West Virginia KidsThrive Collaborative

When kids and families thrive, West Virginia thrives.

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia (WV) Commission to Study Residential Placement of Children and the Kids Thrive Collaborative (KTC) Meeting

Date: Thursday, March 26, 2026

Time and Location: 10:30 a.m. to Noon/Virtual Only

Meeting Information: Zoom link: https://berrydunn.zoom.us/j/96780427958?from=addon
Dial in: (646) 876-9923; Meeting ID: 967 8042 7958

Agenda Items

Item #	Topic and Description	Responsible
1	**Welcome**	**Daron Light, Associate General Counsel**
2	**Commission to Study Residential Placement of Children** • **Approval of December 2025 Meeting Notes**	**Daron Light**
3	**Commission Legislature Responsibility and Goals**	
	• **GOAL 1: Transformational Collaborative Outcomes Management (TCOM) §49-2-125 (e)(3)**	**Linda Gibson**
	• **GOAL 2: Provider Input at Multidisciplinary Team (MDT) and Court §49-2-125(d)(4)**	**Brenda Hoylman**
	• **GOAL 3: Implementation of Every Student Succeeds Act (ESSA)**	**Brittany Gould**
4	**Legislative Update**	**Elliot Birkhead, BBH Deputy Commissioner**
5	**West Virginia (WV) Truancy Information**	**Laura Hunt**
6	**Kids Thrive Key Indicators**	**Laura Hunt**
7	**U.S. Department of Justice (DOJ)**	**Ashley Light**
8	**Meeting Conclusion**	**Daron Light**

Meeting Notes

Item #	Topic and Description
1	**Welcome**

2	**Commission to Study Residential Placement of Children**
	• **Approval of December 4, 2025, Meeting Notes**
	  ○ Susan Fry motioned to approve the minutes.
	  ○ Jessica Fulknier seconded the motion to approve the minutes.
	  ○ There were no objections.
	  ○ December 2025 meeting notes were approved.

3	**Commission Legislature Responsibility and Goals**
	• **GOAL 1: TCOM §49-2-125 (e)(3)**
	  ○ Linda Gibson shared that TCOM assessments are used to inform service intervention and planning.
	  ○ Annual booster train-the-trainer sessions will be completed in July for all certified trainers.
	  ○ The TCOM website contains extensive resources and is currently undergoing a facelift; and no changes to usernames or passwords are expected.
	  ○ The Adult Needs and Strengths Assessment (ANSA) is used primarily for adults, including transitions to end-of-life care, and for youth transitioning out of the home as a special population. All required training has been completed.
	  ○ Joint training with the Department of Human Services (DoHS) is provided monthly, except for December.
	  ▪ Susan Fry asked whether individuals trained in Child and Adolescent Needs and Strengths (CANS) are authorized to use ANSA.
	  • Linda confirmed that CANS training is sufficient for both.
	• **GOAL 2: Provider Input at MDT and Court §49-2-125(d)(4)**
	  ○ Brenda Hoylman shared that the MDT process has been revamped, and the initial approach of engaging providers first has shifted. The decision was made to begin in state with Bureau for Social Services (BSS) county workers.
	  ○ BSS county workers will be asked a set of questions over the coming months. Brenda is currently developing these questions for distribution to BSS county workers.
	  ▪ Laura Hunt requested that Brenda share the questions with the Office of Quality Assurance (OQA) once they are available.

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- **GOAL 3: Implementation of ESSA**
  - Brittany Gould explained the program was created in 2021 to identify and support students in foster care by helping them transition and connect with academic resources.
  - The program is referral-based, and in 2025 it received 849 referrals.
  - Brittany's team closely monitors foster care student enrollment by county and has conducted training across various foster care agencies.

4 **Legislative Update**

- Elliot Birkhead shared the Children and Youth Bills Completed Leg Process - 2026 Regular Session 3.24.26 PDF document and provided an overview of the legislative process to the group. He explained that the Governor has 15 days from enrollment to sign, veto, or allow a bill to become law, and that the Legislature may review bills within the applicable timeframes.
- Elliot encouraged participants to search by Senate Bill (SB) and House Bill (HB) number online for more up-to-date information.
- He provided high-level summaries of each SB and HB to the group and said that the Notes column in the PDF includes his personalized summaries of the bills.
- The PDF document is provided with the meeting notes.

5 WV Truancy Information

- Laura provided an overview of truancy data from the CANS assessment. As of August 31, 2025, 859 children were in residential settings; 190 of those children have significant school attendance–related needs and data indicate they could be served in the community.
- Mia Johnson asked whether the analysis reviewed or accounted for medical necessity when evaluating this data.
    - Laura clarified the estimates are based solely on CANS data and the child's needs as identified by the provider at admission. Based on this analysis, some children could be served through community-based support.
    - Mia asked whether the analysis considered the availability of actual services in the community, given known service gaps.
        - Laura noted that service availability was not considered in this dataset; however, OQA has explored related data and found that while services exist, children are not always connected to them.
        - Kathy Szafran commented in the chat "that court orders may override medical necessity for placement."
        - Mia shared that, from a provider's perspective, it is challenging to present this information without fully disclosing all contributing factors.
        - Susan Fry added that messaging suggested that large numbers of youth are placed at a Level 3.5 solely due to truancy, raising questions about how medical necessity was approved. The group emphasized that placements often involve complex circumstances.
    - Laura added the intent of this analysis is to provide a high-level understanding of truancy-related indicators, not to capture all placement decision factors.
        - Stephanie Bond commented in the chat "I would agree with both Mia and Susan, as often times the blame is placed on the Judges for sending kids away only because the youth has a truancy problem" However, when looking into each specific situation, it shows that the youth have numerous issues that have not been able to be resolved while they are at home."
- A latent class analysis identified subgroups of children with similar patterns of need. The analysis grouped children into four classes (A–D) in order of acuity.
    - Mia asked whether the analysis examined correlations between types of abuse and class membership.
        - Laura said the analysis did not assess specific abuse types, but it considered service use cases, Child Protective Services (CPS) cases, and overlapping cases.
    - Mia also asked whether the analysis considered service gaps that result in children placed out of state.
        - Laura said service gaps were not included in this analysis, though other analyses have examined this. She said that children are placed out of state for various reasons; most commonly for specialized needs such as autism, Intellectual and Developmental Disability (IDD), sexualized behaviors, and self-harm.
- Laura said that many questions remain unanswered, including whether children

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experiencing disruptions were previously connected to services before being placed directly into residential settings. She emphasized the need to focus on prevention earlier before children enter the child welfare system.

- Pamela Kaehler posted in the chat "on the topic of youth/children in residential that could be served in home and community, it is terribly important to assist the caregiver with needed approaches and skills ~ which is not to say they are doing anything wrong, but a different approach can be a very important factor for both stability for the child and satisfaction for the caregiver (most definitely, for foster parents). Please prioritize parent management training, positive behavior support training, etc. to the mix. Foster parents express repeatedly that they feel underprepared, unsupported, exhausted, and blamed when child behavior exacerbates, but we can def help with this."
- Susan Fry added there is significant work ahead and highlighted the value of leveraging collective experience by recommending a cross-collaborative workgroup be established to focus on truancy and bring recommendations back to the Commission.
- **ACTION ITEM: Discuss forming a workgroup with the Commission Chair.**

6. Kids Thrive Key Indicators

- Laura explained that OQA reviews monthly indicators to monitor overall system trends and shared visuals related to:
  - Children's Crisis and Referral Line (CCRL)
  - Children's Mobile Crisis Response (CMCR)
  - WV Wraparound
  - Residential Mental Health Treatment (RMHT)
  - Therapeutic Foster Care (TFC) Capacity

7 DOJ

- Ashley Light provided a status update on the Compliance Report. The DOJ determined that moving forward compliance assessments will occur in October and a mid-year assessment in April. A compliance assessment discussion was previously held in January.
  - The DOJ Compliance Assessment can be found here: DOJ Partnership | Kids Thrive Collaborative

8 Meeting Conclusion

- Lisa said the meeting notes will be posted on the Kids Thrive website. If you have not signed up for notifications, or know someone who would like to be included—please visit the Kids Thrive Collaborative website to sign up for email updates: Get Involved | Kids Thrive Collaborative
- The next quarterly meeting is set for Thursday, June 25, 2026, at 10:30 a.m.

Following the meeting, Dr. Blake Gibson, Assistant Profession, Adult, Child and Adolescent Psychiatry with West Virginia University (WVU) Medicine provided this update via email:

I was unable to make the Kids Thrive Meeting today but wanted to be sure I mentioned some exciting news. Our virtual partial hospitalization program for adolescents has completed all the needed approvals to begin. We will start this summer. In a previous meeting, I briefly mentioned we were working on this, so I wanted to close the loop.

Please see the attachment for more information on the structure and function of the program. In brief, this is an intensive (intermediate) level of care designed to sit between restrictive levels of care (inpatient, RTF) and general outpatient. In other states with both PHP and CSED (wrap around), the two services work well in the same ecosystem to reduce the over/misuse of restrictive levels of care. To this end, we feel this program will be helpful in achieving the aims of Kids Thrive and the joint DOJ/WV partnership. We currently have BCBS, Aetna, and Peak on board, and avidly working on agreements with other payers. WV Department of Education would list participants to be made homebound for the 4–6-week program, which we will work the appropriate schools to ensure takes place.

We welcome any opportunity to discuss our efforts further with the appropriate elements of the department. Please do let us know how we can work as a team to help solve one of our states most challenging issues.

Personalized Bill Tracking List

ChildrensBills - 2026 Regular Session					
Bill	Title	SA(Same As)/ SI(Similar To)	Last Action	Committee Reference	Notes
SB 197 (None)	Relating to crime of sexual abuse by parent, guardian, custodian, or person in position of trust to child		*03/14/26* - To House Governor 3/19/2026 - Journal	**House Reference 1** - Judiciary **Senate Reference 1** - Judiciary	relating to increasing the criminal penalties and fines for crimes against minors.
SB 228 (None)	Relating to use of technology in child abuse and neglect investigations	SI HB5189	*03/14/26* - To House Governor 3/18/2026 - Journal	**House Reference 1** - Health and Human Resources **House Reference 2** - Finance **Senate Reference 1** - Health and Human Resources **Senate Reference 2** - Finance	relating to requiring the Department of Human Services to establish a pilot program in one or more districts comprised of no more than three counties in the aggregate to provide for supplemental caseworker aide services for the Bureau for Social Services; and requiring the Department of Human Services to implement a pilot project in two counties that requires the use of mobile devices to access the department's case management system.
SB 459 (None)	Ensuring meaningful contact between child and step-siblings		*03/14/26* - To House Governor 3/18/2026 - Journal	**House Reference 1** - Judiciary **Senate Reference 1** - Judiciary	Adds language re: Meaningful contact between a child and his or her siblings, "including half-siblings and step-siblings when the child has an established bond with the step-sibling and the step-sibling lives at least part-time with the biological parent."
SB 744 (None)	Relating to Critical Incident Review Team		*03/13/26* - To House Governor 3/13/2026	**House Reference 1** - Health and Human Resources **Senate Reference 1** - Health and Human Resources	requiring the commissioner to send a notification of child fatality or near fatality to the Office of the Inspector General within 24 hours to convene Critical Incident Review Team; clarifying that the Critical Incident Review Team is continued under jurisdiction of the Office of the Inspector General; requiring the Foster Care Ombudsman to chair the Critical Incident Review Team rather than the Commissioner of the Bureau for Social Services.
SB 794 (None)	Relating to appeals of orders or decrees of adoption		*03/14/26* - To House Governor 3/18/2026 - Journal	**House Reference 1** - Judiciary **Senate Reference 1** - Judiciary	clarifying that the Intermediate Court of Appeals does not have appellate jurisdiction over appeals of adoption orders or decrees.
SB 947 (None)	Providing birth certificate copies to homeless individuals under 18		*03/14/26* - To House Governor 3/19/2026 - Journal	**House Reference 1** - Judiciary **Senate Reference 1** - Government Organization	the State Registrar shall furnish, free of charge, a certified copy of an individual's West Virginia birth certificate upon application and a written affirmation of that individual's homelessness: Provided, That the individual is under the age of 18 years. The State Registrar will keep a record of all certificates furnished pursuant to this subsection.

HB 4022 (None)	CPS Allocation	SI SB391	*03/14/26* - To House Approved by Governor 3/14/2026 - Journal	**House Reference 1** - Health and Human Resources **Senate Reference 1** - Health and Human Resources **Senate Reference 2** - Judiciary	Notwithstanding any other provision of this code to the contrary, the commissioner shall allocate and station Child Protective Services workers by county based on population, referrals, and average caseload.
HB 4053 (None)	To establish the blue envelope program.		*03/18/26* - To House Governor 3/18/2026	**House Reference 1** - Judiciary **House Reference 2** - Legal Services **Senate Reference 1** - Transportation and Infrastructure **Senate Reference 2** - Health and Human Resources	The State Police shall develop and implement a program for the promotion, printing, and distribution of envelopes for use by drivers diagnosed with autism spectrum disorder, dementia, or any intellectual and developmental disability to provide to a law enforcement officer for the purpose of easing communication during a traffic stop or upon such law enforcement officer's arrival at the scene of a traffic accident.
HB 4354 (None)	Relating to necessity allowance		*03/18/26* - To House Governor 3/18/2026	**House Reference 1** - Health and Human Resources **House Reference 2** - Finance **Senate Reference 1** - Health and Human Resources **Senate Reference 2** - Finance **Senate Reference 3** - Judiciary	relating to providing adequate clothing and approved necessities for certain children in out-of-home placement; requiring review, inventory, and purchase of clothing and necessities; requiring minimum funding allowance for adequate wardrobe and approved necessities; providing for initial and supplementary allowances; and prescribing methods for payment or reimbursement.
HB 4390 (None)	Relating to the temporary payment to a kinship parent of a subsidy equal to that of a foster parent		*03/18/26* - To House Governor 3/18/2026	**House Reference 1** - Health and Human Resources **House Reference 2** - Finance **Senate Reference 1** - Health and Human Resources **Senate Reference 2** - Finance	a kinship parent shall be eligible for a temporary increase in the payment paid by the Department equal to that paid to a foster parent if at the time of initial placement, the following conditions are satisfied: (1) The kinship parent has submitted to state and national criminal history record checks which shall be submitted within five days of the initial date of placement; (2) The Department is satisfied with the results of the state and national criminal history record checks; and (3) The kinship parent has complied with the initial home screening to identify and to correct life safety issues.Note: The temporary increase in payment amounts becomes payable to the kinship parent within 30 days of the initial kinship placement and will continue for a period of no more than six months.
HB 4393 (None)	Requiring the development and implementation of statewide prevention plan	SI SB436	*03/18/26* - To House Governor 3/18/2026	**House Reference 1** - Health and Human Resources **Senate Reference 1** - Finance	On or before January 1, 2027, the Department of Human Services (DoHS) shall develop a statewide prevention plan, to provide prevention services to children under the age of 18 and their families which include kinship and foster parents.
HB 4730 (None)	Developing a Continuum of Independent Living and Transitional Support Services for Youth Aging Out of Foster Care	SI SB797	*03/10/26* - To House Governor 3/10/2026	**House Reference 1** - Health and Human Resources **Senate Reference 1** - Health and Human Resources	relating to the development of a continuum of services and supports for youth who are preparing to exit foster care or who have aged out of that care.
HB 4749 (None)	Relating to adding requirements to the foster child bill of rights		*03/13/26* - To House Approved by Governor 3/13/2026 - Journal	**House Reference 1** - Judiciary **Senate Reference 1** - Health and Human Resources **Senate Reference 2** - Judiciary	including the right to have timely notice of a hearing that may have legal implications for a child over 13, the right to attend a hearing that may have legal implications for a child over the age of 13, and the right to have the outcome of any hearing that has legal implications for the child explained to them by their guardian ad litem

					or legal counsel.
HB 5048 (None)	To ensure virtual instruction for foster students while in temporary placement facilities.		*03/14/26* - To House Message received	**House Reference 1** - Education **Senate Reference 1** - Select Committee on School Choice	The virtual instruction for the child awaiting residential placement shall occur no more than three days after the child is in the temporary care of the individual, group, or organization.
HB 5214 (None)	Relating to drug testing of parents who have had abuse and/or neglect claims substantiated against them prior to reunification.		*03/14/26* - To House Completed legislative action	**House Reference 1** - Judiciary **House Reference 2** - Courts **Senate Reference 1** - Health and Human Resources **Senate Reference 2** - Judiciary	requiring a parent, who has been adjudicated to have abused or neglected his or her child and whose abuse or improper use of controlled substances contributed to the situation that resulted in initial removal of the child or where there is credible evidence that the abuse or improper use of controlled substances is ongoing, to undergo drug testing, requiring testing for controlled substances suspected by the court or the department, requiring laboratory confirmation of positive results, prohibiting returning a child home for reunification if either parent residing in the home initially tests positive for an illegal substance or a controlled substance for which he or she does not possess a valid and current prescription or medical cannabis card.
HB 5437 (None)	Creating the Vape Safety Act		*03/14/26* - To House Message received	**House Reference 1** - Health and Human Resources **House Reference 2** - Judiciary **Senate Reference 1** - Health and Human Resources	relating to regulating vape or smoke shops; defining terms; requiring license.
HB 5684 (None)	Relating to authorizing the Supreme Court of Appeals to create child protection commissioners		*03/14/26* - To House Message received	**House Reference 1** - Judiciary **Senate Reference 1** - Judiciary	The Legislature hereby finds and declares that a severe shortage of attorneys to represent children in child welfare matters exists throughout the state, and therefore, a compelling state interest exists in expanding the use of retired employees to serve as child protection commissioners or circuit court law clerks. “Child protection commissioner” means an individual appointed by the Supreme Court of Appeals to manage portions of a court case filed pursuant to this chapter.

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Quarterly Meeting

March 26, 2026

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Kids Thrive Collaborative Agenda

1. Legislative Updates
2. Truancy Information
3. Kids Thrive Key Indicators
4. U.S. Department of Justice (DOJ)

West Virginia KidsThrive Collaborative

West Virginia Department of Human Services

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Legislative Update

2. Truancy Information

- The Department of Human Services (DoHS) conducted an analysis of children placed in psychiatric residential or residential mental health facilities as of August 31, 2025.
- The Children's Assessment of Needs and Strengths (CANS) data system was utilized to support need identification, including needs related to school attendance.
- There were 859 children in residential settings as of August 31, 2025, with 190 of those children identified to have significant school attendance-related needs.

1 in every 7 children in residential placements were determined to have attendance-related needs AND have overall mental health needs that could likely be served in the community (14%, n=118).

2. Truancy Information, Continued

- A latent class analysis (LCA) was conducted to identify similar sub-groups of children, referred to as classes, and patterns of need associated with these classes.
- The model identified unique classes, for children with attendance-related needs, labeled as:
  - Class A – Legal, Anxiety, Lower Needs
  - Class B – Social Functioning and Anxiety Needs
  - Class C – Legal, Anger, and Oppositional Needs
  - Class D – Anger, Impulsivity, Social Functioning Needs

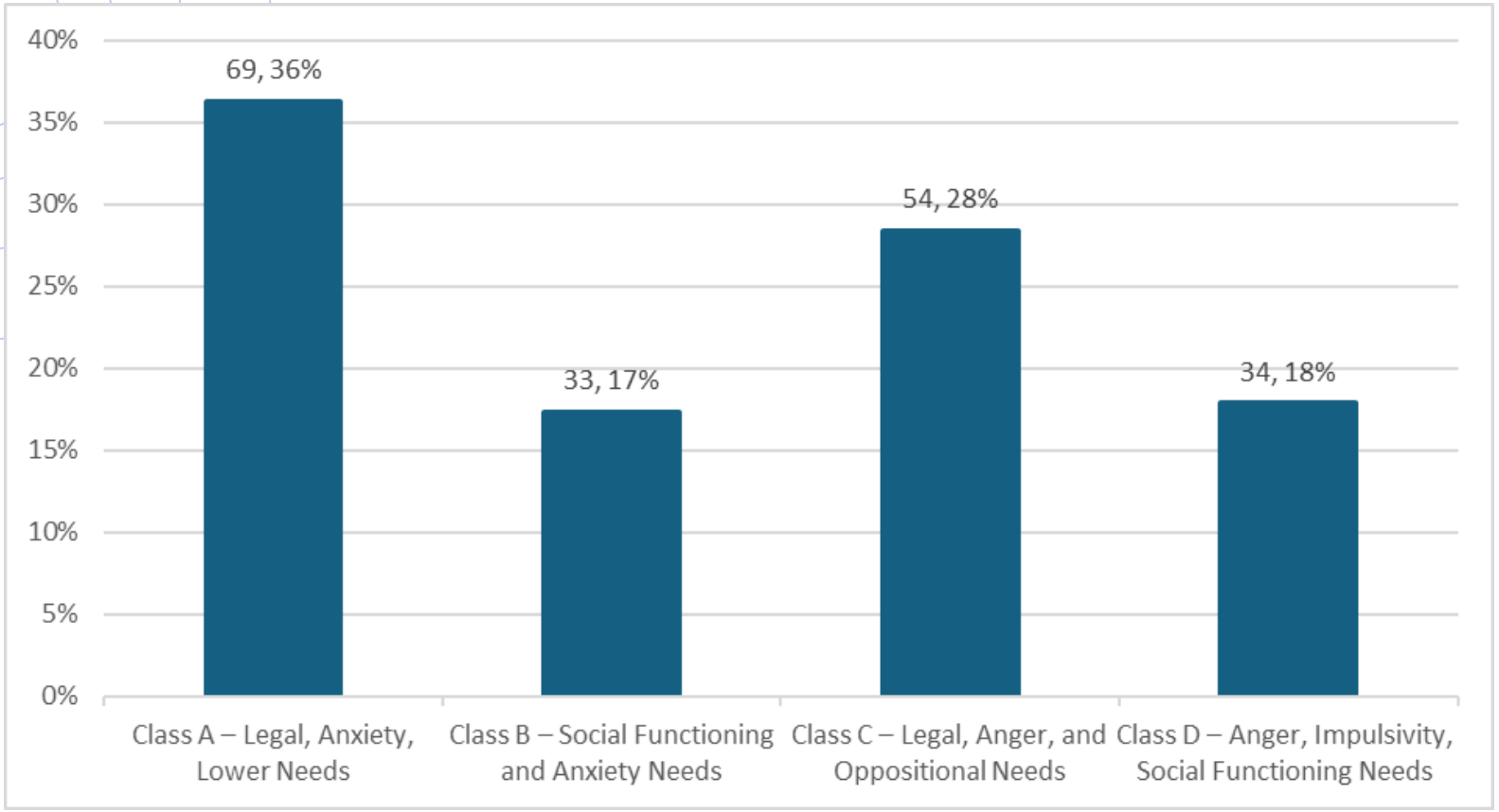
2. Truancy Information, Continued

Most Common Needs Identified by Class for Children With Attendance-Related Needs (n=190), Including Expected Percentage of Children in the Class Who Will Have That Need in Descending Order for Each Class

Class A – Legal, Anxiety, Lower Needs	%[1]	Class B – Social Functioning and Anxiety Needs	%	Class C – Legal, Anger, and Oppositional Needs	%	Class D – Anger, Impulsivity, Social Functioning Needs	%
Legal	69.7%	*Social Functioning*	62.8%	*Legal*	98.0%	*Anger Control*	100.0%
Anxiety	53.5%	*Anxiety*	59.7%	*Anger Control*	88.6%	*Impulsivity*	94.1%
Depression	38.7%	*Attention/Concentration*	58.8%	*Oppositional*	87.6%	*Social Functioning*	88.3%
Attention/Concentration	34.1%	*Depression*	56.2%	*Living Situation*	78.2%	*Living Situation*	84.3%
Living Situation	32.5%	*Adjustment to Trauma*	54.8%	*Substance Use*	76.2%	*Oppositional*	80.9%
		Living Situation	52.7%	*Delinquency*	69.4%	*Attention/Concentration*	78.5%
		Impulsivity	52.1%	*Impulsivity*	64.1%	*Danger to Others*	75.0%
		Attachment Difficulties	46.8%	*Conduct*	58.5%	*Conduct*	70.8%
		Oppositional	42.1%	*Anxiety*	51.0%	*Adjustment to Trauma*	64.7%
		Anger Control	40.3%	*Danger to Others*	50.9%	*Affective/Physiological Dysregulation*	60.6%
		Legal	38.3%			*Sleep*	59.1%
		Sleep	36.8%			*Intentional Misbehavior*	58.4%
		Affective/ Physiological Dysregulation	35.4%			*Depression*	58.0%

2. Truancy Information, Continued

LCA Class Distribution for Children With an Attendance-Related Need (n=190)



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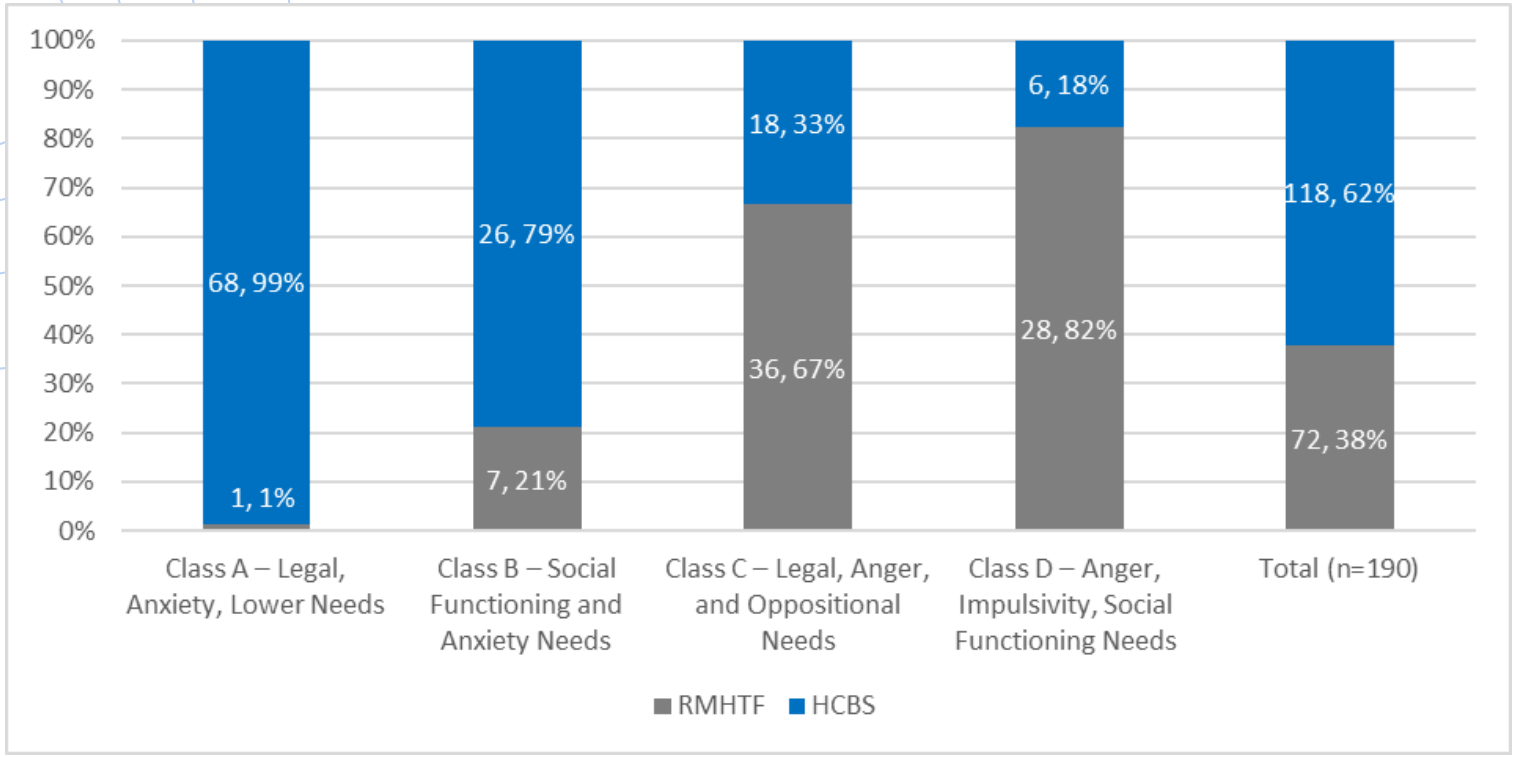
2. Truancy Information, Continued

Estimated Level of Care Need by Class for Children With Attendance-Related Needs (n=190)



Note:
RMHTF in this context includes both residential mental health facilities and psychiatric residential treatment facilities.
HCBS includes a level of care that might include services in the home and community at varying level of need from traditional mental health services to WV Wraparound (intensive). Results have been summarized in these two groups for brevity.

2. Truancy Information, Continued

Children identified as having attendance-related needs and likely could be served in the community were:

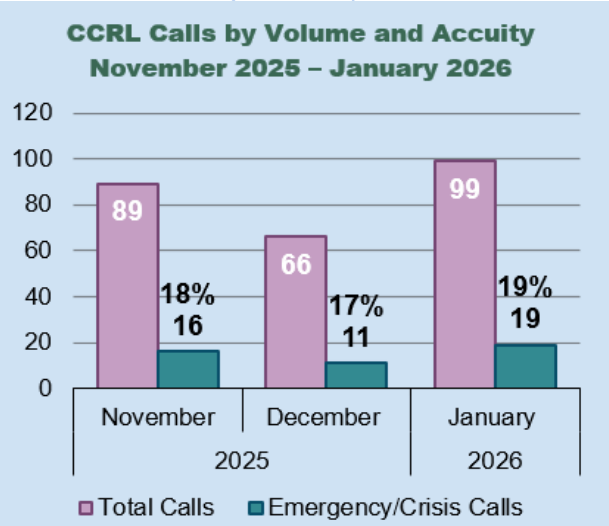
- More likely to be age 15 or older
- Less likely to be placed out of state
- Much less likely to have significant needs such as “Adjustment to Trauma,” “Substance use,” “Danger to Others,” and “Impulsivity”
- More likely to be involved with the child welfare system via a youth services case only
- More likely to have had no prior child welfare placement before residential admission

2. Truancy Information, Continued

What can we do as a collaborative?

- To help avoid unnecessary residential placements and address youth and family needs prior to or in lieu of child welfare involvement, the following should be leveraged:
  - Prevention and early intervention programming for social emotional needs
  - Connection to home and community-based services
  - Proper clinical assessments when needed (and before residential placement)
- Interventions, connections, and unified messaging across state entities has great potential to improve outcomes for the broader population of children with serious emotional disorders by helping:
  - Drive appropriate level of care decision-making
  - Connect families earlier to an appropriate array of services to meet their needs
  - Open in-state residential capacity for children with higher acuity needs, allowing them to be served in WV and closer to home when residential treatment is necessary
  - Optimize use of limited state funding, which can then be redirected from out-of-state (OOS) residential settings to reinforce in-state and in-community mental health resources

3. Kids Thrive Key Indicators

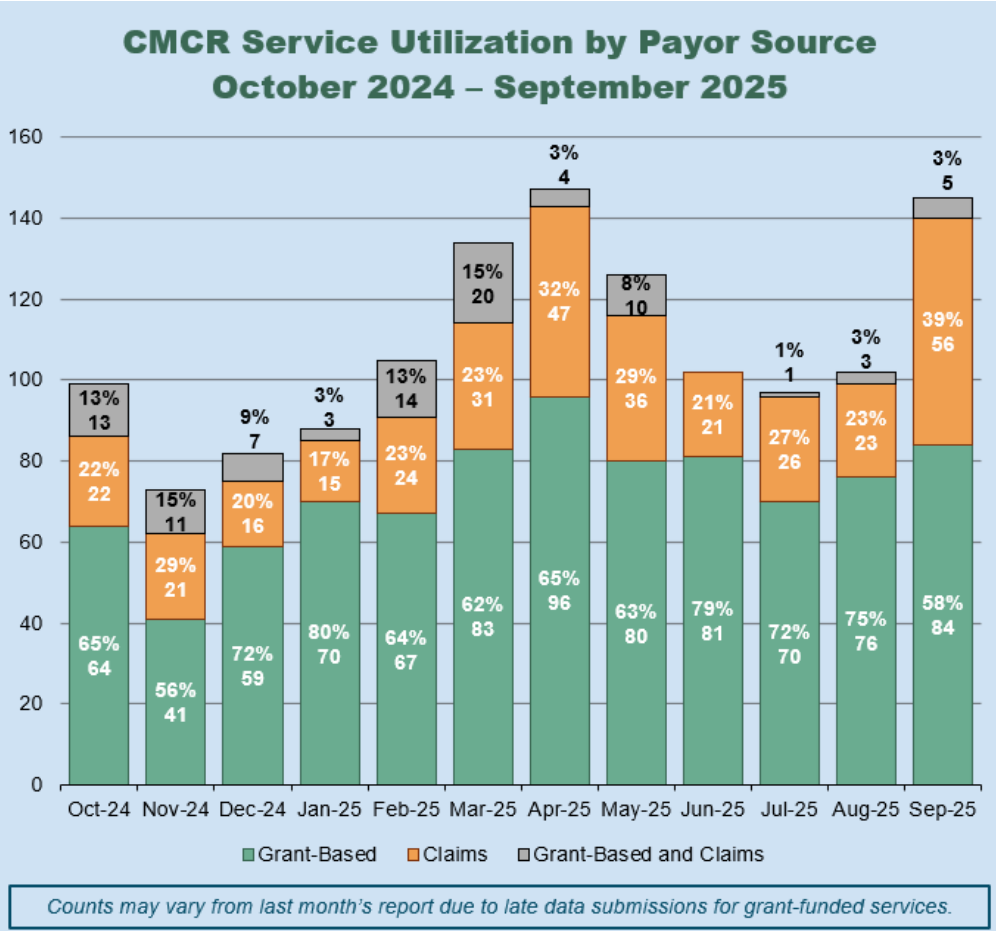


Total Youth Served through CMCR in September 2025

145

Compared to 102 in August 2025.

Due to use of claims data, CMCR is reported on a lag.



Counts may vary from last month's report due to late data submissions for grant-funded services.

September had an increase of 43 Children's Mobile Crisis Response (CMCR) calls from the previous month.

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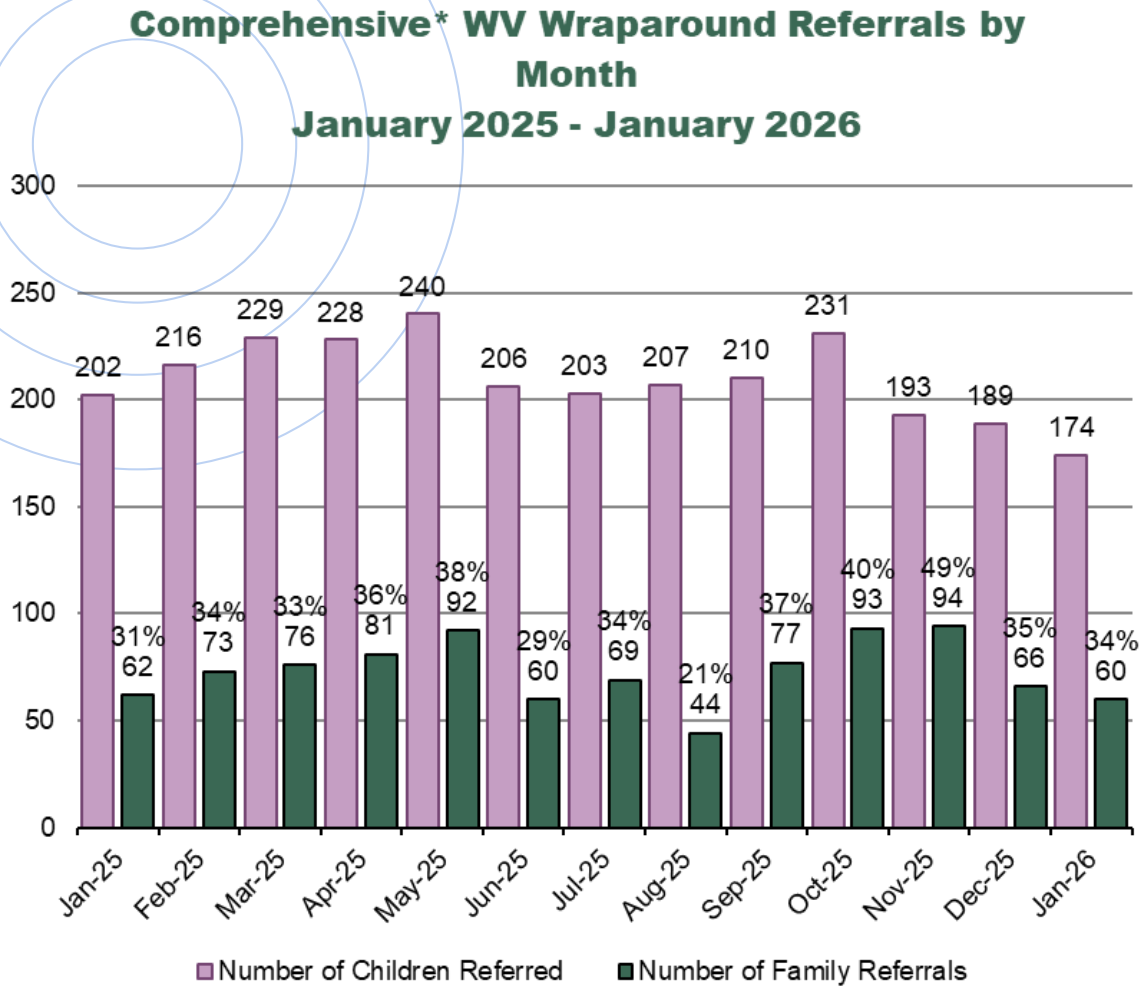
3. Kids Thrive Key Indicators, Continued



The data shows approximately 30% of referrals are family driven.

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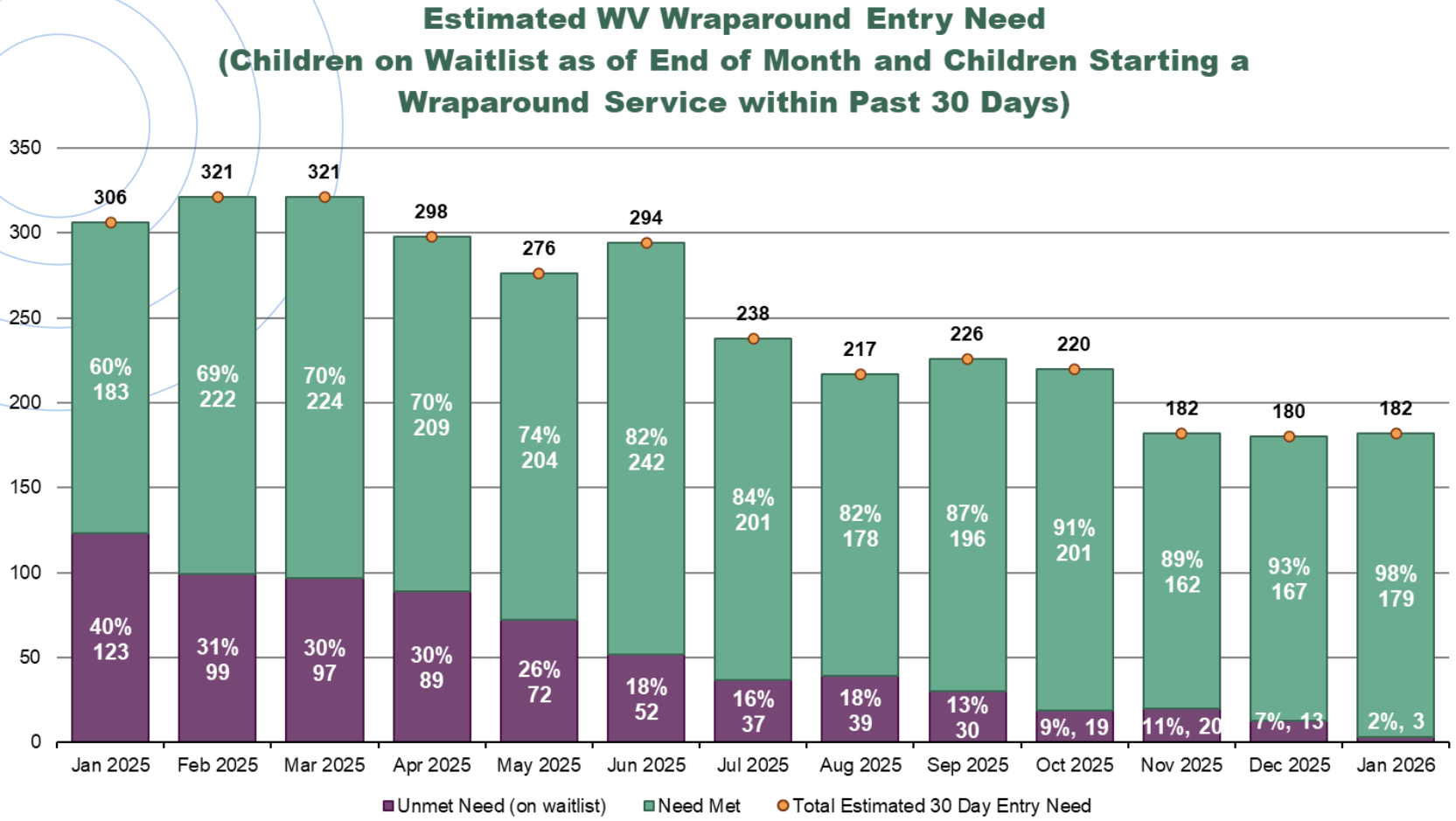
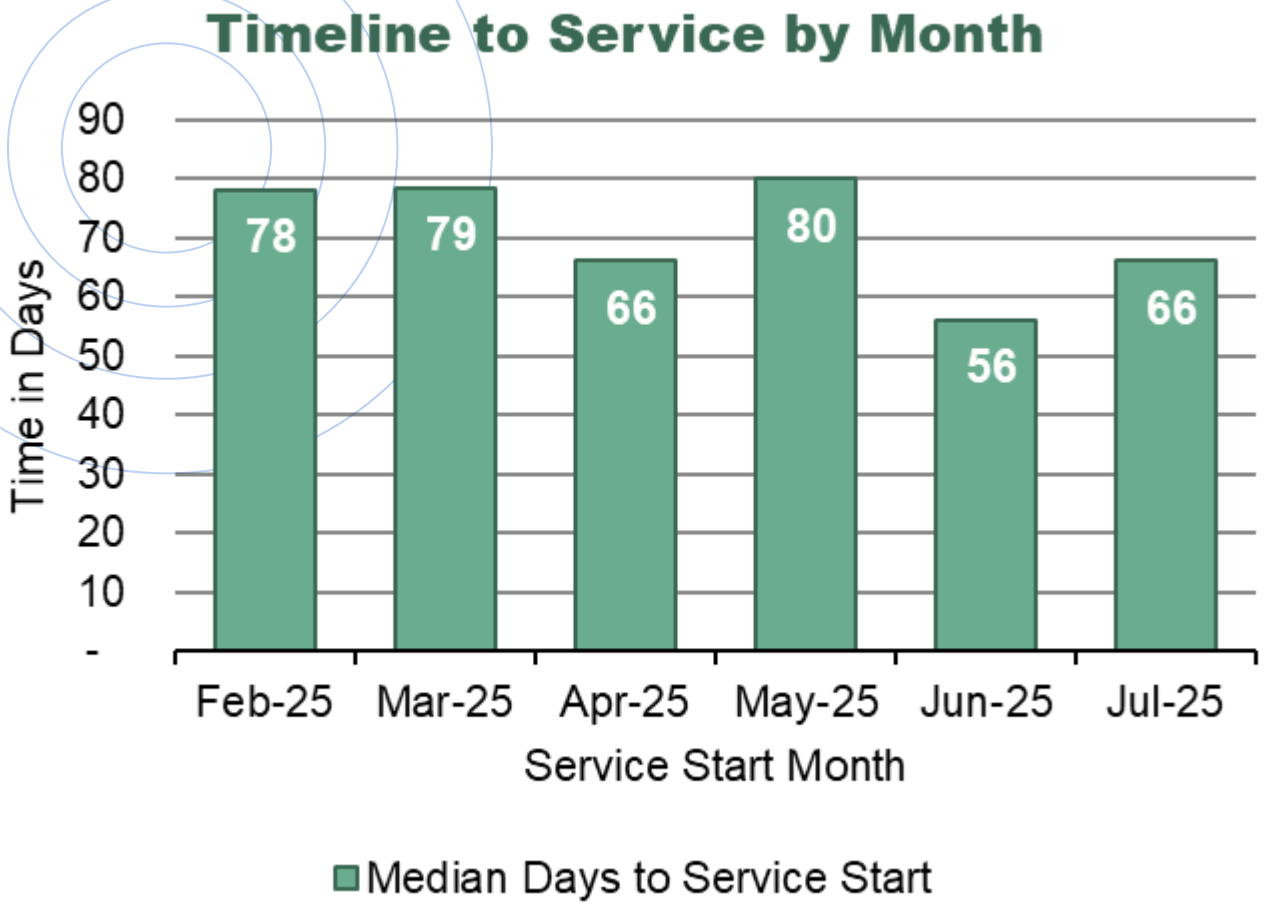
3. Kids Thrive Key Indicators, Continued



Efforts to reduce the WV Wraparound waitlist throughout 2025 are clearly shown through the data, as evidenced by a reduced waitlist for services month over month.

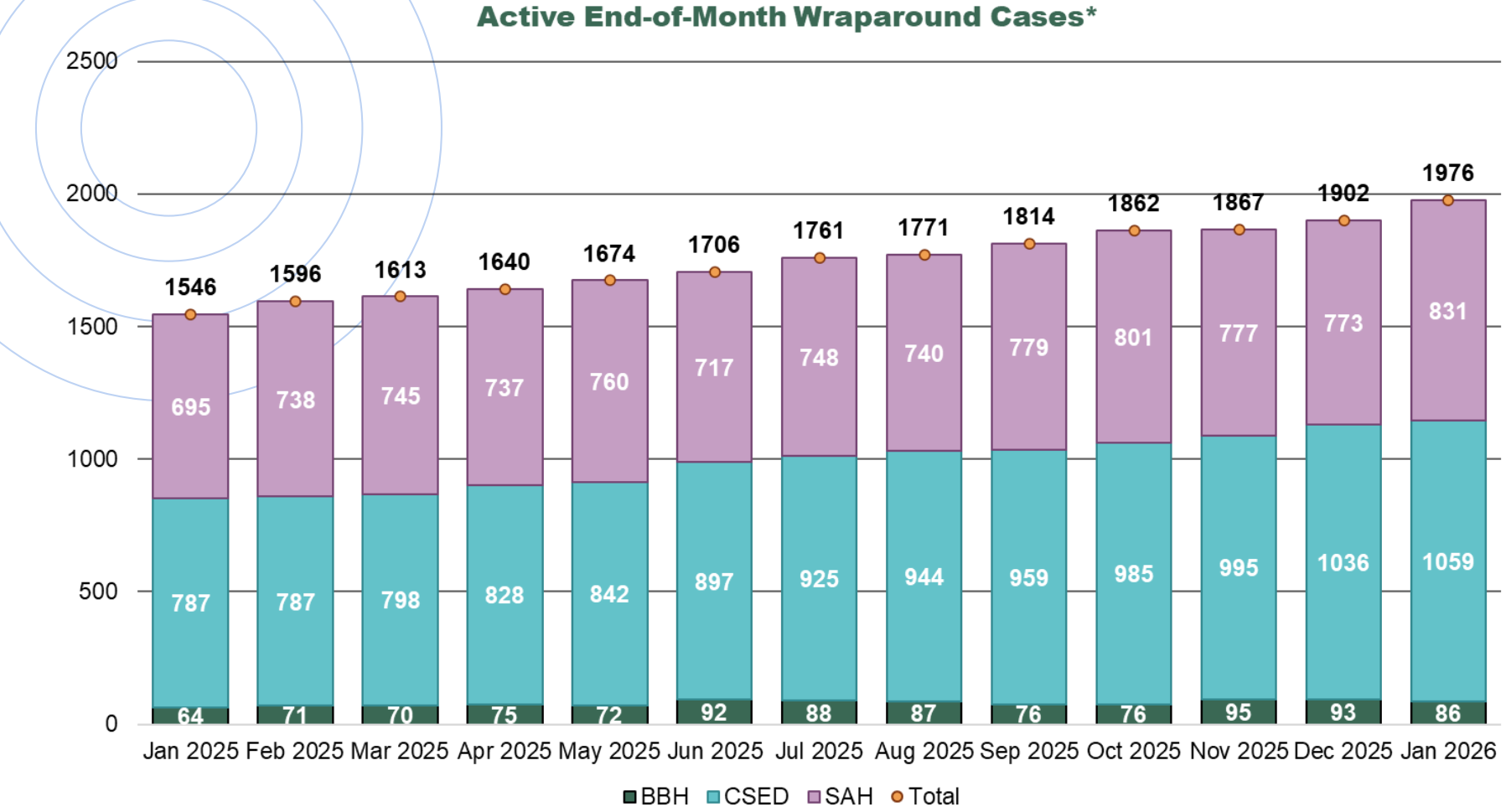
3. Kids Thrive Key Indicators, Continued



Across a six-month period, median timeline to service improved by approximately two weeks.

Note: Time to service start may be influenced by a number of factors, including but not limited to, family responsiveness and Wraparound Facilitator availability to match the family's needs and preferences.

3. Kids Thrive Key Indicators, Continued



*Active in CANS Database

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WV Wraparound utilization continues to grow month over month.

3. Kids Thrive Key Indicators, Continued

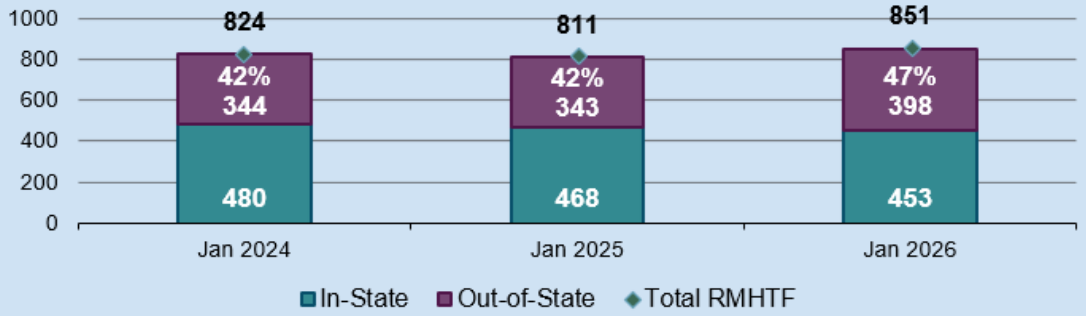
Of youth admitting to RMHT in January 2026,

53%

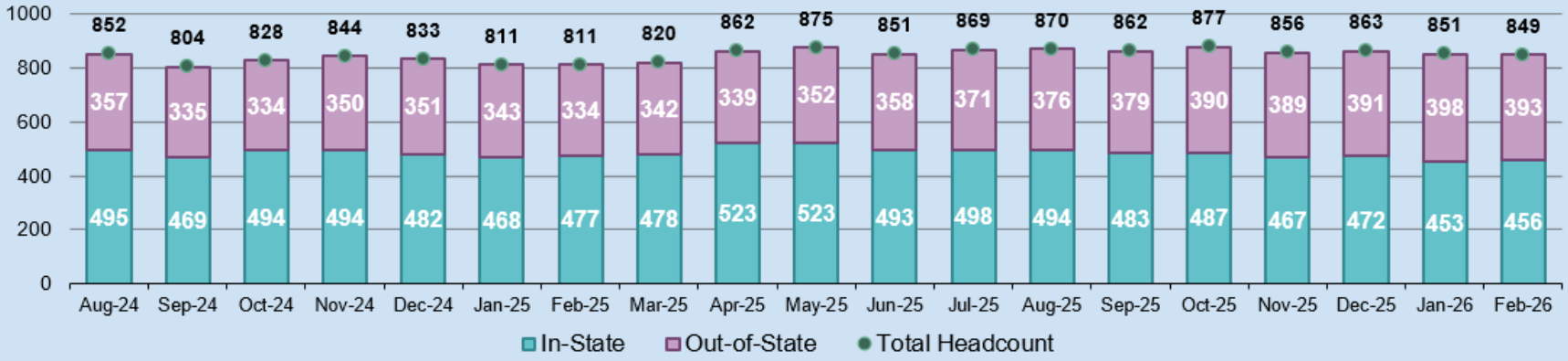
were entering facility-based treatment for the first time

Note, the higher the percentage of new admissions means fewer children readmitting.

Year-Over-Year Headcount by In-State vs Out-of-State Status



Monthly Headcount by In-State vs Out-of-State Status
August 2024 – February 2026



Unless otherwise noted, RMHTF is inclusive of PRTF.

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Overall census has begun to trend downward, while the rate of out-of-state placement continues to increase month over month.

3. Kids Thrive Key Indicators, Continued

Therapeutic Foster Care Capacity

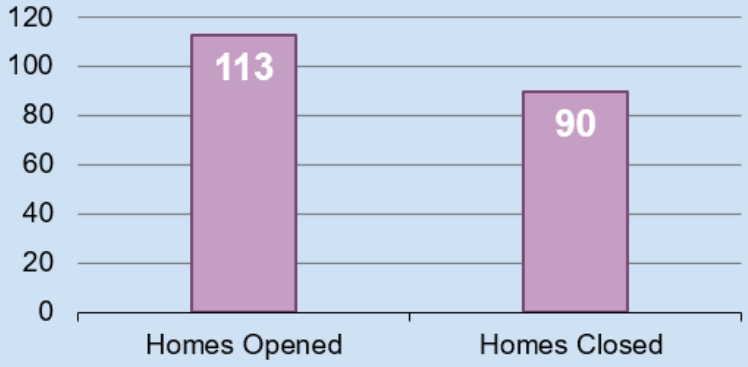
On average, 82% of active homes had a placement

On average,

25%

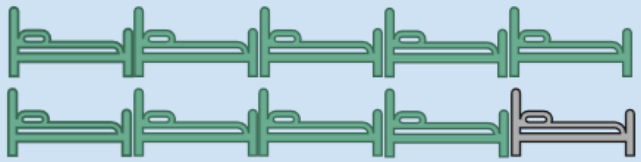
of the 1,192 foster homes statewide were willing to accept youth age 13+

Homes Opened and Closed Q4 2025



Transitional Living for Vulnerable Youth (TLVY) Capacity

92% of 37 available beds* were occupied



*While 59 beds are licensed, only 37 were reported as available due to issues such as staffing, structural issues, or needs of youth in care.

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Foster homes saw a net gain of 23 homes from October to December 2025. Consistent with prior reporting, only a quarter of foster homes are willing to take youth age 13+, which significantly limits placement options for older youth.

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DOJ Update

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Thank you!

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Patient Population

The program will serve adolescents ages 13-18. Patients benefit from strong connections with peers, as well as with the clinical team. The maximum census is 12.

The average length of stay is 24 days, but this varies based on medical need. Admissions are on a rolling basis. The PHP can be used successfully as:

- A step-down from an ED crisis visit
- A step-down from an inpatient or residential stay
- A step-up for adolescents who may be struggling in outpatient care, but who may be able to avoid hospitalization

The program can treat a wide range of conditions and diagnoses, including:

- Depressive disorders
- Anxiety disorders
- Trauma/PTSD
- Suicidality and self-injurious behavior
- ADHD and other disruptive behavioral disorders
- Higher-functioning Autism Spectrum Disorders

Exclusion criteria usually include: families who are unable or unwilling to participate and maintain safety while not in treatment, patients younger than 12, those who are nonverbal, moderate to severe intellectual disability, and patient safety concerns requiring inpatient hospitalization.

Clinical Approach & Programming

The program provides attachment-based, psychodynamic, systemic, solution-focused care. We utilize cognitive-behavioral, acceptance and dialectical behavioral approaches. Treatment is highly individualized, with focus on eco-systemic family therapy. Taken individually, each modality used is evidence based for the conditions treated. *The strength of this program lies in the combination and individualization.* The clinical model stresses family engagement and family functioning throughout the program. Group, individual and family therapy forms the basis of our program, combined with

medication as required. There is a clinical benefit to treating patients in their home environment, surrounded by naturally occurring daily stressors and dyadic interactions.

A typical schedule is:

Time	**Activity**	**Purpose/Clinical Focus**
8.00 am - 8.30 am	Virtual Drop Off	Check in with families on progress, update on any concerns, build a connection between home and program. Families are encouraged to attend.
8.30 am - 9.30 am	Community Meeting	Led by behavioral health staff, focuses on challenges, progress towards goals, interactions with family and friends.
9.30 am - 10.30 am	Process/Skills/Health Group Therapy	**Process groups** encourage patients to bring up their own topics and concerns, giving them agency in the treatment process. Patients are invited to share details of their past and present life experiences, and dream aloud as they navigate their treatment path and goals for change. Topics often stem from recent interpersonal challenges, self-harm triggers, and upcoming family and school meetings, which allows for real-time feedback and support navigating current obstacles. Teens ask one another questions, and group is conversational, allowing for a sense of belonging and bringing awareness to shared experiences. Patients in the mid to end of treatment course are integral in providing their reflections to newer peers, and modeling respectful curiosity, effective communication and successful use of skills. **Relationship groups** encourage patients to survey, discuss, and reflect on relationships in their lives. Evidence based ways to improve relationships (both strengthening healthy bonds, and mitigating unhealthy bonds) are discussed. **Skills groups** are more directed and focus on one particular skill or approach e.g. setting limits, distress tolerance, mindfulness, boundaries and increasing social support. **Health groups** are led by nursing staff and focus on health concerns including education regarding diagnoses, sleep, nutrition, movement and medication management.
10.30 am - 11.30 am	Break/Treatment Team	Full interdisciplinary team meets to discuss patient progress and troubleshoot treatment challenges. This is used as a basis for further conversation in family and individual therapy. Patients are encouraged to use this time for a movement break.

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11.00 am – 12.00 pm	Academic Support	Led by licensed tutors and supported by behavioral health staff. Tutors engage with schools to support academic progress and provide reinforcement as needed and discuss individual goals with patients and families. This continuing academic support eases the transition back to school. Also provides helpful feedback regarding potential patient specific difficulties (regarding inattention, assertiveness, socialization, etc). Realistically, given the intensity of treatment and level of medical care required we anticipate most patients will require homebound, and academic support will be oriented to supporting that, and transition back to school when the program is complete.
12:00 to 1:00 pm	Nursing/Skills/Health Group	**Nursing** is time for staff nurse or MD to discuss various health topics related to medications, side effects, etc. **Skills groups** are more directed and focus on one particular skill or approach e.g. setting limits, distress tolerance, mindfulness, boundaries and increasing social support. **Health groups** are led by nursing staff and focus on health concerns including education regarding diagnoses, sleep, nutrition, movement and medication management.
1.00 pm – 2.00 pm	Expressive Arts Therapy/Group Activity	Group activities may focus on self-esteem, coping skills and communication. Arts therapy includes creative arts (i.e. music therapy, drumming) and yoga and provides patients with additional coping skills learned and initiated in their home environment. These sessions encourage participants to open up and bond as a peer group. Evidence based mind body skill group (e.g. developed by the Center for Mind Body Medicine)
2.00 pm - 5.00 pm	Family & Individual Therapy Sessions & Medication Checks as Required	**Family therapy** is based on building foundations for healthy relationships, including identifying emotions and dealing with trauma. It also provides a focal point for integration with other providers across the continuum of care. **Individual therapy** focuses on each patient's stressors and focuses on gaining self-awareness as a way of moving forward. **Medications** are used alongside therapy to deal with symptoms and medical concerns. Our psychiatrists focus on getting to know each patient and family individually before prescribing.

		Staff care coordination, family sessions with patient/family, community outreach to patient's providers, school meetings/liaison.

Additional details regarding specifics of individual, group or family therapy can be discussed. On a weekly basis per patient our plan is to deliver; at least 5 hours of individual therapy sessions, at least 2 psychiatric appointments, and at least 2 hours of family therapy time. We will seek weekly meetings with Aetna case management to encourage patient enrollment and utilization.

All sessions and programming are formalized and do not consist of significant free time or non-structured activities (i.e., playing card games, coloring, etc.) Of note, following formal programming as listed above, additional outreach is conducted by the treatment team to include care coordination, family sessions with patient/family, community outreach to patient's providers, school meetings/liaison etc.

Interdisciplinary Team

The clinical team collaborates to meet patients' unique needs. Each patient is assigned an individual therapist for twice-weekly individual therapy sessions, a family therapist for twice weekly family sessions, and coordination with other providers. The child and adolescent psychiatrist and clinical lead will follow all patients throughout their treatment enrollment.

The PHP team includes:

- 1 psychiatrist
- 1 clinical lead
- 2 clinicians (social worker/psychologist)
- 1 nurse
- 2 behavioral health specialists (BHS)

Aftercare and Care Coordination

While the average length of stay is 24 days, care coordination is critical as an ongoing component of services throughout the duration of the patient's enrollment to optimize aftercare success. Care coordination will occur with Aetna case management to ensure availability of and access to wrap services, CSED waiver services, and others are in place, as appropriate, for continued support after PHP. These will be discussed as a component of treatment team meetings and with family's to convey the critical nature of all team members.

Memorandum of understandings (MoU) will be established with each school, which will serve multiple purposes. Communication and coordination with the school for "return to school half day" allows the patient to return to school, while still in PHP, to troubleshoot challenges around socialization and learning that may be co-occurring to their presentation. This MoU will also facilitate communication of treatment team recommendations for patient's 504/IEP (if present). It may also facilitate the patient

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attending PHP from school, if appropriate, to improve adherence in multiple environments. A successful transition back to regular school attendance is an emphasis of aftercare and discharge planning for the PHP. We will also work with faith communities, as appropriate and consented to by patient and family, to communicate our recommendations with regards to facilitating continued support for the patient, and to receive support from the faith leaders in supporting patient's spirituality.

Access to Care

The ability of rural and low socioeconomic status patients to participate in PHP is a key strength of the program given its virtual environment that targets access at the patient's moment and location of need. We are seeking philanthropic support for laptop hardware and mobile internet hot spots to ensure that patient's without reliable electronics for video/audio, or internet, could be loaned such services for the duration of the program. Aetna's Mountain Promise also facilitates a laptop for patients in the program, which may further reduce barriers to care.

While no modality, in person or telemedicine, works for every patient and family, engagement in other virtual PHP programming has been high. Attendance is higher at virtual the PHP than in person PHP in partner systems.