



Prepared by:

*West Virginia Department
of Health and Human Resources
Bureau for Public Health
Office of Maternal, Child and Family Health
Division of Research, Evaluation and Planning
<http://www.wvdhhr.org/mcfh/blockgrant/>*

2010 WEST VIRGINIA OMCFH NEEDS ASSESSMENT SUMMARY

The West Virginia (WV) Office of Maternal, Child and Family Health (OMCFH) is the State maternal and child health (MCH) agency serving the needs of women, infants, children, families and children with special health care needs. The OMCFH receives a federal MCH Block grant (Title V) which requires the completion of a population based needs assessment every five years. The goal of the WV Title V Needs Assessment is to assure availability of a comprehensive quality, accessible maternal and child health system that will positively affect pregnancy outcomes and have positive health status (family well-being) for infants, children, adolescents and children with special health care needs by involving multiple stakeholders across WV. The OMCFH identifies health needs based on data/outcomes and partners with community and state stakeholders to develop interventions that will achieve positive results. Other goals of the Needs Assessment are to: collaborate around data collection activities that support the evaluation of care availability, service utilization and the quality of health services for maternal and child health populations; administer population-based health surveillance activities, such as birth defects registry, newborn hearing and metabolic screening which are used to prevent and/or lessen disability and death among children; and collaborate with community resources, government agencies, families and other stakeholders to identify resources essential for healthy families such as childcare services, health care and economic support. The vision of the OMCFH is to provide leadership to support state and community efforts to build systems of care that assure the health and well-being of all West Virginians throughout the life cycle. Allocation of resources is based on need that takes into consideration other available resources, population served and desired outcomes.

- **Methodology:** Findings from the federally required Title V Maternal and Child Health (MCH) Block Grant Needs Assessment are the basis for selecting priorities, objectives and action plans for the WV Maternal, Child and Family Health programs and other partner organizations. The Needs Assessment methods are designed to: a) provide factual information and data to guide activities and policies, b) provide a tool for better decision making, and c) be used as a guide for discussions about health issues and continuing assessment efforts.

The WV Office of Maternal, Child, and Family Health involves program advisories and critical stakeholders in all facets of charting a course for the use of multiple funding streams that support maternal, child and family health activities. The use of stakeholder advisories and task forces to study particular population groups and issues, engagement with established non-Title V advisories where the OMCFH has a seat at the table, surveys about specific topics and lastly, public forums and specific engagement of parents using the parent-to-parent networks are methods used to gather

input and information throughout the year. The end result is that there is not one isolated effort or method to seek input about the OMC FH Needs Assessment, but rather there is continuous study and action plan development throughout each year. These activities culminate in the development of the Five-year Needs Assessment as well as the yearly Title V Progress Report and Application. Findings from the Needs Assessment are used to develop State performance and outcome measures. The OMC FH gathers data and information based on performance measures, health status and capacity indicators and compiles the results and narrative for the Needs Assessment.

- **Methods for Assessing Three MCH Populations:** The following charts display the methods used for assessing the needs of West Virginia pregnant women, mothers and infants, children and children with special health care needs.

Pregnant Women, Mothers and Infants

West Virginia Methods for Assessing Pregnant Women, Mothers and Infants	
Methods	Key Activity Samples
Community Partnerships	<ul style="list-style-type: none"> • Participation and involvement with the Perinatal Partnership resulting in the publication: <i>A Blueprint to Improving WV Perinatal Health</i>. Extensive data collection and evaluation efforts occurred with multiple recommendations and actions. • Use of the cord blood study conducted by Marshall University located in Huntington, West Virginia, financed by the OMC FH. • Participation as a member of the Child Fatality Review Team to investigate causes of preventable deaths and make recommendations. • Spearhead the legislatively mandated Maternal Mortality Review Team to investigate practices that may prevent deaths and determine needs. • Spearhead the legislatively mandated Maternal Risk Screening Advisory to develop a universal risk screening tool for pregnant women to be used by all OB/GYNs

West Virginia Methods for Assessing Pregnant Women, Mothers and Infants	
Methods	Key Activity Samples
	<ul style="list-style-type: none"> • Spearhead the Newborn Metabolic Screening Advisory and discuss practice standards and guidelines for specific newborn disorders and needs within this particular area.
Surveys	<ul style="list-style-type: none"> • <i>West Virginia Key Informant Survey</i> • <i>Worksite Wellness and Perinatal Health Survey</i> • <i>Perinatal Education and Support Program and Services Survey</i> • <i>Right From The Start (the state's perinatal home visiting program) Satisfaction Survey</i>
Data Sources	<ul style="list-style-type: none"> • <i>Legacy of Inequality: Racial and Economic Disparities in West Virginia</i> • <i>Blueprint to Improve West Virginia Perinatal Health</i> • WV Vital Statistics • Right From The Start (WV's perinatal program) • Pregnancy Risk Assessment Monitoring System (PRAMS) • WVU Birth Score (risk tool used to determine risk for post neonatal death and developmental delay in newborns) • Medicaid

Children

West Virginia Methods for Assessing Children	
Methods	Key Activity Samples
Community Partnerships	<ul style="list-style-type: none"> • Participation and involvement with WV Early Childhood Advisory Council, a group of stakeholders whose assignment is to determine needs and design and implement universal pre-K education. • Bureau for Children and Families • Healthy Kids-Preschool Screening
Surveys	<ul style="list-style-type: none"> • Oral Health Advisory and survey • Advisory/Stakeholder meetings • Town Hall Community meetings at 9 sites across WV.
Data Sources	<ul style="list-style-type: none"> • Vital Statistics • YRBSS • WV Department of Education • Birth to Three (WV's Early Intervention Program/Part C) • Early Periodic Screening Diagnosis and Treatment (EPSDT) called HealthCheck in WV • Injury Prevention Program • Oral Health Program • Medicaid • CHIP • Bureau for Children and Families • WIC • Bureau for Behavioral Health and Health Facilities • Department of Highways • Obesity Project

Children with Special Health Care Needs

West Virginia Methods for Assessing Children with Special Health Care Needs	
Methods	Key Activity Samples
Community Partnerships	<ul style="list-style-type: none"> • Commission for the Deaf and Hard of Hearing • WV Early Intervention Interagency Coordinating Council (WVEIICC) • WV Department of Education • Statewide Transition Committee • Child Protective Services • Medicaid • WVU Center for Excellence in Disabilities (CED) • School Based Health • Learn the Signs Act Early Team
Focus Groups	<ul style="list-style-type: none"> • Town Hall meetings for Deaf and Hard of Hearing – 9 Sites • Four consumer, workforce, and agency discussions on direct service supports for persons with disabilities. • Eight Birth to Three/IDEA meetings
Surveys	<ul style="list-style-type: none"> • WV BTT/Part C Parent Outcome Surveys • Parent surveys related to children with special health care needs, services and supports, conducted by CED. • Oral Health Survey of parents of children with special needs • Oral Health Family Survey
Data Sources	<ul style="list-style-type: none"> • Social Security Disability • Early Intervention/Part C • Integrated Data System-Annual Performance Report (APR) • Children with Special Health Care Needs Program • WV Department of Education • Vital Statistics • Birth Defects Surveillance • Newborn Metabolic Screening Program • Childhood Lead Poisoning Prevention Project • Newborn Hearing Screening Project • Child care programs • Bureau for Children and Families

- **Methods for Assessing State Capacity:** By involving stakeholders, advisory committees, participation with state, as well as community focus groups, several methods were used to evaluate WV's capacity that included review of: the financing structure to ensure access to care and treatment; legislation that assures mandates for access and financing; availability of appropriate health care providers and facilities; program capacity offered throughout WV to address population needs; partnerships to utilize resources and not duplicate efforts; and data availability to analyze needs and outcomes.

WV Methods for Assessing State Capacity	
Needs	Capacity
Financing	<p>Evaluated funding from the following sources to support population needs:</p> <ul style="list-style-type: none"> • Medicaid (Title XIX) • CHIP • Title V • Title X • State Appropriations • American Recovery and Reinvestment Act • Patient Protection and Affordable Care Act 2010, Maternal, Infant and Child Home Visitation Program • CDC Funds • HRSA • Insurance
Programs	<p>Evaluated services and ability of the following entities to support population needs:</p> <ul style="list-style-type: none"> • OMCFH • Bureau for Children and Families • Department of Education • Mental Health-Bureau for Behavioral Health and Health Facilities • Office of Environmental Health Services • Health Statistics Center
Partnerships/Access to Care	<p>Evaluated access to care systems to support population needs:</p> <ul style="list-style-type: none"> • Partnerships • Agency Agreements • Health Care Providers-Federally Qualified Health Centers, Local Health Departments, Community Free Clinics • Other State Agencies • Universities/Schools of Medicine

WV Methods for Assessing State Capacity	
Needs	Capacity
Legislation	<p>Evaluated legislation targeted to support population assessment and needs:</p> <ul style="list-style-type: none"> • Newborn Metabolic Screening • Newborn Hearing Screening • Maternal Mortality Review Team • Birth Defects Surveillance • Sudden Infant Death Surveillance • Maternal High Risk Screening • Childhood Lead Poisoning Prevention Program • Birth Score (Identification of high risk infants at birth) • Oral Health Status Study
Data	<p>Evaluated the ability to collect and analyze data sources.</p> <ul style="list-style-type: none"> • Data Availability • Data Access • Analysis Capacity • Data Linkages
Outcomes	<p>Evaluated performance measures and outcomes from surveys.</p> <ul style="list-style-type: none"> • Performance Measures-State and Federal • Surveys

In determining capacity, it is necessary to involve stakeholders, be involved with partnership collaboratives, review current systems of care to determine if the systems are adequate to achieve identified desired health outcomes, and identify current health status of each of the desired outcomes. West Virginia examined current national and state performance measures, health status indicators and state capacity measures and compared WV status data with national and Healthy People 2010 objectives. In most measures, WV comes up short of the national average.

For the Needs Assessment, OMC FH needed to ask staff, stakeholders, constituents, colleagues, parents and residents, “What will it take to improve health status among West Virginians?”

Capacity to address the multiple needs of WV’s women, infants, children and children with special health care needs is analyzed throughout the Needs Assessment, with strengths and weaknesses noted.

- **Linkages between Assessment, Capacity and Priorities:** According to the 2010 Needs Assessment, West Virginia continues to have many health care issues such as

smoking, smoking among pregnant women, infants born prematurely, infants born with low birth weight, high rate of sudden unexplained infant deaths, obesity, injuries, adolescent suicide, fatal car accidents involving youth, and asthma that contribute to poor outcomes.

Geographic and socio-economic issues that influence the ability to achieve desired health outcomes include:

- According to the 2008 Census data, 15% of the population in WV does not have health insurance.
- Six percent (6%) of children do not have health insurance.
- There are still parts of WV where health care is not easily accessible. Winding secondary roads connect the majority of WV's population with little to no public transportation available between many of the small isolated towns.
- The WV Perinatal Partnership has reported that the availability of OB/GYNs and other practitioners to provide prenatal care and delivery continues to be problematic. Not every county has sufficient births to justify labor and delivery at local hospitals, making it necessary for some WV women to be served outside WV's boundaries or several miles from home. Only six counties in WV were considered to have adequate medical manpower to meet the population need.
- Because of the loss of higher paying jobs over the past thirty years in West Virginia, there has been a concurrent rise in WV's poverty rate. WV continues to rank fifth in the nation of the state's population living in poverty.
- West Virginia's unemployment rate reached a 15-year high at 10.5 in January 2010. The number of unemployed people grew from 29,000 in September 2008 to 64,200 in September 2009, an increase of 121 percent.
- A significant issue that plagues WV is that only 75.2% of the population, 25 years and over, is a high school graduate or higher.
- Work disability is also a significant problem in West Virginia. The 2000 U.S. Census Bureau states that 22.5% of the population 16-64 years of age had a disability and 13.2% had a work disability.

It is evident when data/statistics are analyzed for health care outcomes, the higher the education and income level, the better the outcomes. If West Virginia is going to experience better outcomes, education and higher paying jobs must be a top priority. Evidence of this is in Monongalia County, where West Virginia University is located. Because of the availability of a higher educated work force, the city of Morgantown has been one of the fastest growing cities in the U.S. and experiences some of the best health outcomes in WV. It has also been ranked as one of the best small cities in the U.S. to live and raise a family. West Virginia has capacity to address most health

related issues as shared throughout the Needs Assessment; however, there remain areas that need improvement to have an impact on outcomes.

West Virginia Governor Joe Manchin III, signed legislation to expand SCHIP eligibility up to 300 percent of the federal poverty level, and on January 1, 2007, WV began a phase-in expansion by enrolling children in SCHIP with family incomes up to 220% of the federal poverty level. Adoption of this change is estimated to provide comprehensive health care coverage to approximately 400 uninsured children of working families during the first year of implementation. WVCHIP expanded the upper income limit to cover families with incomes at 250% of poverty January 1, 2009. Community health centers have played a critical role in improving access to health care for all populations across WV. The community health center network is supported with state appropriations and there are multiple centers that receive both state and federal resources. Rural areas are in need of additional community health centers.

Governor Joe Manchin III placed emphasis on education and has introduced several bills to address the issue. Using American Recovery and Reinvestment Act funds several schools have added “coaches” to assist those students at risk of not graduating. Several other schools have introduced initiatives to also facilitate keeping kids in school.

WV has systems in place to address access to care, identification of health issues at birth and health care coverage for pregnant women, infants, children and children with special health care needs. There still exist areas that need improvement such as increased reimbursement for home visiting for high risk pregnant women and oral health. These are two identified areas where health care providers have limited the number of patients they treat due to low reimbursement rates.

Mothers surveyed by PRAMS report that one of the reasons they do not see a physician in their first month of pregnancy is that they have not yet received a medical card. A process to expedite the issuance of a Medicaid card for the pregnant woman needs to be reviewed.

Partnership Building and Collaboration Efforts

Historically, many West Virginians had to survive with fewer of life's essentials than many others in the United States. This lack of resources makes working together essential. Because this lesson has not been lost on those in public service and advocacy organizations at the state and community level, WV has learned the value of collaboration. The OMCFH knows that WV cannot afford to duplicate systems that exist and are working well, and knows that it is imperative to join with other stakeholders to create partnerships to achieve goals.

The West Virginia Office of Maternal, Child and Family Health has been well known for its willingness to engage and participate alongside stakeholders in designing systems of care to serve the Title V population. It is imperative that agencies collaborate and not duplicate services when resources are scarce.

The Office of Maternal, Child and Family Health has historically contracted with the Title XIX agency for the administration of EPSDT. In addition to EPSDT, there have also been formalized agreements with community agencies for services offered through the Right From The Start Perinatal Program, Family Planning, and Children with Special Health Care Needs (CSHCN). The Office of Maternal, Child and Family Health administers and participates in the coordination of programmatic services funded under Title XIX to prevent duplication of effort, as required by federal regulation 42 CFR sub-section 431.615 (C)(4). The Office of Maternal, Child and Family Health has administrative responsibility for dental and vision care for persons moving from Welfare to Work, financed by Temporary Assistance to Needy Families (TANF) resources; a copy of the grant agreement may be obtained from the OMCFH. As a component of the Birth to Three/Part C system change initiative, an additional interagency agreement was finalized with the Bureau for Medical Services, utilizing the unique statutory relationship between Title XIX and Title V. The agreement established the Office of Maternal, Child and Family Health as the sole provider of early intervention services. The Department of Health and Human Resources has contracted with a private agency to serve as a central finance office to coordinate all funding sources for early intervention services, house a centralized data system, and provide claims processing.

The Office of Maternal, Child and Family Health has in place many systems that contribute to the early identification of persons potentially eligible for services. These population based systems include Birth Score (administered by WVU), birth defect registry, newborn metabolic screening, childhood blood lead level screening, and newborn hearing screening. In addition, because OMCFH administers the EPSDT Program, children who have conditions that may be debilitating and/or chronic diseases, are referred to the CSHCN Program for further evaluation. This connection with EPSDT, which targets some 200,000 eligible children yearly, provides public health with a

vehicle for identifying youngsters with problems, knowing that economically disadvantaged children are at increased risk. OMCFH, in an effort to increase public awareness, routinely participates in health fairs and community events. The toll-free lines established in 1980, average over 1,000 calls per month. Each caller receives individualized follow-up from Systems Point of Entry staff to assure referrals and pertinent information related to the request met their need. OMCFH toll free lines always receive accolades from monitoring reviews. Evaluation materials are on file and available if desired.

Selection of State Priority Needs

West Virginia health care professionals voiced a strong desire to participate in the process to improve perinatal care. They indicated that although many elements of a cohesive system were present in the state, a move towards a statewide system rather than a fractured regional approach was necessary. The need to utilize new methods of communication, provide better support for medical professionals in rural areas, better utilize intellectual resources, and more fully implement parent support and education programs was emphasized. The West Virginia Perinatal Partnership was born of these desires and in 2010 continues to remain a strong community partnership.

Pregnant Women and Infants

Concerns that respondents of the WV Key Informant Survey administered by the WV Perinatal Partnership, parent surveys, community groups and OMCFH advisories had are as follows:

Tobacco Use

- Tobacco use by pregnant women and in-home smoking by family members
- Medical providers advising pregnant women that just “cutting down” on tobacco use and alcohol use is “ok”
- Patient lack of compliance with medical advice

Discussion:

Because smoking continues to be a significant health concern in WV, two state performance measures were chosen to address the issue. **1) Decrease the percentage of high school students who smoke cigarettes daily and 2) Decrease the percentage of pregnant women who smoke within the last three (3) months of pregnancy.** (Last three (3) months of pregnancy was chosen, because PRAMS data will be used and that is how the survey question reads). The Perinatal Partnership is

addressing the education of medical providers who only advise their patients to cut down on tobacco and alcohol use during pregnancy.

West Virginia has the highest smoking rate for pregnant women in the U.S. 2008 data from the WV Health Statistics Center show that the rate of smoking during pregnancy in WV was 27.0% compared to the national rate of 10.7% in 2005 (last available national information). Alarming rates of these were that 40.7% of Medicaid insured mothers reported smoking while only 11.7% of the non-Medicaid insured women reported smoking during pregnancy.

The state's home visiting perinatal program, Right From The Start (RFTS), provides services to Medicaid insured pregnant women. To address the smoking during pregnancy concern, RFTS continues to implement the intense smoking cessation initiative, called SCRIPT, in partnership with George Washington University Medical Center, Department of Prevention and Community Health. Education tools such as videos, carbon monoxide breathalyzers and smoking cessation guides are funded through the WV Division of Tobacco Prevention and are available for use during home visits. A DVD player has been assigned to each home visiting nurse or social worker to use during home visiting sessions for education purposes. RFTS sees approximately one-third of the Medicaid population.

RFTS collaborates with the WV Tobacco Quitline. The Quitline offers nicotine replacement therapy (NRT) options, free of charge, to pregnant women, with a physician's order. NRT products are also available to family members living in the home of the pregnant woman.

Drug Use

- The growing use of legal and illegal drugs by women during and after pregnancy; the most frequently mentioned drugs used were cocaine, methamphetamine, heroine, and methadone
- Health professionals, especially pediatricians, frequently correlated child neglect with drug use in the home
- Pregnant women treated with methadone and not weaned off prior to delivery
- Lack of a standard medical protocol, taking into account legal and medical implications, for drug/alcohol testing and referring for treatment during pregnancy

Discussion:

Drug use, especially during pregnancy, is a growing concern as presented in the Cord Blood Study. However, the WV OMCFH has not chosen this issue for a performance

measure because the Cord Blood Study was a one-time effort and the data identified does not support the self-reported rate of drug use during pregnancy. The self-reported rate is 3%, while the Cord Blood Study for women who delivered in August 2009 in select hospitals was 19%. The OMCFH has no means of collecting measurable data other than self-report at this time.

The RFTS perinatal home visiting program does screen for drug and alcohol abuse during assessment of risk factors and if identified makes appropriate referrals. The Perinatal Partnership has as one of its 2010 Work Plan goals to “Develop an Approach to Identify and Treat Drug Use During Pregnancy.”

Nutrition and Breastfeeding

- Poor maternal nutrition and a lack of nutrition education
- The rise in obesity, gestational diabetes, type II diabetes, and pre-eclampsia
- Lack of breastfeeding and lack of support for continued breastfeeding
- Not all hospitals in WV adhere to guidelines of the American Academy of Pediatrics regarding support for establishing breastfeeding, both for healthy newborns and for high-risk newborns

Discussion:

A low percentage of WV women choose to breastfeed their infants. This should not be taken as an indication of little effort on the part of WV's Bureau for Public Health. All pregnant women participating in the Right From The Start Program receive information about the benefits of breastfeeding their infants. The RFTS Program collaborates with the WIC Program to provide continuity of care, and this renewed relationship has resulted in increased referrals to the RFTS Program.

WIC goals include providing additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physician practices in order to provide breastfeeding support and guidance. WIC has received additional financial resources to increase personnel dedicated to breastfeeding encouragement.

WV chose not to keep this measure because the OMCFH provides support and education to one third of the pregnant women whose care is paid for by Medicaid. While it is important to have an impact on even one woman, the number of women who choose to breastfeed through the RFTS Program will not have an overall impact on the percentage of all women who breastfeed. The RFTS will continue to educate women served on the importance of breastfeeding, partner with WIC to encourage breastfeeding, track the percentage of women who breastfeed that are enrolled in the

RFTS Program and also track breastfeeding percentages for all women who recently delivered, using PRAMS data.

Teen Pregnancy and Single Mothers

- Insufficient sex education in the schools to help prevent pregnancy
- Lack of education regarding contraception resulting in closely spaced pregnancies
- Inadequate parenting skills, especially among teens and single women
- Poor hygiene among pregnant teens and single women
- Poor dentition, lack of access to dental care, lack of insurance coverage for dental care
- Teen pregnancy is still part of rural culture
- Lack of self-esteem in young women
- Lack of desire for education. The two largest determinants of child health in the U.S. are poverty level and parental education

Discussion:

For more than a decade, births to West Virginia teens have consistently declined, and between 1991 and 2004 teen births had dropped by 24%. Then, in 2006, the rate of teen child bearing in the state increased. According to the WV Health Statistics Center, the number of births to teenage mothers (ages 10-19) increased by 44 (1.6%), from 2,737 in 2007 to 2,781 in 2008. The percentage of total births represented by teenage births was higher in 2008 than 2007 (12.9% vs. 12.4%). The significantly lower fertility rate among older women, however, resulted in teenage births continuing to constitute a higher proportion of total births than was found nationally.

In 2006 and 2007, the increase in teen births occurred specifically among the 18-19 year-old age group. Births to West Virginia resident teens ages 15-17 continued a decline during the same time period with a slight one-year increase in 2006, going from 20.0 per 1,000 females in 2005 to 20.9 in 2006, but declining again in 2007 to 20.2 births per 1,000 females of the age group. Teen girls ages 18-19 have the highest proportion of teen pregnancies. They also have a higher teen pregnancy rate as compared to 15-17 year-olds in the state.

The Adolescent Health Initiative (AHI), housed within OMCFH, facilitates educational opportunities for adolescents and other community members on preventing pregnancy, delaying sexual activity and other risky behaviors. Trainings promote positive decision making and support asset-building targeting both traditional and non-traditional partners.

The AHI partners with the Adolescent Pregnancy Prevention Initiative and community-based non-profits to secure evidence-based pregnancy prevention funding for West Virginia.

The Adolescent Pregnancy Prevention Initiative, also housed within OMCFH, continues to partner with local community groups in order to provide programming that addresses risky adolescent behavior that may result in unplanned pregnancy. Specialists work with community teen institutes and summer camps providing activities such as Mythbusters, a game that counters untrue beliefs about sex that are common among adolescents. Specialists are partnering with community groups to plan healthy events that will interest teens and utilize the increased free time of summer. These events include awareness pool parties, self-esteem workshops and responsibility training.

The Adolescent Pregnancy Prevention Initiative continues to focus primarily on educational classroom presentations for adolescents related to pregnancy prevention, contraception, delaying sexual activity and prevention of sexually transmitted infections (STIs). The OMCFH did not choose this as a performance measure because a national performance measure is already in existence.

Obstetrical-Neonatal Systems Barriers

- Lack of adequate high-risk obstetrical services to refer high-risk pregnant women
- Lack of a fully operational statewide perinatal care program for high-risk mothers and infants needing referral and/or transport to high-risk care
- Lack of certain newborn screening testing
- Lack of high-risk newborn follow-up in the home (especially in rural areas)
- Lack of consistent standards for the induction and delivery of late preterm infants (34-37 weeks)
- Voluntarily inducing labor that produces preterm infants was identified as a major provider issue that contributes to higher use of NICU beds and infant mortality
- Voluntarily inducing labor of first time mothers, resulting in higher rates of caesarian sections for this group
- The “malpractice crisis” and cost of liability coverage
- Insufficient high-risk support from tertiary care facilities to community hospitals, the loss of community hospital based continuing education on high-risk care
- No standard protocol for transferring high-risk pregnant women and infants
- The lack of availability of NICU beds in WV when needing to transfer
- Providers not adhering to recommended standards of the American College of Obstetricians and Gynecologists

- Private insurance carriers do not cover in-home follow up of high-risk infants (such as RFTS services) as Medicaid does

Discussion:

Most of the issues cited above have been discussed throughout the Needs Assessment document. Two of the issues have been implemented: expansion of newborn metabolic screening and an increase in the availability of NICU beds. The Perinatal Partnership 2010 Work Plan addresses obstetrical provider shortage areas, the high rate of elective and c-section deliveries within WV, perinatal outreach educational activities, and seeking support from the WV Legislature and State Government on developing legislation that addresses several areas.

No state performance measures were developed from the concerns because the issues are so broadly focused. OMCFH leadership staff continues active participation on multiple committees of the Perinatal Partnership that are developing plans of action.

Education and Support Programs

- Poor parenting skills and a lack of parenting education and in-home support programs
- Child neglect by parents identified as contributing to infant mortality
- Physicians not referring early enough to the Right From The Start Program (RFTS)
- Increased advertisement and marketing to medical providers and pregnant women for referral to the RFTS Program

Discussion:

OMCFH is serving as the catalyst for driving the application process for developing a perinatal system of in-home visiting care. While RFTS is based on a medical model there are additional home visitation programs/models throughout WV such as Parents as Teachers, Maternal Infant Health Outreach Workers (MIHOW) and Healthy Families America, who provide education and support to pregnant women, infants and families, but do not have service capacity throughout WV. The application for Patient Protection and Affordable Care Act funds for home visitation, education and support services is being submitted to increase home visiting capacity.

OMCFH did not choose a state performance measure to address education and support programs because the issues are very broad at this time and performance measures will be chosen for the Home Visitation Program State Plan.

Late Entry, No Entry, and Poor Prenatal Care

- Many physicians are still reporting concerns over late entry to care as a major concern
- Pregnant women are waiting to have their insurance card or Medicaid in hand prior to making their first appointment for care
- Not enough obstetrical health providers in areas accessible to many women
- In some areas, once a woman calls for the first prenatal appointment there may be several weeks before providers' schedules can fit in a new patient

Discussion:

Although the OMCFH has assured medical providers that the Office will cover the pregnant woman's first visits for prenatal care while she applies for Medicaid, either the women are not knowledgeable, Medicaid workers are not telling women to seek medical care, or physicians are not encouraging women to schedule appointments while they wait for Medicaid coverage. The OMCFH, using Title V dollars, also covers women who are not eligible for Medicaid coverage up to 185% of the Federal Poverty Level. Late entry into prenatal care was not chosen as a state performance measure, because a national performance level already exists.

Prematurity, Low Birthweight and Infant Mortality

An examination of West Virginia birth certificate data showed a marked increase since 1993 in the rate of births occurring at 34 through 36 weeks of gestation. The rate of Cesarean delivery among late-preterm births increased at a faster pace than that among other births over the study period. The birth certificate data confirm a growing problem of late-preterm birth in West Virginia, pointing to a need for a more comprehensive examination of these births. The Perinatal Partnership has made recommendations that elective c-sections should not occur before 39 weeks if not medically indicated.

The number one cause of infant death in WV is Sudden Unexplained Infant Death Syndrome (SUIDS). In 2006, there were 46 SUIDs that accounted for 29.7 percent of the infant deaths. In 2007, there were 29 SUIDs that accounted for 17.8 percent of the

infant deaths and in 2008 there were 35 SUIDs accounting for 21 percent of the infant deaths.

Discussion:

Although WV continues to be slightly above average in these areas of measuring infant health, the OMCFH has chosen a new performance measure that addresses the number of SIDS/SUID deaths that will impact the infant mortality rate, ***“Decrease the number of SIDS/SUID deaths”***. National measures already exist to measure prematurity, low birthweight and infant mortality.

Children/Adolescents

Concerns that respondents had and data indicated are as follows:

Tobacco use

The 2009 YRBS shows that the percentage of students who ever smoked cigarettes daily, which is, at least one cigarette every day for 30 days has decreased slightly to 17.7%, however, the 2009 YRBS also shows that smoking within the last 30 days has decreased from 38.5% in 2000 to 21.8% in 2009. The percentage who reported they have never smoked cigarettes rose from 25.7% to 44.8% from 2000 to 2009.

The Adolescent Health Initiative (AHI) and the Abstinence Education Project (AEP), housed within the OMCFH Division of Infant, Child and Adolescent Health, educate youth about the consequences of tobacco use and encourage responsible behavior. Both programs partner with RAZE, the statewide teen-led, teen-implemented anti-tobacco movement, and other prevention programs to facilitate community-based activities and events promoting awareness.

RAZE is coordinated by the Youth Empowerment Team (YET). YET members include representatives from the Division of Tobacco Prevention, the West Virginia Department of Education’s Office of Student Services and Health Promotion, the American Lung Association of West Virginia and the West Virginia Youth Tobacco Prevention Campaign. There are currently 187 RAZE crews in WV’s schools.

West Virginia’s youth-led tobacco prevention initiative is moving beyond the school system to reach more teens. Initially, the program revolved around the WV Department of Education and funding was routed through schools, where crews were organized. Now, annual \$1,000 grants to form crews are available for community groups as well.

West Virginia is aggressively addressing this problem by implementing evidence-based comprehensive tobacco control programs. The comprehensive plan focuses on four goals: 1) Prevent the initiation of tobacco products among young people; 2) Eliminate exposure to secondhand smoke; 3) Promote quitting among adults and young people; and 4) Eliminate tobacco-related disparities among different population groups. As of January 2009, all 55 counties have clean indoor air regulations. The WV OMCFH has chosen to keep, ***Decrease the percentage of high school students who smoke cigarettes daily*** as a state performance measure.

Oral Health

Following a presentation on the need for a current oral health plan by representatives from the WVDHHR Oral Health Advisory Board, the audience was given opportunity to provide input and feedback from their respected regions. At the conclusion of the meeting, a West Virginia State Oral Health Plan Survey was provided to collect information and identify key priorities that need to be addressed to improve the status of oral health in West Virginia. Participants were asked to rank (1-9) various issues with the most important barriers ranked first.

The following table is a summary of the information collected from the regional community meeting participants.

Priorities at a Glance	Issues Listed According to Rank as Identified by Participants
1	Disease Treatment and Prevention – <i>Direct services, prevention vs restorative, cost and, by whom, etc.</i>
2	Public Education and Outreach – <i>Social marketing of the importance of good oral health.</i>
3	Funding/ Reimbursement – <i>Insurance coverage, Medicaid, PEIA as well as federal funding opportunities.</i>
4	School Based Education and Service Delivery – <i>Services provided at a school or school related site.</i>
5	Oral Health Promotion across the lifespan – <i>Looking at oral health from perinatal, children and adults through seniors.</i>
6	Workforce – <i>Scope of practice, shortage of dental providers, recruitment and retention.</i>
7	Water Fluoridation and Fluoride Programs – <i>Water treatment plants, fluoride rinse programs, etc.</i>
8	Data Collection and Surveillance – <i>On going monitoring of the status of oral health in West Virginia.</i>
9	Burden of Disease and Documentation – <i>An encompassing report on the current status of oral health in West Virginia.</i>

Discussion:

The West Virginia Department of Health and Human Resources Oral Health Advisory, spearheaded by the OMCFH, worked cohesively to develop the West Virginia Oral Health Plan 2010-2015 which was released in March 2010. The Oral Health Advisory will be involved in shaping oral health goals, identifying process improvements and legislative awareness.

The Children's Dentistry Project, (CDP) housed within the OMCFH, in partnership with county school systems, Marshall University, Head Start Agencies, WIC, 4-H, school-based health centers and other community children's programs, are working together to offer a sealant and fluoride rinse program within schools. Payments from existing insurance sources are sufficient to cover operational costs and ultimately improve oral health access. This project was initially offered only to students in one targeted county, but the CDP continues to work with partners to expand this service to students in three additional counties. The CDP provides portable dental equipment to ten primary care facilities for the purpose of offering school-based dental services, including sealant applications, in eight counties.

The Oral Health Program is working with Marshall University to establish a surveillance system for school based oral health activities. Currently, school based oral health centers serve 61 schools in 24 West Virginia counties.

The OMCFH administers the Bureau for Children and Families' Pre-employment Services Dental/Vision Project that supports services to assist persons transitioning from welfare to work. In FY 2009, \$1,305,961 was spent serving 1,926 persons for dental benefits.

The OMCFH has chosen to add a state performance measure, ***"Increase the percentage of WV's children \leq 18 who are Medicaid beneficiaries who have at least one oral health preventive visit in a 12 month period"***.

Obesity

The increasing rates of childhood obesity nation-wide and the prevalence of adult risk factors for cardiovascular disease at earlier ages, reflect a public health crisis that schools, agencies, and allied health professionals in West Virginia are attempting to address with intervention programs and information campaigns. West Virginia has one of the highest obesity rates in the nation for children and adults.

Discussion:

Because of the multitude of initiatives being offered to combat the obesity crisis in West Virginia, the OMCFH will continue to keep two performance measures identified from

the last Needs Assessment, ***“Decrease the percentage of high school students in grades 9-12 who are overweight or obese” and “Increase the percentage of high school students who participate in physical activity for at least 20 minutes a day, 3 days a week”***. Data will be collected using the YRBS.

Injuries

Unintentional injuries were the leading cause of death for children and youth ages 1-24 in WV during the period 2002-2006. Suicide was the second leading cause of death for youth ages 15-24 in West Virginia during the period 2002-2006. Understanding injury rankings among other causes of death is important in determining their physical and economic role in each state.

Discussion:

The federal Maternal and Child Health Bureau Block Grant program requires state MCH programs to report on 18 National Performance Measures (NPM), two of which directly address injuries, “The rate of deaths for children aged 14 years and younger caused by motor vehicle crashes” and the “rate of suicide deaths among youths aged 15-19”. In the United States, the average rate of unintentional motor vehicle (MV) deaths for children aged 0-14 during 2006 is 3.01 per 100,000 population and in WV for the same year it is 4.41.

The West Virginia MCH program reports on two current state performance measures that address injury and violence. ***“Decrease the percentage of high school students who drink alcohol and drive” and “Decrease the rate of high school students who never or rarely wear a seatbelt when riding in a car driven by someone else”***. WV has made progress in these two measures, but is planning on keeping them since they are still above the national rate.

West Virginia continues to develop traffic safety materials targeted at young people. Through collaboration, the Department of Education’s school-based health education is being improved to incorporate information on health-related decision making. The WV Division of Highways will implement plans for the Strategic Highway Safety Plan.

The West Virginia Council for the Prevention of Suicide is working to reduce the stigma associated with seeking and receiving mental health services, reduce cases to lethal means, provide support to suicide survivors, promote support for suicide prevention among providers, and improve public awareness and understanding of suicide.

Racial Disparities

In February 2010, *Legacy of Inequality: Racial and Economic Disparities in West Virginia* was published as a joint project of Partnership of African American Churches, West Virginia Center on Budget and Policy, and West Virginia Economic Justice Project of the American Friends Service Committee. The report briefly chronicles the experience of African Americans in West Virginia and presents a data analysis of disparities, causes and suggested policy initiatives. The recommended policy improvements cover five key areas: jobs and economic development; education; family economic security; criminal justice; and planning and evaluation. The recommendations are as follows:

Jobs and Economic Development:

- Appropriate \$3 million to the West Virginia Economic Development Authority to fund Senate Bill 573 in order to support economic development projects in heavily populated African American communities.
- Appropriate \$2 million dollars to continue funding the Neighborhood Housing and Economic Stabilization Program in minority neighborhoods. This Program has the potential to have a tremendous impact in using housing rehab, new construction and weatherization as an economic development driver and an employment and training initiative in low-income communities around WV.
- Use Temporary Assistance to Needy Families (TANF) Emergency Funds to allow the state or another entity to create a subsidized employment program that specifically targets low-income communities. For instance, the State of New York used the funds to create a “Green Jobs Corp” program that provides public assistance recipients and other low income individuals with employment opportunities in “green jobs.”

Education:

- Reauthorize HB 4669, which created Professional Development Schools (PDSs) in ten counties with high minority and low-socioeconomic populations, and include the following changes: (1) Require the formation of a PDS Team in each county that would include strong community involvement, at least quarterly meetings, and a structure of accountability; (2) Appropriate at least \$100,000 per county to fund the community and parent mobilization training and engagement component of the PDS School Initiative; and (3) Appropriate at least \$200,000 per county to support community tutoring and mentoring programs to support the PDSs.

Family Economic Security:

- Enact a State Earned Income Tax Credit. At the federal level, the Earned Income Tax Credit (EITC) has been one of the most successful anti-poverty and pro-work policies ever enacted. Each year the federal EITC pulls thousands of families in West Virginia out of poverty. West Virginia could build on the success of the national EITC by joining the 24 other states that have adopted a state EITC. A state EITC would further remedy the problem by supplementing income and improving tax fairness.
- Extend Unemployment Insurance to workers who are presently excluded. West Virginia is eligible for \$33.2 million under the American Recovery and Reinvestment Act if WV adopts at least three reforms. The Legislature approved the first improvement last year when it adopted a more inclusive method for calculating benefits. To receive the remaining two-thirds of the funds, the state must adopt at least two additional improvements specified in the Recovery Act, such as covering part-time workers and workers with compelling family reasons for leaving their jobs.

Criminal Justice:

- Enact legislation and appropriate \$1 million to fund a Demonstration Re-Entry Project in Kanawha County, which would be administered by community and faith-based organizations to help the over 250 ex-offenders returning to Kanawha County each year successfully transition back to the community. One of the keys to reducing the over representation of African Americans in WV's juvenile justice and adult corrections systems is effective community-based programs. West Virginia's Community Correction Centers are having some success in reducing regional jail costs, but are having no measurable impact on reducing the over representation of African Americans in the system.

Planning and Evaluation:

- Improve data collection. There is not one single data-gathering agency that collects scientifically significant data on WV's African American population. The Department of Health and Human Resources should oversample those counties that contain substantial African American residents so that current data is always available on this minority population.
- Create a State Office of Minority Affairs charged with reviewing information and coordinating agency-level programs across state government to eliminate the racial disparities identified in this report. Efforts to address these issues at the individual agency level are sporadic at best and in many instances nonexistent.

Discussion:

West Virginia is racially homogenous with 94% White, 4% Black and 2% Other. Measuring health-related racial disparities in West Virginia is challenging due to the small population of racial minorities in WV. For most available data sources, racial and ethnic minority groups must be combined and multiple years of data must be aggregated to obtain reliable estimates and rates for non-White groups.

West Virginia has one of the highest rates of poverty in the nation. While both Whites and African Americans have poverty rates above the national average, there still exist disparities among the two groups. According to 2006-2008 American Community Survey 28.5% of African Americans are in poverty compared to 16.5 percent of Whites. African American children under age five are more than twice as likely as White children to be poor, with 58 percent living below the poverty line. African American adults also experience significantly higher poverty levels, including one in four working-age adults and one in five seniors.

Based on information gathered for the Needs Assessment, the OMCFH is partnering with the Perinatal Partnership to co-sponsor a WV Perinatal Summit on November 11-12, 2010 to address perinatal health issues and disparities. The Keynote Address is titled "Overcoming Disparities: Collaborating for Equality in Birth Outcomes". This program has been designed to bring together multiple disciplines that provide perinatal healthcare through clinical practice, community programs and professional and patient education. Local and regionally recognized faculty will encourage participants to consider collaborative, innovative strategies when faced with challenges in perinatal healthcare delivery and education. An overall objective of this conference is to collaborate to increase favorable birth outcomes, decreasing health disparities and risks for the underserved.

A film to be shown at lunch titled "*Crib: Saving Our Nation's Babies*", a documentary by Tonya Lewis Lee, focuses on maternal and infant health in the African American community. The film was developed as part of the U.S. Office of Minority Health's "*A Healthy Baby Begins With You*" campaign.

Other initiatives that the OMCFH is involved with include: 1) participation of the OMCFH WISEWOMAN Project Director in quarterly Black Medical Society of West Virginia meetings, a nonprofit organization created to bring healthcare professionals together to end health disparities affecting WV's African American communities; 2) participation in discussions with the Advisory Council of the WV Diabetes Control Program on the social determinants of health equity; 3) participation in discussions with REACH WV

staff and members of the Kanawha County REACH coalition to discuss local efforts to reduce the disparate impact of diabetes and other chronic diseases on African Americans in Kanawha County; 4) OMCFH has also been invited to participate on the state's nutrition coalition and tobacco prevention coalition which both have initiatives in place to address disparities in WV; 5) a focus group project that is slated to occur in November 2010 focusing on knowledge of contraceptive methods and prevailing attitudes in the 18-25 year old age group, will include discussion about disparities; and 6) an OMCFH epidemiologist serves on the Minority Health and Disparities Advisory.

The OMCFH did not choose a performance measure in this area because a National Outcome Measure exists (number 2); the ratio of the black infant mortality rate to the white infant mortality rate. The WV OMCFH has reported each year on the National Outcome Measures, although reporting is not required, and will continue to do so to monitor outcomes. This outcome has decreased over the last three years starting in 2006 at 3.3 to 3.2 in 2007 and 2.9 in 2008.

Children with Special Health Care Needs

WEST VIRGINIA CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM FAMILY SURVEY April 2006

With the assistance of the Parent Network Specialists from West Virginia University (WVU) Center for Excellence in Disabilities (CED), all parents of children enrolled in the Children with Special Health Care Needs Program were sent surveys in early 2006.

Survey objectives were to determine the overall satisfaction with services provided by the CSHCN Program, to ascertain the medical and social service needs of the participants and families served by the CSHCN Program, and to help define the scope of services offered by the CSHCN Program in the future.

Results Relating to Medical Care:

- 93% of the respondents were satisfied with the services they received from the CSHCN Program
- 96% of the respondents reported having a medical home or PCP
- When asked where they would like to receive medical care, respondents preferring CSHCN clinics were approximately equal to those preferring a private physician's office. Less than 8% of the respondents indicated a preference for out of state care and about 1% indicated that they would like to receive care in medical school clinics
- 80% of the respondents felt clinic services were average or above
- 96% expressed satisfaction with services received in private physicians' offices

- 90% of respondents were pleased with the DME and supplies they received

Results Relating to Care Coordination Services:

- 89% of respondents felt they received average to above average services regarding referrals to local or community resources
- With regard to transition services provided by CSHCN, 89% of respondents indicated a rating of average or above
- 89% would like more information about medical power of attorney and guardianship issues
- Respondents overwhelmingly listed money as the most significant problem facing them when providing care for their child, followed by transportation problems and a need for respite care

Conclusions/Recommendations:

- The CSHCN Family Survey indicates that the majority of respondents are satisfied with the services they receive from the CSHCN Program.
- The CSHCN Program provides comprehensive care coordination that Medicaid, CHIP or private insurance companies cannot.
- The survey indicates a need for an increased emphasis on care coordination services for the entire family, including educating families about the benefits of these services.
- The survey also indicates a need for an increase in transition services, including assistance with guardianship, conservatorship, wills and financial planning.

As a result of multiple surveys and public forums, several overall system needs became apparent. Within the Direct Health and Enabling Services category, West Virginia is severely lacking in respite services. Respite services are almost non-existent, even for high need, targeted population groups like Medley class members who were previously institutional residents.

Discussion:

The WV CSHCN Program has worked diligently to expand care coordination services to a larger population of children with special health care needs, including those who are not enrolled in the CSHCN Program. One of the major accomplishments in 2009 was a collaborative effort between the CSHCN Program and the WVU School of Medicine/Physician's Office Center (POC). The POC began managing several specialty care clinics that were previously managed by the CSHCN Program. In assuming

management of the clinics, the POC can schedule clients who are not enrolled in the CSHCN Program, but are in need of care coordination services. The CSHCN Program provides a nurse and social worker to offer care coordination services in each of these clinics that will provide continuity of care to a broader population of children with special health care needs.

Similar efforts are under way with Marshall University/Joan C. Edwards School of Medicine in Huntington, WV. The CSHCN Program also works in collaboration with the Cystic Fibrosis clinic offered through Charleston Area Medical Center's (CAMC) Women and Children's Hospital in Charleston, WV. Medical management and genetic counseling is provided by CAMC, while the CSHCN Program provides the nursing and social service components of the care coordination.

Summary:

Eight state performance measures were chosen from the list of concerns/priorities discussed throughout the Needs Assessment that were not already national performance measures. These priorities and state performance measures were chosen with the help of the Perinatal Partnership, OMCfH advisories and parents and are listed below in order of priority as they were chosen from the various groups. Priorities were chosen based on slower improvement in those specific areas and the need to increase efforts within these areas.

State priorities have been summarized and listed below:

A. Pregnant women, women of childbearing age, mothers and infants

1. Decrease smoking among pregnant women
2. Reduce the incidence of prematurity and low birth weight
3. Reduce the infant mortality rate, focusing efforts on African American infants and Sudden Unexplained causes

B. Children and Adolescents

1. Assure that children and adolescents access preventive dental services
2. Reduce smoking among adolescents
3. Reduce obesity among WV's population
4. Decrease the incidence of fatal accidents caused by drinking and driving
5. Increase the percentage of adolescents who wear seat belts
6. Reduce accidental deaths among youth 24 years of age or younger

C. Children with Special Health Care Needs

1. Maintain and/or increase the number of specialty providers in health shortage areas

From the 11 state priorities, eight measures were chosen that incorporates the priority needs and are not already National performance or outcome measures.

- 1) Decrease the percentage of pregnant women who smoke within the last three (3) months of pregnancy.
- 2) Increase the percentage of WV's children <18 who are Medicaid beneficiaries who have at least one preventive dental service in a 12 month period.
- 3) Decrease the number of infant deaths due to SIDS/SUID.
- 4) Decrease the percentage of high school students in grades 9-12 who are overweight or obese.
- 5) Increase the percentage of high school students who participate in physical activity for at least 20 minutes a day, 3 days a week.
- 6) Decrease the percentage of high school students who smoke cigarettes daily.
- 7) Decrease the percentage of high school students who drink alcohol and drive.
- 8) Decrease the number of high school students who never or rarely wear a seatbelt when riding in a car driven by someone else.

For access to the entire Needs Assessment you may contact the OMCFH at 304-558-5388 or online <http://www.wvdhhr.org/mcfh/>.