with more than 14,000 calls (Sept 2015-July 2017) representing West Virginians from all 55 counties who received 24/7 warm hand-off assistance, information and support with substance use and mental health disorders.

The treatment system has *increased capacity for opioid use disorders* (OUD) since legislation was passed in 2016 to regulate opioid treatment and office-based medication-assisted treatment programs to build the capacity of West Virginia’s addiction treatment system.

In 2013, Medicaid covered 5,827 people with opioid use disorders, and paid $6.8 million in OUD claims; by 2016, the number had increased to 14,808 patients, with payment at more than $17 million. The new set of benefits that are anticipated to become available through the Medicaid SUD 115 Waiver will supplement the SUD treatment services that West Virginia already provides through Medicaid, and build upon the infrastructure that is in place and administered by the Bureau of Behavioral Health and Health Facilities through other funding services. According to the WV Bureau of Medical Services SFY 2015 Annual Report, during SFY 2015, 88,965 [Medicaid] members received behavioral health services, including “behavioral health clinic and rehabilitation services, psychiatric services, psychological services, and targeted case management at a cost of $107.2 million.”
Since the announcement of WV’s Opioid STR award ($5.8M) in May 2017, statements of work and Announcements of Funding Availability (AFA processes) have proceeded to expand treatment, treatment access and recovery support from peers in priority populations and critical locations, as well as OUD prevention, education, and training of health care professionals. As of July 2017, updated programmatic specifics include:

- **Ongoing MAT Expansion meetings around Hub development** (for a hub-and-spoke opioid treatment model) have resulted in contemplating additional hubs in Huntington and Charleston, WV and also in Berkeley and Monongalia Counties. This “gold standard” support for MAT expansion for opioid treatment in rural areas is building on resources modeled through WVU’s COAT program (Comprehensive Opioid Addiction Treatment) to make the most of in-state OUD expertise.

- **WV BBHHF** is partnering with the WV Perinatal Partnership in releasing an AFA for 4 additional sites to serve pregnant women with, or at risk of developing, OUD.

- **Expanding capacity of opioid-specific Peer Services** is underway:
  - A Peer/Recovery Workgroup is in development to begin implementation of training 16 ER-based Recovery Coaches/Peer Mentors to serve individuals with or at risk of developing OUD.
  - WV BBHHF is close to putting out a competitive AFA to provide a total of 34 peer/recovery FTEs and to target populations of:
    - homeless individuals
    - youth
    - veterans and their families
    - pregnant women (in partnership with the Drug Free Moms and Babies programs)
    - incarcerated individuals re-entering the community (may also include system navigators)
    - individuals that present for services for OUD at Federally Qualified Health Centers, and
    - individuals that present for MAT at regional medical centers.
  - Specialized webinars are being developed/procured to help assure peers receive necessary training beyond their basic certification to be as knowledgeable and effective as possible with the special populations they are serving.

- **The WV BBHHF** is partnering with the WV Supreme Court of Appeals to develop telehealth in the court system.

- **The WV BBHHF has completed an in-depth needs assessment** for OUD in WV.

- **The WV BBHHF has transferred funding** to the WV Bureau of Public Health to implement 6 Syringe Service Programs.
The WV BBHHF has worked with one of its CSAP Prevention sub-grantees to develop a workplan to support all 6 Prevention Lead Organizations participating in the National Coalition Academy Expansion for Sustainable Prevention Programs, a year-long innovative training program that combines three-weeks of classroom training, distance learning and web support. The WV BBHHF is working to identify and develop key opportunities for education and training activities using SAMHSA and CDC materials for MAT, MAT prescribing guidelines, Opioid Overdose Prevention, and speakers/conference sessions in coordination with WVAADC (WV’s Association for Addiction Counselors) and the WV Medical Professionals Health Program.

**Recovery System:**

Block grant funds provide for community-based recovery support services that include expanding best practices in peer supports. BBHHF has trained over 240 recovery coaches statewide in every region with 29 trained as trainers, and has expanded recovery residences that provide focused short and long-term housing access for people who need safe and supportive housing to promote stability and successful re-entry to community living. The WV BBHHF has led efforts to increase the capacity of recovery supports and services in WV, including:

- Established recovery programming statewide in all regions of WV, tripling the residential treatment capacity between 2012 and 2016
- Collaborating with community partners on becoming a state NARR Chapter in order to, among other things, develop and implement Recovery Residence standards (based on NARR standards) to promote and require evidence based structures within statewide programming
- Expanded recovery beds available for women in recovery including women with children
- Initiated Recovery Coach Academy: training, train-the-trainer, and certification with coverage now statewide (0-250+ recovery coaches in WV since initiation) using the CCAR model
- Support statewide recovery oriented leadership development through the WV Leadership Academy training.

The number of Peer-Operated Recovery Homes and Facilities in West Virginia has increased, providing safe housing for individuals age 18 and older who are recovering from substance use and/or co-occurring substance use and mental health disorders. These facilities house individuals for up to twelve months. Residents are encouraged to participate in outpatient and intensive services provided off-site so that Medicaid may pay for Medicaid reimbursable services that do not occur at the facility. Service areas provided by the facility include: prevention, health promotion and wellness, and recovery support services.

WV BBHHF has played a leadership role in development of and capacity building around recovery supports in West Virginia.
1. The WV BBHHF has a long history of funding and promoting recovery-oriented supports and services. Some of these initiatives include Drop-In Centers, Recovery Residences, the West Virginia Leadership Academy, and other programs that are peer run.

2. In addition, WV BBHHF has supported recovery-oriented training initiatives such as:
   a. the nationally recognized 40-hour Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy™ (which increased WV’s number of Recovery Coaches from 0 in 2012 to over 300 in 2017).
   b. Cross training peer supporters and the general community in the nationally recognized Mental Health First Aid™ curriculum to assist with integrating peers into traditional behavioral healthcare centers, and to increase understanding of how to assist someone experiencing a mental health crisis.
   c. Previous BRSS TACS Awards have also enabled WV to deliver Whole Health Action Management (WHAM) training and promoting Wellness Recovery Action Planning™ (WRAP) groups as well as to introduce shared decision making concepts into behavioral health care promoting self direction.

3. WV BBHHF supports recovery-oriented education as one tool for reducing discrimination and stigma, promoting evidence based and promising practices, and integrating behavioral health into health practice. WV BBHHF works across the state in collaboration with successful recovery-oriented initiatives, changing paradigms to improve access, acceptance, and attitudes related to behavioral health.

WV BBHHF continues to build recovery capacity in WV, evolving the initial focus from start-up (training, funding community initiatives, and promotion) into supporting statewide peer and recovery support capacity and sustainability. The statewide capacity-building efforts have focused on 1) specialized peer services to meet priority needs, and 2) partnering on statewide certification and requirements for evidence based structures within statewide programming. This evolution is occurring with the support of 2 federal grant mechanisms, the BRSS-TACS grant and the Opioid STR grant.

**History of WV peer credentialing process and BRSS-TACS:** WV BBHHF has played a key role in developing the process for peer credentialing in WV, building on the foundational work done by WV BBHHF in the area of training peers to provide recovery support. WV’s BRSS TACS team benefited from support from other states (such as NY and Nevada) working on their own peer credentialing process providing assistance in order to develop WV’s peer credentialing process. Multiple states, including Georgia and Texas, provided assistance as part of the BRSS TACS initiative. In addition, the WV team looked at examples from other states doing Medicaid billing for peer support at the time, including Maryland and Pennsylvania. Peer credentialing materials (including protocol, application, training materials) were completed and reviewed by the BRSS TACS team staff team and a final draft was completed in 2016.

BRSS-TACS Committee envisioned housing the Credentialing Board functions for the first 2 years within BBHHF: hosting trainings, reviewing applications, etc., before spinning it out into the community as the oversight body for the peer credentialing process, reviewing applications, providing CORE Training and examinations, and issuing credentials after CORE Training and
associated exam were passed. The Credentialing Board would have its own standards for training, experience, ethical guidelines, and other requirements specific to the needs of the State’s communities and workforce. BBHHF adopted the “National Practice Guidelines for Peer Supporters” developed by the International Association of Peer Supporters from 2011. In January 2017, the Certification Board for Addiction & Prevention Professionals (WVCBAPP) adopted the Association for Addiction Professional (NAADAC) code of ethics for their peer credential, aligning more of the process.

The peer credentialing training itself as envisioned by WV BBHHF has been broader than what is covered in the Recovery Coach Academy training curriculum, including general information on mental health and individual and developmental disabilities (IDD), as well as information on prevention and on local resources. Peer credentialing training was also envisioned as broader than the Mental Health First Aid (MHFA) trainings, trainers, and training capacity that WV BBHHF supports.

As of July 2017, BBHHF is in the process of implementing its third successful Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS-TACS) grant from SAMHSA to support the peer certification process development. Previous BRSS-TACS grants focused on enhancing peer-delivered services and self-direction as well as developing the behavioral health workforce, enhancing recovery orientation of providers, and enhancing access to peer-run recovery services. West Virginia’s 2017 BRSS-TACS technical assistance has focused on two main goals: 1) continue to identify training and trainers for specialized peer support areas, including MAT, PPW, family, and ER, reentry, and older populations, and 2) assist with development of a statewide peer recovery network.

**Sustainability and WV’s peer certification process: the Medicaid SUD 1115 Waiver.** WV’s peer credentialing and associated training plans have continued to evolve during 2017. The West Virginia Bureau for Medical Services (BMS) submitted a Medicaid Section 1115 waiver application to the Centers for Medicare and Medicaid Services (CMS) on November 22, 2016 outlining the state’s plan to develop a continuum of care for individuals with substance use issues. Services that will be covered by Medicaid, either currently in the State Plan or provided under the new SUD Waiver (and following the ASAM Levels of Care), include peer supports and recovery support services.

The opportunity for WV to have Medicaid-billable peer supports and recovery support services, in addition to Medicaid-billable treatment services for SUD, provides an increased level of possible sustainability for West Virginia. Some adjustments to the peer certification process have resulted. For Medicaid-billable “Peer Support” level services, CMS has recommended that peer mentor/recovery coach educational requirements be determined via a training webinar, and an online test. Existing peer specialists with either national credentials or from the West Virginia Certification Board for Addiction & Prevention Professionals (WVCBAPP) will be exempted from the initial new requirements, and others would have the opportunity to be credentialed by WVCBAPP by January 2018. WV BBHHF will be partnering with WV BMS to develop the web based application and power point training prior to January 2018, when it is anticipated that the Medicaid SUD 1115 Waiver would begin implementation. WV’s goal is to certify an estimated 250-350 people to provide “Peer Supports” in January 2018.
WV BBHHF is monitoring what kinds of Peer Support may need to be developed or continued that would not be covered by the SUD 1115 Medicaid Waiver. There are some states, (e.g., Idaho) that have requested a waiver from the background check process in order to get many people in recovery approved to provide Peer Support. Peer Supports in recovery Residences, may have to stay state funded unless and until BMS receives approval for Licensed and Comprehensive Behavioral Health Centers hiring peers in residential settings with 16 beds or less (in compliance with federal IMD restrictions). However, if the recovery residence has fewer than 16 beds they will be able to offer peer support as a Medicaid service. Faith-based agencies that are not also Licensed Behavioral Health Centers are unlikely to be approved settings so they continue to be under consideration for BBHHF support, as do peer mentors who have non-violent felony records.

WV has identified that increasing the number of peers, their specialization and location, and navigators, is a promising way to connect levels of care and increase access throughout the system. Through the Opioid STR grant, WV BBHHF’s role has been to work with partners to develop add-on peer training focused on particular constituencies and locations and as incubator for the peer certification process. Under the Opioid STR, evidence-based approaches using Recovery Coaching and Peer Mentors will be implemented in Emergency Rooms to serve individuals with or at risk of developing OUD. Sixteen (16) FTEs ($40,000/year salary) will be hired to serve in this role.

Evidence-based approaches using Recovery Coaching and Peer Mentors will be implemented to serve the target populations of homeless individuals, youth, veterans and their families, pregnant women (in partnership with the Drug Free Moms and Babies programs), incarcerated individuals re-entering the community, individuals that present for services for OUD at Federally Qualified Health Centers, and individuals that present for MAT at regional medical centers. Thirty-four (34) FTEs will be hired to serve as Recovery Coaches and/or Peer Mentors. Additionally, specialized webinars will be developed to help assure peers receive necessary training beyond their basic certification to be as knowledgeable and effective as possible with the special populations they are serving. WV BMS (Medicaid) is interested in partnering on efforts to train individuals specializing in MAT Peer Supports.

As a goal of both Opioid STR and BRSS-TACS, WV BBHHF is working with community partners on create a state NARR Chapter in order to, among other things, develop and implement Recovery Residence standards (based on NARR standards) to promote and require evidence based structures within statewide programming.

Future potential areas under consideration for “Peer Support” services could include:

- peer-run mental health respite;
- public defenders’ offices;
- workplace peers;
- WV Community and Technical College System (WVCTCS);
- YSS Youth Recovery Coaching/other youth peer support,
- team post-naloxone/OD experience (similar to Colerain Quick Response Team model for Utilization of Community Paramedicine to Address the Opiate Epidemic);
• peers specializing in interim services;
• LGBTQ+ training/peers;
• African-American and other non-white, non-English speaking populations training/peers;
• syringe exchange/harm reduction locations;
• health department locations;
• PPW with community engagement/system navigator cross trainings/peers;
• Peers specializing in telehealth;
• Crisis Intervention Partner (CIP) peer training; flood/disaster focused training/peers.

CHILDREN, YOUTH AND YOUNG ADULT BEHAVIORAL HEALTH SERVICE SYSTEM IMPROVEMENTS

The BBHFF partners with the state agencies responsible for public education, juvenile corrections and child welfare to develop consistent standards and outcomes for the various federal and state grants that support school-based services designed to prevent students from becoming involved with or deepening their involvement with the juvenile justice system. Additional partners include West Virginia’s early childhood system to coordinate efforts to address emotional, social and behavioral well-being of our youngest citizens and their families (through Project LAUNCH), particularly families impacted by substance use disorder.

West Virginia is currently conducting a demonstration project called Safe at Home West Virginia, which provides wrap-around behavioral health and social services to 12-17 year olds in state custody with specific behavioral health needs who are currently in congregate care or at risk of entering congregate care. BBHFF has implemented a “companion” intensive wraparound initiative specifically designed to serve children and youth with SED who are not in the custody of the state, and their families. The Expanded School Mental Health Services model in partnership with Project AWARE, has been extended to 40 sites in 20 counties. Children’s Mobile Crisis Response and Stabilization teams operate in 14 counties for children with SED, particularly those at risk for out of home placement. Cross training is occurring with staff from programs serving homeless families with children and Home Visitation programs to expand awareness of addiction and improve access to community treatment and recovery resources.

West Virginia’s youth service system also includes behavioral health service centers located in each of the six regions of the state serving as centers of excellence for the implementation of the cross-system collaborative approach. The realignment and infrastructure support for Regional Youth Service Centers in conjunction with additional long standing youth initiatives funded by the Bureau for Behavioral Health and Health Facilities including Partnerships for Success, Suicide Intervention, Children’s Clinical Liaisons, WV System of Care, Expanded School Based Mental Health, Family Advocacy, Support and Training, Children’s Homeless Outreach, and Transitioning Youth to Independence demonstrate the behavioral health experience and capability to effectively promote system-level change, perform intensive community work and integrate behavioral health service state wide.

DISASTER PREPAREDNESS FOR SPECIAL POPULATIONS
The BBHFF employs a fulltime Disaster Coordinator who collaborates for a strong behavioral health response with first responders, hospitals, local health departments, social services,
homeland security and emergency management agencies, faith based community, and voluntary organizations to develop disaster response plans, continuance of operations plans and to conduct table top and other exercises across the State. The BBHHF supports the Voluntary Agencies Active in Disasters (VOAD) and integration of the Disaster Behavioral Health and the Disaster Spiritual Care Programs in order to meet behavioral, emotional, and spiritual care needs of the affected individuals, responders and recovery workers, and the communities as a whole. BBHHF will encourage the regional CBHCs to add trained peers to their disaster response teams.

The BBHHF 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. The BBHHF is working with various groups, such as the BPH, the State Red Cross chapter, West Virginia Division of Homeland Security and Emergency Management, and VOAD, to develop processes, policies, plans and annexes for inclusion of those with access and functional needs in the State’s various Emergency Operations Plans and for the activities listed in The National Response Framework (NRF) under Emergency Support Function #6, including mass care and sheltering, housing and human resources as well as the transition into the Health and Human Resources Recovery Support Function under the National Recovery Support Framework in order to promote self-sufficiency and continuity of the health and well-being of affected individuals, particularly the needs of children, seniors, people living with disabilities whose members may have additional functional needs, people from diverse origins, displaced, and underserved populations. Finally, in the wake of devastating, fatal flooding across much of southern West Virginia, BBHHF sought and was awarded three federal disaster response grants: The Crisis Counseling Assistance and Training Program (CCP), through both its Immediate Services Program and Regular Services Program, for which WV BBHHF received more than $2.5M, assisted individuals and communities in recovering from the June 2016 WV flood disaster through the provision of community-based outreach and psychoeducational services. Through face-to-face outreach, WVBBHHF sub-grantees Prestera Center for Clay and Kanawha Counties, and Seneca Health Services for Greenbrier, Nicholas and Webster Counties assessed emotional needs; provided emotional support, basic crisis counseling, and referrals; and conducted training and educated community partners about disaster.

The Disaster Case Management Program (DCMP), for which WV BBHHF received more than $5M, is providing -- for each flood survivor who needs the services—a case manager to serve as a single point of contact to facilitate access to a broad range of resources and achieve resolution of disaster-caused needs for that individual.

Additional information about the WV Bureau for Behavioral Health’s strengths and capacity:

Data and Information:

The WV State Epidemiological Outcomes Workgroup (SEOW) is housed and led by the WV Bureau for Behavioral Health & Health Facilities in order to facilitate the use of data in
policymaking and program decision-making for substance abuse prevention at the state, county and community level. The SEOW is comprised of 26 organizational and individual partners who serve as subject matter experts (see below for more detail). In 2016, the BBHHF partnered with WV Bureau for Public Health to update county-level data for 55 behavioral health profiles that are posted on BBHHF’s website to disseminate behavioral health information to all West Virginians. In 2017, the Bureau will be working with the SEOW to create a statewide behavioral health profile, the first since 2013, and, in conjunction with the Opioid STR work, building out the opioid data section so that it is more in-depth. With the addition of a new Behavioral Health Epidemiologist and a new Opioid Epidemiologist, buttressed by capacity-building in epidemiology and data throughout the WV Department of Health and Human Resources, in 2018 and 2019, response to both mental health and substance use trends throughout the continuum of care will be improved and tweaked further with additional county and state profile information.

The mission of the WV SEOW is to facilitate statewide prevention improvement by leading a systematic process to gather, review, analyze, and disseminate information about substance use and abuse in WV. The goals are 1) to establish an effective epidemiological team with the capacity to access, analyze, interpret, and disseminate data and apply in a state and regional context, and 2) to establish a systematic framework for ongoing monitoring of prevention needs and outcomes in the state and regions.

Current membership includes representatives from: CAMC Center for Health Services and Outcomes Research; CAMC Health Education & Research Institute; First Choice Services, Inc.; Governor's Highway Safety Program; WV Bureau for Children & Families; WV Bureau for Medical Services; WV Bureau for Behavioral Health & Health Facilities; WV State Epidemiologist; WV Bureau for Public Health, Division of Infectious Disease Epidemiology; WV Bureau for Public Health, Office Maternal, Child, & Family Health; WV Bureau for Public Health, Office of Community Health; WV Bureau for Public Health Office. of Epidemiology & Prevention Services; WV Bureau for Public Health, Epidemiology & Health Promotion; WV Bureau for Public Health, Health Statistics Center; WV Bureau for Public Health, Office Maternal Child and Family Health, Division of Research, Evaluation & Planning; WV Bureau for Public Health, Office Medical Examiner; WV Coalition Against Domestic Violence; WV Coalition to End Homelessness; WV Department of Education, Office of Assessment & Research; WV Division of Corrections; WV Division of Justice & Community Services, Office of Research & Strategic Planning & Justice Center for Evidence Based Practice; WV Division of Justice & Community Services, Office of Research & Strategic Planning, WV Statistical Analysis Center; WV Health Care Authority; WV Higher Education Policy Commission; WV National Guard Prevention, Treatment & Outreach; WV Poison Center, Robert C Byrd Health Sciences Center, Chas Division; WV State Police; WV Supreme Court of Appeals; WV Rural Health Association; WV Controlled Substances Monitoring Program - WV Board of Pharmacy; WV Division of Motor Vehicles; WV Office of Emergency Services; MCOs, including Aetna Better Health of WV and The Health Plan; WVU Injury Control Research Center; WVU School
of Public Health; WVU School of Public Health, Department of Social and Behavioral Sciences; Marshall University, Addiction Studies; WV KIDS COUNT; and WV Legislative Auditor's Office, Performance Evaluation Research Division.

As of this writing, the WV SEOW met last on May 11, 2017. The purpose of the WV SEOW is to:

- examine alcohol, tobacco and other drug-related archival data including National Outcome Measures (NOMs).
- assess the prevalence of substance use, abuse, and dependence and related problems, including co-occurring mental health issues, within specific populations and across the life span.
- determine the scope and extent of substance abuse and substance abuse related problems in WV and perform on-going surveillance of the extent and scope of the problems.
- analyze NOMs data for WV as they may be applied to prevention or treatment efforts.
- develop a WV profile of need-patterns of consumption and consequences of substance use using data sources such as Vital Records, National Survey on Drug Use and Health, Uniform Crime Reports, and Behavioral Risk Factor Surveillance System.
- employ systematic, analytical thinking to understand the epidemiology of the causes and consequences of the use of alcohol, tobacco, and other drugs.
- coordinate with appropriate decision-making entities within WV to provide data in formats to guide effective and efficient use of prevention resources.
- promote an ongoing, in-depth exchange of data and learning among SEOW members, State leaders, and local community leaders who have in-depth understanding of local substance abuse problems.

FOCUS ON BEHAVIORAL HEALTH AT THE FEDERAL, STATE, AND LOCAL LEVEL: WHAT IT MEANS FOR WEST VIRGINIA

This is a time of tremendous change at the federal, state, and local level, for health, and in particular for behavioral health. The extent of significant changes to current health policy -- both at the federal and state level -- remain uncertain: from resolution of repeal or replacement of the Affordable Care Act, to West Virginia’s likely Medicaid SUD 1115 waiver, to West Virginia’s state budget negotiations, the landscape of behavioral health in West Virginia has the potential to change dramatically over the next two years.

Medicaid SUD 1115 Waiver: The West Virginia Bureau for Medical Services (BMS) submitted a Medicaid Section 1115 waiver application to the Centers for Medicare and Medicaid Services (CMS) on November 22, 2016 outlining the state’s plan to develop a continuum of care for individuals with substance use issues. BMS will implement the waiver services in three phases
with immediate coverage of methadone, SBIRT and the Naloxone initiative to begin upon waiver approval.

In designing the SUD benefit package, industry-standard benchmarks for services and provider qualifications were incorporated using criteria established by the American Society of Addiction Medicine (ASAM) to ensure that care is provided by credentialed providers. West Virginia, in cooperation with MCOs, providers and other stakeholders, worked to revise its licensing requirements, provider manuals and managed care contracts to align with the waiver Special Terms and Conditions (STCs). Additionally, provider contracts will be revised to include a Multi-Dimensional Assessment, a Standard Benefit Structure, a Unified Model of Care, Uniform Clinical Operations, Service Review Requirements and Quality Reviews.

Services that will be covered by Medicaid, either currently in the State Plan or provided under the new SUD Waiver (and following the ASAM Levels of Care), include:

- SBIRT (Screening, Brief Intervention and Referral to Treatment)
- Outpatient Services
- Intensive Outpatient Services (IOP)
- Partial Hospitalization Services
- Clinically Managed Low-Intensity Residential Services
- Clinically Managed Population-specific High-Intensity Residential Services (Adult only)
- Clinically Managed High-Intensity Residential Services
- Medically Monitored High-Intensity Inpatient Services
- Medically Managed Intensive Inpatient Services
- Ambulatory Withdrawal Management without Extended On-site Monitoring (Outpatient Withdrawal Management)
- Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)
- Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)
- Medically Managed Intensive Inpatient Withdrawal Management
- Peer Supports
- Care Coordination

Pending final approval by CMS, it is anticipated that coverage will be phased in between December 2017 and July 2018.

In addition, the WV Medicaid SUD 1115 Waiver will include recovery support services; enhanced care coordination for high-risk/high-need Medicaid enrollees with an SUD diagnosis between levels of care and across providers; and an initiative to increase distribution and awareness of naloxone.

**Additional Governor’s Substance Use Disorder Initiatives:** BBHHF has continued its focus on working strategically with the Governor’s Office and other high-level decision-makers and state
agencies, and supported making connections between decision makers and grassroots and community voices. The BBHHF supported the Governor’s Advisory Council on Substance Abuse (GACSA) in its work and completion of its 5-year report on its progress to work as a cross-sector, Governor-appointed entity by Executive Order to provide guidance and recommend priorities addressing substance use and abuse in West Virginia. In close collaboration with grassroots efforts of GACSA-affiliated Regional Task Forces, providing an outlet for community and individual voices to be heard, GACSA has realized progress both in policy action and system-wide capacity improvements and service delivery. (This is a continuation of BBHHF’s overall strategy of cultural proficiency, being mindful of the Appalachian culture discussed in the needs assessment, in which the State has established a substance abuse prevention, treatment, and recovery infrastructure with county alignment.)

Building on the work of GACSA, legislation was introduced during the 2017 Regular Legislative Session to create an Office of Drug Control Policy (ODCP) that will continue to support coordination of emerging and evidence-based programs for the continuum of behavioral health services in West Virginia communities. In order to receive input from a wide-range of persons and entities currently engaged in the State’s ongoing efforts to combat substance use disorder, the Governor’s Advisory Council on Substance Use Disorders is anticipated to act as an advisory body to the ODCP and the ODCP Director, with members appointed by the Governor who have education, experience or special interests regarding substance use disorder prevention, early intervention, treatment and recovery.

The details of the West Virginia Office of Drug Control Policy continue to be developed. The legislation requires the office to develop a state drug control policy and a strategic plan; to coordinate with other entities, including regarding data sharing; to centralize data collection and reporting, including creating a central repository of drug overdose information in West Virginia and establish reporting system requirements and responsibility of entities to report information across state agencies; to develop a plan to add treatment beds in WV; and to provide for rule-making authority and emergency rule-making authority. The ODCP is also expected to coordinate media plans and communications concerning substance use disorders, establish harm reduction programs, and make recommendations regarding health care provider and patient communications.

Other legislation of note:

**Creation of the Governor’s Task Force:**

September 6, 2011 – Executive Order 5-11 created the Governor’s Advisory Council on Substance Abuse and established six (6) Substance Abuse Regional Task Forces to cover all parts of WV

**Good Samaritan Laws:**
April 2015 – SB 523 Good Samaritan Law – Alcohol and Drug Overdose Prevention and Clemency Act signed into law by Governor Tomblin

**Open Prescription for Naloxone:**

March 2015 – SB 335 Opioid Antagonist Act signed into law by Governor Tomblin

March 2016 – SB 431 - Authorizing pharmacists and pharmacy interns to dispense opioid antagonists signed into law by Governor Tomblin

**Public Regulatory Agency Developments and Practices:**

March 2016 – SB 454 - Licensing and regulating medication-assisted treatment programs for substance use disorders signed into law by Governor Tomblin

March 2016 – SB 195 - Authorizing DHHR to promulgate legislative rules relating to the certification of opioid overdose prevention and treatment training programs, chronic pain management licensure, neonatal abstinence centers, and the WV clearance for access; registry and employment screening signed into law by Governor Tomblin

April 2017 – SB 125 - Authorizing DHHR and Health Care Authority promulgate legislative rules, including:

- The legislative rule filed in the State Register on August 26, 2016, authorized under the authority of section thirteen, article five-y, chapter sixteen of this code, modified by the Department of Health and Human Resources to meet the objections of the Legislative Rule-Making Review Committee and refiled in the State Register on January 25, 2017, relating to the Department of Health and Human Resources (medication-assisted treatment-opioid treatment programs, 69 CSR 11).

- The legislative rule filed in the State Register on August 26, 2016, authorized under the authority of section one, article five-y, chapter sixteen of this code, modified by the Department of Health and Human Resources to meet the objections of the Legislative Rule-Making Review Committee and refiled in the State Register on January 25, 2017, relating to the Department of Health and Human Resources (medication-assisted treatment-office-based medication assisted treatment, 69 CSR 12).

**Mandatory Participation in the PDMP/CSMP:**

March 2012 - SB 437 – in addition to requiring mandatory participation to prescribers, providing certain requirements and training for law-enforcement officials in order to access the Controlled Substances Monitoring Program database; permitting the Controlled Substances Monitoring Program Database Review Committee to query the Controlled Substances Monitoring Program database; requiring the Board of Pharmacy to review the Controlled Substances Monitoring
Program database in order to issue certain reports; permitting the Board of Pharmacy to share certain information contained in the Controlled Substances Monitoring Program database with the Department of Health and Human Resources; requiring the Board of Pharmacy to establish an advisory committee; permitting prescribing practitioners to notify law enforcement of certain violations with immunity; requiring the Board of Pharmacy to provide annual reports to the Legislature; requiring various boards that regulate professions with prescriptive authority to require persons licensed by the board to conduct an initial search of the Controlled Substances Monitoring Program database when prescribing a course of treatment that includes prescribing of pain-relieving controlled substances and an annual search of the Controlled Substances Monitoring Program database for certain patients; setting forth penalties for failing to search the Controlled Substances Monitoring Program database in certain circumstances; and, establishing a felony offense and penalties for unauthorized access, use or disclosure of information contained in the Controlled Substances Monitoring Program database.

Public Payor Reimbursement Practices for Providers:

On November 30, 2016, the Governor announced the West Virginia DHHR, Bureau for Medical Services (BMS) submitted a 1115 Substance Use Disorder (SUD) demonstration waiver for approval to the U.S. Centers for Medicare and Medicaid Services (CMS). BMS is still awaiting the final approval letter from CMS.

Other:

May 2013 – Medicaid Expansion – Governor Tomblin expanded Medicaid services in WV

March 2016 – HB 4146 - Providing insurance cover abuse-deterrent opioid analgesic drugs signed into law by Governor Tomblin

March 2016 – HB 4347 - Providing pregnant women priority to substance abuse treatment was signed into law by Governor Tomblin

April 2017 – HB 2620 - All relating to the West Virginia Drug Control Policy Act; creating the Office of Drug Control Policy within the Department of Health and Human Resources; requiring the office to develop a state drug control policy and a strategic plan; requiring the office to coordinate with other entities; setting forth duties of the office; requiring the coordination of funding; requiring data sharing; requiring the office to develop a plan to add treatment beds; required reporting; requiring the office to create a central repository of drug overdose information in West Virginia; establishing the program and purpose; establishing the reporting system requirements; establishing responsibility of entities to report information; setting forth information required to be reported and the agencies which are affected; providing for data collection and reporting; and providing for rule-making authority and emergency rule-making authority.
April 2017 – HB 2428 - All relating to ensuring additional beds for purposes of providing substance abuse treatment.

April 2017 – SB 386 - All relating to medical cannabis generally; authorizing, under limited conditions, the use, possession, growing, processing and dispensing of cannabis for serious medical conditions; and creating the West Virginia Medical Cannabis Act.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

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 sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should 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 SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD 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 M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

**SAMHSA's Behavioral Health Barometer** is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[^1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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

The State of Mental Health in WV: More than 1 in 5 West Virginians has a mental illness or substance use disorder. Around 28% of the population in WV reports daily use of a drug or medication to alter their mood (Gallup-Healthways, 2014). “In West Virginia:

- about 60,000 adults aged 18 or older (4.2% of all adults) per year in 2013–2014 had serious thoughts of suicide within the year prior to being surveyed. In West Virginia, about 79,000 adults aged 18 or older (5.5% of all adults) per year in 2013–2014.
- In West Virginia, about 79,000 adults aged 18 or older (5.5% of all adults) per year in 2013–2014 had SMI within the year prior to being surveyed.
- In West Virginia, about 148,000 adults aged 18 or older with AMI (46.9% of all adults with AMI) per year from 2010 to 2014 received mental health treatment/counseling within the year prior to being surveyed.
- Among adults served in West Virginia’s public mental health system in 2014, 52.4% of those aged 18–20, 36.0% of those aged 21–64, and 94.2% of those aged 65 or older were not in the labor force.”

Rural Populations, Culture and Access

West Virginia is a rural state and the only one located entirely within the Appalachian Region. Its 24,038 rugged square miles of area is home to more than 1.8 million people. West Virginia’s population centers are small in comparison with other states. The capitol city of Charleston (pop. 51,400) 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). There are no federally recognized tribes in West Virginia.

Appalachia is twice as rural as the national average—42% rural compared with 20% for the rest of the United States. Appalachian culture and values influence behavior. At the risk of over-generalization, Appalachian culture is typically marked by self-reliance, the centrality of home place, and the preeminence of family. This strong sense of place and community also results in a robust mistrust of outsiders and “systems” that are perceived to encroach on community-based viewpoints. As a result, the most successful mental health and substance use disorder (SUD) programs are implemented on a county or regional level, where barriers to access services are reduced and individuals have developed trust with service providers and agencies.

The racial composition of West Virginia’s population reflects low ethnic diversity. Caucasians account for 93.6% of the population while 3.2% is African American, 0.7% is Asian and 2.5% is biracial or a mixture of two or more races. Less than 3% of the population in West Virginia speaks a language other than English as their primary language, compared to almost 21% of the
population in the United States. The median age in West Virginia is 41.6. According to the Movement Advancement Project, West Virginia has an LGBTQ population of 45,613 or 3.1% of the total population and 29% of LGBT individuals are raising children in the State.

Health disparities related to race exist in WV, and WV BBHHF welcomes opportunities to partner with organizations working to close this gap as it relates to behavioral health, and through BBHHF’s strategic planning process. In addition, BBHHF is currently working to diversify its peer training efforts.

There are a variety of statewide intermediary organizations focused on supporting minority populations in WV. For example, Fairness WV is the statewide advocacy organization for LGBT West Virginians, and WVU’s LGBTQ+ Center serves as a resource center and as the social, intellectual, and physical hub of the LGBTQ+ community at WVU, helping the University identify, monitor, and assess best practices in programming and policy to ensure an inclusive atmosphere, to help WVU establish a leadership role in the state and among peer institutions on LGBTQ+ matters. Established by Gov. Earl Ray Tomblin in March 2012, the Herbert Henderson Office of Minority Affairs is committed to advancing equality for all minorities across West Virginia and developing innovative ways to address issues affecting minorities through integrity, leadership and collaboration. Race Matters WV is another resource.

While the Mountain State’s mountainous topography and picturesque scenery are remarkable, the rural terrain presents challenges, including isolating residents from services and adding significant physical barriers to the most vulnerable. Consequently, the state suffers from high poverty and unemployment rates, low levels of educational attainment and literacy, and high rates of OUD.

**High Overdose Mortality and Opioid Use**

_data confirms what West Virginians sense when they watch the local news or attend another funeral of a loved one whose life was cut short: no state has been as profoundly affected by the epidemic of opioid drug use as West Virginia. The state has for six years in a row had the highest drug overdose mortality rate in the nation – more than double the rate of the United States as a whole – rates in 2015 were at 41.5 per 100,000 residents. Families and communities are devastated by the effects and service providers and residents are acutely aware of the need for substance abuse prevention, treatment, and recovery services. Below is an excerpt from a February, 4, 2017 obituary of a young 31-year old West Virginia mother, who died of a heroin overdose:

"Her parents have requested that people be aware that a heroin overdose took the life of their precious daughter. The drug epidemic is destroying our families and our community. Please be aware and do all you can to stop this plague. Trust us. No family is exempt from this heartbreaking possibility."

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The increased use of opioids has created societal problems with an increasing cost burden to the state. Opioids are responsible for most overdose fatalities in West Virginia, a number and percentage that continues to grow. From 2007 to 2012, wholesalers shipped 224,260,980 oxycodone doses and 555,808,292 hydrocodone doses to West Virginia, primarily to small, independently-owned pharmacies. In 2015, West Virginia filled more opioid prescriptions than there are people with 1,049 opioid prescriptions per 1,000 West Virginians.

And, as other parts of the country have seen, heroin and fentanyl deaths have increased in WV as well. Overdose deaths from heroin have been rising in WV since 2010; over half of all drug overdose deaths in WV in 2016 involved either heroin or fentanyl or both. Recent West Virginia PDMP data suggests that there are an alarming number of counties that continue to have more opioid prescriptions than residents. Logan, McDowell, and Wyoming Counties have more than 100 opioid prescriptions per 100 people and more than 100 benzodiazepine prescriptions per 100 people in these counties; the top ten ranking counties for overlapping opioid and benzodiazepine prescriptions are Logan, Mingo, Boone, Mason, Lincoln, Wyoming, Harrison, Summers, Cabell, and Raleigh. WV BBHHF is working collaboratively to provide prescriber education, among other efforts (see section in Strengths about efforts to build capacity around opioid use disorder continuum of care).

With respect to opioid use disorders, there are many barriers to accessing medication assisted treatment (MAT). Many treatment providers view utilizing MAT as switching from one form of addiction to another and, therefore, may favor abstinence models. Many insurance policies also dictate limits on dosage, lifetime quotas, and “fail first” policies requiring abstinence treatment.
to be attempted first. Additionally, stigma surrounding substance use and mental health disorders often prevent individuals and families from seeking services, if they are even available.

MAT resources are limited to treat opioid use disorders in rural places like West Virginia: “Management with buprenorphine is an effective, office-based, medication-assisted treatment, but 60.1% of rural counties in the United States lack a physician with a Drug Enforcement Agency waiver to prescribe buprenorphine.” More specific data and strategies to address this issue are a large focus of current West Virginia’s Opioid STR grant implementation.

The WV BBHHF continues to work closely with epidemiologists in the WV Department of Health and Human Resources and its partners regarding identification of counties at highest risk for opioid-related overdose deaths. These efforts will continue as the WV Office of Drug Control Policy evolves and as WV continues its work under the Opioid STR grant. Currently, methodologies are tweaked slightly depending on the type of treatment, prevention, harm reduction, or other modality that is under consideration; the CDC’s CAST (Calculating for an Adequate System Tool is also under consideration as a strategic planning tool for the communities WV BBHHF serves.

One method used by the WV Health Statistics Center is to identify the counties at the highest risk for opiate-related drug overdose deaths by identifying those counties that 1) have both a combination of high numbers (> 10) of opiate-related overdose deaths and death rates that exceed the state rate of 40.6 per 100,000 in 2016 and 2) those counties that had 25 or more opiate-related deaths regardless of the rate. Fifteen (15) counties in West Virginia meet that criteria. Those counties are: Cabell, Berkeley, Mingo, Wayne, Mercer, Wyoming, Kanawha, Jefferson, Mason, Raleigh, Wood, Brooke, Monongalia, Harrison and Hampshire counties. In addition, Mineral and Brooke counties come very close to meeting the criteria.

Another way to estimate impacted areas counties that have higher risk of death in the future is a WV Bureau for Public Health model that is more complex and includes several data elements. At the request of the West Virginia State Medical Officer, a heat map was created based on multiple data sources from 2016, except for drug exposed infants which included data from October 1, 2016 to March 31, 2017. Data points included: drug exposed infants, children removed due to substance abuse, overdose deaths, naloxone administration on EMS runs, and opioid prescriptions. Rates for each data source were calculated and ranked by county. All these rankings were summed to calculate a master ranking, which was then divided into quintiles. WV has 55 counties. The top 11 at-risk counties are Boone, Brooke, Cabell, Hancock, Kanawha, Lincoln, Mercer, McDowell, Nicolas, Summers and Wyoming.

In August 2016, the WV Bureau of Behavioral Health and Health Facilities (BBHHF) invited the WVU Injury Control Research Center (ICRC) to plan, conduct and evaluate a statewide naloxone distribution program. With funding provided by the BBHHF from the Grants to
Prevent Prescription Drug and Opioid Overdose (PDO) federal grant, the ICRC procured naloxone, materials, and equipment to assemble 8,250 naloxone rescue kits for distribution to existing and planned naloxone programs across the state. To facilitate the transfer of funds and oversight of the project, it was incorporated into the Centers for Disease Control “Prevention for States” grant as a rapid response project (RRP). To develop a distribution plan, ICRC prioritized programs by risk level (based upon number and rate of opioid overdose deaths by county of location provided by the WV Health Statistics Center) and naloxone need (self-reported responses to a survey designed and conducted by ICRC). The programs in Berkeley, Boone, Cabell, Kanawha, Logan, Mercer, Mingo and Raleigh counties received the highest mortality risk scores, while naloxone need scores were assigned to programs whose naloxone was depleted, whose supplies were reaching an end of service life, or whose supplies did not meet the needs according to the volume of patients, clients, or responders per shift.

Other sources of estimating current treatment need data include reporting from 1-844-HELP4WV, West Virginia’s 24/7 call-line focused on ‘warm hand-offs’ to increase access to behavioral health services throughout the state. Since its inception in September 2015 – June 25, 2017, HELP4WV has received more than 14,000 calls and has led to 3,030 opioid and/or heroin intakes of the 5,032 total intakes of all substances directed through the call-line. Six were for under age 18 and 916 were for ages 25-34 (1249 of the calls were unknown). Of the 3,030 callers there were 2,012 who received assessment and diagnostics, 118 received MAT, 2,427 received withdrawal management/crisis stabilization, 583 received inpatient-residential services, 42 received recovery support, 82 went to the ER for suicidal or alcohol/ benzodiazepine withdrawal crisis, 60 received outpatient services, and 26 received intensive outpatient services. The top counties for opioid-related calls between September 2015 and June 2017 were: Cabell (426), Kanawha (459), Berkeley (367), Harrison (152), Wood (133), Raleigh (120), Mercer (82), Jefferson (77), Boone (75), and Monongalia (73).

The US Department of Health and Human Services is also working with the WV Bureau for Children and Families to determine trends in prescription opioids sales and foster care caseloads. In terms of office based Medication Assisted Treatment, according to the CSAT webpage for pharmacological therapies, West Virginia has 243 waivered physicians. Most office based providers are in the southern portion of the state with there being obvious gaps in the central, north and eastern parts of the state.

*IV Use and Hepatitis Epidemic*

The increased misuse of prescription and illicit opioids in West Virginia is alarming. Many of these drugs are being injected, leading to the risk of blood-borne viral infections that have reached epidemic proportions. WV has the 2nd highest rate of new Hepatitis C cases in the county and the highest rate of new Hepatitis B cases in the country.
In 2015 West Virginia reported 272 cases of acute Hepatitis B Virus (HBV) infections (14.7 cases per 100,000 population compared with the United States at 1 case per 100,000 population). This is a 300% increase from 2010 (n=93). Many of these cases were from the southern part of the state, from individuals between 25 to 49 years old, and those that reported injection drug use and/or use of street drugs. In 2016, 256 (provisional) cases of acute HBV and 322 (provisional) cases of chronic HBV were reported.

60 cases of acute Hepatitis C (HCV) infections (3.4 cases per 100,000 population in West Virginia compared with the United States at less than 1 case per 100,000 population) were reported in 2015. This is a 286% increase from 2010 (n=21). Of greatest concern is the 6,347 newly reported cases of chronic HCV (334 cases per 100,000 population) in 2015. Similar to HBV, many of the HCV cases were from the southern region of the state, reported use of injected drugs and/or street drugs, had contact with a HCV infected person, and reported incarceration.

Low Socioeconomic Standing

West Virginia is one of the most impoverished states in the country. Median household income is 23% below that of the nation. Per capita income in West Virginia is almost 20% lower than the rest of the country. More than 22% of West Virginia families with related children under age 18 have an income below the poverty level (compared to 18% for the nation). More than 60% of West Virginia families with a female head of household (i.e., no husband present) with related children under age 5 years have incomes below the poverty level (compared to 46.3% for the United States). Approximately 16.1% of West Virginia households utilized the Food Stamp/SNAP benefit program in the last 12 months, compared to 13.2% nationally. According to the Bureau for Labor Statistics, the December 2016 unemployment rate in West Virginia was 5.9%, which is higher than the national rate of 4.7%. “Coal-impacted” communities—primarily located in the southern counties of the state—have higher rates of unemployment and poverty due to reductions in the coal economy.

Correlated with low economic standing is low educational attainment levels, which have a direct impact on socioeconomic wellbeing. While the population with a high school degree or higher in West Virginia is comparable to that of the nation (86% and 87.1%, respectively), significantly fewer West Virginians hold bachelor’s degrees than the whole of the United States (19.6% and 30.6%, respectively). According to the West Virginia Department of Education, approximately 17% of West Virginia adults have significant difficulty with literacy tasks related to everyday life and work, while an additional 32% face some degree of difficulty with certain literacy skills.1

Uninsured and Underinsured

With implementation of the Affordable Care Act (ACA), West Virginia has seen significant improvements in its rate of insurance coverage:
• More than 93% of all adults have health insurance coverage.
• Before implementation of the major coverage provisions of the ACA, an estimated 20.7% of West Virginians aged 18 to 64 were uninsured. With implementation, West Virginia cut this rate by more than half to 8.7%.
• The share of young adults without health insurance coverage dropped from nearly 27% in 2013 to 10.5% in 2015.
• Every West Virginia county saw at least a 10-percentage point decline in the share of its residents without health insurance.

Thus, while the state has made progress, there are still individuals without health insurance and others who have insufficient coverage to meet their healthcare needs. In West Virginia, if an individual or family is unable to access services offered through qualifying health plans, Medicaid, or the state’s 13 Comprehensive Behavioral Health Centers, they can access the BBHHP’s state-funded charity care dollars, given that the service need is a Medicaid-eligible service. While Medicaid expansion provided first-time services for many, others who were covered by the state’s charity care mechanisms were faced with co-pays for the first time, depending on the plan. Additionally, many individuals who decided to go to the Health Insurance Marketplace now have plans that have not adequately met their healthcare needs, and now find themselves underinsured for behavioral health services.

Should components of the ACA at the federal level change, or if WV would otherwise see change to Medicaid expansion, the State could see uninsured rates nearly or more than triple. In a 2017 study from Harvard Medical School and New York University, to study what would happen if the ACA were repealed, researchers determined that an estimated 214,501 West Virginians with mental illness or drug abuse would lose access to behavioral health services. Should changes occur in behavioral health coverage, emergency room visits may increase or failed recovery and more individuals could be at increased risk for overdose.

Individuals Reentering the Community from Criminal Justice Settings

Between 2000 and 2009, the number of people in West Virginia’s prisons increased at a rate triple the national average, while the state’s resident population remained flat. Further, the prison population is expected to increase 24% from 2013 to 2018. The United States Bureau of Justice Statistics reported that in December 2015 there were 6,881 sentenced prisoners in West Virginia under the jurisdiction of state or federal correctional authorities. In 2015, 3,644 sentenced prisoners under this jurisdiction were released in West Virginia. Approximately 60% (2,188) of those releases were conditional, including releases to probation and supervised mandatory releases.

• In 2012, the Council on State Government’s (CSG) Justice Center began working with state leaders in West Virginia to develop data-driven, consensus-based policy options designed to reduce corrections spending and increase public safety. CSG Justice Center experts conducted a comprehensive analysis of West Virginia’s criminal justice data and
interviewed stakeholders across the criminal justice system to identify challenges facing the state. They concluded:

- The biggest driver of growth in the state’s prison population between 2007 and 2011 was the number of people whose community-based supervision had been revoked, which compounded the length of time they spent in prison once re-incarcerated.
- The number of people who completed their sentence in prison and returned to the community without any post-release supervision increased significantly during the same period. Inefficiencies in correctional intake and parole decision-making processes contribute to this trend.
- Failure to adhere to the terms of probation or parole often stemmed from an individual’s substance use and addiction needs and contributed to the growing prison population. Few of those under supervision received treatment in their communities.

More than half of the state’s correctional facilities are deemed to be Health Care Shortage Areas for mental health services. Facilities are unable to offer an array of treatment options, notably excluding both MAT and individual counseling services in many cases. For those being held in prisons due to overcrowding in jail facilities, access is particularly inadequate because they do not have access even to services available through prisons.

- Drug offenders now comprise about 25% of all new prison admissions, up from about 10% in 2000
- Correctional population forecasts project that state prisons will house 1,200 drug offenders by 2024 - a growth rate exceeding 50% from 2014.

According to SAMHSA, half of all incarcerated people have mental health problems, 60% have SUD, and one-third have both. Two thirds of people in prison meet the criteria for SUDs yet less than 15% receive treatment after admission. When over 700,000 federal and state prisoners are released to communities in the United States every year, correctional behavioral health problems then become community behavioral health problems.

West Virginia is aware of the challenges many offenders encounter when they are released back into the community and the high risk of recidivism. In West Virginia, nearly 73% of offenders who returned to the custody of the WVDOC in 2004-2005 did so within 18 months of their release. The highest return rate (24.9%) came within 6 months of being released from the WVDOC. From 2003 to 2013, the number of individuals reincarcerated due to parole violations escalated, in part driving the increase in overall incarceration rates in the state. In line with the national rates, many of these parole violations are a result of OUDs.

In 2013 the West Virginia Legislature passed the Justice Reinvestment Act (JRA), a key subsection of Senate Bill (SB) 371. Among other things, SB 371:
Strengthened community-based supervision by requiring supervision agencies to use risk assessments to ensure that supervision practices focus on individuals most likely to reoffend and respond to probation and parole violations with swift, certain, and more cost-effective sanctions;

Placed the Division of Justice and Community Services in charge of training agencies in the use of these risk assessments, the assurance of reliability, and the tracking of results; and

Expanded access to substance abuse treatment by creating a new “treatment supervision” sentencing option that provides substance abuse treatment to individuals under supervision and by expanding the use of drug courts throughout the state by 2016.

Veterans

Military veterans are twice as likely to develop an opioid addiction, as well as twice as likely to overdose, when compared to the civilian population. West Virginia has one of the highest per capita military service rates in the country, and WV BBHHF needs better information about the needs of WV military veterans.

Aging Population and Older Adults with SMI

Where once the median age of a West Virginia resident was nearly identical to the median age in the U.S., West Virginia’s median age in 2013 was four years greater than the U.S. (43.0 years compared to 38.9 years). “By 2056 the population of U.S. adults aged 65 years and older is projected to become larger than the population aged 17 years and younger. The West Virginia Health Statistics Center (WVHSC) projects that this event will occur about the year 2029 for West Virginia, much earlier than for the rest of the country.” This is a priority population about which WV BBHHF needs additional state-specific data.

Pregnant Women and their Infants

In 2014, 20,556 infants were born in West Virginia. The five hospitals with the highest number of births were Cabell Huntington Hospital (Huntington), Charleston Area Medical Center’s Women and Children’s Hospital (Charleston), Camden-Clark Medical Center (Parkersburg), University Health Care Jefferson Medical Center (Ranson), and West Virginia University Hospitals (Morgantown).

Thirty-five of the state’s fifty-five (63.6%) of counties provide no delivery services for pregnant women. These problems are heightened further for women in these rural communities, many of whom are single heads of household. Public transportation is practically non-existent, so accessing services is often dependent on a family member or neighbor for transportation.

Substance use in pregnancy (including the use of tobacco, alcohol, prescription, and illicit drugs) has long been identified by West Virginia healthcare professionals as a major factor contributing to poor health outcomes for mothers and babies. (For example, WV’s smoking rate among pregnant women, at 27.3%, is the highest in the US (CDC, 2016) and nearly triple the national
rate. To address this issue, the West Virginia Perinatal Partnership (WVPP) formed the Substance Use in Pregnancy Committee to study the extent of the problem and the state’s efforts to respond to it; make policy recommendations; identify best practices; and develop a collaborative and coordinated approach to best meet the needs of this high-risk population.

To determine the prevalence of intrauterine substance exposure in West Virginia, the Substance Use in Pregnancy Committee conducted a statewide study of umbilical cord tissues in 2009. This study confirmed that the problem was serious and widespread—nearly 1 in 5 umbilical cord tissue samples tested positive for at least one substance. The study found that while marijuana was the most widely substance found in the tissue, nearly a quarter of those that tested positive contained an opioid. Notably, most of the cords tested positive for more than one substance.

According to 2014-16 West Virginia data, 22 Neonatal Abstinence Syndrome (NAS) is reported in 37 per 1,000 West Virginia live births, which is more than five times the national average of nearly 7 out of every 1,000 births (WV Health Statistics Center). The West Birth Score Office, funded by the Office of Maternal Child and Family Health (OMCFH) of the Bureau for Public Health (BPH), identifies newborns who are at greatest risk for poor health outcomes and preventable death in the first year of life. These infants are linked to pediatric services and case-management for close follow-up. Data collection for October 1, 2016 to March 31, 2017 revealed overall intrauterine substance exposure of 14.4% (1,384/9,614) and NAS in 5.6% of births in WV (541/9,614).

SUDs have overwhelmed West Virginia’s foster care system. As many as 70% of referrals to Child Protective Services (CPS) have a substance abuse component, according to statistics from the Centralized Intake Unit of the West Virginia Bureau for Children and Families (BCF). This is consistent with data from the state court’s Child Abuse and Neglect (CAN) Database, which indicate about 80% of CPS referrals from family court and circuit court judges have a substance abuse factor. Drug abuse of the caretaker/parent accounts for 74% of maltreatment findings related to SUDs.

Currently, there are only two trauma-focused, family-centered substance use disorder residential treatment centers for women and their children in the entire state, and these centers cannot meet the high demand for services. Turning Pointe, located in Beckley, is a 16-bed residential program that serves approximately up to 11-12 pregnant and postpartum women with infants and children up to age 18 months. Women and their infants typically remain in care for a maximum of three months. Family therapy and other services are provided for older dependent children. Prestera Center also offers long-term residential substance use treatment for women and their dependent children in both Huntington and Charleston. Prestera’s Renaissance program, in Huntington, serves women and children together, but only has capacity to serve 19 women and 12 children. Marshall Recovery Center for Families (MRCFF) will fill a significant gap within Huntington and the surrounding area by expanding critical services to pregnant and postpartum women and their families in a therapeutic setting that is family-centered and offering trauma-informed
therapy and other needed services for the families to help them on the road to recovery. MRCFF is an 18-unit residential treatment facility that will provide evidenced-based, trauma-informed, and family-centered treatment services to pregnant and postpartum women with substance use disorders (SUD) and co-occurring disorders, and services for their children and families. MRCFF will support the successful, long-term recovery of our clients and their families by building and strengthening their skills through education, support, and counseling through culturally-sensitive, family-centered treatment. This program will address a pressing need in the catchment area by increasing access to care for pregnant and postpartum women and their families, a population that is underserved and increasingly at risk. Services available will include MAT for pregnant women; peer supports for pregnant women, and case management including individualized family services plans.

Children, Youth, and Families

Children and Youths with SED. The National Research Institute reports that there were approximately 193,838 children with SED, aged 9 to 17, in West Virginia in 2014. SAMHSA’s Behavioral Health Barometer West Virginia, 2015, indicates approximately 14,000 adolescents in West Virginia aged 12–17 (10.9 percent of all adolescents) per year in 2013–2014 had at least one major depressive episode (MDE) within the year prior to being surveyed. Further, almost 5,000 adolescents in West Virginia aged 12–17 with a MDE (44.7 percent of all adolescents with MDE) per year from 2010 to 2014 received treatment for their depression within the year prior to being surveyed.

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. In 2013, 4,695 West Virginia children were victims of abuse or neglect (Administration for Children and Families, 2013). 7.7 percent of West Virginia high school students have been physically forced to have sexual intercourse at least once in their lives, 10.8 percent have experienced physical dating violence (including being hit, slapped, or physically hurt by their boyfriend or girlfriend), and 8.7 percent have experienced sexual dating violence. About 7.5 percent of West Virginia high school students reported that they attempted suicide in the 12 months before the survey, and 15.4 percent report that they have seriously considered attempting suicide (West Virginia High School Youth Risk Behavior Survey, Centers for Disease Control and Prevention, 2013).

According to the U.S. Department of Health and Human Services Administration for Children and Families’ most recent report, Child Welfare Outcomes 2010-2013: Report to Congress, the statistics for West Virginia’s children ranked the state among the most challenged for child welfare outcomes:

- The entry rate for foster care is 8.6 percent, the highest rate in the U.S.
From 2010 to 2013 the number of child maltreatment victims steadily increased from 3,961, a rate of 10.2 per 1000 to 4,695, a rate of 12.3 per 1000.

In WV, 12.8 percent of the child maltreatment victims are under one year of age.

In 2013, 54.3 percent of the maltreatment of children was neglect, 33.9 percent was physical abuse, 27.3 percent was emotional abuse, 5.2 percent was sexual abuse, and 1.2 percent was medical neglect.

In 2013, the median length of stay in foster care was 9.7 months.

In 2013, there were 1,036 children awaiting adoption. A total of 877 children were adopted.

WV is one of four states where less than 40 percent of the children legally available were adopted in less than 12 months.

In 2013, child fatalities were at their highest in four years at 17, a rate of 4.5 per 100,000.

West Virginia’s FY 2013 data showed that we had 3,263 children age zero-to-17 that entered care. Of the 1,488 children 12-17 years of age, 71 percent of those youth were placed in congregate care.

The WV Bureau for Behavioral Health, as part of a statewide collaboration under the WV Department of Health & Human Resources, is collaborating with both public and private stakeholders-- including service providers, school personnel, behavioral health services, probation, and the judiciary-- to demonstrate that children currently in congregate care can be safely served within their communities to achieve success. By providing a full continuum of supports to strengthen our families and fortifying our community-based services, we are demonstrating that youth currently in congregate care can achieve the same or higher indicators for safety and well-being while remaining in their home communities.

West Virginia has significant dedication at the state level to prevent children with substantial mental health conditions from being needlessly removed from their families and communities to obtain the care they need. We are focusing on providing a full continuum of supports to strengthen our children and families. By fortifying and enhancing community-based services, children currently in congregate care and those and those at risk of going into care can safely remain in their home communities and experience improved well-being outcomes.

According to SAMHSA’s Behavioral Health Barometer, 2015, West Virginia’s percentage of serious mental illness (SMI) among adults aged 18 or older was higher than the national percentage (4.2%) in 2013–2014. About 79,000 adults aged 18 or older (5.5% of all adults) per year in 2013–2014 had SMI within the year prior to being surveyed. The percentage did not change significantly from 2010–2011 to 2013–2014. Adults in West Virginia and nationally 18-25 years old reported
As of May 29, 2017, a total of 825 youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 48 Youth from out-of-state residential placement back to West Virginia, 125 Youth have stepped down from in-state residential placement to their communities, and eight youth have returned home from an emergency shelter placement. West Virginia has been able to prevent the residential placement of 442 at risk youth.

The breakdown of placement type at time of enrollment is as follows:

- 63 were or are in out-of-state residential placement
- 185 were or are in in-state residential placement
- 386 were or are prevention cases
- 28 were or are in an emergency shelter placement.

The National Children’s Health Survey shows that West Virginia ranks 11th in the country for preventive medical care visits with 88.7% of children receiving one or more visits in the last year. This is due to a combination of efforts, from WV Bureau of Medical Services (BMS) to the WV Department of Education. WV is building on that effort to make sure our most vulnerable children are not only screened by a primary care provider in a timely manner and also that they are screened for medical and behavioral health needs, as well as trauma.

Estimates from multiple surveys of West Virginia youth indicate the rate of binge alcohol use by persons 12 to 17 years of age is one of the highest in the nation. The state’s prevalence of illicit drug use (and more addictive substances) and first-time use are notably higher and starting earlier than national averages among some of the youngest age groups surveyed. Rates of non-marijuana illicit drug use (indicating use of more addictive drugs) and non-medical use of pain medication in the state significantly exceed national rates, particularly within the highest risk age group of 18-25 year olds. The rate of abuse of pain killers is higher than the national average within this age group in five of the six regions of the state. 15.0% of students in grades 9 through 12 reported using prescription drugs (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription one or more times during their life.

Adverse Childhood Experiences, commonly referred to as ACEs, higher scores are associated with substance use disorders and depression, as well as other physical diseases, and are linked to criminal justice system involvement and homelessness. While 45.5% of West Virginia adults report zero ACES, the average was 1.4.

“In West Virginia, the most common ACE was household substance abuse, followed by separation/divorce, verbal abuse, mental illness, domestic violence, physical abuse, sexual abuse, and incarceration of a household member. Approximately 21% or 271,996 West Virginia adults would be considered high risk for having or developing health problems based on having three or more ACEs.”
Youth and Grandparents

According to Generations United’s www.grandfamilies.org, in West Virginia:

- 22,000 (6%) children live with a relative with no parent present.
- 41,482 (10.9%) children under 18 live in homes where householders are grandparents or other relatives.
- 35,393 (9.3%) of these children live with grandparents.
- 6,089 (1.6%) of these children live with other relatives.

And 21,304 West Virginia grandparents are householders responsible for their grandchildren who live with them. Of these:

- 8,884 (41.7%) do not have parents present.
- 13,553 (63.6%) are under age 60.
- 9,906 (46.5%) are in the workforce.
- 4,453 (20.9%) are in poverty.
- 7,158 (33.6%) have a disability.
- 5,219 (24.5%) are unmarried. xvi

Homeless Individuals

The high prevalence of OUD among individuals experiencing homelessness has been well-documented, and the specific impact of the opioid crisis on this population is an issue of increased concern and focus in West Virginia. National data reveals that homeless adults are nine times more likely to die from an overdose than their counterparts who were stably housed.24 According to statewide data from homeless service providers (from the West Virginia Homelessness Management Information System), almost 12% of people experiencing homelessness in 2015 were classified as chronically homeless—those that require the most services. The percentage of veterans experiencing homelessness classified as chronically homeless was almost double that amount at 21%. In addition, 25% of veterans experiencing homelessness or classified as chronically homeless have SUD, serious mental illnesses or co-occurring mental and SUD. In 2015, West Virginia’s homeless providers served 450 families who experienced homelessness, with one or more family members that have serious mental illnesses or co-occurring mental and SUD, and 215 youth who experienced homelessness and had a serious emotional disturbance.

Disaster, Vulnerable Populations, and Behavioral Health

According to Doyle Rice in the June 27, 2016 edition of USA Today:
"Steep mountains, narrow valleys and a deadly train of storms came together in West Virginia to cause the horrendous flooding that killed 23 people last week, forced thousands to evacuate and destroyed or damaged thousands of homes and businesses. West Virginia got hit by a phenomenon meteorologists call 'training' because the thunderstorms line up over the same location like the cars of a freight train... The vicious line of storms dumped "one-in-1,000-year" amounts on the state last week."

In 2016 West Virginia Bureau for Behavioral Health and Health Facilities was funded more than $7.5M by FEMA for Disaster Case Management and Crisis Counseling Assistance and Training Programs. From all accounts, both from the Volunteer (VOAD) and grantee providers, the after-effects of this disaster will continue to lead to behavioral health needs on the part of flood survivors and their communities and require behavioral health response for at least five years after the 2016 flood, putting additional stress on an already stressed system of providers.

“A state of emergency was declared in 44 counties; of these, a federal disaster declaration was granted for 12 counties. Approximately 3,500 persons were temporarily displaced and were living with family, in group shelters, or in tents, during the cleanup and recovery phase.... Behavioral symptoms (such as anxiety, depressed mood, and problems sleeping) since the flood were increased in at least one member in 60.4% of households; 8.5% received help for behavioral health concerns, but 11.4% needed help and did not receive it. Eighty percent of households [reported that they] did not need behavioral health services. Fifteen percent of households increased use of tobacco products since the flood. Regarding individual mental health, 41.7% of individuals described 14 or more days out of the last 30 as not good, compared to 16.8% (BRFSS data) in 2012. Of households, 6.8% received care from mobile clinics and 4.0% received prescriptions from mobile pharmacies. The most frequent reason for difficulty accessing care was that the usual clinic was closed (78.5%). The most frequent reason for difficulty accessing prescription medications was that the usual pharmacy was closed (51.3%)."xvii

Workforce, the Economy, and Behavioral Health: WV and “Deaths of Despair”

As noted by the World Health Organization:

“It is well known that mental health problems are related to deprivation, poverty, inequality and other social and economic determinants of health. Economic crises are therefore times of high risk to the mental well-being of the population and of the people affected and their families. The economic crisis is expected to produce secondary mental health effects that may increase suicide and alcohol death rates."xviii

In 2017, the Brookings Institutexix received significant attention when they released research indicating that middle-aged whites in the U.S. with a high school diploma or less have
experienced increasing midlife mortality since the late 1990s. Due in large part to rises in the number of “deaths of despair”—death by drugs, alcohol and suicide—”…[t]his has the profoundly negative implication that policies, even ones that successfully improve earnings and jobs, or redistribute income, will take many years to reverse the mortality and morbidity increase, and that those in midlife now are likely to do much worse in old age than those currently older than 65. This research on “deaths of despair” has significant relevance to behavioral health in West Virginia.

From 1999 to 2010, West Virginia was one of 7 states with an increase of more than 10 percent in the death rates of people ages 25 to 44; between 2010 and 2015, West Virginia’s death rate for that age group increased more than 20 percent.

“A statistical analysis shows that the factors that play the most important role in explaining why West Virginia has a lower labor force participation rate than the U.S. average are that the state’s population is older, has completed less formal education and is in relatively poor health.”

West Virginia is the only state in the nation with a declining population; it is the state with the lowest workforce participation rate; it has the least proportion of college graduates; and it also has the lowest workforce participation rate for women. West Virginia has a low level of education; a high level of disability -- Of West Virginia’s civilian non-institutionalized population with some sort of disability, only 18.3 percent are employed. The breakdown of the labor force 20 to 64 years of age shows that 66.2 percent of males and 58.6 percent of females are employed. Long term unemployment is a concern for West Virginia’s workforce, including among young workers who might otherwise be at the beginning of long working lives. From 2014 to 2015, both the number of adults 20-24 and ages 25-44 who exhausted their unemployment benefits increased, from 97 to 227 for 19-24-year olds, 931 to 1,652 for 25-44 year olds. Unemployment among 16-19 as well as young adults 20-24 in West Virginia is also higher than that of the average population, with only an estimated 58.4 percent of 20-24-year olds employed of the 66.9 percent in the labor force, for a 12.6 percent unemployment rate of those participating in the workforce. The average labor force participation rate (LFPR) in West Virginia has historically been lower than the nation for several decades and has been declining since 2008, mirroring the national trend. While it is anticipated that the overall LFPR for the U.S. will decrease, it is likely that the West Virginia LFPR will experience a steeper decline due to the State’s relative age demographics.

Regionally, it is anticipated that significant population decreases will occur primarily in the south-west (Boone, Logan, McDowell, Mingo, Wayne, Wyoming), central West Virginia (Fayette, Clay, Roane, Ritchie), and the northern panhandle (Brooke, Hancock, Wetzel), while both the north-central region (Monongalia) and eastern panhandle (Berkeley, Hampshire,
Jefferson) are expected to experience substantial growth and therefore the greatest employment gains. xxii

Although there is demand for jobs in health care, many West Virginians may not have the education and skills to be eligible for these jobs. “Many outside of our state erroneously believe that most West Virginians are employed in the coal-mining industry, but coal mining and other extraction occupations make up only a small part of the entire labor force. The largest employment groups currently are Office & Administrative Support (111,051) and Healthcare Practitioners & Support (78,662). Current greatest demand in 2015, by job opening: 1. Registered Nurses (2,000+); 2. Customer Services Representatives (1,954), and 3. Licensed Practical and Licensed Vocational Nurses (1,871).

System Capacity – Need for Workforce Development and Initiatives

Workforce Development is a critical priority for the WV Bureau for Behavioral Health and Health Facilities. West Virginia has the second highest rate of serious mental illnesses in the country, yet 49 of the state’s 55 counties have federally-established Mental Health Professional Shortage Area designations. The discussion of workforce has been a priority at all levels. The Governor’s Advisory Council on Substance Abuse recognized the need to elevate the issue and formed a Workforce Committee, which has been chaired by the Executive Director of Workforce WV, the state’s workforce development government agency. The “West Virginia Substance Use Disorder Workforce Inventory and Analysis Report, 2016” (forthcoming) was requested by the GACSA’s Workforce Committee and is in-depth and heavily researched. Details include West Virginia specifics on what other states have called “the gray tsunami”: an aging workforce close to retirement currently working for low pay in a field that needs to grow significantly to meet expanding, urgent needs.

The current core SUD field: Estimates from the forthcoming report put the total number of licensed psychiatrists, mental health nurses, psychologists, professional counselors, social workers, certified addictions professionals at 6,460 for all of WV. An estimated 2,068 of these are estimated to compose the behavioral health workforce, which may not be an unduplicated number of professionals, since many in the field may hold multiple licenses. Professionals with a SUD specialty or likely to provide treatment services to persons with SUD are estimated at 1,191 FTE professional positions, but it has not been possible to estimate the extent to which these professionals are currently providing SUD-related treatment or support; many of the professionals making up this workforce likely spend some significant portion of their available time addressing other types of behavioral health issues. The initial report focuses on the SUD workforce but also has significant implications for the broader behavioral health workforce. Additional follow-up to the report is in the planning stages for implementation after the report’s release.
BBHHF state workforce faces similar conditions of increased demands and shortages. In 2016-17, West Virginia BBHHF’s Strategic Plan included a high priority for systems integration to be achieved via a strategy of discretionary federal grant awards and public/private partnerships. While this strategy was successful, and successful discretionary federal grant awards increased, the capacity of state staff to manage this increased level of grant writing, administration, implementation, and reporting activity was severely tested, when added to current grant activity managing $93M of sub-grantee grants. In addition, as of June 2017, the BBHHF’s Central Office vacancy rate was 43%.

For the state-owned behavioral health facilities, temporary contract staff and overtime are currently being used to meet the needs of individuals served within residential behavioral health facilities, especially given the shortage of LPNs and other nursing staff in these facilities.

The WV BBHHF has focused on several key initiatives and we are planning to build on the momentum built from these initiatives to address the topic of workforce development and system capacity in the future.

In addition to the research on WV’s SUD workforce, WV BBHHF, as WV’s SSA, was 1 of 4 states in the US to receive SAMHSA (the Substance Abuse and Mental Health Services Administration) and NAADAC (The [national] Association of Addiction Professionals) support to host a 2017 behavioral health workforce forum. The goal of the forum was to reach out to college/university students to build awareness and provide education about the benefits and opportunities available in the substance use and mental health disorder professions, with the goal of increasing the number of college and university students who choose to join the behavioral health field. The forum featured speakers who have been successful in their education and advancement in the workforce, and it offered both student and employer perspectives. The WV forum was held at Marshall University in April 2017 and simultaneously live-streamed for groups of college, community college, and even high school students around the state to watch at satellite locations, as well as made available for even more students to watch at a later date. Exhibitors included local behavioral health providers, both at the host site at Marshall and at the satellite sites. (The program starts ~ 30 minutes in on the recording: https://livestream.com/marshallu/events/7269848/videos/154912895 https://www.naadac.org/west-virginia-workforce-forum ).

The WV Behavioral Health Workforce Forum was planned by a committee that will next meet in August 2017 to plan follow up on the work and ideas generated through the forum and its planning. Members of the planning committee included representatives from the WV Behavioral Health Providers Association, the WV Association of Addiction Professionals, the WV Certification Board for Addiction and Prevention Professionals, the WV Higher Education Policy Commission, the Deputy Commissioner of the WV BBHHF, the President of NAADAC, Marshall University, West Virginia University, the WV Perinatal Partnership, and providers.
In addition, over the past several years the WV Bureau for Behavioral Health & Health Facilities has supported a range of training and professional development initiatives as diverse as peer training, the Integrated Behavioral Health Conference, Addictions 101 training for supervisor and front-line state services and protective services workers, and the annual Appalachian Addiction & Prescription Drug Abuse Conference (a collaboration between the WV Medical Professionals Health Program, WV State Medical Association, the WV Osteopathic Medical Association, the WV Society of Addiction Medicine, and the WV Department of Health and Human Resources). BBHHF continues to work within state government to support the evolution of current behavioral health professionals and billing for services, for example, on WV’s Medicaid Section 1115 Waiver. BBHHF plans to continue to support the evolution of behavioral health workforce development initiatives in the future.

**Public Comment on the State Plan**

**Preparing for Public Comment on the State Plan:** West Virginia BBHHF staff is building on its history of engaging multiple regional and statewide intermediary organizations in addition to its critical partnership with the West Virginia Behavioral Health Planning Council by attending meetings and phone calls to gain feedback throughout the year. WV BBHHF staff focus on the WVBPHC includes meeting attendance, regular phone and email contact, and semi-regular participation as requested in the WVHPC’s own Strategic Planning Technical Assistance in 2017, in order that WV BBHHF receive ongoing feedback about potential focus areas for the Block Grant. Next, during the Block Grant drafting process, the WV BBHHF disseminated a survey via email to its list serv of 1,495 subscribers (with a special email sent to WVBHPC members) to inform the BBHHF’s Strategic Plan process. BBHHF received 61 responses from stakeholders that BBHHF used to shape its initial Block Grant draft.

**Public Comment:** West Virginia’s Substance Abuse/Mental Health Block Grant was made available on its website, [http://www.dhhr.wv.gov/BHHF/Pages/default.aspx](http://www.dhhr.wv.gov/BHHF/Pages/default.aspx) at the beginning of August 2017. An email blast to WV BBHHF list serv subscribers gave notice of the availability of the draft on the website. Access to the portal and comments via the website/portal are available.

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2. 2016 US Census Bureau estimates released in May 2016 show that Charleston’s population has dropped to under 50,000. Estimates showed Huntington population stands at 48,638 as West Virginia’s second largest city. Parkersburg, the third largest, had 30,991. Morgantown came in fourth with 30,708. [http://wvmetronews.com/2016/05/19/charleston-population-drops-below-50000-mayor-says-numbers-are-not-official/](http://wvmetronews.com/2016/05/19/charleston-population-drops-below-50000-mayor-says-numbers-are-not-official/)
3. [https://racematterswv.net/reports-and-data/](https://racematterswv.net/reports-and-data/)
4. [http://lgbtq.wvu.edu/about-us](http://lgbtq.wvu.edu/about-us)
5. WV Health Statistics Center.

West Virginia Substance Use Disorder Workforce Inventory and Analysis, 2016, prepared by Steve Heasley and Alyse Schrecongost (forthcoming).


Orsini, M., Haas, S. M., & Spence, D. (2015). Predicting Recidivism of Offenders Released from the West Virginia Division of Corrections: Validation of the Level of Service/Case Management Inventory. Charleston, WV: Criminal Justice Statistical Analysis Center, Division of Justice and Community Services, Department of Military Affairs and Public Safety.


WEST VIRGINIA’S AGING POPULATION, 1950 TO 2013


Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance – United States, 2015

“West Virginia Adverse Childhood Experiences (ACEs),”

“Response and Recovery Needs of Communities Affected by Flooding – West Virginia, August 2016.” Centers for Disease Control and Prevention, National Center for Environmental Health, Division of Environmental Hazards and Health Effects Health Studies Branch January 2017.”

“Impact of Economic Health Crises on Mental Health,” World Health Organization, Regional Office for Europe.
http://www.euro.who.int/__data/assets/pdf_file/0008/134999/e94837.pdf


WV Center on Budget and Policy, http://www.wvpolicy.org/state-of-working-west-virginia

Workforce WV United State Plan Summary, WV Rehabilitation Services.
Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA’s ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA’s NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA’s success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA’s centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA’s state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities’ movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:
Quality and Data Collection Readiness

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

The BBHHF data reporting system collects client data containing demographic data, services provided, and information for federal and state reporting, such as Treatment Episode Data Set (TEDS), Block Grant Reports and URS tables. These reports, both duplicated and non-duplicated counts of persons in a variety of demographic groups, such as age, gender, race, disability group (MH, SA, IDD), employment status, housing status, funding (Medicare, Medicaid, or private pay), service locations (i.e., in-state psychiatric hospitals, community setting, group homes), legal and drug involvement. These data are also used to report back to providers the number of records sent each day, the number of persons served this year, and quality issues, such as missing or unexpected changes in data (date of birth). Logic validations are also used (i.e. Age<14 and divorced, married, widowed).

The BBHHF data and collection reporting system collects data relating to both substance abuse and mental health services clients. This data is collected for the 13 regional Comprehensive Behavioral Centers which serve more than 23,000 unique patients each year. The BBHHF does not collect data on the non-comprehensive clinics. The BBHHF does not currently collect data on the non-comprehensive clinics through a portal or other data system format – BBHHF currently receives sub-grantee reporting via spreadsheets emailed to BBHHF’s Central Office. The BBHHF is currently able to collect and report on measures at the individual client level, for the 13 Comprehensive Clinics served by the state. The BBHHF data reporting system collects client data containing demographic data, direct services provided, and information for federal and state reporting, such as Treatment Episode Data Set (TEDS), Block Grant Reports and URS tables. To be able to report on all clients, including those not served by the 13 Comprehensive Clinics, the BBHHF would need to incorporate a data collection system that includes data for support services and non-comprehensive providers. West Virginia DHHR/BHHF is currently considering two possible approaches to collection and reporting of ALL grantees/providers. These two approaches are described below. However, a time for delivery of either model has not yet been determined.

a. Internal development of a client level data collection model for ALL state providers. This approach would provide for data collection and reporting of all client level data but would be external to the State’s current fee-for-service model. Providers would be provided with a client-server application to submit client level data, demographics, and service data.

b. Expansion of the State’s existing Utilization Management contract expanding data collection to include non-comprehensive providers and support services following a model similar to that used for the comprehensive providers. This approach is an optional part of a developing Request For Proposal (RFP) currently underway.
Substance Abuse Prevention

The BBHHF Data and Technology Team have developed a Primary Prevention data base to collect Substance Abuse Primary Prevention data from the State’s six Regional Prevention Grantees. Currently, BBHHF contracts with First Choice Health Systems to collect and report data from the Partnerships for Success (PFS) grant. Both data reporting systems collects demographic data, services provided and information for federal and state reporting, such as Program Evaluation for Prevention (PEP-C) or other block grant reports.

These systems report both duplicated and non-duplicated counts of persons in a variety of demographic groups, such as age, gender, race and ethnicity.

These data are used also used to report back to providers the age, gender, race, ethnicity and type of service provided based on the Institute of Medicines categories and utilization of the Center for Substance Abuse’s six primary prevention strategies.

The BBHHF Data and Technology Team have procured a vendor, and are in the process of designing a new web portal and database to collect SAPT data. The new design will be segmented into the six key strategy types that include Community Based Process, Capacity Building, Education, Environmental Strategies, Information Dissemination, and Problem ID and Referral. In addition, we will also have a separate area to track information and reporting for SYNAR.

The new reporting system will allow the users to enter required data more accurately with key reporting features and more in depth reporting. It will have the capability to report demographic data, services provided, and information for state and federal reporting. Additional features are anticipated to be included in the new system that will allow program staff to better understand implementation strategies and for the development and implementation of programs across the state.
# Planning Tables

## Table 1 Priority Areas and Annual Performance Indicators

<table>
<thead>
<tr>
<th>Priority #</th>
<th></th>
<th>Priority Area:</th>
<th>Prevention of Substance Abuse and Promotion of Good Mental Health</th>
<th>Priority Type:</th>
<th>SAP, MHS</th>
<th>Population(s):</th>
<th>SMI, SED, PWWDC, PP, ESMI, PWID</th>
</tr>
</thead>
</table>

**Goal of the priority area:**

Promote emotional health and wellness and prevent or delay the onset of complications from substance abuse and mental illness. Integrate Suicide Prevention Initiatives into existing prevention efforts.

**Objective:**

- **Objective 1:** Support a range of evidence-based prevention and promotion practices.
- **Objective 2:** Support evidence-based programs, practices, and strategies that target a wide variety of audiences and populations.
- **Objective 3:** Strengthen partnerships across SAP and MI efforts to facilitate integration of substance abuse prevention and behavioral health promotion.

**Strategies to attain the objective:**

<table>
<thead>
<tr>
<th>Priority #</th>
<th></th>
<th>Priority Area:</th>
<th>Systems Integration</th>
<th>Priority Type:</th>
<th>SAT, MHS</th>
<th>Population(s):</th>
<th>SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB</th>
</tr>
</thead>
</table>

**Goal of the priority area:**

Goal 1: Support coordinated care and services across systems

Goal 2: Improve the physical health outcomes of individuals with SUD and/or substance use and co-occurring or co-existing disorders.

**Objective:**

- **Goal 1:**
  - Objective 1: Remove financial barriers and incentivize effective care coordination and integrated service delivery for all populations.
  - Objective 2: Maintain a 24/7 behavioral health help line to provide education, crisis supports, peer warm lines, facilitated referrals, and follow up.
  - Objective 3: Cross-train staff about addictions, mental illness and developmental disabilities.
  - Objective 4: Develop a cross-system plan to identify and improve outcomes for individuals with co-existing mental health and developmental disabilities who do not meet Medicaid (IDD Waiver) eligibility, who are at risk for hospitalization, homelessness or incarceration.
  - Objective 5: Support person- and family-centered care, support, and opportunities for input and planning.

- **Goal 2:**
  - Objective 1: Require all behavioral health providers to screen for infectious health diseases upon intake, with particular attention given to IV drug users.
  - Objective 2: Partner with the WVDHHR Bureau for Public Health to expand harm reduction programs.
  - Objective 3: Promote integration of behavioral health and health programs among primary care programs, including obstetrics, and behavioral health planning.
### Strategies to attain the objective:

**Priority #:** 3  
**Priority Area:** Access to community-based, recovery oriented systems of care  
**Priority Type:** SAT, MHS  
**Population(s):** SMI, SED, PWDC, PP, ESMI, PWID  

**Goal of the priority area:**
- Goal 1: Increase access to crisis services and treatment services to reduce unnecessary use of hospitalization and residential facilities  
- Goal 2: Increase access to recovery support services  
- Goal 3: Implement a behavioral health network for youth and young adults  
- Goal 4: Increase use of innovative telehealth practices

**Objective:**

- **Goal 1:**  
  - Objective 1: Promote development of crisis response services statewide for youth and adults with SED, CMI  
  - Objective 2: Increase evidence-based programming in community-based services, including supportive housing.  
  - Objective 3: Increase access to Medication-Assisted Treatment.  
  - Objective 4: Continue best practices in process improvement for diversion and discharge from institutional placement.

- **Goal 2:**  
  - Objective 1: Develop Peer-Operated Recovery Residences in all catchment areas of the state.  
  - Objective 2: Expand recovery-oriented supported housing services.  
  - Objective 3: Develop and deliver training to Certified Recovery Coaches and trained peers in specialty areas (e.g., Medication Assisted Treatment, Pregnant & Postpartum Women, Offenders Re-Entering the Community, Emergency Department/Emergency Response System).

- **Goal 3:**  
  - Objective 1: Expand ESMI services beyond initial pilot location.  
  - Objective 2: Implement regional youth service networks to plan and implement evidence-based practices to meet the needs of youth with SED and SUD and their families.  
  - Objective 3: Expand WV’s youth-led statewide Recovery Leadership Team to incorporate youth and families from the mental health perspective.

- **Goal 4:**  
  - Objective 1: Partner with universities and community providers to increase use of telemedicine, particularly for screening and treatment services for youth, pregnant/postpartum women, offenders re-entering the community, and individuals with transportation barriers.  
  - Objective 2: Use social media to communicate/educate/increase social engagement.  
  - Objective 3: Promote use of electronic health records and software that can be used across systems/organizations to improve access to care.

### Strategies to attain the objective:

**Priority #:** 4  
**Priority Area:** Quality of Behavioral Health Services
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goals of the priority area:
- Goal 1: Implement evidence-based clinical practices for priority populations.
- Goal 2: Expand trauma-informed practices throughout WV systems of care.

Objectives:

Goal 1:
- Objective 1: Promote national Centers of Excellence for information and technical assistance.
  (examples: ATTC Center of Excellence for Behavioral Health for PPW: Illinois Center of Excellence for Behavioral Health and Justice)
- Objective 2: Plan and implement regional centers in WV to foster clinical supervision and peer support to promote awareness of and fidelity to clinical evidence-based practices.
- Objective 3: Develop a WV-based Center of Excellence in Behavioral Health Clinical Practice and Workforce.

Goal 2:
- Objective 1: Partner with WV ACES Coalition to promote trauma-informed practices across systems that also serve individuals with behavioral health needs, e.g., judicial system, corrections, education, health.
- Objective 2: Develop statewide plan in coordination with federal technical assistance and guidance to align multiple existing initiatives and levels of readiness to implement trauma-informed care in the behavioral health system.
- Objective 3: Provide intentional technical assistance to providers as recommended by the readiness assessment.

Strategies to attain the objective:

Priority #: 5
Priority Area: Identify and respond to emerging behavioral health issues.
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWWDC, PP, ESMI, PWID

Goals of the priority area:

Objective:
- Objective 1: Improve response time to emerging trends and timely data sharing.

Strategies to attain the objective:

Objective 1:
1. Coordinate efforts with WV State Epidemiological Work Group, Governor’s Advisory Council on Substance Use Disorders, WV Behavioral Health Call Line, the Prevention Lead Organizations, the WV Office of Drug Control Policy, and community partners to determine new trends of substance use prevalence, method of use and resource availability, and outcomes.
2. Capture data at the State and County levels at a minimum and the zip code level if available.
3. Produce and disseminate current and relevant data and resources while still insuring that proper vetting occurs.

Footnotes:
## Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017   Planning Period End Date: 6/30/2019

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
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<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$12,624,900</td>
<td>$0</td>
<td>$18,926,846</td>
<td>$20,650,824</td>
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<td>$0</td>
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<tr>
<td>a. Pregnant Women and Women with Dependent Children**</td>
<td>$1,850,000</td>
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<td>$0</td>
<td>$7,675,782</td>
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<tr>
<td>b. All Other</td>
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<td>$0</td>
<td>$18,926,846</td>
<td>$12,975,042</td>
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<tr>
<td>2. Primary Prevention</td>
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<td>$0</td>
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<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$3,366,640</td>
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<td>b. Mental Health Primary</td>
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<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)</td>
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<td>4. Tuberculosis Services</td>
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<tr>
<td>5. Early Intervention Services for HIV</td>
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<td>6. State Hospital</td>
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<td></td>
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<td>7. Other 24 Hour Care</td>
<td></td>
<td></td>
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<td>8. Ambulatory/Community Non-24 Hour Care</td>
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<td>9. Administration (Excluding Program and Provider Level)</td>
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<td>$116,580</td>
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<td>10. SubTotal (1,2,3,4,9)</td>
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<td>11. SubTotal (5,6,7,8)</td>
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<tr>
<td>12. Total</td>
<td>$16,833,200</td>
<td>$0</td>
<td>$0</td>
<td>$18,926,846</td>
<td>$21,681,870</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* Prevention other than primary prevention
** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.
Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017   Planning Period End Date: 6/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$320,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary*</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$320,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**</td>
<td>$441,106</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td>$3,749,399</td>
<td>$40,099,798</td>
<td>$4,907,472</td>
<td>$126,268,122</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$220,553</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. SubTotal (1,2,3,4,9)</td>
<td>$0</td>
<td>$220,553</td>
<td>$0</td>
<td>$320,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>11. SubTotal (5,6,7,8)</td>
<td>$0</td>
<td>$4,190,505</td>
<td>$40,099,798</td>
<td>$4,907,472</td>
<td>$126,268,122</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>12. Total</td>
<td>$0</td>
<td>$4,411,058</td>
<td>$40,099,798</td>
<td>$4,907,472</td>
<td>$126,588,122</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside
## Planning Tables

### Table 3 SABG Persons in need/receipt of SUD treatment

<table>
<thead>
<tr>
<th></th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Women</td>
<td>165</td>
<td>32</td>
</tr>
<tr>
<td>Women with Dependent Children</td>
<td>5529</td>
<td>1254</td>
</tr>
<tr>
<td>Individuals with a co-occurring M/SUD</td>
<td>8971</td>
<td>2060</td>
</tr>
<tr>
<td>Persons who inject drugs</td>
<td>3243</td>
<td>902</td>
</tr>
<tr>
<td>Persons experiencing homelessness</td>
<td>829</td>
<td>220</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>165</td>
<td>32</td>
</tr>
<tr>
<td>Women with Dependent Children</td>
<td>5529</td>
<td>1254</td>
</tr>
<tr>
<td>Individuals with a co-occurring M/SUD</td>
<td>8971</td>
<td>2060</td>
</tr>
<tr>
<td>Persons who inject drugs</td>
<td>3243</td>
<td>902</td>
</tr>
<tr>
<td>Persons experiencing homelessness</td>
<td>829</td>
<td>220</td>
</tr>
</tbody>
</table>

Please provide an explanation for any data cells for which the stats does not have a data source.

**Footnotes:**

Printed: 8/3/2017 10:26 AM - West Virginia - OMB No. 0930-0168  Approved: 06/12/2015  Expires: 09/30/2020
The "Aggregate Number Estimated In Need" was calculated using the median value of the previous 60 months based on the report date (top right) of data.

The "Aggregate Number in Treatment" is a count of person who received SUD services within the last 90 days.
**Table 4 SABG Planned Expenditures**

Planning Period Start Date: 10/1/2017  Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2018 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td>$6,312,450</td>
</tr>
<tr>
<td>2. Primary Substance Abuse Prevention</td>
<td>$1,683,320</td>
</tr>
<tr>
<td>3. Early Intervention Services for HIV *</td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$420,830</td>
</tr>
<tr>
<td><strong>6. Total</strong></td>
<td><strong>$8,416,600</strong></td>
</tr>
</tbody>
</table>

* For the purpose of determining the states and jurisdictions that are considered “designated states” as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to
do so.

Footnotes:
# Planning Tables

**Table 5a SABG Primary Prevention Planned Expenditures**

Planning Period Start Date: 10/1/2017  Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>FY 2018</th>
<th>SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information Dissemination</strong></td>
<td>Universal</td>
<td></td>
<td>$129,032</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$129,032</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>Universal</td>
<td></td>
<td>$264,598</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$264,598</td>
</tr>
<tr>
<td><strong>Alternatives</strong></td>
<td>Universal</td>
<td></td>
<td>$52,266</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$52,266</td>
</tr>
<tr>
<td><strong>Problem Identification and Referral</strong></td>
<td>Universal</td>
<td></td>
<td>$19,600</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$19,600</td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td>Selective</td>
<td>Indicated</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Community-Based Process</td>
<td>$788,894</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td>$378,930</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 1926 Tobacco</td>
<td>$50,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Total Prevention Expenditures</th>
<th>$1,683,320</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total SABG Award*</td>
<td>$8,416,600</td>
</tr>
<tr>
<td></td>
<td>Planned Primary Prevention Percentage</td>
<td>20.00 %</td>
</tr>
</tbody>
</table>

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures
## Planning Tables

### Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017  Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2018 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$1,683,320</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td></td>
</tr>
<tr>
<td>Selective</td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$1,683,320</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong></td>
<td><strong>$8,416,600</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>20.00 %</strong></td>
</tr>
</tbody>
</table>

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

**Footnotes:**
## Planning Tables

### Table 5c SABG Planned Primary Prevention Targeted Priorities

<table>
<thead>
<tr>
<th>Targeted Substances</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>b</td>
</tr>
<tr>
<td>Tobacco</td>
<td>b</td>
</tr>
<tr>
<td>Marijuana</td>
<td>b</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>b</td>
</tr>
<tr>
<td>Cocaine</td>
<td>e</td>
</tr>
<tr>
<td>Heroin</td>
<td>e</td>
</tr>
<tr>
<td>Inhalants</td>
<td>e</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>b</td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
<td>e</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
<td>b</td>
</tr>
<tr>
<td>Military Families</td>
<td>b</td>
</tr>
<tr>
<td>LGBT</td>
<td>b</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>e</td>
</tr>
<tr>
<td>African American</td>
<td>e</td>
</tr>
<tr>
<td>Hispanic</td>
<td>e</td>
</tr>
<tr>
<td>Homeless</td>
<td>b</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
<td>e</td>
</tr>
<tr>
<td>Asian</td>
<td>e</td>
</tr>
<tr>
<td>Rural</td>
<td>b</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
<td>e</td>
</tr>
</tbody>
</table>
## Planning Tables

### Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

**Planning Period Start Date:** 10/1/2017  
**Planning Period End Date:** 9/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. MHBG</th>
<th>B. SABG Treatment</th>
<th>C. SABG Prevention</th>
<th>D. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
<td>$47,569</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$47,569</strong></td>
<td><strong>$0</strong></td>
<td><strong>$0</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

**Footnotes:**
Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question
1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "health system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.27

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.30

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.31 SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.32 The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care. Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently and collaborate with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who...
Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers. SAMHSA recognizes that certain jurisdictions receiving block grant funds should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states’ Medicaid authority in ensuring parity within Medicaid programs.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states’ Medicaid authority in ensuring parity within Medicaid programs.


29 http://www.samhsa.gov/health-disparities/strategic-initiatives


Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorder settings.

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

In July 2015, West Virginia integrated behavioral health services into Medicaid managed care. Since the MCOs are responsible for managing the physical and behavioral health services provided to the vast majority of enrollees, they have been able to integrate mental health and SUD treatment services with physical health treatment services. This integration has also moved West Virginia toward value-based purchasing for both physical and behavioral health services. West Virginia Bureau for Medical Services is exploring mandating providers to share patient information with other providers treating the individual, in accordance with all HIPAA-related federal rules and regulations.

School-Based Health Centers (SBHCs) are health clinic sites sponsored and managed by Community Health Centers. A range of services are offered to children, adolescents and the school community. SBHCs are housed within a school site. The SBHC provides preventive and immediate care, behavioral health services, health education, and sometimes dental care. Most SBHC services are provided during the school day. Referrals to other health care providers are available as needed. There are now 143 school-based health centers in West Virginia. Expanded School Mental Health (ESMH) refers to programs that build upon the core services typically provided by schools. It is a three-tiered framework that includes the full continuum of behavioral health services.
According to the SAMHSA-HRSA Center for Integrated Health Solutions, “SAMHSA awarded 100 community behavioral health organizations more than $262 million collectively in Primary and Behavioral Health Care Integration. The PBHCI Grant program is part of an effort by Congress and the Health and Human Services Administration to help prevent and reduce chronic disease and promote wellness by treating behavioral health needs on equal footing with other health conditions. CIHS provides a robust array of training and technical assistance to PBHCI grantees who are leading the national charge of integrating primary care and behavioral health services.” In West Virginia, behavioral health integration grants have been awarded thus far to four FQHCs in 2014, twenty-six FQHCs in 2015, along with five expanded SUD service grants to FQHCs in 2016.

The WVU School of Social Work has been awarded over $1 million in federal grants to develop and implement the Integrated Mental and Behavioral Health Training Program (IMBTP), a program that trains masters-level social work (MSW) students to practice in integrated behavioral health settings, and to become leaders in integrated models of rural service delivery. The two grants, funded by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA), are part of a national effort to increase the number of practitioners prepared to work in integrated behavioral health and primary care. The School of Social Work has recently submitted another proposal to HRSA to expand and extend the program for another four years.

The IMBTP emphasizes prevention and clinical intervention with those at risk for (or who have already developed) behavioral health disorders, with particular focus on integration with primary care and family involvement in prevention and treatment. Essential components of the training program include: 1) specialized field placements in behavioral health settings with an emphasis on integrated behavioral health and primary care; 2) completion of the new WVU Graduate Certificate in Integrated Mental & Behavioral Health; 3) specialized training workshops for MSW trainees and field instructors; and 4) mentorship, professional networking, leadership development, & employment placement support.

Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The Bureau for Behavioral Health & Health Facilities is designated as both the State Mental Health Authority and the Single State Agency for SUDs and as such has developed integrated plans for both disability groups, including but not limited to this application for block grant funding. While the joint Block grant application is still relatively new, though, BBHHF has been implementing mental health and SUD integration strategies for a number of years, including but not limited to State and Medicaid funding of mental health and SUD providers, sponsorship of co-occurring training at both stand alone events and the Integrated Behavioral Health Conference, and assistance with the evolution of the state planning council from the Mental Health Behavioral Health Planning Council to the Behavioral Health Planning Council.

As noted elsewhere, the behavioral health system in West Virginia is structured into thirteen regional Comprehensive Behavioral Health Center (CBHC) regions that cover the state and provide publicly funded services to adults and children and youth with serious mental illness and SEDs, SUDs, IDD and co-occurring disorders. As a result, while each of these CBHCs employs specialized staff to deliver different kinds of treatment services, the CBHCs are generally able to provide services to people with single or multiple behavioral health issues.

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Finally, WVU also offers a Graduate Certificate in Integrated Mental and Behavioral Health. The goal of the program is to train students to become effective mental and behavioral health care providers. To be admitted to the Certificate program, applicants must demonstrate graduate student status at West Virginia University (either degree or non-degree) and be in good standing. The capstone course requires students to complete an individualized project that applies content learned in the certificate program to their target population of focus. In order to complete this capstone course, students must have access to field placement, clinical practicum, internship, or employment setting in which they have the ability for “hands-on” practice with the target population. The Graduate Certificate in Integrated Mental and Behavioral Health consists of 15 credit hours.
3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?
   [ ] Yes [ ] No

and Medicaid?
   [ ] Yes [ ] No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

The Rates & Forms Commission within the Offices of the Insurance Commissioner (OIC) reviews plans when they are filed and verifies that MH/SUD services are provided. The plans are certified and become QHPs if they meet all of OIC's requirements. The plans must re-certify annually and again it is verified that MH/SUD services are provided. At any time, if there is a complaint regarding coverage, the OIC investigates and plans risk losing their certification if MH/SUD services are not provided as detailed in their submitted plan. Plans are not monitored within the year unless there is a complaint.

According to the West Virginia Offices of the Insurance Commissioner, “West Virginia Code Section 33- 25A-12 states that HMO’s must maintain a grievance procedure by which enrollees (or their authorized representatives) may report grievances with respect to any provisions of the HMOs’ health maintenance contracts. West Virginia Code Section 33-25A-12(4) further states that each HMO must submit to the Commissioner an annual report in a form prescribed by the Commissioner which describes its grievance procedure and contains a compilation and analysis of the grievances filed, their disposition, and their underlying causes. A description of the HMO’s grievance procedure must be attached to the Annual Grievance Report form. The form for this report is Attachment A to this Informational Letter. Each HMO must complete this form to account for all matters handled through its expedited and formal grievance procedures, and attach additional information and/or explanations on a separate sheet of paper. The report must cover all enrollees of the HMO, including PEIA and Medicaid enrollees. However, the report is not required to cover Medicare and Administrative Services Only (“ASO”) enrollees. The completed report and a description of the grievance procedure are due on or before March 1st following the end of the calendar year covered by the report. An HMO will be required to submit a corrective action plan if it receives ten (10) or more confirmed complaints regarding any of the above listed categories within a reporting period. Written plans of action will be submitted for semiannual calendar year periods (e.g., January-June, July-December).”

In addition, according to the West Virginia Offices of the Insurance Commissioner, the Office of Consumer Advocacy “protects consumer’s insurance interests by investigating alleged violation of state consumer protection laws, taking appropriate legal action to stop unfair or deceptive practices in the marketplace and promoting consumer education and awareness. The Office works to ensure that consumers are provided with insurance services meeting acceptable standards of quality, equity, and dependability at fair rates by enforcing insurance laws and providing consumer protection awareness. Any suspected violation of West Virginia laws or regulations is forwarded to the Insurance Commissioner for enforcement.

All HMO’s have a grievance procedure to provide adequate and reasonable procedures for the resolution of grievances initiated by enrollees. Grievances are not considered formal until a written grievance is executed and must be filed within one (1) year from the date of occurrence. If a subscriber is not happy with the outcome of the appeal through the HMO, they may then appeal to the Offices of the Insurance Commissioner (If he or she is an HMO subscriber through a state agency, such as PEIA or Medicaid, he or she must appeal to that agency, before appealing to the Offices of the Insurance Commissioner). A formal complaint can be filed with the West Virginia’s Offices of the Insurance Commissioner’s Consumer Service Division. If a solution can not be reached the Consumer Advocate may provide legal representation on behalf of the consumer at administrative hearings arising from the consumer complaints.

According to the West Virginia's Offices of the Insurance Commissioner's 2016 Annual Report, the Office of Consumer Advocacy assisted consumers with complaints during 2015, which yielded financial awards totaling $1,435,718.96 . . . [In addition] The Consumer Service Division assists . . . insurance consumers with questions and complaints. The division received a total of 2,139 written complaints from insurance consumers in 2015. Over the course of the year, the Division responded to an average of 93 consumer inquiries per day."

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? [ ] Yes [ ] No

6. Do the behavioral health providers screen and refer for:

   a) Prevention and wellness education [ ] Yes [ ] No

   b) Health risks such as
     i) heart disease [ ] Yes [ ] No
     ii) hypertension [ ] Yes [ ] No
     viii) high cholesterol [ ] Yes [ ] No
     ix) diabetes [ ] Yes [ ] No

   c) Recovery supports [ ] Yes [ ] No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based
   [ ] Yes [ ] No
contractual relationships that advance coordination of care?

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

The West Virginia Offices of the Insurance Commissioner (OIC) requires plans to complete and submit a report whenever they apply to use “cost containment measures”, which allow plans to limit inpatient and outpatient behavioral health services if their costs increase by 2% due to covering behavioral health services (for small employer fully-insured plans it is 2% in “anticipated costs”; for large employer fully-insured plans it is “actual costs”).

W. Va. Code §33-2-9 requires the Insurance Commissioner to “thoroughly examine the financial conditions, and business affairs” of all insurers licensed to transact business in the State of West Virginia every five years. The Insurance Commissioner may accept company examinations from other states provided that the state conducting the examination is accredited by the National Association of Insurance Commissioners (NAIC). The code section further grants the Insurance Commissioner the authority to examine other entities which transact the business of insurance: these entities include but are not limited to agencies, third party administrators, and insurance adjusting firms; examination of these types of entitles are conducted solely at the Commissioner’s discretion. Examinations may be conducted on-site or through analysis of data which the company submits to the regulator. These examinations ensure that insurers are complying with all applicable laws and rules relating to rates, forms, agent appointments and other agent issues, claims handling, policy cancellations and non-renewals, discrimination, and many others. Depending upon the findings and recommendations of the examination, the Insurance Commissioner may order the company to take corrective action, make restitution to consumers, or assess a fine or other sanctions.

During the year 2010, Five Hundred Fifty Thousand, Three Hundred Eleven Dollars and Fifty Cents ($550,311.50) in penalties were assessed as a result of a disciplinary actions taken against insurers for violation of among other things, §33-12C-7, Surplus lines tax; §33-16-3a, Required policy provisions - Mental health; §33-44-1, et seq., in addition, One Hundred Fifteen Thousand Three Hundred Five Dollars and Seventy Nine Cents ($115,305.79) in restitution was received by insureds as a result of disciplinary actions taken against insurers for violation of, among other things, W. Va. Code §33-16-3a, Required policy provisions - Mental health. These actions were the result of market conduct examinations and collaborative market conduct actions with other states.

A June 2011 market conduct examination of The Health Plan of the Upper Ohio Valley Inc., conducted by the West Virginia Offices of the Insurance Commissioner, found two issues of potential non-compliance with state-parity provisions. It found that the company had not complied with the mental health parity regulation issued by OIC that requires plans to receive approval before they implement cost containment procedures. It also found that the company needed revise its “forms, policies, and procedures” to ensure that enrollees receive coverage for substance use disorders, anorexia, and bulimia, as required by state law. The company agreed to comply with these recommendations.

Furthermore, oversight of parity is incredibly complex and falls to both federal and state agencies. In light of this, a January 2016 U.S. Department of Labor report given by Secretary Thomas E. Perez to Congress, Improving Health Coverage For Mental Health And Substance Use Disorder Patients, page 5, notes that “MHPAEA is subject to joint interpretive jurisdiction by the Departments of Labor, Health and Human Services, and the Treasury, Regulatory and subregulatory guidance is developed jointly by the Departments to ensure consistency. The Department of Labor enforces ERISA with respect to approximately 2.3 million private-sector, employment-based group health plans. The Department of Labor is precluded by law from enforcing the Health Insurance Portability and Accountability Act (HIPAA) and related Acts, such as MHPAEA against a health insurance issuer. With respect to plan fiduciaries, the Department has the authority to file law suits for fiduciary violations and to directly impose fines with respect to plan administrators. The Department of Health and Human Services (HHS) administers the PHS Act and has direct enforcement jurisdiction with respect to nonfederal governmental plans. In addition, under PHS Act 272313, if a State notifies HHS that it does not have statutory authority to enforce or that it is not otherwise enforcing one or more provisions in Part A of Title XXVII of the PHS Act, or if HHS determines that the State is not substantially enforcing the requirements, HHS enforces them on group and individual market issuers and has the authority to impose a civil monetary penalty on issuers that fail to comply with the relevant sections of the PHS Act in that State. Under the Internal Revenue Code, the Treasury has authority over group health plans (including church plans) and their sponsors, and IRS enforces the requirements of HIPAA and related Acts, such as MHPAEA, through the imposition of an excise tax. Participants and beneficiaries may also bring private action against a plan under section 502 of ERISA.”

The DOL Report, pg. 17, goes on to note that:

“Approximately 171 MHPAEA violations have been cited since October 2010. The Employee Benefits Security Administration (EBSA) has encountered violations related to dollar limits, higher copays, quantitative treatment limitations and NQTLs, with the latter comprising the majority of the violations that EBSA has cited. The types of MHPAEA violations EBSA commonly finds in investigations include:

• Imposing broad preauthorization requirements only on mental health or substance use disorder benefits
• Imposing more restrictive visit limits on mental health/substance use disorder benefits
• Requiring written treatment plans to access care (only) for mental health services and
• Conditioning treatment on whether the mental health or substance use disorder treatment has a likelihood of success when a comparable limitation is not applied to medical/surgical treatment.
EBSA has also encountered plans that refused to cover out-of-network benefits for mental health benefits, or have imposed more restrictive visit limits on mental health benefits. EBSA has succeeded in bringing these plans into compliance with the law and providing participants with benefits to which they are entitled. EBSA has also worked with several large insurance companies to remove impermissible barriers to mental health benefits, ensuring that hundreds of thousands of plans are no longer imposing these requirements.

10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Footnotes:
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, the Healthy People 2020, National Stakeholder Strategy for Achieving Health Equity, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary’s top priority in the Action Plan is to “assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.”

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA’s and HHS’s attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

48 http://www.thinkculturalhealth.hhs.gov
51 http://www.whitehouse.gov/omb/redreg_race-ethnicity
Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
   
   a) Race
   
   b) Ethnicity
   
   c) Gender
   
   d) Sexual orientation
   
   e) Gender identity
   
   f) Age

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) standard?

6. Does the state have a budget item allocated to identifying and remedializing disparities in behavioral health care?

7. Does the state have any activities related to this section that you would like to highlight?

   Please see https://wvsystemofcare.org/self-study-tools/culturally-competent-care-tools-trainings-how-tos/ for a list of State Health Disparity resources available to and used by both grantee and state agency staff.

   Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality / Cost, (V = Q / C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General, The New Freedom Commission on Mental Health, the IOM, and the NQF. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in *Psychiatry Online*. SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS) are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT) was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and
training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

56 http://psychiatryonline.org/
57 http://store.samhsa.gov
58 http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  
   Yes  No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   a)   b) Leadership support, including investment of human and financial resources.
   b)   e) Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c)   b) Use of financial and non-financial incentives for providers or consumers.
   d)   e) Provider involvement in planning value-based purchasing.
   e)   b) Use of accurate and reliable measures of quality in payment arrangements.
   f)   e) Quality measures focus on consumer outcomes rather than care processes.
   g)   e) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h)   b) The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:
4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP, the RAISE model. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?
   - Yes
   - No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?
   - Yes
   - No

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   WV has a pilot program with Youth Service System (YSS) to address FEP (ESMI), First Episodes Psychosis. The program at YSS is called Quiet Minds. The purpose is through the model known as Coordinated Specialty Care utilizing OnTrak NY as the model that fit best with West Virginia as our guide. Here is the list of program criteria, rule outs, and service types:

   Eligibility criteria includes:
   • 15 and 25 years of age, and their families, who are experiencing a first episode of psychosis
   • Residents of Hancock, Brooke, Ohio, Marshall, Wetzel or Tyler County
   • DSM-5 diagnostic criteria: schizophrenia, schizoaffective disorder, and schizophreniform disorder, as well as other specified/unspecified schizophrenia spectrum and other psychotic disorders
   • Individuals having experienced psychotic symptoms lasting at least one week but less than two years
   • Individuals who have had not more than 18 months of prior cumulative treatment with anti psychotic medication

   Rule outs include:
   • substance/medication-induced psychotic disorder
   • psychotic disorder due to another medical condition
   • bipolar disorder with psychosis
   • depressive disorders with psychotic features
   • serious or chronic medical illness significantly impairing function independent of psychosis
   • intellectual disability evidenced by an IQ of less than 70
3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

The Quiet Minds program has had successful integration in the community by a well-rounded Advisory committee. There has also been extensive training offered to ready the workforce and team of practitioners that serve individuals. The Evidence Based Practice (EBP) includes trauma-informed care, suicide assessment and prevention, motivational interviewing, cultural competence, and person-centered care along with other training to include Recovery from First Episode Psychosis, Schizophrenia and other psychotic disorders, and family focused assessment and care. They have created a network in addition to Youth Service System’s agency to complete the Coordinated Specialty Care (CSC) model including psychiatrist, therapist, employment, education, housing, peer supports, and case management. This network is designed to create a referral system, capture early episodes, and have rich community resources.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI?

5. Does the state collect data specifically related to ESMI?

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?

7. Please provide an updated description of the state’s chosen EBPs for the 10 percent set-aside for ESMI.

Our model emulates OnTrak NY. We have teams to include psychiatrist, therapist, supportive employment, supportive education, Recovery coaching/ youth peer supports, and case management and family psycho-education. The goal is to facilitate early identification and treatment of psychosis in a collaborative, recovery-oriented approach involving individuals experiencing first episode psychosis, therefore reduce the disruption to the young person’s functioning and psychosocial development. Components of the CSC model that Quiet Mind uses are outreach, assessment, treatment, community resources, supportive employment, education, health promotion, and advocacy. The service network that has been developed is in the Northern Panhandle of West Virginia including a 6-county region. Youth Service System is the central agency providing the full model in Ohio county. They are the lead agency that is working collaboratively throughout the region with colleges, law enforcement, primary health care, hospitals, and other systems to reach the target population. There is an active stakeholder advisory group that is key to building the system, services, and identifying resources to help in making this initiative successful.

Also reference question 2 above.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state’s ESMI programs including psychosis?

A media campaign to include Hubspot - an integrative software and utilization that is a central collection point of multimedia. Also, there are TV commercials, 30-minute special and interview, billboards, banners, and brochures. The next two years will strengthen the model, assess outcomes, continue workforce training to expand to other regions in the state by bringing awareness of ESMI, use data to address areas to focus more targeted efforts, and expansion of services.

9. Please explain the state’s provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Programmatic and client level data that we are collecting. We have reached out to and plan to gain guidance from OnTrak NY with their processes, tools, lessons learned and understanding barriers to help shape our programming.

Data Collection

Programmatic data may include:
- the number of professionals who are introduced to the program
- the number of people trained in FEP programs
- the number of speeches and presentations given
- the number of commercials on TV
- the number of TV specials or interviews provided by Quiet Minds personnel

Client level data:
- the number of inquiries and referrals made to the central referral unit
- the number of individuals served by the Quiet Minds program
- the services received by each
• the number of families participating in the program
• employment/education information
• living situation
• relationship with family
• hospitalizations
• the number of individuals referred who do not meet admission criteria and how these individuals were linked with alternative services

10. Please list the diagnostic categories identified for your state's ESMI programs.

Eligibility criteria includes:
• 15 and 25 years of age, and their families, who are experiencing a first episode of psychosis
• who are residents of Hancock, Brooke, Ohio, Marshall, Wetzel or Tyler County
• DSM-5 diagnostic criteria: schizophrenia, schizoaffective disorder, and schizophreniform disorder, as well as other specified/unspecified schizophrenia spectrum and other psychotic disorders
• individuals having experienced psychotic symptoms lasting at least one week but less than two years
• Individuals who have had not more than 18 months of prior cumulative treatment with antipsychotic medication

Rule outs include:
• substance/medication-induced psychotic disorder
• psychotic disorder due to another medical condition
• bipolar disorder with psychosis
• depressive disorders with psychotic features
• serious or chronic medical illness significantly impairing function independent of psychosis
• intellectual disability evidenced by an IQ of less than 70

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person’s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person’s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person’s needs and desires.

1. Does your state have policies related to person centered planning?  
   Yes □  No □

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.  
   N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
   West Virginia has a number of existing programs for people with disabilities, which include people with mental health issues, which emphasize self-direction, including the state’s three Home and Community Based Waivers, Money Follows the Person/Take me Home WV, and the Ron Yost, and Lighthouse programs.

   West Virginia Bureau of Senior Services Lighthouse program
   Lighthouse is designed to assist those seniors who have functional needs in their homes, but whose income or assets disqualify them for Medicaid services. The Lighthouse Program, available in each county, is funded entirely by state monies and provides support in four areas: personal care, mobility, nutrition, and housekeeping.

   An individual may receive up to sixty hours of service per month, based on a client assessment and resources available. To participate in the program one must be at least sixty years of age and meet the functional eligibility need. Lighthouse has a sliding scale fee reimbursement in place.

   Medicaid Aged and Disabled (A & D) waiver program
   Personal Options is the self-directed service model within the Home and Community Based West Virginia Medicaid Aged and Disabled Waiver (ADW) Program. To participate in Personal Options, an individual must be medically and financially eligible for ADW services. In Personal Options, the participant is an employer who hires individuals as an employee(s). Participants may advertise for an employee or hire friends or family members as their employee(s). As an employer they will be responsible for verifying the hours worked by employees and the tasks that were completed. A spouse, legal guardian, or legal representative acting as decision-maker on the participant’s behalf cannot be hired as an employee. All employees must meet ADW policy requirements such as age, training, background checks, etc.

   Participants have an individualized monthly budget based on his/her assessed needs. Budget funds must be used to purchase needed ADW services such as personal assistance/homemaker services, RN assessments, transportation, and case management. Participants can also use part of their monthly budgets to purchase other items and services that promote improved health/safety in the home, or reduce the need for Medicaid services. (Note: Each participant may save and spend a maximum of $1,000 each year for Participant-Directed Goods and Services.) Participants do not handle any money directly. All funds are handled by a Fiscal/Employer Agent.

   Personal Options participants have flexibility when determining their employee's/employees' hourly wage and work schedule. The hourly wage cannot exceed the Medicaid reimbursement rate. Participants in Personal Options have the support of a Resource Consultant and a Fiscal/Employer Agent. Resource Consultants assist participants in developing a service plan and a monthly spending plan to meet their individualized needs. Resource Consultants also assist participants with the responsibilities of self-direction, such as recruiting, hiring, training and managing employees as well as filing all necessary paperwork to become a registered employer with state and federal government authorities. Resource Consultants monitor health and safety of participants and report any incidents or fraudulent activity.

The Fiscal/Employer Agent performs payroll and tax functions on behalf of the participant including processing timesheets,
Medicaid Traumatic Brain Injury Waiver program
Participant-direction is an optional service delivery method that gives people accessing the Traumatic Brain Injury Medicaid Waiver program an alternative to receiving services through traditional provider agencies. Participant-direction allows choice and control over some of waiver services so that consumers may live as independently as possible in their home and community. In West Virginia, the participant-direction option is called Personal Options.

The person accessing TBI Waiver services is the Employer of Record. He/she may appoint a Program Representative to assist with the employer responsibilities. The person can determine when the employee(s) works and rate of pay. The hourly wage paid to a Personal Attendant may not exceed the Medicaid rate minus all mandatory deductions and must be at least the current minimum wage amount.

Self-Direction through Personal Options includes Personal Attendant Services and Non-Medical Transportation. People choosing Personal Options may choose to transfer back to the Traditional Services Option at any time. Personal Options Supports include:
• Financial Management—PCG/Public Partnerships, LLC (PPL) serves as the Fiscal/Employer Agent, performing payroll and tax functions on behalf of people who choose Personal Options. PPL’s services are paid for by the Bureau for Medical Services at no cost to the consumer.
• PPL Resource Consultant—Provides consumers with training and ongoing assistance regarding employer responsibilities, spending plan development and budget utilization.
• Case Management—This required service of the TBI Waiver program is provided through a traditional agency provider. The PPL Resource Consultant is not the consumer’s Case Manager.

Ron Yost Personal Assistance Services (RYPAS) program
The Ron Yost Personal Assistance Services program, abbreviated as RYPAS, provides financial assistance for personal care services to assist elderly and/or disabled West Virginia residents in achieving their activities of daily living. Assisting in these activities, such as bathing and grooming, helps them to remain living in their homes and communities. Although this is not a Medicaid program, it is modeled after the Medicaid concept of Cash and Counseling. This concept is also referred to as participant direction, self-direction, and consumer direction. The idea is that the program participant has control over who provides their care instead of the program administrators. Thereby, increasing the satisfaction of the participant and lowering the administrative cost of the program.

Friends, neighbors, and even many family members, can be hired to provide personal assistance, transportation, and to assist with light home maintenance that the program participant cannot manage on their own. To be eligible for this program, participants must live in West Virginia and have a disability that is expected to continue for a minimum of 12 months. The disability must be significant enough that it requires the individual to receive assistance in order to complete their activities of daily living such as eating, dressing, bathing or basic mobility. Individuals must not be eligible to receive Medicaid services. This means the program has lower income limits that change based on the applicant’s constituent group (an elderly individual has different criteria than a younger adult).

Generally speaking, to receive personal care from WV Medicaid at home for aging persons requires their monthly income not exceed $2,205 and their countable assets (which exclude home equity) not exceed $2,000. Persons under these limits will be eligible for Medicaid, and therefore, cannot be eligible for the Ron Yost Program. Ron Yost also has fixed upper income limits, above which financial assistance is not provided. The latest published information, as of 2017, sets the annual upper income limit at $38,000. Funding is provided on a sliding scale. Those with larger discrepancies between their expenses and incomes are eligible for more assistance and will receive priority. For instance, those with an annual income under $21,999 are reimbursed the maximum allocated hourly wage for care assistance, while those with an income between $34,000 and $34,999 are reimbursed 46% of the allocated maximum hourly wage for care assistance.

This program provides financial assistance in the form of reimbursement checks to participants so that they can hire personal care assistants. Program participants are allocated up to $7.25/hour to pay a personal assistant. The maximum allowable hours of assistance for any one program participant was unpublished at the time of writing. Personal assistants can provide care with the following types of activities and instrumental activities of daily living: Basic mobility in and around the home, Transportation assistance away from the home, Bathing and personal hygiene, Dressing, Meal preparation, Meal planning and grocery shopping, Basic housekeeping and laundry, and Bill paying.

Take Me Home WV
The West Virginia Bureau for Medical Services (BMS) received a Money Follows the Person (MFP) Rebalancing Demonstration Grant in 2011 from the Centers for Medicare and Medicaid Service (CMS) to assist State Medicaid agencies in enhancing opportunities for people to live and receive long-term care services and support in their own homes and communities. This initiative, Take Me Home, West Virginia, provides additional services and support to eligible Medicaid members moving from long-term care facilities to their own homes.
To be eligible to participate in Take Me Home, West Virginia, an individual must:
• Live in a nursing facility, hospital, institution for mental disease or a combination of any of the three for at least 90 consecutive days (excluding Medicare rehabilitation days) and
• Receive Medicaid benefits on the last day prior to transitioning from the long-term care facility to the community and
• Choose to move to a “qualified residence”

Take Me Home participants receive assistance from existing home and community based services programs such as the Aged and Disabled Waiver, the Traumatic Brain Injury Waiver and Medicaid State Plan Services for which they are eligible. They may also receive the following grant supported services and support:

• Transition Navigation: Transition Navigators work one-on-one with participants and/or legal representatives to develop a Transition Plan and facilitate services and support necessary for the person to live in his/her community. They are available to assist participants for one year after the transition.
• Community Transition Services: These are one-time services essential to facilitate the move home. These services may include for example: rental and moving deposits, moving expenses and home accessibility modifications.
• Take Me Home Goods and Services: These are (self-directed) equipment, services, or supplies not otherwise provided through the Medicaid State Plan that address a need in the Transition Plan, including assistive technology.
• Supported Housing: Available only to participants transitioning from an Institution for Mental Diseases (IMD), supported housing is independent housing in the community coupled with needed community mental health services.
• Extended Direct Care Services: Participants may extend the use of certain Medicaid Waiver and State Plan services for which they are eligible. This may include more direct-care service per month than what is currently available through the Aged and Disabled or Traumatic Brain Injury waiver programs.

4. Describe the person-centered planning process in your state.

BBHHF is in the midst of implementing a new initiative to develop and promote opportunities for self-direction and peer employment by enhancing the CommonGround™ shared decision support and Partnership with Pat Deegan & Associates for technical assistance in regard to expansion of shared decision support center activities.

After much planning and consultation with Pat Deegan & Associates it was determined that the best strategy was to provide access to a series of courses provided through the CommonGround™ Academy. These courses were made available to clinical staff at Prextera (a comprehensive behavioral health center) and to peer staff at First Steps Wellness and Drop-In Center (a peer ran organization). 80 individuals were trained on the concepts of recovery and shared decision making through the CommonGround™ Academy.

With additional consultation with Pat Deegan & Associates it was decided to move the CommonGround program to a new provider in Morgantown who appears to be more philosophically aligned with the approach, a free clinic in Morgantown known as Milan-Puskar HealthRight. Milan-Puskar has served as a cutting-edge provider in the behavioral health arena for the past 15 years, using state funding to employ clinical and peer recovery support staff to screen and work with clients seeking mental health and SUD services. The CommonGround Academy is a workforce development initiative training a diverse team of clinicians and peers alike in principles of recovery oriented systems and core components of self-direction. The academy includes topics such as moving from a maintenance to recovery model, strategies for engaging individuals in recovery, moving from compliance to alliance, supporting self-determination, and supporting person centered care.

CommonGround helps people prepare before the appointment, so that during the appointment he/she is ready to work with his/her doctor to find the best decisions for his/her treatment and recovery. Before the appointment, CommonGround helps people prepare a 1-page Health Report that summarizes how he/she is doing and what his/her concerns are. Additionally, CommonGround links people to information about their treatment and suggestions that help them manage their disorder and make progress in their recovery. During the appointment, people's CommonGround Health Report acts like an amplifier, helping their doctor quickly understand their goals, concerns and progress. Together they arrive at a shared decision about the next best steps for treatment and recovery. People's shared decision is printed out so he/she can bring it home as a reminder about what he/she will do to help him/herself before the next appointment.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction?  
2. Are there any concretely planned initiatives in our state specific to self-direction?  

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

a) How is this initiative financed?
   Through a 2015 BRSS TACS grant awarded to BBHFF.

b) What are the eligibility criteria?
   Initially, anyone seeking services and supports at either a Comprehensive Behavioral Health Center or a Wellness and Recovery Center in Huntington. Moving forward it will include anyone seeking services from Milan-Puskar HealthRight seeking mental health and SUD services.

c) How are budgets set, and what is the scope of the budget?
   The technical assistance from Pat Deegan & Associates was paid for by the 2015 Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) award from SAMHSA. The cost for the training and technical assistance was $25,000. The only ongoing expense to sustain this project is access to the CommonGround software platform and data support which is $8,000 a year.

d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
   Consumers using Milan-Puskar as a provider will be better able to direct their own services using the CommonGround™ shared decision support.

e) What, if any, research and evaluation activities are connected to the initiative?
   This is a pilot initiative helping get a consumer self-direction resource established in West Virginia and the lessons learned will be applied by the provider agency, Pat Deegan & Associates, and the state, with the goal being to expand access to this tool and to help make the West Virginia behavioral health system more consumer-directed and recovery-oriented.

f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.
   N/A

Does the state have any activities related to this section that you would like to highlight?
Please indicate areas of technical assistance needed to this section.

**Footnotes:**
Environmental Factors and Plan

7. Program Integrity - Required

**Narrative Question**

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SM1 and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: [http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf](http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf). States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SM1 and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

**Please respond to the following items:**

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  

   - Yes
   - No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard?  

   - Yes
   - No

**Does the state have any activities related to this section that you would like to highlight?**

BBHHF continues to develop and refine Program Integrity (PI) efforts that are applied to all grant and contract awards. Program Integrity efforts include programmatic oversight and evaluation, financial reviews and compliance tests of allowable activities, reporting requirements and eligibility from provider records evaluations. Financial evaluations are performed in conjunction with programmatic and compliance reviews, in addition to, standard systematic state financial monitoring efforts. All PI efforts are applied to each grant and contract regardless of whether the award is a general revenue funded program or a sub-recipient award of Federal Substance Abuse or Mental Health Block Grant funding. Block grant awards receive specific monitoring efforts which includes the federal block grant requirements and eligibility standards.

Please indicate areas of technical assistance needed to this section

**Footnotes:**
Environmental Factors and Plan

8. Tribes - Requested

Narrative Question
The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation\(^{59}\) to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. 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 that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state’s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SAMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

\(^{59}\) http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?  
   West Virginia has no federally recognized Tribes

2. What specific concerns were raised during the consultation session(s) noted above?  
   N/A

   Does the state have any activities related to this section that you would like to highlight?  

   Please indicate areas of technical assistance needed to this section

Footnotes:
Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

**Assessment**

1. **Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?**
   - Yes
   - No

2. **Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)**
   - Data on consequences of substance using behaviors
   - Substance-using behaviors
   - Intervening variables (including risk and protective factors)
   - Others (please list)

3. **Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)**
   - Children (under age 12)
   - Youth (ages 12-17)
   - Young adults/college age (ages 18-26)
   - Adults (ages 27-54)
   - Older adults (age 55 and above)
   - Cultural/ethnic minorities
   - Sexual/gender minorities
   - Rural communities
   - Others (please list)
4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)
   a. Archival indicators (Please list)
   b. National survey on Drug Use and Health (NSDUH)
   b. Behavioral Risk Factor Surveillance System (BRFSS)
   b. Youth Risk Behavioral Surveillance System (YRBS)
   e. Monitoring the Future
   b. Communities that Care
   b. State - developed survey instrument
   e. Others (please list)

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?  
   [ ] Yes  [ ] No

   If yes, (please explain)
   Prevention allocations are determined at a minimum of 20% of total block grant funds. Each region receives formula based funding founded on population and high risk needs. The strategic prevention framework model is utilized to determine need at the local level as well as county profiles developed by the Bureau for Behavioral Health and Health Facilities in coordination with the WVSEOW.

   If no, (please explain) how SABG funds are allocated:

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section
1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?  
   - Yes  
   - No  
   If yes, please describe.  
   The West Virginia Certification Board for Addiction & Prevention Professionals (WVCBAPP) currently is the sole credentialing body for professionals working in the Substance Use Disorder Prevention field. WVCBAPP currently credentials Level I Prevention Specialist and Level II Prevention Specialist. One of the six prevention leads currently serves on the WVCBAPP Board. Presently, several capacity building trainings are being provided by regional lead prevention professionals. They provide training and technical assistance and work to build the capacity of the prevention network and regional communities. Grantees are also trained and provide trainings to community members in evidence based programs determined by the needs of the community that reflect the risk factors.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?  
   - Yes  
   - No  
   If yes, please describe mechanism used.  
   All grantees have the same requirements within their statements of work that guides them as to the mandatory trainings they need annually as a prevention workforce.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?  
   - Yes  
   - No  
   If yes, please describe mechanism used.  
   One mechanism used to determine readiness is a coalition readiness assessments. They are completed and community capacity is determined by using the Strategic Prevention Framework model.  
   Does the state have any activities related to this section that you would like to highlight?  
   Please indicate areas of technical assistance needed related to this section.

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities;

- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.
Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? 
   
   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan.
   
   The most recent strategic action plan was developed for years 2011-2014. An updated plan has been drafted for years 2016-2018 and is being finalized for release.
   
   The strategic plan was used to plan primary prevention set-aside; however, the strategic plan has expired and a new one has been drafted. Once the updated strategic plan has been finalized it will be used to determine the set-aside for primary prevention.
   
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)
   
3. Does your state’s prevention strategic plan include the following components? (check all that apply):
   
   a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   
   b) Timelines
   
   c) Roles and responsibilities
   
   d) Process indicators
   
   e) Outcome indicators
   
   f) Cultural competence component
   
   g) Sustainability component
   
   h) Other (please list):
   
   i) Not applicable/no prevention strategic plan
   
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?
   
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?
   
   If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based.
GACSA receives information from a local and regional level from the six established Governor’s Regional Substance Abuse Taskforces located throughout the state.

Does the state have any activities related to this section that you would like to highlight?

WV Partnership to Promote Community Well-Being was established by Executive Order No. 8-04 under former Governor Joe Manchin. This partnership was designated as the single state planning authority for substance abuse prevention, intervention and recovery. Its duties included: establishing a grant application process, oversee the implementation of grant funds, establish a long-term strategic plan and make recommendations to the Governor and the Legislature for future funding, establish a data-gathering system to monitor the social and financial impact of substance abuse in WV, compile, analyze and disseminate the data, review state laws and rules that control drug and alcohol policies and make recommendations. When Governor Earl Ray Tomblin was elected the WV Partnership to Promote Community Well-Being became known as the Governor’s Advisory Council on Substance Abuse (GACSA) retaining many of the responsibilities of the former partnership. GACSA receives information from a local and regional level from the six established Governor’s Regional Substance Abuse Taskforces located throughout the state.

WV BBHFF and the members of the GACSA are currently waiting on newly elected Governor Jim Justice, to see if the GACSA will be continuing its efforts in the present form or be transitioning with a new name and/or focus.

Please indicate areas of technical assistance needed related to this section.
1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) SSA staff directly implements primary prevention programs and strategies.
   b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
   c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   d) The SSA funds regional entities that provide training and technical assistance.
   e) The SSA funds regional entities to provide prevention services.
   f) The SSA funds county, city, or tribal governments to provide prevention services.
   g) The SSA funds community coalitions to provide prevention services.
   h) The SSA funds individual programs that are not part of a larger community effort.
   i) The SSA directly funds other state agency prevention programs.
   j) Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) Information Dissemination:
      a. Building a Stronger Community Against Addiction
      b. Rebrand Press Conference
      c. Kick Butts Day
      d. Job Fairs
      e. Earth Day Activity (Brand initiative)
      f. Concerned Persons Group
      g. Tobacco Free Day
      h. YMCA Health Kids Day
      i. SADD Mock Crash
      j. YEP (after school)
      k. Prom Promise
      l. Loved Ones support group
m. Kids and Family Day at the Capitol
n. Information Booths in various regions
o. Red Ribbon Week Activities
p. Community Fair Dissemination
q. School Spirit PSA Contest (SADD Chapters)
r. Facebook and Social Media
s. Community Forums
t. Sticker Shock

b) Education:
   a. WV Substance Abuse Trends
   b. Fetal Alcohol Spectrum Disorders
c. Training for Intervention Procedures TIPS
d. Marijuana Workshops
e. Generation RX
f. Teen Court Training
g. Go for Good Health
h. Underage Drinking
i. Synar Training
j. Synthetic Drugs
k. Parent 360 RX
l. 40 Developmental Assets
m. Current Drug Trends
n. Risk and Protective Factors in Early Childhood (Head Start)
o. SBIRT
p. Opiates Cabinet to Streets
q. Day of Hope Strategy Development
r. Take Home Naloxone Project
s. Mental Health First Aid
t. Keep a Clear Mind
u. Matrix Model
v. Too Good for Drug
w. Alcohol: True Stories
x. All Stars
y. Drugs: True Stories
z. Healthy Alternatives for Little Ones (HALO)
aa. Keep a Clear Mind
bb. Matrix Model
cc. Not on Tobacco (N-O-T)
dd. Parents as Teachers (PAT)
e. Positive Action
ff. Second Step
gg. Signs of Suicide (SOS)
hh. STARS for Families
ii. TCU Mapping
jj. Too Good for Violence
kk. Wellness Outreach at Work
c) Alternatives:
   a. The Empty Chair
d) Problem Identification and Referral:
   a. Teen Courts
   b. Juvenile Drug Courts
c. Synar Compliance Checks
d. Alcohol Compliance Checks
e) Community-Based Processes:
   a. Community Resource Meetings
   b. FRN Meetings
c. Regional Coalitions meetings
d. SADD Conference
e. Health Children and Families Meetings
f. Collaborations with colleges regarding prevention strategies
g. Tobacco Prevention Coalition Meetings
h. Head Start Policy Council Meetings
j. Prevention Consortiums

f) Environmental:
   a. Drug Take Back Box
   b. Deterra Packets
   c. Drug Testing Kits (free from HIDA)
   d. Random Drug Testing at Schools (Partnering with School)
   e. Social Hosting Ordinance

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?
   If yes, please describe
   Recommendations are made thru the Governor's Advisory Council on Substance Abuse
   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.
Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities;

- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

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- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan.

   A State Epidemiological Work Group is currently being re-developed and will enhance the data systems that will evaluate the prevention efforts from the last 5 years, as well as, identify gaps and address future needed prevention strategies.

2. Does your state’s prevention evaluation plan include the following components? (check all that apply):

   a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks

   b) Includes evaluation information from sub-recipients

   c) Includes SAMHSA National Outcome Measurement (NOMs) requirements

   d) Establishes a process for providing timely evaluation information to stakeholders

   e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making

   f) Other (please list):

   g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

   a) Numbers served

   b) Implementation fidelity

   c) Participant satisfaction

   d) Number of evidence-based programs/practices/policies implemented

   e) Attendance

   f) Demographic information

   g) Other (please describe):

   Youth Engagement

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>a)</strong></td>
<td>30-day use of alcohol, tobacco, prescription drugs, etc</td>
</tr>
<tr>
<td><strong>b)</strong></td>
<td>Heavy use</td>
</tr>
<tr>
<td><strong>b)</strong></td>
<td>Binge use</td>
</tr>
<tr>
<td><strong>b)</strong></td>
<td>Perception of harm</td>
</tr>
<tr>
<td><strong>c)</strong></td>
<td>Disapproval of use</td>
</tr>
<tr>
<td><strong>d)</strong></td>
<td>Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)</td>
</tr>
<tr>
<td><strong>e)</strong></td>
<td>Other (please describe):</td>
</tr>
</tbody>
</table>
Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question
Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

State priorities have included the development and expansion of peer and family supports, the West Virginia Leadership Academy, recovery education, housing and homeless outreach to people with mental health issues and co-occurring addictions, and coordination and delivery of services for returning veterans and their families, integrated primary care and mental health services, and operational support for the West Virginia Mental Health Planning Council.

- BBHHF receives the annual Projects for Assistance in Transition from Homelessness (PATH) grants to aid individuals who are homeless and mentally ill. All 6 regions of the state have a PATH provider in addition to the WV Coalition to End Homelessness who oversees the Balance of State. Outreach efforts have been the focus in all trainings with PATH providers and are specifically mentioned in all grant agreements.

- BBHHF received technical assistance regarding rural homeless outreach and plans to continue this as an ongoing request for assistance. In order to prevent and end homelessness in West Virginia, Governor Earl Ray Tomblin revitalized the West Virginia Interagency Council on Homelessness through Executive Order No. 9.13. The Council is charged with the development and implementation of a plan to prevent and end homelessness in the State of West Virginia. This council is housed within and chaired by the BBHHF.

- Recovery Programs have been developed; currently there are twenty three operational Level 2 Peer Operating Recovery Homes; four Level 3 Peer Operating Recovery Facilities for a total of 280; and fourteen Level 4 Treatment Provider Operated Recovery Facilities located throughout each region of the state.

- Money Follows the Person - Take Me Home WV - In addition to expanding transition navigator services to all 55 counties in the state, Take Me Home leverages available Federal grant dollars to enhance services and supports for those who wish to leave institutions and receive services in a community or home-based setting. TMH WV employs a full-time Housing Coordinator to assist with identifying both short and long-term solutions to lack of appropriate housing.

- The Huntington West Virginia Area Habitat for Humanity veterans housing initiative which is designed to help veterans own their own homes.

- The West Virginia Department of Veteran’s Assistance’s transitional unit was established at the state’s Veterans Home.

- Prevent Suicide WV offers suicide prevention services across the life span, establishing a coordinated State and regional learning, referral, and intervention approach with education, juvenile justice, homelessness programs, corrections, senior services, veterans’ services, behavioral health and other healthcare public/private partners.

- Permanent Supportive Housing provides support services for up to 16 hours per day to individuals who have a diagnosis of serious mental illness or co-occurring with a substance use diagnosis, who have been identified as high risk or who are committed to and/or discharged from an in-patient state hospital/diversion facility. These services offer support in their own housing and in the community as determined by individual needs. Individuals who do not currently have their own residence will be assisted in obtaining housing. The goal is for individuals to live fully in the community of their choice while having access to staff to support them throughout the day and evening.

- Day Program Services are provided to individuals with a diagnosis of mental illness, substance abuse, intellectual/developmental disability, or co-occurring disorders in a community-based setting and may vary in services based on the population and disorder. Services may be located within a residential or non-residential setting and are to be provided 5 days/week, 3 hours daily. The goal
is to optimize self-help and adaptive skills that are person-centered and guided by the consumer’s needs, wishes, desires and goals. These services enhance existing relationships, open doors to information, diminish feelings of isolation and foster community engagement.

- Drop-In Centers serve the needs of individuals with a mental health and/or co-occurring substance use disorder outside of the traditional mental health system. The Centers provide a safe, inviting, nonjudgmental environment for individuals to socialize, communicate and participate in activities that support recovery. They also allow individuals the opportunity to learn to live in the community and to take control of their lives. Individuals are able to interact with others who have shared similar experiences. They are designed to be consumer-driven in governance.

- Group Homes provide support twenty-four hours a day seven days a week (24/7) to individuals with a diagnosis of severe persistent mental illness and/or a co-existing diagnosis of mental health and substance use disorders. This program promotes the recovery of the individuals residing in the home. The programs identify the strengths, needs, aptitudes and preferences of the individuals being served, then design skill development activities, and develop the supports that the residents need to be successful in their environment of choice.

- The Transitional Living Program (TLP) provides safe housing for individuals, age eighteen (18) and older who are in recovery from co-occurring mental health and substance use disorders. The service follows and/or is concurrent with behavioral health treatment and is intended to assist those individuals for a period of months or until it is determined that an individual is able to safely transition into a more integrated environment.

- Recovery Coaching and Peer Support Services are provided by individuals who have “lived experience” and are a valuable resource to individuals seeking treatment and in recovery. Peer support services are designed to help individuals remove personal and environmental obstacles to his or her recovery, link the newly recovering person to the recovering community, and serves as a navigator and mentor in the management of personal and family recovery.

- BBHHF provides informational “tool kits” and training about services available for individuals with an intellectual or developmental disability to increase linkage of individuals experiencing homelessness.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

- Physical Health
- Mental Health
- Rehabilitation services
- Employment services
- Housing services
- Educational Services
- Substance misuse prevention and SUD treatment services
- Medical and dental services
- Support services
- Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
- Services for persons with co-occurring M/SUDs

Please describe as needed (for example, best practices, service needs, concerns, etc)

BBHHF funds each of the 13 regional Community Behavioral Health Centers (CBHCs) and a number of independent community agencies to provide community based supports to people with mental health issues, addictions and non-waiver funded people intellectual developmental disabilities. $10 million in BBHHF Charity Care funds are available to support people who are uninsured and/or underinsured seeking Medicaid eligible treatment services from the 13 regional CBHCs.

3. Describe your state’s case management services

BBHHF uses State funds to support Community Engagement Specialists at both the CBHCs and other providers. Community Engagement is a service which identifies, connects and/or provides personal and community supports to individuals with a diagnosis of mental illness, substance use, or co-occurring disorders, and who are committed, have a history of commitment, or are in danger of commitment to a state psychiatric, private diversion facility, or correctional facility. Engagement and integrated...
community supports are necessary for individuals to achieve and sustain recovery in the community. By establishing social networks, income, integrated resources, and navigational support, individuals can live a meaningful life in a community of their choice.

The Community Engagement program is intended to support all individuals who have a history of and/or are at risk of involuntary commitment such that they can live in local communities of their choosing. This program’s work is supported by Community Engagement Specialists (CES) who serve as the stewards of the programs implementation efforts. The CES are the brokers and facilitators of a wide range of community based and collaborative efforts and strategies designed and intended to support the varying needs of those served. The CES can be characterized as someone who understands mental health and co-occurring/co-existing disorders; the varying manifestations associated with such disorders; appreciates the unique needs of individuals and therefore can create the synergy necessary to support successful community based living.

The Community Engagement Specialist (CES) works in the community to assist individuals with serious mental illness, substance use, co-occurring or co-existing disorder(s) that are at risk of psychiatric hospitalization or are currently committed. Any individual at risk who resides in or is from the grantee’s area is eligible for assistance from the CES; individuals do not have to be an active consumer of the grantee to be eligible for this service as a significant focus is placed on identification and engagement. The CES engages and collaborates with all available community resources to prevent the need for involuntary commitment, improve community integration, and promote recovery by addressing the often complex needs of eligible individuals.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Community Engagement Specialist (CES) program, group homes, day support programs, Peer (Drop-in) Centers, Permanent Supported Housing Programs and Crisis Stabilization Units have been enhanced to serve individuals at risk for admission to or have been discharged from a hospital.
Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

**Criterion 2**

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state’s behavioral health system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>79,030</td>
<td>18,000</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>21,255</td>
<td>7,000</td>
</tr>
</tbody>
</table>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

BBHHF uses prevalence data provided by NRI based on SAMHSA estimation methodology.

Incidence data provided by annual URS Tables.
Narrative Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

**Criterion 3**

Does your state integrate the following services into a comprehensive system of care?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td><strong>a)</strong> Social Services</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td><strong>b)</strong> Educational services, including services provided under IDEA</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td><strong>c)</strong> Juvenile justice services</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td><strong>d)</strong> Substance misuse prevention and SUD treatment services</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td><strong>e)</strong> Health and mental health services</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td><strong>f)</strong> Establishes defined geographic area for the provision of services of such system</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>
Describe your state's targeted services to rural and homeless populations and to older adults

The BBHHF receives the annual Projects for Assistance in Transition from Homelessness (PATH) grant. All 6 regions of the state have a PATH provider in addition to the WV Coalition to End Homelessness who oversees the Balance of State. Additionally, the BBHHF has received SAMHSA’s Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant which will serve individuals and families who are experiencing homelessness and have substance use disorders, serious mental illnesses, serious emotional disturbances, or co-occurring mental and substance use disorders. Specifically, this includes chronically homeless individuals, homeless or chronically homeless veterans, and homeless families and youth.

Governor Earl Ray Tomblin revitalized the West Virginia Interagency Council on Homelessness through Executive Order No. 9-13. The Council is charged with the development and implementation of a plan to prevent and end homelessness in the State of West Virginia. This council is housed within and chaired by the BBHHF.

The West Virginia Department of Education McKinney-Vento Act formula is funding 18 grants for three years. The Office for Coordination of Education of Homeless Children and Youths in each state, which gathers comprehensive information about homeless children and youth and the impediments to their regular attendance at school. These grants also help state educational agencies ensure that homeless children, including preschoolers and youths, have equal access to free and appropriate public education. States must review and revise laws and practices that impede such equal access. States are required to have an approved plan for addressing problems associated with the enrollment, attendance and success of homeless children in school. States also must make competitive sub-grants to local educational agencies to facilitate the enrollment, attendance and success in school of homeless children and youths. This includes addressing problems due to transportation needs, immunization and residency requirements, lack of birth certificates and school records, and guardianship issues.

The Children’s Homeless Outreach Program provides a secure healthy environment, case management, life skills education, brief counseling, referrals and linkage to community services and supports for children and their families who are experiencing homelessness and are residing in one of the homeless shelters.

Permanent Supportive Housing provides support services for up to 16 hours per day to individuals who have a diagnosis of serious mental illness or co-occurring with a substance use diagnosis, who have been identified as high risk or who are committed to and/or discharged from an in-patient state hospital/diversion facility. These services offer support in their own housing and in the community as determined by individual needs. Individuals who do not currently have their own residence will be assisted in obtaining housing. The goal is for individuals to live fully in the community of their choice while having access to staff to support them throughout the day and evening.

BBHHF provides informational “tool kits” and training about services available for individuals with an intellectual or developmental disability to increase linkage of individuals experiencing homelessness.

Older Adults

Older adults with serious mental illness have access to all services available to adults with serious mental illness. West Virginia’s Bureau for Senior Services is responsible for services including transportation, meals, exercise classes, and in-home services. BBHHF staff consistently attends meetings with the Bureau for Senior Services to assist with analysis of need and consultation with development of services. The BBHHF funds mental health services for older adults who are unable to travel to their local behavioral health center that require in-home services.
Describe your state's management systems.

The BBHHF includes three interrelated sections which are Operations, Programs and Policy, and Administration. Operations 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. Administration is responsible for fiscal management, technology and shared data systems. Programs and Policy provides oversight and coordination of planning, development, funding, and monitoring of community behavioral health services and supports.

See Step 1: Assess the strengths and needs of the service system to address the specific populations for a full description of West Virginia’s financial resources, staffing, training for mental health service providers, and how the state intends to expend this grant for the FY 2018-2019 Block Grant.

Disaster Preparedness and Emergency Health Services

The BBHHF employs a full time Disaster Coordinator who collaborates with first responders, hospitals, local health departments, social services, homeland security and emergency management agencies, faith based community, and voluntary organizations to develop disaster response plans, continuity of operations plans and to conduct table top and other exercises across the State. The BBHHF supports regional preparation, planning, mitigation, response and long term recovery activities across the state, including the Voluntary Agencies Active in Disasters (VOAD) and integration of the Disaster Behavioral Health and the Disaster Spiritual Care Programs in order to meet behavioral, emotional, and spiritual care needs of the affected individuals, responders and recovery workers, and the communities as a whole. BBHHF encourages the regional CBHCs to add trained peers to their disaster response teams.

The BBHHF is an active member of the BPH’s Special Populations workgroup, which has adopted Kentucky’s approach to this issue by supporting local relationships between people with disabilities, first responders, health care providers and hospitals. This workgroup assembles resources to help people with disabilities plan for and survive local and regional disasters. Finally, the BBHHF is working with various groups, such as the BPH, the State Red Cross chapter, West Virginia Division of Homeland Security and Emergency Management, and VOAD, to develop processes, policies, plans and annexes for inclusion of those with access and functional needs in the State’s various Emergency Operations Plans and for the activities listed in The National Response Framework (NRF) under Emergency Support Function #6, including mass care and sheltering, housing and human resources as well as the transition into the Health and Human Resources Recovery Support Function under the National Recovery Support Framework in order to promote self-sufficiency and continuity of the health and well-being of affected individuals, particularly the needs of children, seniors, people living with disabilities whose members may have additional functional needs, people from diverse origins, displaced, and underserved populations.

Finally, in the wake of devastating, fatal flooding across much of southern West Virginia, BBHHF sought and was awarded three federal disaster response grants: The Crisis Counseling Assistance and Training Program (CCP), through both its Immediate Services Program and Regular Services Program, for which WV BBHHF received more than $2.5M, assisted individuals and communities in recovering from the June 2016 WV flood disaster through the provision of community-based outreach and psychoeducational services. Through face-to-face outreach, WVBBHHF sub-grantees Prestera Center for Clay and Kanawha Counties, and Seneca Health Services for Greenbrier, Nicholas and Webster Counties assessed emotional needs; provided emotional support, basic crisis counseling, and referrals; and conducted training and educated community partners about disaster.

The Disaster Case Management Program (DCMP), for which BBHHF received more than $5M, is providing -- for each flood survivor who needs the services—a case manager to serve as a single point of contact to facilitate access to a broad range of resources and achieve resolution of disaster-caused needs for that individual.
Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Improving access to treatment services

Does your state provide:

a) A full continuum of services
   i) Screening
   ii) Education
   iii) Brief Intervention
   iv) Assessment
   v) Detox (inpatient/social)
   vi) Outpatient
   vii) Intensive Outpatient
   viii) Inpatient/Residential
   ix) Aftercare; Recovery support

b) Are you considering any of the following:
   Targeted services for veterans
   Expansion of services for:
   (1) Adolescents
   (2) Other Adults
   (3) Medication-Assisted Treatment (MAT)
Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2
Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  
   Yes  No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services?  
   Yes  No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  
   Yes  No

4. Does your state have an arrangement for ensuring the provision of required supportive services?  
   Yes  No

5. Are you considering any of the following:  
   a) Open assessment and intake scheduling  
      Yes  No  
   b) Establishment of an electronic system to identify available treatment slots  
      Yes  No  
   c) Expanded community network for supportive services and healthcare  
      Yes  No  
   d) Inclusion of recovery support services  
      Yes  No  
   e) Health navigators to assist clients with community linkages  
      Yes  No  
   f) Expanded capability for family services, relationship restoration, custody issue  
      Yes  No  
   g) Providing employment assistance  
      Yes  No  
   h) Providing transportation to and from services  
      Yes  No  
   i) Educational assistance  
      Yes  No  

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

West Virginia has an integrated system of behavioral health services provided by 13 comprehensive behavioral health centers who given priority consideration and targeted programs to PWWD. The grant process is West Virginia includes a Statement of Work (SOW) that details required service activities, goals/ objectives and performance and outcome measures. The standard SOW includes a requirement that all Pregnant and Post-Partum women are given precedence in the assessment and admission process with a timeline that these consumers must receive these services within 48 hours of the inquiry for services. When bed availability is limited the program is required to make a referral and follow up with other service providers in the state. Admission of pregnant women is a data element on all monthly reports. Providers are required to report any problems with admission to the Bureau of Behavioral Health and Health Facilities who many help explore other treatment options for these patients. The state 24/7 call line, has been instructed to prioritize any service requests for pregnant women and notify the Bureau of Behavioral Health and Health Facilities of any barriers to receiving services for this population.
Narrative Question

Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

**Criterion 4,5&6**

**Persons Who inject Drugs (PWID)**

1. Does your state fulfill the:
   a) 90 percent capacity reporting requirement
   b) 14-120 day performance requirement with provision of interim services
   c) Outreach activities
   d) Syringe services programs
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

2. Are you considering any of the following:
   a) Electronic system with alert when 90 percent capacity is reached
   b) Automatic reminder system associated with 14-120 day performance requirement
   c) Use of peer recovery supports to maintain contact and support
   d) Service expansion to specific populations (military families, veterans, adolescents, older adults)

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   All Statements of Work for provider grants includes language that consumers who inject drugs is a priority population and should be given precedence when making admission determinations. West Virginia works closely with the Bureau of Public Health’s Infectious Disease Surveillance Unit to keep abreast of issues related to the incidence of infectious disease in West Virginia. The Bureau of Behavioral Health and Health Facilities coordinates closely with the Bureau of Public Health on standards for Syringe Service Programs and the expansion of these programs statewide. Likewise, all providers are required to provide screening for infectious disease as part of the programming for all services and report screening results to local health departments. Required monthly reporting reflects the training completed during the month including infectious disease training. There is a BBHHF staff person assigned to each grant who monitors compliance with this training and intervenes when they see a trend reflecting that the training is either not taking place or not being provided on a consistent basis. These compliance issues are communicated to the BBHHF compliance unit for follow up.

**Tuberculosis (TB)**

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

2. Are you considering any of the following:
   a) Business agreement/MOU with primary healthcare providers
   b) Cooperative agreement/MOU with public health entity for testing and treatment
   c) Established co-located SUD professionals within FQHCs

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   All provider grants are assigned a staff person at the BBHHF to ensure compliance with required block grant directives. Additionally, required training for all SUD providers, as directed by the Statement of Work, includes staff training and consumer screening for Tuberculosis. All bureau staff are trained and directed that infectious disease, including Tuberculosis, is a priority for all consumers receiving SUD services and that compliance with these services is a part of their responsibility. The Manager ensures that those under his/her supervision understands the importance of these requirements. Provider found to be out of compliance with this requirement are placed on notice that their grant could be jeopardized corrective action is not taken immediately. The BBHHF compliance unit is made aware of compliance issues with specific providers and that compliance with these issues should be a priority when inspecting these programs.
Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?  
   - Yes  
   - No

2. Are you considering any of the following:
   a) Establishment of EIS-HIV service hubs in rural areas  
   - Yes  
   - No
   b) Establishment or expansion of tele-health and social media support services  
   - Yes  
   - No
   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS  
   - Yes  
   - No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes (42 U.S.C. § 300x-31(a)(1))?  
   - Yes  
   - No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  
   - Yes  
   - No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  
   - Yes  
   - No

If yes, please provide a brief description of the elements and the arrangement

The BBHHF provides funding to the Bureau of Public Health to support to existing Syringe Service Projects and the development of additional programs statewide. BBHHF has worked closely with the BPH to develop standards for SSP’s to ensure consistence in the delivery of these services. The BPH is aware of the limitations of this funding in terms of the restrictions on purchase of syringes but instead provider support through staffing and other support personnel.
Criterion 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Criterions 8, 9 & 10

Syringe System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state’s approach for improvement

Yes [ ] No [ ]

2. Are you considering any of the following:

a) Workforce development efforts to expand service access

Yes [ ] No [ ]

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services

Yes [ ] No [ ]

c) Establish a peer recovery support network to assist in filling the gaps

Yes [ ] No [ ]

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)

Yes [ ] No [ ]

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations

Yes [ ] No [ ]

f) Explore expansion of service for:

i) MAT

Yes [ ] No [ ]

ii) Tele-Health

Yes [ ] No [ ]

iii) Social Media Outreach

Yes [ ] No [ ]

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?

Yes [ ] No [ ]

2. Are you considering any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services

Yes [ ] No [ ]

b) Establish a program to provide trauma-informed care

Yes [ ] No [ ]

c) Identify current and prospective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education

Yes [ ] No [ ]

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)

Yes [ ] No [ ]

2. Are you considering any of the following:

a) Notice to Program Beneficiaries

Yes [ ] No [ ]

b) Develop an organized referral system to identify alternative providers

Yes [ ] No [ ]

a) Develop a system to maintain a list of referrals made by religious organizations

Yes [ ] No [ ]

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?

Yes [ ] No [ ]

2. Are you considering any of the following:

a) Review and update of screening and assessment instruments

Yes [ ] No [ ]

b) Review of current levels of care to determine changes or additions

Yes [ ] No [ ]
c) Identify workforce needs to expand service capabilities
   Yes  No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background
   Yes  No

Patient Records
1. Does your state have an agreement to ensure the protection of client records?
   Yes  No

2. Are you considering any of the following:
   a) Training staff and community partners on confidentiality requirements
      Yes  No
   b) Training on responding to requests asking for acknowledgement of the presence of clients
      Yes  No
   c) Updating written procedures which regulate and control access to records
      Yes  No
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure
      Yes  No

Independent Peer Review
1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?
   Yes  No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.
   50

3. Are you considering any of the following:
   a) Development of a quality improvement plan
      Yes  No
   b) Establishment of policies and procedures related to independent peer review
      Yes  No
   c) Develop long-term planning for service revision and expansion to meet the needs of specific populations
      Yes  No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?
   Yes  No

If YES, please identify the accreditation organization(s)
   i) Commission on the Accreditation of Rehabilitation Facilities
   ii) The Joint Commission
   iii) Other (please specify)
**Criterion 7&11**

**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  
   - Yes  
   - No

2. Are you considering any of the following:  
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  
     - Yes  
     - No  
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  
     - Yes  
     - No

**Professional Development**

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:  
   a) Recent trends in substance use disorders in the state  
     - Yes  
     - No  
   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  
     - Yes  
     - No  
   c) Performance-based accountability  
     - Yes  
     - No  
   d) Data collection and reporting requirements  
     - Yes  
     - No

2. Are you considering any of the following:  
   a) A comprehensive review of the current training schedule and identification of additional training needs  
     - Yes  
     - No  
   b) Addition of training sessions designed to increase employee understanding of recovery support services  
     - Yes  
     - No  
   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services  
     - Yes  
     - No  
   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  
     - Yes  
     - No

**Waivers**

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:  
   a) Allocations regarding women  
     - Yes  
     - No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:  
   a) Tuberculosis  
     - Yes  
     - No  
   b) Early Intervention Services Regarding HIV  
     - Yes  
     - No

3. Additional Agreements  
   a) Improvement of Process for Appropriate Referrals for Treatment  
     - Yes  
     - No  
   b) Professional Development  
     - Yes  
     - No  
   c) Coordination of Various Activities and Services  
     - Yes  
     - No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

http://ohflac.wvdhhr.org/laws.html
Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question
In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state’s CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?  
   - Yes
   - No

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.

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Footnotes:

60 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

61 Ibid

**Please respond to the following items**

<table>
<thead>
<tr>
<th></th>
<th>Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?</th>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2.</td>
<td>Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3.</td>
<td>Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4.</td>
<td>Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5.</td>
<td>Does the state have any activities related to this section that you would like to highlight. The BBHHF is in the process of further developing our statewide plan for trauma-informed care. Please indicate areas of technical assistance needed related to this section.</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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Footnotes:
Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.¹²

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.¹³

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

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


¹³ http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services?

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances?

5. Does the state have any activities related to this section that you would like to highlight?

West Virginia’s Justice Reinvestment Initiative (JRI), known colloquially as Senate Bill 371, was passed by the 2013 regular session of the Legislature. Among the many changes to West Virginia criminal procedure was added §62-15-6, relating to “Treatment Supervision” of offenders sentenced to a community correctional setting, but requiring that substance abuse treatment be ordered and accepted by the felony offender as a condition of the less than incarceration alternative sanction.

The “treatment” component of this effort was to be designed by the Division of Justice and Community Services (D/JCS) in consultation with the Governor’s Advisory Council on Substance Abuse (GACSA), and to use appropriated funds to serve those offenders under “treatment supervision” in each judicial circuit and on parole supervision. Senate Bill 371 provided a foundation for the development of a joint plan between the Department of Military Affairs and Public Safety (DMAPS) and the Department of Health and Human Resources (DHHR) to implement an effective system of treatment supervision for substance dependent or addicted individuals under community supervision. This partnership focuses on engagement of behavioral health services treatment providers, the delivery of targeted training to treatment providers on the needs of the offender populations and increased collaboration between providers and community corrections professionals with the objectives of expanding effective
In addition to the Justice Reinvestment Initiative described above, West Virginia is the recipient of a States Strategic Response to the Opioid Crisis Grants Program (STR) grant award. As part of the STR grant, funds have been allocated to support the development of training for as well as personnel costs for the implementation of specialized peer recovery coaches serving target populations within the WV opiate use population. The reentry and offender population is an area of focus for the use of peer recovery coaches. Peer recovery coaches will be trained and strategically placed to expand the WV Division of Corrections Vivitrol program where offenders who are poised for release, have completed a substance use program and has volunteered to take part in the Vivitrol program will be given the shot of Vivitrol upon release then engaged by a Recovery Coach and/or Community Engagement Specialist working in the community with the goals of bridging the gap between the time an offender is released and when they can access treatment or recovery services in their community.

Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question
There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient’s needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA’s activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? jn Yes jn No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? jn Yes jn No

3. Does the state purchase any of the following medication with block grant funds? jn Yes jn No
   a) Methadone
   b) Buprenorphine, Buprenorphine/naloxone
   c) Disulfiram
   d) Acamprosate
   e) Naltrexone (oral, IM)
   f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? jn Yes jn No

5. Does the state have any activities related to this section that you would like to highlight?
West Virginia is the recipient of the State Targeted Response to the Opioid Crisis (STR) grant. Proposed by the grant is expansion of West Virginia University’s Comprehensive Opioid Addiction Treatment (COAT) model through the use of a “Hub and Spoke” model and ECHO. Additionally, the BBHHF is providing technical assistance to office based opioid treatment providers to comply with administrative regulations imposed by the WV legislature and also working with the Opioid Treatment Providers to comply with Medicaid regulations now that the legislature has approved reimbursement for Methadone by Medicaid.

Please indicate areas of technical assistance needed to this section.

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:
Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful. SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, *Practice Guidelines: Core Elements for Responding to Mental Health Crises*, "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

---


Please respond to the following items:

1. **Crisis Prevention and Early Intervention**
   a) Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) Psychiatric Advance Directives
   c) Family Engagement
   d) Safety Planning
   e) Peer-Operated Warm Lines
   f) Peer-Run Crisis Respite Programs
   g) Suicide Prevention

2. **Crisis Intervention/Stabilization**
   a) Assessment/Triage (Living Room Model)
   b) Open Dialogue
   c) Crisis Residential/Respite
   d) Crisis Intervention Team/Law Enforcement
   e) Mobile Crisis Outreach
   f) Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. **Post Crisis Intervention/Support**
   a) WRAP Post-Crisis
   b) Peer Support/Peer Bridges
Follow-up Outreach and Support
Family to Family Engagement
Connection to care coordination and follow-up clinical care for individuals in crisis
Follow-up crisis engagement with families and involved community members
Recovery community coaches/peer recovery coaches
Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:
Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making.

The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual’s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders](https://www.samhsa.gov/). States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery...
Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders. Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  
      Yes

   b) Required peer accreditation or certification?  
      Yes

   c) Block grant funding of recovery support services.  
      Yes

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system?  
      Yes, through the West Virginia Behavioral Health Planning Council

2. Does the state measure the impact of your consumer and recovery community outreach activity?  
   Yes

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

   For adults, recovery supports are available across West Virginia (WV) in a variety of settings. These settings range from traditional settings, such as behavioral healthcare clinics, to less formal settings, such as peer run “drop-in” centers. Recovery supports may include a variety of services and supports, such as peer support groups, Wellness Recovery Action Planning (WRAP), connection to a recovery community/resource, or one on one peer support. Also, collegiate recovery groups have recently begun to have a presence on several college campuses which serve not only transition age youth but also adult non-traditional students.

   There is a network of Youth Service Centers across the state which serve children with SED and their families. Children and families in West Virginia also have access to the Family Advocacy, Support & Training (FAST) program with Legal Aid of West Virginia. The FAST program supports families that are attempting to navigate the school system and/or the behavioral healthcare service system and trains families to become self-advocates. Families can also contact the Mountain State Parent Child Adolescent Network (MSPCAN), which is the Statewide Family Network grantee from SAMHSA for West Virginia. MSPCAN provides educational and training opportunities for families, family to family peer support, as well as resources and referrals for accessing needed community services and supports.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

   The peer run “drop-in” centers mentioned in question 3 of this section offer integrated recovery supports to individuals with substance use disorders (SUD) as well as those experiencing a SMI. At these peer centers people can access one on one or group peer support and/or recovery coaching. Recovery coaching is an approach to peer support that in West Virginia is specific to individuals with a substance use disorder. Individuals visiting a peer center also have access to supports such as WRAP, linkage to community resources, including 12 step and other recovery communities, and recovery residences. Recovery residences across West Virginia provide peer run housing and intensive recovery supports on an individualized level. Residents participate daily in activities in their recovery community and receive the support they want in order to find jobs, apply to schools or access other income supports. Recovery Coaching is also available to people living in recovery residences which can assist them with initiation and maintenance of a recovery lifestyle. A recovery coach can assist anyone with building and implementing a recovery plan, and help the individual navigate both the service system and the recovery community of his or her choice. There is a network of traditional and peer run treatment providers in West Virginia that provide an array of short and long term treatment options in a variety of settings which outpatient and inpatient services/supports. In addition, Medication Assisted Treatment is also provided in a number of settings, including Federally Qualified Health Centers, Opioid Treatment Providers, Comprehensive Behavioral Healthcare Center clinics, as well as private physician offices.

5. Does the state have any activities that it would like to highlight?

   The Bureau's Recovery Coaching Initiative has expanded the availability of peer support in West Virginia. Adding the Recovery Coach Academy® curriculum, from the Connecticut Community for Addiction Recovery, as a workforce development tool with existing and new peer supporters has helped take recovery supports for those experiencing a SUD and/or SMI to a whole new level. Recovery coaching is available in a variety of inpatient and outpatient settings and is offered as a stand-alone support or as an adjunct to other supports and services. In the last four years WV has trained over 300 recovery coaches and over 30 recovery coach academy trainers.

   Mental Health First Aid (MHFA) was introduced in West Virginia about 4 years ago. Since inception, the BBHBF staff alone have trained over 350 community members offering over 20 courses in the Adult MHFA curriculum. The Adult MHFA courses have been
offered in a variety of settings, including colleges and universities, civic organizations, faith based organizations, and justice involved settings. For the Youth MHFA component BBHHF partners with The West Virginia Department of Education (WVDE), through Marshall University and it’s Project AWARE staff, to bring the Youth Mental Health First Aid curriculum to adults working with youth in WV. With a network of over 70 Youth MHFA trainers, this collaboration has resulted in over 90 Youth MHFA courses being offered in the community with over 900 individuals participating in the workshop.

Please indicate areas of technical assistance needed related to this section.

Training and curriculum development specific to peer support for individuals receiving medication assisted treatment.

Footnotes:
Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA’s mission to reduce the impact of M/SUD on America’s communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court’s Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include:
   - housing services provided.
   - home and community based services.
   - peer support services.
   - employment services.

2. Does the state have a plan to transition individuals from hospital to community settings?

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   West Virginia was awarded a Money Follows the Person (MFP) Rebalancing Demonstration Grant by the Centers for Medicare and Medicaid Services in 2011. West Virginia’s Money Follows the Person initiative is called Take Me Home, West Virginia. The Program expects to transition approximately 600 individuals from facility-based living to their own homes and communities over the demonstration period, which ends in 2018. The Program targets Medicaid beneficiaries who: are elderly (65 and older), or; have a physical disability, or; have a serious mental illness. At the end of the demonstration period the WV Medicaid Office, known as the Bureau for Medical Services (BMS), will be transitioning the services provided under this initiative to the existing Medicaid HCBS waiver programs currently available in the state.

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

   Utilizing the MFP resources for transitioning individuals with SMI from Institutions for Mental Disease (IMDs) to the community. MFP eligibility criteria requires the last day in an institution to be paid for by Medicaid, however due to the IMD exclusion this has been an ongoing barrier.

Footnotes:
Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question:

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of those who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2015 Report to Congress on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services,
SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and...
• residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

69 The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America’s #1 Public Health Problem.

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?  [ ] Yes  [ ] No
   b) The recovery and resilience of children and youth with SUD?  [ ] Yes  [ ] No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
   a) Child welfare?  [ ] Yes  [ ] No
   b) Juvenile justice?  [ ] Yes  [ ] No
   c) Education?  [ ] Yes  [ ] No

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?  [ ] Yes  [ ] No
   b) Costs?  [ ] Yes  [ ] No
   c) Outcomes for children and youth services?  [ ] Yes  [ ] No

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?  [ ] Yes  [ ] No
   b) Mental health treatment and recovery services for children/adolescents and their families?  [ ] Yes  [ ] No

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult behavioral health system?  [ ] Yes  [ ] No
   b) for youth in foster care?  [ ] Yes  [ ] No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The BBHFF has embedded system of care values into requests for new services (Announcements of Funding Availability), grant agreements for existing services, and all training and technical assistance offered to providers, families and community members. For example:

• All BBHFF grantees must demonstrate compliance with training and service standards consistent with a system of care approach: individual and family engagement; person-driven/centered plans of care; cultural competency; trauma-informed services; consumer feedback/satisfaction.
• A statewide behavioral health plan is under development that identifies a comprehensive array of services for children with serious emotional disorders, using nationally recognized and evidence based/informed service models. The plan recognizes the need to shift service capacity from being residually “top heavy” to offering more regional and community-based non-residential services and supports.
• The statewide plan is guiding the redistribution of funds. State funding, made available for redirection as a result of Medicaid expansion, is targeted for gaps in community-based services, such as peer supports, in-home visitation, and intensive care coordination, and supporting “infrastructure” such as interagency planning teams and cross-agency clinical case reviews.
The BBHHF is partnering with the state agencies responsible for public education, juvenile corrections and child welfare to develop consistent standards and outcomes for the various federal and state grants that support school-based services designed to prevent students from becoming involved with or deepening their involvement with the juvenile justice system.

The BBHHF is partnering with WV’s early childhood system to coordinate efforts to address emotional, social and behavioral well-being of our youngest citizens and their families. All the above examples have the common denominator of bringing together state and community organizations to develop and implement services that are consistent with system of care values and principles.

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years?  
   - Yes  
   - No

2. Describe activities intended to reduce incidents of suicide in your state. 
   Increase the capacity of professionals and community organizations to effectively deliver integrated evidence-based suicide prevention, intervention and postvention practices.

   Provide education & disseminate EBP materials in schools & agencies serving at-risk individuals; Create webinars regarding universal and selective evidence-based practices and utilization of recommended toolkits; Provide technical assistance/consultation on best practices and toolkit implementation; Promote train the trainer models for culturally competent evidence-based trainings; Train crisis response teams comprised of public/private organizations associated with the comprehensives; mental health working with JJ; and schools in ASIST; Train 24-hour crisis and referral lines in ASIST; Incorporate Suicide Prevention/Intervention skills in higher learning curriculums

   Improve Outreach, Screening, Identification and Referral of At-Risk individuals in order to increase access to services

   Increase the promotion and utilization of the National Suicide Prevention Lifeline; Implement multifaceted marketing campaign to include Social Media; PSAs; text campaigns; dissemination of locally developed and SAMHSA materials; Develop standardized communication designed to reach vulnerable sub-populations identified for increased risk; develop Communication strategies that convey messages of help, hope, and resiliency; Provide for outreach events; Provide ongoing training understanding cultural considerations of specialized populations (LGBTQ; Veterans; Military families; MH/SA; attempt survivors; survivors of suicide loss); Provide for EB gatekeeper trainings; Enhance the ability of est. 24/7 referral lines to provide for assessment of suicide risk; Implement suicide risk screening in schools; juvenile justice; health centers; and emergency medical settings; Incorporate suicide screening & risk assessment in current risk assessment & intake procedures.

   Improve continuity of care and follow-up for attempt survivors and their families discharged from emergency departments and psychiatric units and the National Suicide Prevention Lifeline;

   Establish collaborations between emergency departments; inpatient psychiatric hospitals and the WV National Suicide Prevention Lifeline to provide for collaboration efforts and MOUs in order to ensure rapid follow-up after discharge; Disseminate attempt survivor packets consisting of SAMHSA and locally developed materials to EDs and inpatient psychiatric facilities; Development and implementation of protocols to ensure immediate and continuous follow-up for individuals discharged from the EDs, inpatient facilities and National Suicide Prevention Lifeline callers; Facilitate referral/continuity of care for at-risk identified individuals

   Reduce access to lethal means through a comprehensive approach of increasing awareness and education; enhancing protocols and practices;

   Develop multi-media campaign to educate communities about the importance of promoting efforts to reduce access to lethal means; Provide for means restriction education to mental health providers; educators; professional associations; parents; and individuals serving at-risk youth; Encourage providers who interact w/individuals at risk to assess for access to lethal means; Work with-in pre-existing prevention and community serving agencies and coalitions in order to provide for the appropriate restriction & containment of prescription medications; Cultivate partnerships with firearm advocacy groups and retailers in order to increase suicide awareness and promote safe firearm storage practices; Implement Suicide Proofing in safety planning; Collaborate with medical and mental health professionals to ensure incorporation of lethal means counseling into suicide risk protocols and safety plans.
Improve the current data collect and results information system

Expand state and local capacity to routinely collect, analyze, report and use suicide death and non-fatal attempt data to implement prevention efforts and inform decisions; Work within interagency efforts to assimilate data collection in a centralized location- Child Fatality review; Police agencies; Emergency Medical Services; Hospitals, etc.

3. Have you incorporated any strategies supportive of Zero Suicide?  
   j n Yes j n No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  
   j n Yes j n No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?  
   j n Yes j n No

If so, please describe the population targeted.

Continued efforts to providing follow-up services in regards to access to treatment and supportive services for attempt survivors and their families have been initiated through partnerships with Emergency Departments, Inpatient hospitals, homeless shelters, CBHCs; and additional agencies serving individuals at risk. Increased support for attempt survivors and their families also included the continued dissemination of educational packets after an attempt had occurred. Packet contents include: SAMHSA’s After an Attempt: A Guide for Self; After an Attempt; A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department; Now What Do We Do?; a letter to the attempt survivor and their family introducing the content; and a locally developed referral and resource card. In addition, a referral mechanism for attempt survivors and their families was established as means of encouraging help-seeking behaviors and linkage to follow-up services.

Does the state have any activities related to this section that you would like to highlight?

An updated Statewide Suicide Prevention Plan will be completed in December 2017.

Please indicate areas of technical assistance needed related to this section.

Additional strategies for working with Emergency Departments in regards to referral of attempt survivors for continuity of care.

Implementation of suicide prevention and intervention trainings in health care systems.

Strategies for increased participation for adoption of the Zero Suicide Model within behavioral health care and health care agencies.

Footnotes:
Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question
The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA 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 any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions or consultation on the benefits available to any Medicaid populations.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  
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<th>Yes</th>
<th>No</th>
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   If yes, with whom?

   The BBHHF is continually looking for ways to leverage existing partnerships for greater benefit and new opportunities. For example, the WV Department of Education, a longstanding state partner, recently engaged in a new partnership with BBHHF providing substance abuse prevention services in the school system statewide.

   Additionally, BBHHF has significantly increased the level of our partnership with West Virginia's two major universities (Marshall and West Virginia) This increased partnership has resulted from increasing partnership between BBHHF and the universities on SAMHSA and other Federal grant projects and recent state legislation. Enrolled Committee Substitute for Senate Bill 634, relating to exempting certain contracts between the Department of Health and Human Resources and West Virginia University, Marshall University or West Virginia School of Osteopathic Medicine from state purchasing requirements. Effective Ninety Days from Passage - (July 2, 2017). SB 634 will allow BBHHF to enter into contracts and grant agreements with the three state universities and their medical schools, including but not limited to clinical, data and research, and training services.

2. Has your state identified the need to develop new partnerships that you did not have in place?  
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<th>Yes</th>
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   If yes, with whom?

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

   Governor's Advisory Council on Substance Abuse: Strategic plan development and implementation advisement and making recommendations to the Governor for policy changes.
Governor's Regional Task Forces: Identifying community need and making local recommendations

WV Behavioral Health Planning Council: Assures community voice in planning and program implementation

WVSEOW Membership: Determines need to help the State make data informed decisions

Bureau for Children and Families: Coordination of children's service and family preservation and system of care initiatives

Bureau of Medical Services (Medicaid): Rate setting, service coverage for behavioral health and determining service definitions

Bureau of Public Health: Partner on related projects involving moms and babies, school wellness and physician best practices

Department of Education: Partner on administration of statewide school climate survey and implementation of regional wellness staff, implementation of behavioral health courses in schools, project launch and school based mental health services

WV State Police: Provide staffing for Synar and FDA Tobacco Programs

Benedum Foundation: Funding partner with Moms and Babies Recovery project

Department of Military Affairs and Public Safety: Partner on Justice Reinvestment Initiatives and Vivitrol Pilot in correctional facilities

WV DD Council: Coordination of best practice implementation for individuals with intellectual and developmental disabilities

WV State Medical Association: Coordinate Appalachian Addictions Conference and other prescriber education programs

WV Board of Pharmacy: Partner on the data and receipt of PDMP data

WV Higher Education Commission: Implementation of behavioral health education in higher education State Universities Partnership to determine behavioral health education in med schools, recruit and use of residents and physicians for MAT and other psychiatry services through telehealth

WV Office of Veterans Affairs: Coordination of behavioral health services

WV National Guard: Partner to provide cross-training for behavioral health and military

WV Behavioral Health Provider's Association: Work with to determine provider needs in making system improvements

WV Childcare Association: Partner for training and referral mechanisms

WV Primary Care Association: Coordination of integrated care

WV Collegiate Initiative: Infusion of prevention programs in schools

WV Perinatal Partnership: Substance use in pregnancy initiatives

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council’s comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc. . . )
   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   Governor Earl Ray Tomblin issued Executive Order No. 5-11 on September 6, 2011, which created the Governor’s Advisory Council on Substance Abuse (GACSA). Appointed council members include Cabinet level positions in the Department of Health and Human Resources, Department of Military Affairs and Public Safety, and the Department of Veterans Assistance; persons in leadership positions representing the State Police, Chiefs of Police, Sheriffs, Supreme Court, Education, WorkForce West Virginia, Behavioral Health and Health Facilities; experts from the fields of behavioral medicine, substance abuse prevention and treatment, peer and recovery supports, the faith-based and minority communities, homelessness, domestic violence prevention; and, a range of health professionals, among others. Responsibilities of the GACSA include: provide guidance regarding implementation of the Statewide Substance Abuse Strategic Action Plan; identify planning opportunities with other interrelated systems to increase both public and private support concerning substance abuse initiatives; recommend a list of priorities for the improvement of the substance abuse continuum of care; receive input from local communities throughout West Virginia; and, provide recommendations to the Governor to improve education, data needs, employment opportunities, communication, crime prevention, and other matters related to substance abuse. The six Regional Substance Abuse Task Forces met publicly every other month initially, now quarterly, to gather community input and funnel recommendations up to the GACSA, which then issues a yearly report with recommendations subsequently made to the Governor and his state agencies.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i [ ] Yes [ ] No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

   [ ] Yes [ ] No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   The mission of the WV BHPC is to improve the mental health service system and function as a catalyst for change. The Council is federally mandated to review and comment on the State mental health plan, monitor, review, and evaluate allocation and adequacy of mental health block grant services, and advocate for services for individuals with mental illness and co-occurring substance abuse issues. The members of the Council and its subcommittees, including the Executive, Membership, Children and Families Services, Adult Services, Housing and Olmstead Committees, work collaboratively with the member state agencies to solicit input from the applicable stakeholders and provide input on agency priorities and plans, including but not limited to the Community Mental Health Services and SAPT Block Grant applications. The Council accomplishes this by: meeting at least quarterly
in different areas of the State; developing strategies to accomplish Council goals pursuant to the federal mandate; actively participating in a wide range of state and local initiatives that impact behavioral health, homelessness, and community services; and, partnering with the BBHFF to assure the availability of person centered, high quality behavioral health services throughout the State and conducting independent assessments of need which are reported to the BBHFF.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.\textsuperscript{73}

\textsuperscript{73}There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

**Footnotes:**

Attachments include:

Letter signed by the Chair of the Planning Council stating the Planning Council reviewed the application

Agenda for July 20, 2017 WVBHPC meeting where the FY 2018-2019 application was discussed.
### Behavioral Health Advisory Council Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email (if available)</th>
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<tbody>
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<tr>
<td>Debi Gillespie</td>
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<td>JK McAtee</td>
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<td>Donna Moss</td>
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<td>Linda Pauley</td>
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<td><a href="mailto:linda_pauley@yahoo.com">linda_pauley@yahoo.com</a></td>
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<td>Louann Petts</td>
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<td>Cathy Reed</td>
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<td>James Ruckle</td>
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<tr>
<td></td>
<td></td>
<td>Charleston WV, 25305 PH: 304-766-4881</td>
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<td></td>
</tr>
<tr>
<td>Diane Whitlock</td>
<td>State Employees</td>
<td>West Virginia Department of</td>
<td><a href="mailto:dwhitloc@k12.wv.us">dwhitloc@k12.wv.us</a></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Education</td>
<td></td>
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<td></td>
<td></td>
<td>Capitol Complex</td>
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<tr>
<td></td>
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<td>Building 6 Rm 330</td>
<td></td>
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<td></td>
<td></td>
<td>Charleston WV, 25305 PH: 304-558-2696</td>
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</tbody>
</table>
### Behavioral Health Council Composition by Member Type

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Family Members of Individuals in Recovery* (to include family members of adults with SMI)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Parents of children with SED*</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Vacancies (Individuals and Family Members)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Others (Not State employees or providers)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td><strong>23</strong></td>
<td></td>
</tr>
<tr>
<td>State Employees</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Federally Recognized Tribe Representatives</td>
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</tr>
<tr>
<td>Vacancies</td>
<td>2</td>
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</tr>
<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
<td><strong>22</strong></td>
<td></td>
</tr>
<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<td></td>
</tr>
<tr>
<td><strong>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</strong></td>
<td><strong>0</strong></td>
<td></td>
</tr>
<tr>
<td>Persons in recovery from or providing treatment for or advocating for substance abuse services</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Members of the Planning Council are involved in the review of the application during the application preparation process and throughout the year when the application is reviewed and discussed at regular quarterly Planning Council meetings. Planning Council members have the opportunity during these meetings to provide input on the BBHHPF’s planning and funding decisions. Feedback and recommendations to modify the application will be considered and reflected in the application during the public comment period before final submission to SAMHSA. The Council Chair will once again be invited to submit a letter from the Council recommending modifications and/or comments on the application.

**Footnotes:**
West Virginia does not collect racial, ethnic, or LGBTQ demographic information from planning council members.
Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a) Public meetings or hearings?  
      Yes    No

   b) Posting of the plan on the web for public comment?  
      Yes    No

   c) Other (e.g. public service announcements, print media)  
      Yes    No

   If yes, provide URL:
   http://www.dhhr.wv.gov/bhhf/Pages/default.aspx

Footnotes: