Maternal and Child Health Services
Title V Block Grant

State Narrative for West Virginia

Application for 2014
Annual Report for 2012

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are located at the following address:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

/2014/ /2013/ In accordance with Public Law 97-35, the Joint Standing Finance Committee of the WV Senate and House of Delegates holds the Federal Block Grant Public Hearing each year for legislators and the general public. Public Notice is issued and interested citizens, groups and organizations are encouraged to attend. Written and oral comments on allocation and possible uses of the funds are accepted and considered. //2013// //2014//

While there has been established federal expectation that public forums be held around the Block Grant, WV has found this to be an expensive and inefficient, less than effective means of having topical discussions about the use of Title V resources. To counter this, OMCFH involves critical stakeholders in all facets of charting a course for the use of multiple funding streams that support maternal, child and family health activities in WV; the use of stakeholder advisories, surveys, task forces to study particular population groups and issues, engagement with established non-Title V advisories and lastly public forums and specific engagement of parents using parent-to-parent

networks. The end result is that there is not one isolated event to seek public input about the use of Office resources but rather have on-going study and action plan development, as evidenced by the following examples:

The establishment of the WV Perinatal Partnership, which includes multiple personnel from the OMCFH and the involvement of the Office Director, has developed an action plan for changes in the perinatal system. The details of the plan and action steps are woven throughout the Block Grant Application and Five-Year Needs Assessment. Successes have included procurement of legislative resources and statutory changes necessary to expand metabolic screening to the 29 tests as recommended by the Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases. /2013/ In direct response to physician requests to add critical congenital heart disease (CCHD) screening before infant discharge from the hospital, OMCFH and the Perinatal Partnership supported population based screening. The 2012 legislature mandated screening for CCHD and the OMCFH has been involved in the implementation processes with the physicians and birthing facilities. Also in 2012, because of community requests, severe combined immune deficiency (SCID) will also be added to the screening panel in 2013. //2013//

/2012/ In addition, because of Perinatal Partnership recommendations, legislation passed that allowed the State to establish the expectation that all medical practitioners serving pregnant women use a risk screening instrument regardless of the woman's insurance carrier. Screening information is sent directly to the OMCFH to be used for planning purposes that ultimately affects direct patient care. /2013/ In 2011, the first year of data collection, over 50% of the women who were pregnant had a screening form submitted. Analysis of collected data has been completed. Work is ongoing with the OBGYNs to complete and submit screening forms on all pregnant women as required by law. //2013//

Another example is the Birth to Three/Part C Early Intervention Program which has experienced such extremes in participation that the State had to make changes in eligibility definitions in order to keep the system solvent. Parents of participants were involved in the decision making process. Public forums have been historically held for parents and participants of CSHCN and Birth to Three services.

The OMCFH Maternal Mortality Review Team (MMRT) was established in response to Perinatal Partnership recommendations resulting in a Legislative mandate. The Team has since reviewed cases from /2013/ 2007, 2008, 2009 and 2010. //2013// The MMRT has made several recommendations to enhance care of the pregnant woman who presents to the ER. As a result, educational materials designed for medical personnel and patient awareness have been developed on cardiac issues during pregnancy and distributed to emergency rooms located throughout WV.

During the 2011 Legislature, legislation was mandated to add infant mortality review to the maternal mortality review as a result of the Perinatal Partnership involvement. /2013/ In 2012, Memorandums of Understanding were developed with all birthing facilities to allow review of infant charts as well the infant's mother's prenatal and delivery medical records. Reviews are currently occurring for the 2011 infant deaths. //2013//

During fiscal year 2010, public forums for Oral Health were held across the state and resulted in development of a State Oral Health Plan using collected feedback. /2013/ In response to continued requests for more action, a full-time State Dental Director was hired and housed within OMCFH. The Secretary for the WV DHHR conducted a meeting in June 2011 to discuss the need and barriers for an adult oral health project. This project is still under development.//2013//

Drug and alcohol abuse among WV pregnant women has been a growing concern among the medical community. The medical community asked the OMCFH to participate in and fund an initial research project to look at the burden. The OMCFH did fund the initial study and has plans to fund an additional drug and alcohol use during pregnancy study in FY 2012. //2012//

/2012/ The WV Developmental Disabilities Council held public forums around the State with 194 persons participating. Health care issues cited from the forums were: 1) availability and affordability of health care services, including providers who accept Medicaid; 2) availability of knowledgeable health, dental and vision care providers for people with DD, including those who are nonverbal; 3) health insurance policy restrictions and exclusions; and 4) consumer information about available health services and resources.

The DD Council also distributed a "Meeting the Needs of People with Developmental Disabilities" survey through the mail and Survey Monkey on the Council's website. Four hundred sixty surveys were returned. Of the surveys returned the three most important health related issues were: 1) dental services for adults with developmental disabilities receiving Medicaid; 2) coverage for nutritional supplements; and 3) coverage for durable medical and other equipment. //2012//

/2014/ The WV Birth to Three/Part C Early Intervention Program (WVBTT) routinely collects public input regarding system implementation and improvement activities. WVBTT gathers input annually from families through a family survey that was developed by the National Center for Special Education Accountability and Monitoring (NCSEAM). The survey data, covering effectiveness of practice and results for families, is used to direct continued quality improvement efforts. //2014//

/2012/ Every five years WV local health departments are required by the Office of Community Health Systems and Health Promotion within the Bureau for Public Health to complete a needs assessment for their assignment area. The expectation is that the local health departments hold public forums and complete surveys from residents in their county assignment areas to determine resident needs. This has been a great tool to receive input from each community. Based on needs, strategies are developed that target improvement. Common health issues that residents across WV felt were important are: affordable prescription drugs, driving while drinking, child abuse, chronic disease conditions (heart, diabetes, cancer), obesity, smoking, health insurance for adults, early detection and treatment of cancer, poverty, unemployment, drug use and lack of public transportation. Focus groups raised the issue of needing more physician specialists, emergent care in small town communities and the concern for the overall decreasing number of physicians due to malpractice costs. In one of the counties, citizens interviewed wanted the community to offer more centrally located hiking trails, more childrens' activities/playgrounds/outdoor facilities. They also expressed concern for lack of physicians and urgent care centers. In another county, residents felt they needed knowledge about what services are available and how to access care/information to improve their health, in addition to the previous common health issues mentioned. And yet another county identified resident priorities as: job quality, with many families working, but still living in poverty; lack of recreation or programs for teens and young children with teen pregnancy and child abuse listed as concerns; and lack of knowlege about resources. In most of the surveys and focus groups the two main sources of information for adults was television and newspapers. The OMCFH partners with local health departments and the Office of Community Health Systems and Health Promotion to deliver services and education on topics of need. //2012//

/2012/ The Adolescent Pregnancy Prevention Initiative (APPI)/Family Planning Program in the Bureau for Public Health, WV Department of Health and Human Resources has been addressing a rising problem among young adults in the state - unplanned pregnancies and high risk sexual activity. This problem is also being addressed at the national level, and, according to a recent national study of 1800 young adults between the ages of 18 and 29, among the 77% who said it is very important to avoid pregnancy right now, 34% said it is likely they will have unprotected sex in the near future. These findings are significant and concerning to health policy planners.

APPI, the Family Planning Program and the contracted media vendor, Arnold Agency, are teaming up to address this issue in West Virginia by first understanding some of the parallels between the national FogZone research report and young adults in WV. In order to explore this

and other objectives, R.L. Repass & Partners, Inc. planned and conducted a series of focus groups among the targeted audience throughout West Virginia. Three focus groups were conducted in Logan, Charleston, and Elkins, West Virginia among targeted respondents. Groups were recruited based on the age of the respondents and gender.

Focus group results indicated a need for improved educational programs for adolescents and young adults addressing sexual health. Many young adults discussed that there were few opportunities for them to learn about more than just the biological aspects of sex. A few individuals reported experiences where additional information was given, but that a fear tactic was frequently utilized with teenagers: "If you have sex you will get pregnant or get an STD". Therefore there was little knowledge among focus group participants about how young adults can best protect themselves. The respondents all seemed to be in agreement that more opportunities for discussing sexual health and at more frequent intervals would be appreciated. //2012//

/2014/ The Oral Health Program is actively involved in the WV Oral Health Coalition (OHC). The OHC serves as a valuable source of community input from key stakeholders and oral health advocates. The purpose of the Coalition is to advocate for oral health policy as well as use collaborative efforts to promote oral health activities statewide. Membership into the OHC is open to anyone who has an interest in oral health and requires no membership fee. //2014//

/2014/ The Block Grant application, Needs Assessment and Needs Assessment Executive Summary are posted on the OMCFH web site to elicit requests and responses. The Needs Assessment Executive Summary and the application were sent to OMCFH stakeholders and partners for review and comments. The current application will be placed on the website in September 2013 after the Block Grant review and will also be distributed to stakeholders. //2014//

An attachment is included in this section.

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2014, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The West Virginia Office of Maternal, Child and Family Health is the State maternal and child health agency serving the needs of women, infants, children, families and children with special health care needs. The OMCFH receives the 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 promote 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.

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

Please see the attachment for the complete Needs Assessment Summary.

III. State Overview

A. Overview

West Virginia is surrounded by Pennsylvania, Maryland, Virginia, Ohio, and Kentucky and is commonly referred to as a South Atlantic state. The Appalachian Mountains extend through the eastern portion of the state, giving West Virginia the highest elevation of any state east of the Mississippi River. The second most rural state in the nation, 20 of West Virginia's 55 counties are 100% rural according to the Census Bureau definition, with an additional 14 more than 75% rural. West Virginia is the only state that lies entirely in the Appalachian Region. Even so, West Virginia is located within 500 miles of 60% of the nation's population. The state is traversed by two north/south and one east/west interstates that connect its major population centers. In addition, I-68, which ends at Morgantown, where West Virginia University is located, provides access to Washington, D.C. and Baltimore, MD. Interstate 68 also connects with Interstate 79 providing access to Charleston, WV, our state capitol. Winding secondary roads connect the majority of the state's population, with little to no public transportation available between many of the small, isolated towns. Therein lies the single most often cited issue with access to health care for many of the state's residents.

/2012/ According to Wikipedia, WV was only one of ten states in 2009 which grew economically. While per capita income growth fell 2.6% nationally in 2009, WV's grew at 1.8%. Through the first half of 2010, exports from WV topped $3 billion, growing 39.5% over the same period from the previous year and ahead of the national average by 15.7%. Morgantown, WV was ranked by Forbes as the #10 best small city in the nation to conduct business in 2010. The city is also home to West Virginia University, the 95th best public university according to U.S. News and World Report in 2011. //2012//

/2014/ West Virginia is the state with the largest single natural scenic and outdoor recreational area in the eastern United States; the Allegheny Highlands. Eighty percent of the state is forested with over 110,000 square miles of hardwood forest, wind-swept mountains and photo-perfect valley landscapes. West Virginia covers 24,078 square miles, with a 2011 estimated population of 1,855,364 people -- with 819,192 people living in rural West Virginia (USDA-ERS). Charleston is the state capital. The state's largest cities are Charleston, Huntington and Parkersburg. According to the U.S. Census Bureau, 94.1% of the state's population is white, 3.5% is Black/African-American, and 1.3% is of Hispanic/Latino origin (2011).

There are 56 hospitals in West Virginia (Kaiser, 2010), 19 of which are identified by the Flex Monitoring Team as Critical Access Hospitals (March 2013). There are three tertiary care hospitals; WVU (Ruby Memorial) located in Morgantown, Charleston Area Medical Center (CAMC) located in Charleston, and Cabell/Huntington located in Huntington. There are 50 Rural Health Clinics in West Virginia (Kaiser, 2012) and 28 Federally Qualified Health Centers provide services at 174 sites in the state (Kaiser, 2010). 14.0% of West Virginia residents lack health insurance (Kaiser, 2011). According to the Economic Research Service, the average per-capita income for West Virginia residents in 2009 was $32,080, although rural per-capita income lagged at $29,695. Estimates from 2010 indicate a poverty rate of 20.2% exists in rural West Virginia, compared to 16.6% in urban areas of the state. 2010 ACS data reports that 21.5% of the rural population has not completed high school, compared to 15.3% of urban populations. The unemployment rate in rural West Virginia is 8.5%, while in urban West Virginia, it is 7.6% (USDA-ERS, 2011). //2014//

/2014/ As of May, 2013, 31 of WV's 55 counties were classified as medically underserved areas with an additional 12 counties classified as partially underserved. Only three counties in the entire State were considered to have adequate medical manpower to meet the population need. The WV Board of Medicine, as of December 31, 2012, reported that the current number of licensed physicians in WV is 6,020. Of this 6,020, only 4,000 are

actively practicing. The Board of Medicine also reports that there are 732 physician assistants. West Virginia has one School of Osteopathic Medicine and historically their physicians have established practices in our state. The Board of Osteopathy reported June 12, 2012, 1,131 D.O.s and 184 physician assistants were licensed in WV. All have increased since 2010. //2014// //2013/The WV Perinatal Partnership, which includes representatives from the OMCFH, 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 WV women to be served outside the boundaries of our state. The Board of Medicine, in 2011, reports that there are 168 M.D.s and another 35 D.O.s delivering infants across the state. This is an increase over the number delivering in 2010. //2013//

The WV University School of Medicine has been recognized as one of the top ten schools of medicine in the country for rural medicine. WVU made the top ten list for the first time in U.S. News & World Report's 2009 edition of "America's Best Graduate Schools." Rankings are based on ratings by medical school deans and senior faculty in the nation's 125 accredited medical schools and 20 accredited schools of osteopathic medicine. School of Medicine students learn and care for patients in rural areas of WV as part of the requirements for graduation. They work in partnership with rural communities and other health care providers in rural clinics across the state. Rural health training at WVU is about education and community service. Forty-eight percent of WVU School of Medicine graduates choose to practice in primary care areas, such as family medicine, internal medicine, emergency medicine, and pediatrics.

The other medical school is located at Marshall University in Huntington, WV and provdes medical residents to Cabell/Huntington Hospital.

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. In a previous meeting with Senator Jay Rockefeller, the Office was advised that the community health centers would be able to apply for resources under the American Recovery and Reinvestment Act that would allow them to expand their physical plants. The Office is working with community health centers on this issue in hopes that the physical expansion of the facilities will allow them to recruit dental health practitioners. The lack of available oral health services for adult persons in the state is a critical problem. Also, $1,000,000 was spent on oral health equipment for community health centers during the 2010 fiscal year. This equipment was ready for use July 1, 2010.

The OMCFH has been a strong supporter of the evolving community health center network dating back to the early 1980's. The networks at that point were struggling, and beginning in the ‘80's to this date the Office has used the community health centers to provide patient care for maternal and child health populations and used resources to offset the cost on a fee-for-service basis. Using this system, the community health centers and OMCFH have a symbiotic relationship that works to the mutual benefit of all: the patient, the health center and the Office.

The community health center network operates more than 106 health care sites across the state which includes school-based health centers and multiple free clinics. The purpose of the School-Based Health Center Program is to provide easy access to preventive and primary health care for school-age children at their local elementary, middle, or high school. These centers are operated and administered by a community-based healthcare clinic in their area. Each center is located within the school building, or on the school campus. When the school is closed, the student may seek care at the healthcare clinic which operates their school's center. Currently, funding is provided through the Division of Primary Care to 49 school-based health centers serving 64 schools in 24 counties, making health services available to over 25,000 students. Also, funding is provided to one more primary care organization which supplies referrals to the students at 3 high schools in their county. Additional school-based health centers are planned.

Each student receiving services at a school-based health center must be enrolled with written parental permission. Follow-up with the parent/guardian is conducted at the time of service, or immediately following. Services which may be provided by a school-based health center include: preventive education, yearly physicals, immunizations, chronic disease management, check-ups, acute and intermediate care, oral health, mental health, counseling, and ancillary and enabling services.

/2014/ According to the WV School-Based health Assembly's 2012 Annual Report current funding is provided through the Division of Primary Care to 68 school-based health centers serving 80 schools in 28 counties, making health services available to over 25,000 students. Also, funding is provided to one more primary care organization which supplies referrals to the students at 3 high schools in their county. Additional centers are planning to open soon.

Currently, in WV, there are now 34 primary care organizations. Most, but not all, provide services to more than one clinical site. These primary care centers also house 17 Black Lung clinic sites. This system of healthcare is constantly endeavoring to grow in accessibility and variety of services provided.

West Virginia has 11 qualifying free clinics which rely heavily on grants provided by the West Virginia State Legislature administered through the Division of Primary Care. Each year grants totaling nearly $3,000,000 provide comprehensive medical care to more than 75,000 enrolled patients with approximately 250,000 office visits each year. //2014//

According to 2011 Census data, 14% of the population in the state does not have health insurance. In March 2006, Former West Virginia Governor Joe Manchin lll signed legislation to expand SCHIP eligibility up to 300 percent of the federal poverty level, and on January 1, 2007, the state began a phase-in expansion by enrolling children in SCHIP with family incomes up to 220 percent 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. /2012/ The state Children's Health Insurance Board submitted its request March 31 to the federal Centers for Medicare and Medicaid Services to expand eligibility for CHIP coverage to children from families with incomes of up to 300 percent of the federal poverty level. For a family of four, that would increase the income cut-off to $67,050 a year, making an estimated 720 uninsured children eligible for CHIP coverage. Anticipated implementation is July 2011. //2012// /2013/ In July 2011, CHIP expanded its income limit for eligibility to 300% FPL. Starting with 220% of the FPL, families are required to make monthly premium payments based on the number of children enrolled in the family. Members in this group receive full medical, drug, dental and vision benefits, but with copayments for some dental services. //2013// ***/2014/ In May 2013 Governor Thomblin approved Medicaid expansion that is expected to offer insurance for an additional 200,000 WV residents. Refer to Budget Narrative for more detail. //2014//***

West Virginia reached its population peak a half century ago with 2,005,552 residents counted in the 1950 Census. The state's population has not exceeded the two million mark since then, but has fluctuated between 1.7 and 1.9 million depending on the state's economy. Four of the state's five largest cities have lost population since 1990. Charleston, the state capitol and largest city, and Huntington are the only places with populations exceeding 50,000. Population estimates from U.S. Census show West Virginia among the most racially homogeneous states in the country. /2012/ The 2010 census reported that 93.9% of WV residents are Caucasian, 3.4% Black or African American, 0.2% American Indian and Alaska Native, 0.7% Asian, 0.3% some other race and 1.5% were more than one race. The Hispanic population was reported as 1.2%. //2012//

/2012/ West Virginia has one of the oldest median age (40.4 years) and percent of people age 60

and older in the nation according to 2010 U.S. Census data. Between 2000 and 2010 people age 85 and older increased by 24.8%; the number of individuals age 90 and older grew by 41.3%. Although the population has fluctuated between 1.8 and 2.0 million over the last 50 years, the rate of births have declined from 50,000 births in 1950 to 21,225 births in 2009 dropping from a rate of 25.4 births per 1,000 to 11.3 births per 1,000. In 1997 West Virginia saw its first natural decrease, having 137 more deaths in that year than births, the first state in the nation to experience such a phenomenon. This trend continued through 2003. Because of its older population, West Virginia ranked first among the states in the percentage of its residents enrolled in Medicare (18.4%, compared to a national average of 13.9%). Older West Virginians value their independence, self-sufficiency and preservation of the family homestead. This lifestyle is demonstrated by the fact that residents maintain one of the highest percent of home ownership in the nation at 74.3% compared to 66.9% nationally. Almost 85% of individuals age 65 and older own their home. //2012//

Over the past 30 years dominant industries in West Virginia have shifted from mining and manufacturing to services and service producing jobs. Traditionally, mining and manufacturing wage scales are much higher than those in service occupations and include benefits such as medical, dental, and vision plans. Service jobs, on the other hand, are often part-time and do not include insurance plans. Low wages earned at such jobs often do not allow individuals to purchase their own health insurance coverage. /2013/ Since 2011, there has been an increase in the natural oil and gas business which has boosted the state economy. WV ranks second in the nation in non-agricultural job growth according to a report compiled by Arizona State University's W.P. Carey School of Business. The report provides analysis based on figures from the U.S. Bureau of Labor Statistics. The data shows that WV gained 19,200 jobs between January 2011 and January 2012.//2013//

/2014/ /2013/ According to Workforce West Virginia, West Virginia's seasonally adjusted unemployment rate for April 2013 was 6.6% compared with a national rate of 7.5%. //2014// State and federal minimum wage remained the same at $7.25 per hour. This is down from last years rates of 8.8% and 9% respectively. //2013//

/2013/ Work disability is a significant problem in West Virginia. The U.S. Census Bureau states in 2010, 17.2% of the population 18-64 years of age had a disability. //2013//

/2012/ Because of the loss of higher paying jobs over the past thirty years in West Virginia, there has been a concurrent rise in the state's poverty rate. According to figures supplied by the U.S. Census Bureau, 17.8% of the state's residents are living in poverty, compared to the national average of 14.3%. In 2009 the median household income in West Virginia was $37,423, while nationally it was $50,221. Of residents age 65 and older, 11.9% are living below the poverty level, while 24.1% of children under age 18 are living in poverty. The percent of high school graduates or higher, of the population 25 years and over, is 81.6%. //2012///

/2012/ There are approximately /2013/ 387,418 //2013//children under the age of 18 in West Virginia, making up 21% of the total population. While West Virginia remains predominately white (93.9%), racial diversity of the State's children is increasing. According to the 2005-2009 American Community Survey 5 year Estimates, 92.1% of children are white, 3.8% black, 3.0% multi-racial, and 1.1% other. /2013/ According to the 2009/2010 National Survey of Children with Special Health Care Needs, 18.5% of West Virginia's children have a special health care need as compared to the United State's rate of 15.1%. //2013// Multi-racial children are at higher risk of special needs. //2012//

Former Governor Joe Manchin III developed the West Virginia Kids First Screening Initiative so that children could benefit from a caring health professional working closely with their parents and school. The Kids First Screening Initiative unites parents, health professionals and teachers to give West Virginia's children the positive start in life they deserve by working together to assure WV children entering kindergarten are healthy and ready to learn. Every child, at first school

entry, receives comprehensive screening that includes hearing, speech, language, and growth and development using the EPSDT/HealthCheck protocol. Beginning with the 2008-09 school year, all children entering school received this wellness exam.

According to America's Promise Alliance, children need "Five Promises" to succeed in life. Since his inaugural speech in 2005, Former Governor Manchin asked that the state unite in committing to keep these five promises for WV children. The promises are: 1. Caring adults 2. Safe places 3. A healthy start 4. Effective education 5. Opportunities to help others. The Kids First Screening Initiative is a part of keeping these valuable promises for the children of WV`. The former Office Director of OMCFH was intimately involved in the design and development of this project.

In the last ten years the number of cases of autism spectrum disorder has grown from one in 500 to one in 100 children across the nation. This disorder has huge implications for state governments and the health care economy. WV, like state governments across the country, is grappling with policy questions of who is going to pay, how can services be coordinated, and how can OMCFH ensure evidence-based interventions are available to families.

Previous legislative sessions prior to 2011 had autism bills introduced but without success. The bills had provisions requiring insurance coverage for the diagnosis. Advocates for the legislation argued that twelve states already require private health insurers to cover autism treatments. Insurance lobbyists argued that the legislation was an attempt to shift responsibility for services from school systems to the health care systems. Obviously the health and educational challenges of autism are inextricably intertwined. /2012/ In 2011, autism legislation passed, HB 2693, requiring insurance coverage for autism treatments. //2012//

State efforts in regards to this growing concern includes: 1) Part C/IDEA - West Virginia Birth To Three; 2) Medicaid Waivers, not to be confused with a specific Autism Waiver; 3) Marshall University - Autism Training Center; 4) West Virginia University (WVU) Center for Excellence in Disabilities; and 5) Education. All of these efforts are addressing services for people with autism.

/2013/ WVBTT in collaboration with the WV Department of Education, received a grant from the national Technical Assistance Center on Social Emotional Intervention (TACSEI) to develop professional development infrastructure that will support early childhood professionals gain knowledge and skills needed to promote positive social emotional development and address challenging behaviors in young children. WV is supporting demonstration sites which are infusing TACSEI Pyramid model strategies across their child care centers. WV has been the first state to work with TACSEI to modify the Pyramid strategies for use by early intervention professionals working with families in home based settings. In 2010-2013 this effort will be expanded to include professionals in the State's home visitation programs.

Marshall University Autism Training Center and WVBTT, in coordination with the WV Department of Education are developing an autism initiative specific to early intervention professionals. The initiative will start in the fall of 2013 and expand on TACSEI, adding content specific to supporting children with autism. An early intervention Autism Academy is being planned for the summer of 2013. //2013//

The OMCFH operates in partnership with the federal government and the state's medical community, including private practicing physicians, county health departments, community health centers, hospitals and various community agencies to address WV residents' needs. The OMCFH strives to provide the necessary education and access to treatment needed in order for residents to make informed decisions regarding their own individual health needs. Categorical programs to address specific needs for targeted groups are limited with 80 percent of the Office's energy being used to develop systems for the provision of population-based and target specific preventive interventions, as well as infrastructure for the support of the maternal, child and family health populations.

Availability of services for WV's MCFH population has increased dramatically, however, there remain areas of the state that continue to lack medical practitioners. In addition, meeting the needs of chronic or disabled populations is impaired by the lack of medical sub-specialty providers, such as occupational therapists, physical therapists, speech pathologists, dentists; and as is typical with most states, pediatric sub-specialties are mostly available at tertiary care sites. To attend to these problems, the Bureau for Public Health, in collaboration with the West Virginia University School of Medicine, sponsors a rural practice rotation for physicians, social workers, dentists and other specialty providers, with the intent of encouraging the establishment of rural practices, as well as expanding immediate service capability, since these practitioners render hands-on care.

The Perinatal Partnership found that many providers, especially at small rural hospitals, complained that pregnant women and/or their newborn infants needing tertiary care were being turned away due to a lack of bed capacity at the three tertiary care centers in the state. Further study demonstrated this to be true finding the Neonatal Intensive Care (NICU) facilities have been functioning at 100 percent capacity. Physicians with the tertiary care facilities reported that they were turning away both high-risk maternal transports and infant transports, primarily due to no availability of NICU beds.

The Partnership's Committee on Adequacy of NICU Beds recognized that the cost to operate NICU beds and the physical capacity of some tertiary facilities to add more beds posed problems. At the same time, it was of utmost importance to care for newborns as close to home as possible and it was recommended that the tertiary care facilities seriously study their capability to increase NICU beds. To assist in accomplishing this, it was recommended that the West Virginia Health Care Authority should immediately evaluate and update the current methodology utilized in determining Certificate of Need approval of NICU beds. The need to upgrade some community hospitals and equip them to handle newborns needing added care but not necessarily needing transfer to a NICU was discussed. Also, community hospitals could be upgraded to handle NICU "back referrals" for infants needing intermediate but not intensive care. Community hospitals that had the capacity or were willing to upgrade their capacity to accommodate infants that needed added care as they transition into health were asked to begin addressing this issue.

Between 2004 to 2007, the state's three tertiary care facilities were at NICU bed capacity with just 89 NICU licensed beds. Between October 2007 and October 2008, 31 infants were turned away from one of the three NICU's due to lack of bed availability. This information was presented to the Legislative Oversight Committee on Health and Human Resources in an effort to increase attention to perinatal system shortcomings in WV and resulted in expansion of the NICU bed capacity to 118 in 2009.

The Perinatal Partnership noted that to avoid unnecessary admissions to NICU, all birthing facilities and maternity providers should curtail elective delivery prior to 39 weeks gestation, following ACOG recommended guidelines for elective delivery.

WV House Bill 2388 established a mandate for the universal testing of newborns for hearing loss. The Newborn Hearing Screening Advisory, as established in statute, has made testing recommendations, developed screening protocols, and assisted the Office of Maternal, Child and Family Health with the development of user friendly education materials for inclusion in hospital birth packets and distribution through the state's perinatal program called Right From The Start (RFTS). The passage of the West Virginia Birth Score, in this same legislation, further strengthened the state's ability to universally screen all newborns for developmental delay, hearing loss, and conditions that may place infants at risk of death in the first year of life. The original Birth Score instrument was modified to accommodate hearing screening, so one instrument and one tracking system addresses the mandate. All WV birthing facilities began universal newborn hearing screening effective July 1, 2000. The Birth Score Office and the OMCFH Newborn Hearing Screening Project coordinator offer on-going technical assistance related to the operation of the initiative.

In 2002, three additional bills were passed: SB 672 establishing a Birth Defects Surveillance System, HB 216 requiring screening of all children under the age of 72 months for lead poisoning, and HB 3017 requiring the creation of a state oral health program. Although all of these programs existed previously, legislative mandates ensure continuance of these health efforts.

The 78th West Virginia Legislature, passed in the 2007 session, H. B. 2583 mandating the expansion of newborn screening to include 29 disorders. The West Virginia Newborn Screening Program, housed within the Office of Maternal, Child, and Family Health within the Bureau for Public Health, partnered with the State Laboratory to expand newborn screening to include all 29 disorders in order to adhere to national standards recommended by the United States Department of Health and Human Services, Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases. The Bureau for Public Health submitted legislative rules that allowed for financial sustainability by invoicing the hospitals for each live birth receiving a screen. The fee charged is based on cost and is sufficient to cover the cost of the newborn metabolic system. Screening for all 29 newborn disorders became effective February 4, 2009. ***/2014/ Addition of Critical Congenital Heart Disease (CCHD) occurred in 2012 and Severe Combined Immunodeficiency Disease (SCID) to the newborn screening panel will occur in 2013. //2014//***

West Virginia purchased Ages and Stages (ASQ:3) kits in 2009 for use by childcare, medical practitioners, and the IDEA/Part C system to improve early identification efforts of children experiencing delay. ASQ:SE kits were also purchased in April 2010 /2013/ with 300 distributed to participating HealthCheck providers. An additional 100 kits were purchased in 2012 after a QA initiative revealed that only about 25% of providers were conducting developmental screenings as recommended by Bright Futures. //2013// There is also discussion about monies being dedicated to quality improvement in early childhood care centers, since three quarters of the nation's children between the ages of 3 and 5 and more than half of the children ages 2 and under spend time in some form of non-parental care. Many of these children are cared for by relatives, but a large proportion - 57% of children aged 3 to 5 and 20% of infants and toddlers are in center-based care. The quality of care in childcare settings varies dramatically, with low income children generally receiving the lowest quality care. Voluntary participation in statewide quality rating and improvement systems are the best way to improve the overall level of quality.

Childhood is a unique and valuable stage in the human life cycle. The most important influence in the life of a young child is the family. Parent education and home visiting programs strengthen the family and support parents. Many early childhood home visiting programs focus on families who are at risk, such as young, first-time mothers, mothers of low birthweight infants and low income families. West Virginia RFTS Program focuses on low income, medically high risk pregnant women; its goal is improving pregnancy outcomes and infant well-being, and is managed by the OMCFH in partnership with licensed nurses and social workers employed by community-based agencies statewide. Birth to Three, the State's Early Intervention/Part C/IDEA Program (BTT) provides developmental services in the child/family's natural environment with 99.9% of children in BTT receiving the majority of services in home and community settings. This Program is considered educational in nature, has no income guidelines, and is for a subset of the population. BTT (Part C/IDEA) is an investment in early childhood, administered with oversight by the U.S. Department of Education/Office of Special Education Programs' guidelines by the OMCFH.

Other home visiting programs in WV support parents and caregivers in preparing children for school entry and lower risks associated with growing up in poverty. The multiple programs serving early childhood populations provide unique opportunities for overall improvement in child and family well-being. Refer to Agency Capacity for additional detail.

/2012/ The WV Department of Health and Human Resources (WVDHHR) on behalf of Governor Earl Ray Tomblin, designated the Office of Maternal, Child and Family Health as lead agency to coordinate, develop and implement the WV Home Visitation Program (WVHVP). The primary

focus of this Program is to increase the infrastructure within WV to expand home visitation services to clients residing in the identified highest at-risk counties. The WVHVP proposes to meet the requirements and expectations of the assignment to: expand the home visitation infrastructure and training capacity; develop and implement a statewide continuum of evidence-based home visitation from pregnancy to five (5) years of age; establish effective partnerships among WV home visitation programs and identified resource agencies; and develop an integrated surveillance and reporting system to monitor and evaluate selected home visitation performance and outcome measures required to show improvements in federally mandated benchmark areas. //2012//

/2014/ WV has been successful in implementing a Help Me Grow system, integrating a cross model data collection system, enhancing professional development activities with cross model trainings, establishing statewide monitoring and continuous quality improvement (CQI) activities providing required frameworks to successfully expand home visitation activities from prenatal through age five (5). Bringing together key state and local stakeholders to share in decision making processes has been a critical component of the WVHVP. The WVHVP Stakeholders workgroup was formed with representation from the WV Early Childhood Advisory Council, Department of Education, Division of Alcohol and Substance Abuse, WV Coalition Against Domestic Violence, Bureau for Children and Families (BCF), Head Start, Right From The Start Program, PAT, HFA, Early Head Start, HAPI and other interested parties. As WVHVP expands, these same Stakeholders will provide local support for the service agencies in targeted counties. From the beginning, WVHVP has encouraged open discussions and assurances of no surprises or hidden agendas. This collective process, led by WVHVP Stakeholders workgroup, has enabled active participation at both state and local levels in establishing processes and making decisions.

WVHVP implemented Help Me Grow (HMG) to solidify a comprehensive, statewide, coordinated system for early identification and referral of children for developmental and behavioral problems in the current process and ensure necessary linkages with evidence-based home visitation programs. The HMG model provides assurances to:

•Support child health care providers, as well as early care and education providers, human service providers, and families in effective developmental screening;
•Provide a centralized call center with care coordination capacity to assist families and professionals in connecting children to appropriate programs and services; and
•Develop a system that facilitates greater access and collaboration.

Initially the plan for HMG was to pilot within one or two high-risk counties and based upon the pilot results, move forward with statewide implementation. Once approval was received to utilize Development Grant funds for HMG, concentrated efforts were made to launch statewide, as opposed to piloting. WVHVP contracted with the HMG National Center for technical assistance in using the HMG framework for developing a project that is securely integrated into the State's early childhood system. Continuous verbal and written communications between HMG National Center and WVHVP, along with a review of existing documents, provided enough detail for HMG consultants to conduct a two day site visit on March 13-14, 2012 followed by a report outlining recommendations. The first day meeting provided an opportunity for HMG consultants to meet with WVDHHR staff and learn about the programs offered and relationships among the various programs, along with pediatric practices, community-based organizations, including those providing home visitation services. The second day meeting agenda included introductions and background information on the programs represented through the WVHVP Stakeholder workgroup. The consultants completed a presentation on the HMG system, including critical concepts, connecting home visitation and HMG, the role of HMG National Center, and HMG West Virginia. The meeting also included a Strengths, Weaknesses, Opportunities and Threat (SWOT) analysis brainstorming session which results were

reflected in the recommendations by the HMG National Center. A report providing recommendations was submitted to WVHVP from the HMG National Center and affiliate status was acknowledged for West Virginia.

Based upon HMG National Center recommendations, the following has been completed:

•Developed a HMG Leadership Team to serve for identifying, researching and addressing issues/needs as HMG is implemented.
•Established a HMG access data system to ensure data collection from the inception of the project. This included review of data needs and requirements around home visiting programs, other WVDHHR OMCFH programs and grant requirements, HMG common indicators, ASQ3 requirements and community-based programs.
•Integrating HMG into the already established OMCFH Systems Point of Entry (SPE) phone system. A core component of the HMG system is a centralized telephone access point and West Virginia is well poised through the OMCFH SPE to design, implement and maintain the centralized telephone access point for both families served and community-based partners.
•Used the strong relationship between the HealthCheck Program staff and pediatric and family practices to promote HMG and the home visiting resources available to patients and families.
•Established contractual agreements with the State approved media vendor to develop HMG specific brochures, fact sheets, website and display materials. This consists of developing outreach and marketing strategies that include, but not limited to physician outreach and the use of ASQ3 by home visiting programs, health care providers and community-based programs.
•Hired a HMG Coordinator and support staff.
•Established roles and responsibilities of FRNs.
•Received endorsement from the OMCFH Pediatric Medical Advisory Board and Governor's appointed ECAC. //2014//

/2012/ In FY 2009, the West Virginia Children's Health Insurance Program (WVCHIP) reported having 169,387 children enrolled in the Title XIX Medicaid Program, and 24,238 children enrolled in the Title XXI Children's Health Insurance Program. Information reported by the Primary Care Association indicates there are eighteen community-based dental clinics where dental services are provided free or at a reduced cost regardless of the funding source. Six local health departments offer oral health education services only, and four provide preventative oral health services. In the past year there were six mobile dental clinics in West Virginia which provided preventative services, where two clinics were Missions of Mercy (MOM) dental clinics which provided preventative and restorative dental services at no charge on a first come, first serve basis.

The Board of Dental Examiners reported for FY 2010 that there were 1,218 licensed dentists in the State, and 863 of those had physical addresses within West Virginia's borders. Of those 1,218 licensed dentists, 577 had at least one paid Medicaid claim and 610 had at least one paid WV CHIP claim. The Board of Dental Examiners also reported during that same time there are 1,314 licensed dental hygienists in the State, and 848 currently have West Virginia addresses. The State does not allow dental hygienists to bill Medicaid, however those hygienists who have a public health practice permit can bill under a supervising dentist. Medicaid in WV currently only offers emergency services to adults and pregnant women who are eligible for services. WV has six counties with only one dentist, and has twenty counties with less than five dentists.

In September 2010, the Association of State and Territorial Dental Directors released a national analysis of state oral health plans, "The State Oral Health Plan Comparison Tool". Out of 42 states with oral health plans, WV is one of 18 states that scored 19 or better on the Comparison Tool. WV met 19 of the 22 established benchmarks.

West Virginia frequently receives negative national attention for the poor oral health of its residents. In 2010 West Virginia was given an "F" by The Pew Center on the States in their report entitled "The Cost of Delay: State Dental Policies Fail One in Five Children." However, this report was not designed to recognize the significant investments and efforts that West Virginia has made in oral health over the last year. For example, in 2010, the Office of Maternal Child and Family Health (OMCFH) provided funding to Marshall University School of Medicine to develop and conduct a random oral health survey for children in West Virginia which follows Centers for Disease Control and Prevention guidelines and recommendations. In March 2010, West Virginia released its first Oral Health Plan, which was developed through a culmination of statewide efforts of oral health professionals to identify barriers and strategies to improve oral health. This process was a partnership between public and private organizations, legislators and community leaders. The State Plan outlines objectives and identifies responsible stakeholders to achieve goals for improved oral health across West Virginia. In 2011, the Pew Center raised West Virginia's oral health grade to a "C". //2012//

/2014/ In 2012, the Oral Health Program hired a full-time State Dental Director. This is the first time in state history that WV has had a full-time state dental director. Previously, this position was a part-time contracted position. Therefore, WV did not meet the recommendations of the Centers for Disease Control and Prevention (CDC) recommendations, and it was extremely difficult for oral health issues to get the much needed attention they deserved. The Office of Maternal Child and Family Health within the West Virginia Department of Health and Human Resources, evaluated the contracted position, demonstrated the need, and advocated for a full-time dental director with the West Virginia Division of Personnel (DOP). DOP acknowledged the need and created a new position. This accomplishment is particularly important because it demonstrates the State's recognition of oral health as a vital part of overall health and its dedication to making oral health a priority in the state. In addition, as recommended by the CDC, a full-time epidemiologist has been added to the OHP team. This position is housed under the Division of Research, Evaluation and Planning of OMCFH, but will work directly with OHP. This position will include conducting program and project evaluations, establishing Burden of Disease documentation, and updating WV's ever changing oral health plan. Additionally, this role will be critical in establishing and implementing a statewide oral health surveillance system.

In FY 2012, West Virginia reported having 208,420 children enrolled in the Title XIX Medicaid Program, and 22,262 children enrolled in the Title XXI Children's Health Insurance Program. Information reported by the Primary Care Association Indicates there are thirty-three community-based dental clinics where dental services are provided free or at a reduced cost regardless of the funding source. Six local health departments offer oral health education services only, and five provide preventative oral health services.

The Board of Dental Examiners reported for FY 2012 that there were 1,245 licensed dentists in the State, and 880 of those who practiced within West Virginia. Of those 1,245 licensed dentists, 627 had at least one paid Medicaid claim and 503 had at least one paid WV CHIP claim. The Board of Dental Examiners also reported during that same time there are 1,349 licensed dental hygienists in the State, and 897 currently have West Virginia Address. The State does not allow dental hygienists to bill Medicaid, however those hygienists who have a public health permit can bill under a supervising dentist. Medicaid currently only offers emergency services to adults and pregnant women who are eligible for services. //2014/

/2013/ Overview of CSHCN Program: (Added to this section due to lack of space in Agency Capacity section).
The Children with Special Health Care Needs (CSHCN) Program receives referrals directly from the Newborn Screening Program, Newborn Hearing Screening Program, and Social Security disability determinations. Last year, efforts to utilize the birth defect registry to

target newborns at risk of or diagnosed with a chronic medical condition for referral to the CSHCN Program proved difficult with privacy and confidentiality regulations as well as the data file containing no demographic information necessary for follow up. However, to address early identification and building the medical home, the CSHCN Screener(r) has been implemented in ten pediatric provider offices, with 40 practitioners, as part of the Tri-State Children's Health Improvement Consortium (T-CHIC) which is a five year project funded by a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant. As a foundational piece of the comprehensive pediatric provider care coordination model implemented in this project, and guided by the CHSCN Program care coordination model, the CSHCN Screener(r) is administered via family interview when children are identified for needed referral through their well-child exam. Referrals are received directly from the pediatric provider care coordinator if a child is identified as a child with a special health care need via CSHCN Screener(r) definitional domains. Furthermore, emotion-based public awareness materials and CSHCN program applications continue to be distributed directly to medical providers, early childhood providers, and Medicaid application centers (West Virginia Department of Health and Human Resources county offices) through CSHCN Program staff and Parent Network Specialists.

Through a cooperative agreement with the state's Medicaid program dating back to 1967, the CSHCN Program maximizes Title XIX, Title V as well as state funds to provide for evaluation, diagnostic/assessment, treatment, habilitation, and care coordination of children at risk of or diagnosed with a chronic medical or disabling condition. This partnership includes a centralized system for provider credentialing, medical necessity determination, prior authorization and billing processes for medical foods, durable medical equipment and medical services to children who have health financing by Title V.

The CSHCN Program partners with medical schools and hospitals to maximize and build the system of care in West Virginia. In efforts to ensure children can receive quality care within one hour drive from their home, and facilitate communication with a child's medical home, the CSHCN Program supports providers and practices with care coordination services by partnerships with: 1) West Virginia University to conduct six (6) specialty clinics in eight (8) locations throughout the state in the areas of cardiology, cleft and craniofacial surgery, genetics, myelodysplasia, and neurology; 2) Charleston Area Medical Center to conduct two (2) specialty clinics in Charleston WV in the areas of cystic fibrosis as well as cleft and craniofacial surgery; and 3) Marshall University to conduct two (2) specialty clinics in Huntington WV in the areas of spina bifida and cardiology. The CSHCN Program independently hosts, by individual contracts with providers, an additional 35 specialty clinics in 17 locations throughout the state in areas of cardiology, neurology, orthopedics, nutrition and ear, nose and throat, supported by donated office space and supplies provided by Women's and Children's Hospital, Beckley Health Right, St. Mary's Hospital, St. Joseph's Hospital, WV School for the Deaf and Blind, Ohio Valley Medical Center, Broaddus Hospital, Princeton Community Hospital, Wetzel County Center for Children and Families, Summersville Pediatrics, Associates in OB/GYN, West Virginia University Center for Excellence in Disabilities, University Pediatrics School Solution Center, Dr. John Eckerd, Dr. Monique Gingold, Dr. George Herriott, Dr. Jeffrey McElroy, Dr. John Draper, and Dr. Thomas Scott.

HealthCheck and the CSHCN Program are partnering with the Tri-State Children's Health Improvement Consortium which is a five year project funded by a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant with participating states of Alaska, Oregon and West Virginia. The goal of the project is to establish and evaluate a national quality system for children's health care which encompasses care provided through the Medicaid program and the Children's Health Insurance Program. HealthCheck and the CSHCN Program, in addition to 10 independent medical practices, will participate in evaluating the use of newly developed evidence-

based measures of the quality of children's healthcare, promote the use of health information technology (HIT) in children's healthcare delivery, and contribute to the development of a comprehensive pediatric provider care coordination model. At the beginning of the third year of the project, quality assurance reviews have been completed to gather baseline measurement for the initial core set of Children's Health Care Quality Measures, the reporting system and training of provider practices is in place to begin gathering ongoing data concerning the quality measures, an electronic personal health record has been developed and piloted, and each of the ten practices have been provided a care coordinator utilizing a care coordination model guided by the CSHCN Program services model.

The CSHCN Program continues a partnership with the West Virginia State Implementation Grant working to build a family-centered, culturally competent and community based system of care for Children with Special Health Care Needs. The three year project will develop a model of integrated services supported by health information technologies to create a Virtual Medical Home. Thus far, the CSHCN Program has piloted a care coordination care plan in specialty care practices in two locations with the goal to include the families as part of the care coordination team for their child. The Care Coordination Care Plan also provides documentation to the families, Primary Care Physician (PCP) and the patient's local care coordination team, on what was recommended for the child and who will be responsible for arranging what is needed following a specialty care visit. A copy of the form is given to the patient's family as a guide for what the next step will be for their child. A copy is faxed to the patient's regional care coordination team, to keep them informed of what recommendations the specialist had and what they might be responsible to arrange. Also a copy will be sent to the patient's PCP. The pilot has proven helpful in increasing family involvement, and adherence to the physician recommendations. However, the form is not user-friendly since it is not electronic for upload into electronic medical records. The focus next year will be on ensuring a Care Coordination Care Plan that is compatible with multiple electronic medical records prior to distribution in other specialty care clinics.

The CSHCN Program also sponsors a telehealth clinic at St. Joseph's Hospital in Parkersburg WV initiated through the West Virginia State Implementation Grant. Telehealth clinics provide access to specialty care appointments in the patient's local community by using Mountaineer Doctor Television (MDTV). Using telehealth clinics allows specialty and primary care providers as well as care coordinators to be a part of the clinic and, in essence, become the Virtual Medical Home. In 2011, negotiations began to expand telehealth clinics to a large pediatric practice in Lewisburg WV, and a new pediatric practice in Harper's Ferry, WV.

The Office of Maternal, Child and Family Health/Social Security Administration Task Force resumed partnership in 2011 with the goal of identification and referral of children with special health care needs, and expedited disability determinations as a result of a seamless referral and information sharing system. //2013//

/2012/ Life Course Model:
/2013/ The life course approach, also known as the life course perspective or life course theory, refers to an approach developed in the 1960s for analyzing people's lives within structural, social, and cultural contexts. The life course approach examines an individual's life history and sees for example how early events influence future decisions and events such as marriage and divorce, engagement in crime, or disease incidence. A life course is defined as "a sequence of socially defined events and roles that the individual enacts over time". In particular, the approach focuses on the connection between individuals and the historical and socioeconomic context in which these individuals live. The method encompasses observations including history, sociology, demography, developmental psychology, biology, public health and economics. So far, empirical research from a life

course perspective has not resulted in the development of a formal theory. //2013//

UCLA submitted an abstract on Life Course Research to the Maternal and Child Health Research Division and included the age breakdown for the life course as follows: Maternal, prenatal, infancy (0-12 months), toddlerhood (1-2 years), early childhood (3-5 years), middle childhood (6-11 years), adolescence (12-18 years) and young adulthood (19-21 years). The WV OMCFH has been building this life course model for years, but had not assigned a formal name to the model. Following is the age breakdown and programs the WV OMCFH offers to support the MCH population during these critical/sensitive periods:

Maternal: Family Planning Program; media campaign targeting young men and women of childbearing age addressing readiness for parenthood; violence and injury prevention; quality assurance monitoring of health care facilities that contract to provide Family Planning services; conference calls that target specific subjects and share the latest techniques in order to continue to attract and develop highly qualified professionals

Prenatal: population based maternal risk screening; Right From The Start (the state's home visitation program); transportation to medical appointments; coordination of the Maternal, Infant and Early Childhood Home Visitation Program that includes partnership with all home visitation programs; Maternity Services Program that funds prenatal care visits for teenagers and mothers without health insurance or awaiting confirmation of insurance coverage; violence and injury prevention; quality assurance monitoring of community agencies that contract to provide Right From The Start services

Infancy: population based high risk infant screening called Birth Score; newborn screening and
formula/supplements; newborn hearing screening; birth defects surveillance; Children with Special Health Care Needs (CSHCN) to age 21; coordination of Infant and Maternal Mortality Review Team; SIDS/SUID surveillance; management of the EPSDT/HealthCheck Program; Birth to Three (Early Intervention/Part C); Fostering Healthy Kids, a partnership with the Bureau for Children and Families coordinated through the CSHCN Program that case manages health management for children placed in Foster Care; Right From The Start; Maternal, Infant and Early Childhood Home Visitation Program; quality assurance monitoring of RFTS and BTT providers; violency and injury prevention

Toddlerhood: EPSDT/HealthCheck Program; Birth to Three; Home Visitation Program; Children's Dental Program (CDP); CSHCN; Childhood Lead Poisoning Prevention Program (CLPPP); Fostering Healthy Kids; metabolic formula/supplements; quality assurance monitoring of contracted agencies/service providers; violence and injury prevention

Early Childhood: Kids First screening for children entering school; Childhood Lead Poisoning Prevention Program; Healthcheck; Childrens Dental Program; CSHCN; HealthCheck; Fostering Healthy Kids; Early Childhood Health; metabolic formula/supplements; genetic counseling; Maternal, Infant and Early Childhood Home Visitation Program; quality assurance monitoring of agencies/service providers; violence and injury prevention

Middle Childhood: HealthCheck; CSHCN; metabolic formula/supplements; genetic counseling; Home Visitation Program; Fostering Healthy Kids; quality assurance monitoring of agencies/service providers; violence and injury prevention

Adolescence: HealthCheck; CSHCN; genetic counseling; Adolescent Health Initiative (AHI), Adolescent Pregnancy Prevention Initiative (APPI); Family Planning; metabolic formula/supplements; Fostering Healthy Kids; quality assurance monitoring of agencies/service providers; violence and injury prevention

Young Adulthood: HealthCheck; CSHCN; genetic counseling; healthy pregnancy/healthy baby media campaign; Family Planning; domestic violence prevention; metabolic formula/supplements; quality assurance of agencies/service providers; rape and sexual assault prevention; violence and injury prevention

Adulthood: Pre-employment Dental/Vision Program; Donated Denture; Family Planning; domestic violence prevention; Breast and Cervical Cancer Screening Program; WISEWOMAN; metabolic formula/supplements; Infant and Maternal Mortality Review Team; quality assurance monitoring of agencies/service providers; rape and sexual assault prevention; violence and injury prevention

(The above programs and the partnerships involved with each are discussed in-depth throughout the Application).

In applying LCT as a strategic framework, it is important to note that much of the current work of the OMCFH integrates health services and support systems across the lifespan, with particular attention to critical/sensitive periods, to maximize protective factors and minimize risks. WV has built a strong population based risk identification system, beginning with maternal high risk screening, several Programs/Projects for identification of infants at risk, early childhood screening, screening of children entering school for the first time, and early childhood health screening. Other OMCFH programs/projects focus on a healthy pregnancy for identified high risk women. Fostering Healthy Kids focuses on the health of foster children, while the Bureau for Children and Families focuses on social and environmental, building a shared relationship that overlaps to ensure the children's overall needs are being met.

With the Home Visitation Program there is expanded opportunity to work with families in a holistic approach to reduce poor health and social outcomes. A strong referral system exists in all OMCFH Projects, Programs and Initiatives increasing the capacity to improve outcomes across several critical periods in the LCT model. In adolescence, the focus is on building assets, reducing risky behaviors, pregnancy prevention and making wise decisions. In adulthood, the WV OMCFH focuses on breast and cervical cancer screening for low-income women, healthier lifestyles for women, and oral health care for persons actively seeking employment. In-depth information on OMCFH programs is included in the Agency Capacity section and referenced throughout the Application Narrative.

/2014/ With cultural challenges and implications of domestic violence on the young child, the Home Visitation Program will utilize a two-fold training approach targeted for early childhood educators. Through a partnership with the WV Coalition Against Domestic Violence, multiple training opportunities will be provided. Four (4) trainings in separate geographic locations will be held on the impact of domestic violence on young children using the Futures Without Violence Healthy Moms, Healthy Babies evidence-based curriculum, materials, videos and family handouts. Trainings will be open to all childhood programs providing services to families with children birth to five. In addition, a series of "Lunch and Learn" Go To Meeting sessions will be held focusing on particular aspects of the Futures Without Violence curriculum, including:

•Impact of Domestic Violence on Mothering: Helping Moms Promote Resiliency for Children;

•Childhood Exposure to Domestic Violence and Its Impact on Parenting;

•Fathering After Violence;

•Mandated Reporting for Child Abuse; Challenges and Considerations; and

•Preparing Your Program and Supporting Staff Exposed to Violence and Trauma

In addition, WVHVP has worked collaboratively with ECAC to:

•Implement Michigan's Association for Infant Mental Health (MI-AIMH) Endorsement for Culturally Sensitive Relationship Focused Practice Promoting Infant Mental Health;
•Utilize the Strengthening Families framework within early childhood programs; and
•Increase use of Ages and Stages Questionnaires-3 within all early childhood programs through cross program training opportunities and advocating for developmental screening within all early childhood arenas.

Competently trained supervisors and home visitors are the cornerstone of home visiting success. Staff will be provided guidance to have a family centered focused approach of support and preservation of families through a respectful, strengths-based approach that views the family as central to the child's well-being. An initiative that will be followed through links several of the emphasis areas together in regards to development of a family-centered approach, engaging hard to reach populations and effective implementation of evidence-based services. Working in collaboration with TEAM for WV Children/Prevent Child Abuse WV and the Center for Health and Safety Culture at Montana State University, WV is implementing a very promising Positive Community Norms (PCN) initiative. This initiative has been commended for its promise and innovation by the Centers for Disease Control & Prevention's (CDC) Child Maltreatment Prevention Knowledge to Action (K2A) Work Group. Earlier this year, representatives from WV were invited to share additional information about the PCN initiative with CDC members of the CDC's distinguished K2A Workgroup.

The primary purpose of the WV PCN initiative is to utilize a scientific positive community norms approach to:

Provide communication tools for home visitors and others to support efforts to reduce and prevent child maltreatment and promote positive outcomes for children in West Virginia by:

•growing positive parenting norms supporting safe, stable nurturing relationship; and
•creating safe sleeping environments and behaviors, and
•reducing shaken-baby syndrome.

The initiative is a strong example of a public-private partnership utilizing funding from the MIECHV Development Grant as well as private support from the Claude Worthington Benedum Foundation. The initiative is being overseen by a broad-based Stakeholders group including a combination of public and private representatives including state agency representatives, parents, home visitors, community based organizations, health care representatives, and others. The initiative is being co-led by Jeffrey Linkenbach, Ed.D., a leader in utilizing positive community norms to make dramatic impacts on a variety of health and safety issues including smoking, substance abuse, traffic safety, and more recently in the field of child maltreatment prevention.

As part of the baseline data step, the State is implementing a large-scale parent survey to collect data about parents' norms of behavior as well as their perceptions about the norms of other parents' behavior. The survey is aligned with an Integrated Behavior Model, which recognizes that there are many factors that influence whether an individual will engage in a particular behavior. Addressing an issue such as safe infant sleep is more challenging than just helping people have knowledge about safe sleep -- they must be willing to put that knowledge into action. The Integrated Behavior Model recognizes a person's beliefs, attitudes, perceived norms, environmental constraints, and other aspects -- in addition to their knowledge and skills -- all influence whether someone will engage in

a particular behavior. By aligning the Parent Survey with this Integrated Behavior Model approach, the PCN initiative will have a better idea of what opportunities exist to influence behavior in a positive manner to address the goals of the initiative and ultimately help WV achieve its MIECHV benchmarks. //2014//

B. Agency Capacity

The Office of Maternal, Child and Family Health (OMCFH) has historically purchased and/or arranged for health services for low income persons, including those who have health care financed under Title XIX. The Medicaid expansion of the 1980's resulted in health financing improvements, but it was Title V energy that developed obstetrical risk scoring instruments and recruited physicians to serve mothers and children, including those with special health care needs. It was also Title V that established standards of care, and developed formalized mechanisms for on-site quality assurance reviews.

Income eligibility coverage for pregnant women is 185% of the Federal Poverty Level in response to patient demand, using Title V monies. Although the OMCFH is less and less involved as a health care financier, the Office continues to provide gap filling services when indicated.

The OMCFH is constituted of three divisions, plus a Quality Assurance/Monitoring Team, Early Intervention IDEA/Part C, Home Visitation Program and the Administrative unit. With the exception of the Children with Special Health Care Needs Program (CSHCN), the OMCFH does not deliver direct services but rather designs, oversees and evaluates preventive and primary service systems for WV women and men of reproductive age, infants, children, adolescents, and children with special health care needs.

/2014/ Home Visitation:
The West Virginia Department of Health and Human Resources (WVDHHR) on behalf of Governor Earl Ray Tomblin, designated the OMCFH as lead agency to coordinate and implement the West Virginia Home Visitation Program (WVHVP). Collective efforts between state and local stakeholders will expand infrastructure and training capacity; develop and implement a statewide continuum of evidence based home visitation from pregnancy to five years of age; and identify resource agencies. Based upon risk factors, current capacity and allocated funding, a data driven decision was made with the WV Home Visitation Stakeholders workgroup to target Boone, Cabell, Mason, McDowell and Wayne Counties from identified twenty-two highest risk counties in the state Needs Assessment.

The Home Visitation Program is a partner with multiple programs within the Office of Maternal, Child and Family Health and Department of Health and Human Resources to implement a Help Me Grow system specifically to detect developmental and behavioral problems early, and share resources with families. //2014//

Quality Assurance/Monitoring Unit:
The OMCFH Quality Assurance/Monitoring Team has over 30 years proven experience in conducting on-site clinical reviews. These reviews occur with medical and educational providers who contract with the Office - private physicians, primary care centers, local health departments, hospitals, etc. The reviews are conducted on site and include patient interviews, chart reviews, and provider interviews. Formal reports are submitted to each program, as well as the health care provider. This unit was given oversight of OMCFH internal quality improvement projects and the Supervisor has served on multiple assignments.

WV Birth to Three/Part C IDEA (BTT):
BTT provides therapeutic and educational services for children ages 0-3 years and their families who have established, diagnosed developmental delays, or are at risk of delay through a network of credentialed practitioners statewide. The goal is to prevent disabilities, lessen effects of existing impairments, and improve developmental outcomes. Services are provided based on individual child/family assessments and delivered by community-based practitioners who are credentialed by Birth to Three. The service system is supported by Title V, federal Part C/Early Intervention, State appropriations and Title XIX funds.

Division of Perinatal and Women's Health (PWH):
The focus of the PWH Division is to promote and develop systems which address availability and accessibility of comprehensive health services for women across the life span and high risk infants in the first year of life. Administrative oversight includes an integrated perinatal care and education system paid for by Title V and Title XIX. PWH programs include the Family Planning Program under which the Adolescent Pregnancy Prevention Initiative is housed; the Breast and Cervical Cancer Screening Program; WISEWOMAN; universal maternal risk screening and the Right From The Start (RFTS) perinatal program that includes the Newborn Hearing Screening Project and the Birth Score Project. Additionally, these programs provide linkage and referral to other women's, infants', and children's services.

Family Planning Program (FPP):
The FPP provides an array of confidential preventive health services for low-income women, men and adolescents through a community-based provider network of locations. Sites include county health departments, primary care centers, hospital outpatient centers, private providers, free clinics and university health sites. FPP services include contraceptives; health histories; gynecological exams; pregnancy testing; screening for cervical and breast cancer; screening for high blood pressure, anemia, and diabetes; screening for STDs, including HIV; basic infertility services; health education and counseling, and referrals for other health and social services. Free or low cost pregnancy testing is offered to enable early identification of pregnancy and timely referral into prenatal care.

Any female or male capable of becoming pregnant or causing pregnancy whose income is at or below 250% FPL is income eligible to receive free or low-cost clinical examinations and free contraceptives through the FPP. These publicly funded clinics help women prevent 13,800 unintended pregnancies each year.

FPP clinics offer counseling and referral for patients regarding future planned pregnancies, management of current pregnancies, or other individual concerns (i.e., nutrition, sexual concerns, substance use and abuse, sexual abuse, domestic violence, or genetic issues). FPP clients seeking pregnancy or planning a pregnancy in the future are offered prenatal multi-vitamins with folic acid as part of their pre-conceptual counseling. Clients in need of enhanced preconception counseling or genetics testing are referred to tertiary care facilities or specialty providers for additional assessment.

Screening for domestic and intimate partner violence continues to be monitored by the FPP. FPP Specialists inquire about screening and availability of resources for victims at annual site visits. Findings are documented in their reports and entered in a data base. All FPP providers (100%) provide resources on site for services to those who are victims of domestic or intimate partner violence.

A Domestic Violence Intervention Guide was developed within the FPP for use by clinicians. A poster was also created to be placed in the restrooms with tear-off safety-plans for victims to take with them. The intervention guides and posters with tear-off safety plans were mailed to all FPP provider sites and are available by request.
/2013/ In 2011, RFTS distributed posters and brochures for the WV Committee Against Domestic Violence entitled "End Domestic Violence". //2013//

Adolescent Pregnancy Prevention Initiative (APPI):
/2014/ APPI influences and supports teens as they explore and determine responsible sexual and reproductive options for the future. The goal of the program is to reduce the number of pregnancies among adolescents using an abstinence based approach which includes: encouragement of reproductive life planning, improvement of decision-making skills, development of refusal skills and delaying techniques, and information regarding access to family planning services (including contraceptive methods.)

APPI is made up of 5 full-time employees: 1 Director and 4 APPI Prevention Specialists, who conduct education and outreach activities statewide. Each Specialist covers a region and works within that area to increase public awareness of problems associated with early sexual activity and childbearing. Specialists collaborate with public schools and existing community organizations to promote local prevention education to encouraging healthier decisions making for youth.

APPI also administers the federal Personal Responsibility Education Program (PREP) grant which assists in reaching an additional 600 teens per year with evidence-based teen pregnancy prevention curricula.

APPI is a focus area of the Family Planning Program (FPP). Confidential access to FPP services is crucial in helping sexually active teens obtain timely medical advice and appropriate care to delay childbearing. Minor clients seeking reproductive health care can only be assured of confidential services by a Title X-funded FPP network provider. //2014//

Right From The Start (RFTS):
West Virginia's RFTS began in 1989 as a partnership between OMCFH and WV Medicaid to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal home visitation services to low-income women up to sixty days postpartum and care coordination for Medicaid eligible infants up to one year of age. RFTS also provides direct financial assistance for obstetrical care for WV pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if they are a WV resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit.

The state is divided into eight regions for management of RFTS. Each region has a Regional Lead Agency (RLA) that provides a Regional Care Coordinator (RCC) to oversee activities of the community based Designated Care Coordinators (DCC). In addition to assigning patient referrals and promoting the project, the RCC coordinates training and education for DCC staff, and recruits obstetrical care providers and designated care coordination agencies.

Currently, there are 188 DCCs dedicated to the core public health function of assisting with access to early and adequate prenatal health care. In addition to RFTS DCCs, there are 85 obstetricians, nurse practitioners, nurse midwives and family practice physicians in WV and bordering states that have Letters of Agreement with the Project to provide quality obstetrical and delivery care to pregnant women.

HAPI:
WV Healthy Start/HAPI (Helping Appalachian Parents and Infants) Project is a federally funded Healthy Start grant which uses DCCs in RFTS Region VII for service provision. The purpose of this project is to work collaboratively with existing systems, most notably RFTS and the WV Birth Score Office, to provide comprehensive services to those women, infants and families at highest

risk. In addition to the care coordination and health education offered through RFTS, the HAPI Project also provides prenatally targeted screening and referral for depression, domestic violence, substance use and oral health services. The HAPI Project focuses on helping women to become healthier between pregnancies, encourages spacing of pregnancies, provides assistance with travel and childcare, and focuses on mental health issues.

RFTS SCRIPT:
WV continues to have the highest rate of pregnant smokers in the U.S. To address this issue, RFTS adopted an intense smoking cessation initiative, the WV Right From The Start SCRIPT (Smoking Cessation/Reduction in Pregnancy Treatment). SCRIPT was developed by Dr. Richard Windsor, MS, PhD, MPH, George Washington University Medical Center, Department of Prevention and Community Health. RFTS SCRIPT uses the 5 A's (Ask, Assess, Advise, Assist, Arrange), best practice method for smoking cessation education with pregnant women supported by the Treating Tobacco Use and Dependence: Clinical Practice Guideline, Agency for Healthcare Research and Quality and by the American College of Obstetricians and Gynecologists Bulletins.

The smoking cessation program was implemented statewide in WV in January 2002, through the OMCFH and incorporated as protocol into the RFTS Program in October 2003. The WV RFTS SCRIPT uses the existing home visitation network and protocols established in the RFTS Program. Registered nurses and licensed social workers, provide services to pregnant women and infants throughout WV.

Newborn Hearing Screening:
The Newborn Hearing Screening (NHS) Project ensures that all children born in WV are screened at birth for the detection of hearing loss. Case management services are provided by the RFTS Program for every infant who either fails the hearing screen or is not screened prior to hospital discharge. The NHS Project has adopted goals set forth by Healthy People 2010 and the Centers for Disease Control and Prevention who recommend that all newborns be screened for hearing loss prior to one month of age, have an audiological evaluation by three months of age, and if needed, have appropriate intervention services by six months of age. Children in need of intervention are referred to CSHCN and WV Birth to Three. Referrals are also made to the Ski*Hi Parent/Child Program for home-based family education and support for deaf and hard of hearing children and their families, administered by the WV School for Deaf and Blind.

Access to Rural Transportation (ART):
ART provides payment for transportation of RFTS Maternity Services eligible clients to medical or other predetermined medical care appointments (i.e. childbirth classes). The provision of transportation assistance is important to the goal of improving pregnancy outcomes and to the wellness of women and infants in WV. RFTS Maternity Services clients receive transportation assistance via the ART system while Medicaid eligible clients receive this coverage via the Non-Emergency Medical Transportation (NEMT) system.

Birth Score:
High risk infants are referred to RFTS by the WVU, Birth Score Program. The Birth Score Developmental Risk/Newborn Hearing Screen instrument is a population-based assessment designed to identify infants at birth that may be at risk for developmental delay or death within the first year of life. Infants who are identified as high risk receive an accelerated number of six medical visits in the first six months of life. Other Medicaid-sponsored infants who are considered at risk are referred to RFTS from various sources for care coordination.

In 2007, the Birth Score Developmental Risk/Newborn Hearing Screen instrument was revised and questions added pertaining to the mother's oral health and substance abuse during pregnancy. The numerical Birth Score was changed so that the newborn is considered High Birth Score if the score is 99 or greater. All WV birthing sites implemented the modified Birth Score August 1, 2007. All High Birth Score infants continue to be referred to the RFTS Program for care

coordination from birth through age one year.

Breast and Cervical Cancer Screening Program (WVBCCSP):
The WVBCCSP is a comprehensive public health program that assists uninsured/underinsured, low income WV women (at or below 200% of the Federal Poverty Level) between the ages of 25 and 64 in receiving quality breast and cervical cancer screening services. These services are offered through a statewide network of over 350 screening and referral providers. The WVBCCSP is funded through a federal cooperative agreement with the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). West Virginia was one of the original four states to receive funding to implement the Program in 1991. Today, the NBCCEDP spans all fifty states and the District of Columbia, five U.S. territories, and eleven American Indian/Alaska Native organizations.

/2014/ Since its inception, the WVBCCSP has enrolled over 134,200 women and provided more than 176,600 mammograms, 270,000 clinical breast exams, 260,600 Pap tests, and 4,300 hrHPV tests. Annually, the Program serves more than 16,000 women. However, the Program does more than simply screen and diagnose women. There are eight core components of the WVBCCSP including: Program Management; Screening, Diagnostic, and Patient Navigation Services; Data Management and Utilization; Quality Assurance and Quality Improvement; Professional Development; Partnerships, Coordination and Collaboration; Public Education and Targeted Outreach; and Program Monitoring and Evaluation. //2014//

To assist NBCCEDPs in providing treatment to women diagnosed with breast and/or cervical cancer, the 2000 Congress gave states the option to provide medical assistance for treatment through Medicaid as a part of the passage of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). WV was one of the first states to take advantage of this opportunity. This means that when an uninsured woman under the age of 65 is diagnosed with breast and/or cervical cancer and/or certain precancerous conditions, she is eligible for a Medicaid card. The card will pay for all her health care services that are included in the Medicaid State Plan, not just those to treat the cancer diagnosis.

WISEWOMAN:
WV's WISEWOMAN Program is a public health program that works with the WVBCCSP to provide women access to cardiovascular risk factor screening and lifestyle interventions. WISEWOMAN participants must be enrolled in the WVBCCSP and be between the ages of 40-64 years. As part of a WVBCCSP eligible woman's routine breast and cervical cancer screening exam, she will be provided blood pressure readings, total and HDL cholesterol screening, blood glucose screening, calculation of body mass index, assessment of smoking status, and evaluation of personal and family medical history. As follow-up to her screening exam, she will be offered risk reduction counseling and lifestyle interventions that will address nutrition, physical activity and tobacco use. The majority of WISEWOMAN provider sites are community health centers, since their federal assignment is assuring health access, and this provides an opportunity to be identified as the woman's health home.

/2012/ The WV WISEWOMAN Program Coordinator is involved with several initiatives that address health-related racial and socio-economic disparities in WV. These initiatives includes participation in the following: 1)quarterly meetings of the Black Medical Society of WV, a nonprofit organization created to bring healthcare professionals together to end health disparities affecting WV's African American communities; 2) discussions with the Advisory Council and staff of the WV Diabetes Control Program regarding the social determinants of health equity; 3) the WV Minority Health Coalition, which addresses education and outreach programs to all minority communities within WV; 4) the WV Nutrition Network which promotes healthy lifestyles through collaborative partnerships and social marketing efforts to improve eating habits and increase physical activity levels; and 4) the Bonnie's Bus workgroup focusing on increasing the numbers of African American and other minority women accessing the screening services available through

the mobile mammography unit.

Statistics show an increased incidence of poor perinatal outcomes among minority women, and certain perinatal risk factors appear to be more prevalent among this population. Prenatal care is important in evaluating risk, promoting health, and managing complications in pregnancy, yet disparity of and access to care place these vulnerable women at increased risk. The Perinatal Partnership is interested in studying disparities find a solution that works for West Virginia. The Minority Health Division is currently working with the Black Medical Society. //2012//

Division of Infant, Child and Adolescent Health:
/2012/ The goals of this Division are to recommend and implement standards of child health supervision from infancy to adolescence, implement care coordination for children with special health care needs, identify strategies for the prevention of childhood injuries, and coordinate prevention and education programs to improve child health. Both families and medical professionals are a key component of meeting these goals through their involvement in strategic planning and advisory committees. //2012//

Adolescent Health Initiative (AHI):
The primary goal of the AHI is to improve the health status, health related behavior, and availability/utilization of preventative, acute, and chronic care services among the adolescent population of WV and promote risk resiliency and strengthen youths' personal assets.

Formal work with the AHI began in 1988. Introduction of the developmental asset principles of Search Institute brought about a change in the mission in 1993. Search Institute identified 40 positive experiences and qualities everyone can bring into the lives of youth, called the developmental assets. Organized training opportunities are provided by a workforce hired from the community they serve and offered in the community that the youth live. This workforce, called AHI Coordinators, is located in each of the eight regions of the state. These Coordinators offer young people, parents, and other significant adults in a child's life skill building sessions on conflict resolution, communication, increased awareness of harmful consequences of substance use, and strategies to develop self-reliance and improve responsible decision making.

Since the inception of the federal abstinence education funding, WV has been at the forefront of administering these grant dollars by providing long-term, intensive programs in an asset development framework in public schools and community organizations. Abstinence education is primary health prevention that teaches youth the physical, emotional, social, intellectual, spiritual and financial benefits of abstaining from sexual activity.

/2014/ The Adolescent Health Initiative (AHI) administers the Title V State Abstinence Education Grant Program as one component of the OMCFH's multi-faceted approach to address the problem of teen pregnancy and the proliferation of sexually transmitted diseases/infections (STDs/STIs).

An effective teen pregnancy prevention program integrates well with West Virginia's asset-based approach to reducing risk behavior and increasing protective factors among youth. Federal funding for abstinence education expired in June, 2009 but was reinstated as part of the Patient Protection and Affordable Care Act in 2010. In Fiscal Year 2012, the AHI contracted with three local programs located throughout the state to offer an evidence-based curriculum program. The programs provide in-school and after school curriculum classes and educational services that include but are not limited to alcohol, drug and tobacco prevention, violence prevention, life skills and character development. //2014//

EPSDT/HealthCheck:
The OMCFH administers the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for EPSDT members not enrolled in a health maintenance organization (HMO) statewide, for all children receiving Physician Assurred Access Services

(PAAS) and children receiving SSI. The program is administered under an OMCFH contract with the state's Medicaid agency, Bureau for Medical Services. OMCFH has provided EPSDT administration for 30 years.

/2013/ EPSDT's promise to children eligible for Medicaid is the provision of screening services; diagnosis to determine the nature or cause of physical or mental disease, conditions, or abnormalities identified during screening services; and treatment of all medical conditions discovered during screening services even if the service is not a part of the Medicaid State Plan.

EPSDT screening services include: 1) one or more physical exams each year based upon an age dependent periodicity schedule; 2) dental services; 3) vision services; 4) appropriate immunizations; 5) hearing services; 6) laboratory tests; 7) other necessary health care as described in section 1905(a) of the Social Security Act to correct or ameliorate health problems discovered during the screening services 8) health education and anticipatory guidance; and comprehensive health and developmental history. //2013//

/2014/ HealthCheck actively endorses the American Academy of Pediatrics' Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents and the Joint Principles of the Patient-Centered Medical Home, as clarified by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA). HealthCheck employs nine (9) community-based Program Specialists to ensure Medicaid providers are familiar with the Bright Futures standard of care and to provide ongoing technical assistance regarding the EPSDT benefit and Medicaid Redesign concept and processes. //2014//

Oral Health Program (OHP):
/2012/ The mission of the Oral Health Program (OHP) is to improve the oral health status of West Virginia by providing a structured approach to meeting the oral health needs of everyone in the State. The primary goals of the Program are to provide preventative education and improve oral health care access. Recent successes of the program are due to the collaborative efforts with other government agencies and community partners. Activities of the OHP continue to be guided by the WV Oral Health Advisory Board consisting of key stakeholders. The Oral Health Advisory Board was established in 2008 and continues to meet on a routine basis to advise the OHP in addressing oral health issues of West Virginia.

/2013/ Over the last year, the OHP has undergone a number of significant changes which includes the development of an Oral Health Plan that follows CDC's guidelines. The OHP provides an overview of the burden of oral health disease, goals, and strategies to improve the oral health status of all West Virginians. The Plan was created from feedback and input received during community and town hall meetings held across the State with final input received from the WVDHHR Oral Health Advisory Board.

The hiring of full-time State Dental Director, Dr. Jason Roush, continues to build upon existing collaborations. New in 2012, the OHP will support regional Oral Health Coordinators to promote and provide oral health education. The OHP continues to support fluoridation efforts in the community in addition to providing oral health supplies and educational materials to community partners. The OHP also provides fluoride water testing for private water systems and if needed, the clinician can prescribe fluoride supplements to ensure optimal fluoride levels are present.

Last year, the OHP and Oral Health Coalition (OHC) submitted and received DentaQuest Oral Health 2014 planning grant titled, "West Virginia-Champions for Oral Health." The OHP and OHC will focus on two priorities: Prevention and Public Health Infrastructure and Medical and Dental Collaboration. This grant will build on existing efforts to establish and enhance the infrastructure and capacity to plan, implement, and evaluate population-based prevention and promotion programs by adding a full-time epidemiologist to the program. Second, the OHP and OHC will partner with West Virginia University School of Dentistry to improve medical and dental

collaboration by developing and implementing an educational curriculum for non-dental health care providers in order to expand the number and types of health care professionals providing preventative oral health services.

In recognition of science-based evidence supporting good oral health for adults which contributes to better overall health, this program supports two dental projects for adults throughout the State. The Pre-Employment Services Project provided dental and vision services for approximately 3,500 eligible individuals in 2011 who are receiving Temporary Assistance for Needy Families (TANF) from the WVDHHR with the goal of assisting adult persons to transition from "Welfare to Work." The Donated Denture Program provides dentures and/or partials for a limited number of low-income senior citizens (at or below 133% of the federal poverty level) and adults under 65 with disabilities who are receiving Supplemental Security Income (SSI) benefits. Participating dentists do the work for free, but receive Continuing Education credits, while the Program pays the lab bills. Due to extra funding in 2011, 340 eligible persons throughout West Virginia received dentures and/or partials free of charge. //2013//

/2014/ The West Virginia OHP recently received grant funding from the Health Resources and Services Administration (HRSA) for the Dental Workforce Project. Over the three year grant period, the Program will be awarded approximately 1.5 million dollars to improve access to oral health care in West Virginia. The goals of the Dental Workforce Project are to increase the number of dental school graduates choosing to provide services in West Virginia and to increase the number of persons with an identified dental home within dental health provider shortage areas. West Virginia proposes to accomplish this by: a) assisting communities in forming relationships with dental students to increase recruitment and retention in West Virginia communities; b) providing financial and technical support for graduates agreeing to practice in West Virginia and; c) providing technical assistance to dental service sites to facilitate financial viability and sustainability of services. //2014//

Early Childhood Comprehensive Systems (ECCS):
/2012/ The ECCS facilitates collaboration with partners in order to attain a statewide system that builds protective factors within families and communities. This Project ensures that families of young children are resilient, able to assess their children's developmental needs and assure their children are healthy and ready to learn at school entry. //2012// ***/2014/ The ECCS has integrated/transitioned roles and functions to the Home Visitation Program. //2014//***

Children With Special Health Care Needs (CSHCN):
/2012/ The West Virginia Children with Special Health Care Needs (CSHCN) Program is improving the health of children at risk of or diagnosed with a chronic medical condition by providing family-centered, community-based, coordinated care through multidisciplinary teams. This vision is being strengthened through program redesign which was initiated in September 2010. All state, local and contracted CSHCN staff are serving on one of four redesign teams to develop tools or supports to implement best practices outlined by the American Academy of Pediatrics' policy statement, "Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs," and the Association of Maternal and Child Health Programs', "Meeting the Needs of Families: Critical Elements of Comprehensive Care Coordination in Title V Children with Special Health Care Needs Programs." These efforts build capacity for the CSHCN Program to work towards the Title V mission by offering medical and care coordination services that are accessible, continuous, comprehensive and compassionate; creating the optimal system of care for all children, particularly children with special health care needs. //2012//

/2012/ Through a cooperative agreement with the State's Medicaid program dating back to 1967, the Children with Special Health Care Needs Program maximizes Title XIX, Title V, as well as, state funds to provide for evaluation, diagnostic/assessment, treatment, habilitation, care coordination, and transition to adult services for children at risk of or diagnosed with a chronic

medical or disabling condition.

The CSHCN Program provides nursing and social work services for enrolled children and their families throughout WV through development of needs assessments and care plans, as well as, managing medical clinics, contributing in community clinics, organizing nutrition clinics and supplying medical foods that help children, youth, and families be healthier at home, in school and in the community. This care coordination and clinic system contributes to building the medical home model in WV, improving the system of care and strengthening family voices in health care. //2012//

/2013/ The CSHCN Program direct services continues to increase the number of low income children receiving health assessments, diagnosis and treatment with pediatric specialists in their own community as well as provide rehabilitation services for disabled individuals receiving benefits under Supplemental Security Income. To the extent it is not provided under Medicaid, CSHCN direct services ultimately influences and improves public policy necessary to support community-based systems of services specific to meeting the needs of children with special health care needs. //2013//

/2014/ Beginning in February 2013, CSHCN policies and procedures were revised to incorporate modifications as a result of the CSHCN program redesign completed in December 2011. The CSHCN Program redesign created a care coordination model that centered around the American Academy of Pediatrics (AAP) Policy Statement, "Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs." All state, local and contracted CSHCN Program staff participated in review of the policy and procedure modifications by completing an Individual Assessment Tool, recording their comments using the instructions on the Assessment Tool as a guide. These efforts of inclusion build capacity for the CSHCN Program to work towards the Title V mission by offering medical and care coordination services that are accessible, continuous, comprehensive and compassionate; creating the optimal system of care for all children, particularly children with special health care needs. //2014//

Systems Point of Entry (SPE):
SPE serves as the centralized information, patient education distribution and referral center for the Office of Maternal, Child and Family Health. SPE is responsible for intake and eligibility review for the CSHCN Program. SPE also does eligibility review for the Right From The Start (RFTS) Program for WV residents who have been denied services through Medicaid for their pregnancy. SPE is very unique in that whenever any type of contact is made, whether, by phone on one of OMCFH's two toll-free lines, email, or applying for one of the various programs, SPE focuses on the overall needs of the client/family, making community referrals whenever appropriate.

/2014/ SPE is responsible for the main office numbers and two toll-free numbers located in OMCFH. The three main toll-free responders provide referrals and information to all callers free of charge by either a licensed social worker or a registered nurse. In CY 2012, there were an estimated 24,000 calls received on the toll-free lines. //2014//

/2013/ In November 2011, in conjunction with the new Home Visitation Program, SPE hired a Social Service Worker II to assist with answering the two toll-free lines as well as to assist families with home visitation services referrals.

SPE receives monthly reports from WVCHIP on clients who are receiving pregnancy related services. SPE reviews to assist the client in receiving either WV Medicaid or Right From the Start services for their pregnancy as WVCHIP does not cover pregnancy related services.

The Data Entry Unit for the OMCFH is housed within SPE and consists of six data entry operators

who currently enter 90% of all OMCFH's program data.

SPE, in collaboration with the Bureau for Children and Families, works with the Bureau for Behavioral Health and Health Facilities in reviewing all Benjamin H. Project clients to ensure they are receiving all assistance available while on the Waiver waiting list. //2013//

Violence and Injury Prevention Program (VIPP):
/2012/ The VIPP is in the beginning stages of building infrastructure and developing a childhood injury component. This Program moved from the Office of Community Health Systems and Health Promotion to the OMCFH in 2010. At this time, the Program is staffed with a full-time program manager and a part-time coordinator. /2013/ An epidemiologist was hired in November 2011 and assigned to work with both the Home Visitation and Violence and Injury Prevention Programs. //2013// The Violence and Injury Prevention Program's curent primary activities include: the facilitation of sexual violence prevention programs throughout the State, and the maintenance and expansion of collaborative projects that will encourage reporting, investigation, arrest, and prosecution of sexual assault and stalking in our state. //2012//

/2013/ The Violence and Injury Prevention Program strives to provide a more coordinated approach to prevention efforts across the State. Several partnerships have emerged as a result of collaborative efforts. Current coordinated efforts include: partnering with WVU's Injury Control Research Center to develop a comprehensive report on the Burden of Injury in WV; providing safety seats to Emergency Medical Services for children to place on every ambulance in the State to ensure safer travel for pediatric patients; along side the WV Council for the Prevention of Suicide, developing educational campaigns to address the problem of adolescent bullying and suicide; partnering with the State's Oral Health Program to encourage young athletes to wear mouth guards; and developing a basic home injury prevention training and curriculum for the State's Home Visitation Program. //2013//

/2012/ Fostering Healthy Kids Project (FHK):
The FHK Project is a collaborative pilot project between the Bureau for Children and Families and the OMCFH to improve healthcare coordination for children placed in relative/kinship care and/or WVDHHR foster family homes. This Project ensures that all children in foster care receive a timely EPSDT screen and assistance with accessing medically necessary treatment. //2012//

Division of Research, Evaluation and Planning (REP):
The REP is responsible for epidemiological and other research activities of the OMCFH, including all programmatic data generation and program/project evaluation endeavors, as well as ensuring that the OMCFH's planning efforts are data-driven. Most of OMCFH's program specific databases are housed in this Division, and are linked with Program leadership. There are currently 8 epidemiologists assigned to different Programs within OMCFH and 5 data programmers.

The Division administers the Pregnancy Risk Assessment Monitoring System (PRAMS) Project, and the Childhood Lead Poisoning Prevention Project (CLPPP), sponsored by the Centers for Disease Control and Prevention (CDC); birth defects surveillance; and in conjunction with the Office of Laboratory Services, the Newborn Screening Project, supported by State funds and revenue generation. This Division is responsible for SSDI data integration activities and grant application as well as the Title V Block Grant application and Needs Assessment. The Division is also responsible for development of data applications and data analysis for most OMCFH programs and projects.

Pregnancy Risk Assessment Monitoring System (PRAMS):
This is a population-based surveillance system of maternal behaviors and experiences before, during, and in the early infancy of the child. The Project is an integral component of the Office. Data and information gathered by the Project are used by the West Virginia Bureau for Public Health as a resource for both the development of maternal, child and family health programs and for evaluating the new and existing programs and projects. Some of the data gathered includes

smoking during pregnancy, intendedness of pregnancy, entry into prenatal care, etc.

Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID) Project:
This project collects and reports data regarding the occurrence of SIDS/SUID deaths in the State. When a SIDS/SUID death is reported, the local police are contacted who conduct a home visit and complete a home interview. Educational and grief information is sent to the family upon request. Training is provided to emergency room personnel, police, and funeral home personnel to sensitize them and offer strategies for responding to families. The Infant Mortality Review nurse, as well as the OMCFH Director, are members of the Child Fatality Review Team. /2012/ In 2011, Legislation mandated the development of an Infant Mortality Review Team to be incorporated with the Maternal Mortality Review Team. //2012//

Newborn Screening:
Expansion of newborn screening to include the 29 nationally recommended tests was mandated by the 2007 Legislature. Newborn screening rules were passed during the 2008 Legislative session mandating insurance companies pay for system costs. In February 2009, WV began screening for all 29 of the nationally recommended disorders using the State Laboratory. Follow-up is provided by OMCFH nursing personnel, in collaboration with the child's primary care physician. Children with inborn errors of metabolism receive special consultation through the WVU, Department of Pediatrics-Genetics Program, as part of a contractual agreement with OMCFH. The nurses track all medically prescribed food products/formulas and have responsibility for assuring timely shipment of formulas to families, in addition to coordination of care between the medical community and the family. /2013/ CCHD and SCID are being added in 2012. //2013//

Genetics Project:
This project provides clinical genetic services preconceptually and for children with congenital defects at six satellite locations under the auspices of WVU, Department of Pediatrics. Services include diagnosis, counseling and management of genetically determined disease, prenatal diagnosis and counseling, and evaluation of teratogen exposure. These services are almost solely financed by Title V. The Genetics Program staff provides all technical guidance for the medical community caring for children with metabolic disease. With the expansion of newborn screening for metabolic diseases to meet the national standards, the Genetics Project has had to expand as well. WV only has one Geneticist and the WVU Department of Pediatrics is recruiting for additional physician positions. In order to meet current service demand, WVU has expanded the number of genetic counselors using OMCFH resources to support their salaries.

Childhood Lead Poisoning Prevention Project (CLPPP):
This Project is a collaborative effort between two Offices in the Bureau for Public Health, OMCFH and the Office of Environmental Health Services (OEHP), funded by the CDC. An Advisory guides the operation of the Project, assisting the state with determining the extent of childhood lead poisoning in WV. To this end, extensive data collection and analysis are routinely distributed. The OEHP provides assessment of home and environment for residences of children with elevated blood lead levels. A new database is being planned for the CLPPP.

Birth Defects Surveillance System:
This Project tracks the incidence of specific diagnostic codes using the birth files, death files and monthly hospital reports of infants reported with a birth defect. Infants identified with a birth defect are referred to CSHCN.

C. Organizational Structure

/2014/ West Virginia's Office of Maternal, Child and Family Health is located within the state's Bureau for Public Health, administered by the umbrella organization, the Department of Health and Human Resources.

The mission of OMCFH is to provide leadership to support state and local efforts to design and build systems of care that assure the health and well-being of all West Virginians. The majority of OMCFH resources are allocated to develop systems of care for population-based and target-specific prevention services, as well as build infrastructure for support of maternal, child and family health populations. OMCFH maintains an annual operating budget of approximately $54 million, with 177 staff in professional, technical and administrative support positions. Experiences gained from administrative oversight of varied grant requirements, program models, funding streams, and data driven decision making, place OMCFH in a unique position to effectively design and deliver evidence-based MCH services. OMCFH uses a leadership team management approach with the Office Director, Division Directors, Human Resources Director and Quality Assurance Monitoring Director actively participating in decision-making and strategic planning. //2014//

As previously discussed in the agency capacity section, the OMCFH houses the CSHCN Program, Birth to Three/Early Intervention/Part C Program, Title X Family Planning, the State's Perinatal Home Visitation Program called Right From the Start, federal Maternal, Infant and Early Childhood Home Visitation Program, Oral Health Program, EPSDT/HealthCheck Program, Newborn Screening Program, Childhood Lead Poisoning Prevention and Surveillance, Birth Defects Surveillance, Infant and Maternal Mortality Review Team, Breast and Cervical Cancer Screening and other programs that lend support to developing and assuring a system of quality care across the life span. The Bureau's overall goal is to attain and maintain a healthier West Virginia.

The Office of Maternal, Child and Family Health provides operational guidance and support to providers throughout West Virginia to improve the health of families. In addition to providing funding support for service delivery, the Office of Maternal, Child and Family Health funds projects intended to develop new knowledge that will ultimately improve service delivery within the health community.

It is important to remember that improvement in the health of West Virginia's perinatal population is a result of a carefully crafted, highly-interdependent partnership. Tertiary care centers, primary care centers, local health departments, private practitioners and agencies have worked with the Office of Maternal, Child and Family Health (OMCFH) for 30 years to make a difference in the health and well-being of the state's people. In conjunction with its medical advisory boards, OMCFH has designed a system that offers early and accessible health care to low income, medically indigent and under insured women and children.

Nationally, federal health agencies, insurance providers, health researchers, and policy groups are promoting the need for "Continuum of Care" with patients. It is recognized that continuity of coordinated, quality care is the best model of care for patients and is the most cost effective method for providing and paying for services. Continuum of care is best achieved through consistent access to quality health providers and services. Gaps in consistent care result in increased need for intensive and crisis care, which leads to higher costs for health care services. Research supports greater patient compliance with care plans when a positive relationship with their health care provider is well established. Ensuring access to health care for low-income women and children has been an ongoing concern for state and federal officials. The Bureau for Medical Services (Medicaid), the Bureau for Children and Families and the Office of Maternal, Child and Family Health (OMCFH) have worked collaboratively to develop special initiatives that extend support services to women, infants and children at-risk of adverse health outcomes. This partnership has not only expanded the state's capacity to finance health care for low-income adults and children, but has also strengthened the delivery of care by establishing medical service protocols, recruiting medical providers, expanding care coordination services, and offering nutrition counseling which contribute to improved patient well-being.

West Virginia Medicaid and the OMCFH share a common commitment to the goal of ensuring

healthy births, reducing the incidence of low birth weight, and improving the health status of West Virginia's children, particularly those with special health care needs. These agencies also recognize the importance of maximizing scarce fiscal resources and the benefit of collaborative efforts in the development of programs that support shared goals. West Virginia's efforts to improve the health status of pregnant women and children have been successful over time as evidenced by broadened medical coverage, streamlined medical eligibility processes, shared government funding for targeted populations, targeted outreach, risk reduction education, and development of comprehensive programs that address both medical and behavioral issues.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

/2014/ Currently there are 177 staff positions in OMCFH that include 4 senior management, 81 professionals, 28 medical professionals, 59 clerical and 5 technicians. //2014//

Parent Network Specialists System (PNS):
/2012/ In conjunction with the West Virginia University Center for Excellence in Disabilities (WVUCED), Title V supports the PNS system. This statewide system features five parents of children of varying ages who have a disability and are located in geographically strategic areas of WV. These PNSs provide one-on-one information, referral services and follow-up to families who have a child with a disability. PNSs receive on-going training in pertinent areas such as Title XIX MR/DD Waiver and Medicaid processes, the Health Insurance Portability and Accountability Act (HIPAA) regulations, roles of other agencies, and availability of resources.

The PNS project also partners and directly supports the goal of the WV Family to Family Health Information Center to improve health care and health care supports throughout WV for children with developmental delays, chronic illnesses and special needs by empowering families to advocate for their children and youth. //2012//

/2013/ Ultimately, PNSs serve as a member on the CSHCN Program multidisciplinary care teams specializing in assessing and care planning for developmental, educational, vocational and support system needs of the child and family. This parental perspective and expertise is essential in CSHCN Program care teams working with the child's family to ensure that all medical, non-medical, psychosocial and educational needs of the child and family are met in the local community in order to coordinate and facilitate the children's participation in both primary and specialty health care services. //2013//

The PNS Project has produced a Care Notebook for parents and other family members caring for a child with a special health care need. The Care Notebook is a case management tool and a resource guide, which can be used as a single repository of information (e.g., medical, emergency contacts, and care provider contact information) that parents can have available to take to appointments or to leave at home as a reference for care providers. The annotated resource guide section provides contact information for disability-related agencies and services.

The PNSs offer direct services through the CSHCN Program's multidisciplinary care team by engaging in the needs assessment and care planning process, providing direct, non-medical services, information or support to families, engaging in assisting families with transition through the educational and vocational systems, and helping to empower families to advocate for themselves in regards to educational and vocational needs.
//2012//

/2012/ The Developmental Disabilities Council continues to run ongoing Partners in Policy Making Educational Series. The new sequence will start in September 2011 and run through May 2012. //2012// Also available to WV residents is the Tiger Morton Catastrophic Medical Fund. This fund

assists persons with medical expenses who have had a catastrophic medical incident and either are underinsured or uninsured. Referrals to this fund are managed by the Systems Point of Entry staff within OMCFH.

Meeting the health and psychosocial needs of persons with developmental disabilities are reflected in part as: WV Special Olympics sponsor Camp Tommy, a day camp held annually for the developmentally and physically disabled. The camp is held in the Buckhannon-Upshur High School during the third week in July. Approximately 100 campers of all ages participate. A variety of planned programs as well as crafts, sports, games and socialization is provided. The camp received a contribution of $5,000 from the OMCFH.

The CSHCN Program, through the OMCFH, supports the Mountaineer Spina Bifida Camp held in June for those children up to age 21 with the diagnosis of Spina Bifida or Myelodysplasia. In 2011, the camp celebrated its 26th year of residential camping where children learn independent self care skills while participating in crafts, fishing, swimming, games, talent shows and a "prom" night. The CSHCN Program provides financial support for transporting equipment and supplies to staff who volunteer as counselors.

Data Reporting and Evaluation Capacity:
The WV OMCFH has applied for and received the State Systems Development Initiative (SSDI) Grant from HRSA for many years. This Grant has allowed the OMCFH to increase data collection and analysis capacity over the years. The SSDI Project is housed within the Division of Research, Evaluation and Planning. The Division has developed a Data Mart that has access to data from all of OMCFH's programs as well as birth records, infant death records and Medicaid eligibility files. This enables the OMCFH to examine and analyze data using multiple data sources to report on outcomes. New databases planned for collection and reporting of program data include Home Visitation, Infant Mortality Review and newborn screening case management. The Breast and Cervical Cancer Screening database that connects billing and services is in the process of being replaced.

The Division of Research, Evaluation and Planning has access to multiple data sets to be able to match data to evaluate program activities and results that fall under the OMCFH umbrella. These data bases include: birth and infant death files, newborn hearing screening, newborn metabolic screening, childhood lead screening, birth defects, SIDS/SUID, PRAMS, Birth Score (newborn high risk assessment screening), Medicaid eligibility files, FACTS (Families and Children Tracking System), Family Planning, Right From The Start, Early Intervention/Part C and CSHCN. /2012/ There are four database programmers and a web designer housed within this Division to assist OMCFH with development of data collection and reporting. /2013/ This Division also houses the Epidemiologist section and has expanded capacity to nine epidemiologists. Areas of assignment for the Epidemiologists include: PRAMS, MCH issues, Birth to Three, Breast and Cervical Cancer Screening, WISEWOMAN and Family Planning, women's health issues including maternal risk screening and RFTS, home visitation and injury prevention, CSHCN, and oral health. //2013//

Maternal Risk Screening:
Since the 1980s, West Virginia has screened low income, government-sponsored women for adverse outcomes, and although the screening instrument has changed numerous times over the last 25 years, the use of information to prevent or treat conditions associated with poor pregnancy outcomes has remained the same. Low income pregnant women who receive government-sponsored health care were routinely screened using the Prenatal Risk Screening Instrument (PRSI).

A survey of West Virginia medical obstetrical practitioners was completed by OMCFH to determine their current risk screening practices including the instrument used, and the PRSI was most often cited as the tool used. Out of 120 surveys returned, 40% reported regular use of the PRSI, 14% used an ACOG tool, 4% used the POPRAS, 14% used an in-house tool and 28%

were not using a risk assessment form. The PRSI includes both medical history and psychosocial information to assess risk. Screening differs from assessment in that screening only identifies those most likely to be at increased risk and should result in further assessment to determine intervention and service need. In short, risk screening is the beginning of the process.

In recognition of the need for population-based maternal risk screening, Senate Bill 307, "Uniform Maternal Screening Act", was signed into law on May 28, 2009 by former WV Governor Joe Manchin III. The bill required the Bureau for Public Health, Office of Maternal, Child and Family Health (OMCFH) to convene a diverse maternal risk advisory council to develop a uniform maternal risk screening tool to help pregnant women for potential at-risk pregnancies and to meet annually to revise the tool as needed. The Advisory Council and OMCFH were required to develop a statistical matrix to measure incidents of high-risk pregnancies.

Preparations started on selecting, appointing and establishing the Maternal Risk Screening Advisory Committee in June 2009. As outlined in the legislation, representatives included at least one private maternity service provider; at least one public maternity provider; representation from each of the State's three medical schools; at least one certified nurse midwife; at least one representative of a tertiary care center; Bureau for Public Health Commissioner (or designee); and OMCFH Office Director (or designee).

The Committee agreed to adapt the OMCFH, Right From The Start Program's Prenatal Risk Screening Instrument, which had been widely used by numerous OB providers throughout the State for years. Members wanted to keep the form simple, one page, user-friendly and electronically compatible.

After the Committee's suggestions were incorporated and a consensus was reached, the new universal screening tool was finalized in June 2010, and was identified as the West Virginia Prenatal Risk Screening Instrument (PRSI). The new tool contains the 4P's, an opt-in/opt-out for client referral services and an alert to the prenatal provider that the client may need a referral for a maternal fetal medicine consultation. //2012//
/2013/ Universal maternal risk screening was implemented statewide of January 1, 2011. //2013//

/2013/ For CY 2011, 11,082 PRSIs were received, roughly 50% of the state's pregnancies. Although there were gaps identified within the data on the completed forms, a data snapshot was developed by the epidemiologist and presented to the Advisory. Increased provider education is planned to encourage compliance and correct completion of the PRSI. ***/2014/ In CY 2012, 11,489 PRSIs were completed roughly 60% of the state's pregnancies for that year. Of those, 3,895 or 34% were referred from the physician's office to the State's perinatal program for outreach and follow-up. //2014//***

Drug Free Moms and Babies Project:
In response to the startling 2009 cord tissue drug study revealing that nearly 20% of WV babies were found to have one or more illicit substances or alcohol present at birth, the WV Perinatal Partnership, in collaboration with the WVDHHR, OMCFH; the Bureau for Behavioral Health and Health Facilities; and the Benedum Foundation, launched an exciting new initiative called the "Drug Free Moms and Babies Project". Under this jointly funded program, four pilot sites are to establish integrated recovery models for pregnant women who are using illicit substances and alcohol. The goal is to identify programs that can be successful in supporting healthy baby outcomes by providing prevention, early intervention, addiction treatment and recovery support services. The pilots will follow mothers from pregnancy through the infant's 2nd birthday to support the women in their recovery from addiction and to prevent future drug exposed pregnancies. Basic requirements for participation include: Integration of the Screening, Brief Intervention, Referral and Treatment (SBIRT) model; program evaluation; provider outreach education; long term follow-up; and recovery coach services. ***/2014/ The sites are in the very early stages of service delivery and outcome data is not yet available. //2014//***

/2014/ In 2013 the WVDHHR is partnering with Cabell Huntington Hospital to establish an off-site facility to serve neonatal abstinence syndrome (NAS) infants. This unit will free up NICU beds, be a cost savings in NICU costs and provide a calm environment for NAS infants to receive care. //2014//

ASTHO/MOD Partnership:
In mid-April 2012, OMCFH joined the Association of State and Territorial Health Officials (ASTHO)/March of Dimes partnership to work towards reducing premature births and ensuring more healthy births in West Virginia. Dr. Marion Swinker, MD, MPH, Commissioner for the Bureau for Public Health, signed the pledge to reduce prematurity by 8% in the State by 2014. Planning meetings have been scheduled with representatives from the March of Dimes, WV Chapter, and the WV Perinatal Partnership. Tentative intervention opportunities include co-branding March of Dimes print patient education materials and "Healthy Babies are Worth the Wait" public service announcements to increase consumer awareness and knowledge of the benefits of full term deliveries. ***/2014/ This campaign targets reduction of preterm births and elective inductions and c-sections. The project will provide framed posters for maternity care provider's offices and a hand out showing brain development the last weeks of pregnancy for every prenatal client. //2014//***

Autism Spectrum Disorder/Developmental Disabilities (ASD/DD):
The rising number of individuals identified and diagnosed with autism spectrum disorder and other major disabilities poses a challenge to OMCFH. In 2011, the WV Legislature passed a bill requiring insurers to cover screening, diagnostic and treatment services for children with ASD. In response to this legislation, the WV Children's Health Insurance Program (WV CHIP) released an Autism Policy in February 2012, with OMCFH requested to review and provide input on the draft policy content.

In early 2012, OMCFH convened an internal workgroup to determine appropriate roles and approaches to pursue in building, improving and maintaining a State level system of care for children and youth with Autism Spectrum Disorder/ Developmental Disabilities (ASD/DD) and their families. The group was charged with conducting an environmental scan to review current OMCFH policies, procedures, activities and initiatives related to ASD/DD, then to brainstorm about expected or potential OMCFH roles, responsibilities and approaches in addressing ASD/DD.

In the assessment of current roles, staff discussed and identified challenges and pressing needs in the service delivery system (provider availability, diagnostic services), data sources, financing, family participation and outreach/awareness.

For the environmental scan and self-assessment, the Title V Index was used to address leadership related to ASD/DD in 6 core areas of involvement: Overall Leadership; Partnerships across Public and Private Sectors; Quality Improvement; Use of Available Resources; Coordination of Service Delivery; and Data Infrastructure. Each of the identified existing OMCFH roles and activities related to ASD/DD were grouped under one of these leadership areas to aid in better understanding of capacity, system-building and sustainability.

OMCFH staff continue to identify and refine an action plan to better address ASD/DD, with linkage to the MCHB Six Critical Indicators of Quality for a System of Care for CYSHCN to meet the diverse and complex needs of children with ASD/DD: Medical Home; Insurance and Financing; Early and Continuous Screening; Easy-to-Use Services; Family-Professional Partnerships; and Transition to Adulthood. For example, one critical role will be the development and launch of a Learn the Signs, Act Early public informing and provider education campaign to promote earlier identification of young children from birth to age five at risk of developmental delays. //2013//

/2014/ The American Academy of Pediatrics' Bright Futures (the national guidelines for

preventive pediatric health care) standard for autism screening is universal (performed for every child at a particular visit) and includes administering an autism-specific screening tool at the 18-month preventative care visit, in addition to general developmental screening. Bright Futures also recommends repeating the autism-specific screening at the age of 24 months or at any encounter when a parent raises concern. The American Academy of Pediatrics does not approve/endorse any specific tool for autism-specific screening purposes, neither does the HealthCheck Program. However, HealthCheck educates WV's pediatric practices on the availability of the Modified Checklist for Autism in Toddlers (M-CHAT™), a free validated autism-specific screening tool for clinical, research, and educational purposes. //2014//

Brief biographical sketches of the Office Director and Division Leaders:

Anne Amick Williams, RN, BSN, MS-HCA - OMCFH Director
EDUCATION:
Marshall University Graduate College, Master of Science in Management/Healthcare Administration, 1999
West Virginia University School of Nursing, Bachelor of Science in Nursing, 1986, Graduated Magna Cum Laude

PROFESSIONAL EXPERIENCE:
Director, OMCFH (2010 to Present)
Director, Division of Perinatal and Women's Health, OMCFH/BPH (2006 to 2010)
Director, Family Planning Program, OMCFH/BPH (1991 to 2006)
Clinical Nurse I -- NICU (1988 to 1991) Charleston Area Medical Center -- Women's and Children's Hospital
Clinical Nurse I -- Pediatrics Unit (1986 to 1988) Charleston Area Medical Center -- Women's and Children's Hospital

Kathryn G. Cummons, MSW, ACSW - Director, Division of Research, Evaluation, and Planning
EDUCATION:
Master's of Social Work, West Virginia University, 1988
Bachelor's of Social Work, West Virginia University, 1974
Minors in Psychology and Speech
PROFESSIONAL EXPERIENCE:
Director, Research, Evaluation, and Planning, OMCFH/BPH (9/2000 - Present)
Clinical Social Worker, Comprehensive Psychological Services (12/99 - 9/2000)
Clinical Social Worker, Charleston Area Medical Center (9/89 - 7/90) and (5/98 - 12/99)
Director of Social Work Services and Discharge Planning, Charleston Area Medical Center (8/90 - 5/98)
Administrator, Northern Tier Youth Services (7/84 - 5/89)
Supervisor, Lutheran Youth and Family Services (6/81 - 7/84)

Christina Mullins, M.A. Director, Division of Infant, Child and Adolescent Health (including CSHCN)
EDUCATION:
Psychology, MA, Marshall University, 1997
Psychology, BA, Marshall University, 1995

PROFESSIONAL:
Director, Division of Infant Child and Adolescent Health, Bureau for Public Health (2/09 - Present)
Director, Breast and Cervical Cancer Screening Program, Bureau for Public Health (2004 - 2009)
Associate Director, Division of Tobacco Prevention, Bureau for Public Health (2002 - 2004)
Associate Director, Tobacco Prevention Program, Bureau for Public Health (2000 - 2002)
Coordinator, Tobacco Prevention Program, Bureau for Public Health (2000)
Supervised Psychologist, Allied Behavioral Services (1997 - 2000)

Teaching Assistant, Psychology Department, Marshall University (1996 - 1997)

Alta Denise Smith, MS, MCHES--Director, Division of Perinatal and Women's Health
EDUCATION:
Master's Degree in Community Health Education, West Virginia University, 1998
Bachelor's Degree/Board of Regents, West Virginia State College, 1996
Associates of Science/Radiologic Technology, Morris Harvey College, Charleston, WV, 1977

PROFESSIONAL EXPERIENCE:
Director, Division of Perinatal and Women's Health, OMCFH/BPH (3/11 - Present)
Director, Family Planning Program, OMCFH/BPH (2/06 - 3/11)
Coordinator, Adolescent Pregnancy Prevention Initiative, OMCFH/BPH (4/99 - 2/06)
Resources Specialist, Family Planning Program, OMCFH/BPH, (2/98 - 4/99)
Radiologic Technologist, St. Francis Hospital, Charleston, WV (97 - 2/98)
Radiologic Technologist, CAMC, Charleston, WV (11/91 - 97)
Radiologic Technologist, C-Radiation Therapy Consultants (11/85 - 91)

E. State Agency Coordination

/2014/ The foundation of public health is rooted in partnerships and the need to expand this role has never been more important. Each year, funding for public health programs continue to shrink, while the demand for these services has remained consistent. Provision of high quality services to the maximum eligible population is always the goal of West Virginia public health programs. //2014//

The Office of Maternal, Child and Family Health has historically contracted with the Title XIX agency for the administration of EPSDT. In addition, there have also been formalized agreements with community agencies for services offered through the Perinatal Program/Right From The Start, Family Planning Program, Breast and Cervical Cancer Screening Program and the Children with Special Health Care Needs Program. 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 called the Pre-Employment Services Project. These efforts are financed by 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 has been 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 Part C early intervention services for Medicaid eligible children. The Department of Health and Human Resources developed a central finance structure for early intervention services in order to facilitate timely payment to practitioners and maximize available fund sources.

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 800 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. Evaluation materials are on file

and available if desired.

One of the strategies the Office of Maternal, Child, and Family Health has applied to ensure the quality of EPSDT services, is to partner with others. Partnerships bring additional experience, expertise and resources to bear on improving EPSDT. HealthCheck and WV Birth to Three routinely work in partnership for early identification of developmental delays in children. Recently, ECCS, HealthCheck and WV Birth to Three purchased more than four hundred (400) Ages & Stages Questionnaires, Third Edition (ASQ-3™) starter kits after consulting with the WV Chapter of the American Academy of Pediatrics (AAP). HealthCheck Regional Program Specialists distribute the ASQ-3™ starter kits and provide training to primary care providers (medical homes) throughout the state. WV Birth to Three sponsored a training by Brookes Publishing on the ASQ-3™. Participants included child care providers, early intervention and Head Start personnel. WV Birth to Three is piloting the ASQ-3™ in their initial intake process. Furthermore, HealthCheck and the WV Immunization Program have agreed on a collaborative effort to diminish unnecessary barriers to achieving better immunization rates among the WV population by promoting the Vaccines for Children (VFC) Program with primary care physicians (medical homes).

/2012/ The "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents" facilitates collaboration between the HealthCheck Program, the Title XIX state agency, and the Children's Health Insurance Program, and continues to be the foundation of all HealthCheck Program initiatives. Particularly, HealthCheck purchased and distributed 300 ASQ-3™ kits to primary care providers throughout the State in support of the developmental surveillance and screening. HealthCheck purchased and distributed 550 Body Mass Index (BMI) kits to primary care providers throughout the State in support of the Bright Futures health promotion theme, healthy weight. HealthCheck partnered with the West Virginia Department of Education, Children's Health Insurance Program, West Virginia University, West Virginia Birth to Three, and the West Virginia Autism Training Center to apply for a U.S. Department of Health and Human Services -- Maternal and Child Health Bureau State Planning Grant for improving access to comprehensive, coordinated health care and related services for children and youth with autism spectrum disorder (ASD) and other developmental disabilities. /2013/ The WV Autism Training Center at Marshall University did not receive the grant. //2013//

HealthCheck has a strong collaborative effort with the West Virginia Department of Education-Office of Healthy Schools to support the Bright Futures standard for pediatric preventive healthcare as well as the medical home approach to providing comprehensive primary care. Recognizing that the Bright Futures standard is best carried out by a personal physician or primary care provider (PCP) that coordinates care across conditions and settings, HealthCheck and the West Virginia Department of Education - Office of Healthy Schools have created and nurtured a true partnership through which children, families, education, and health professionals all work together to ensure each West Virginia public school enterer receives a comprehensive wellness screening, per the Governor's Kids First Screening Initiative and WV Code SS18-5-17.

With the statewide implementation of Medicaid managed care, services for most Early and Periodic Screening, Diagnosis, and Treatment eligible individuals are integrated into qualified health plans (QHPs). The HealthCheck Program continues to work with the Title XIX state agency to ensure quality of the qualified health plans (QHPs) via technical consultation with primary care providers in keeping with the American Academy of Pediatrics "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents". //2012//

/2013/ HealthCheck and the Children with Special Health Care Needs (CSHCN) Program convened their medical advisory boards on January 12, 2012 to obtain provider input regarding healthcare coordination for children in foster care (all of which meet the federal definition of "children with special health care needs").

In coordination with the Bureau for Medical Services and the Pediatric Medical Advisory Board, HealthCheck established a standardized procedure for medical practitioners to document

recommendations for treatment to correct or ameliorate conditions discovered by screening (initial, periodic, and/or interperiodic) services afforded to Medicaid-eligible children and youth up to 21 years of age. Accordingly, HealthCheck's age-appropriate preventive health screen forms were revised to include additional documentation/medical necessity certification. Moreover, the form is available via the HealthCheck website in a fillable PDF format for providers to save and import to their electronic medical records. //2013//

/2014/ HealthCheck and the WV Home Visitation Program effectively collaborated to execute a Help Me Grow system in West Virginia that validates the medical home approach to providing comprehensive primary care. Funded with MIECHV Development Grant funds, the Home Visitation Program will provide admininstrative oversight of Help Me Grow and HealthCheck will provide ongoing support for the physician outreach component of the Help Me Grow system. Help Me Grow (HMG) was implemented to solidify a comprehensive, statewide, coordinated system for early identification and referral of children for developmental and behavioral problems in the current process and ensure necessary linkages with evidence-based home visitation programs. //2014//

Helping Appalachian Parents and Infants(HAPI):
The OMCFH and West Virginia University maintain an agreement for joint implementation of the Risk Reduction Through Focus on Family Well-Being/Helping Appalachian Parents and Infants (HAPI) Project, a Healthy Start grant, in RFTS Region VII. The OMCFH and WVU continue to collaborate to provide services to high-risk pregnant women and infants through the Healthy Start, HAPI Project. Mental health providers and dentists continue agreements to participate in the program to provide patient services. HAPI Project services encompass care coordination provided to pregnant women and infants, including a preconception phase, as per the existing RFTS Program. The HAPI Project focuses on helping women become healthier before becoming pregnant, encourages spacing of pregnancies, provides child care services, oral health care reimbursement, transportation assistance to doctor appointments and payment for mental health services. Curriculum for patient education was developed by WVU. OMCFH, as the subcontractor, acts as the fiscal agent for HAPI. Billing procedures have been developed by OMCFH and patient service invoices are processed by the state on behalf of the grantee, WVU. /2013/ OMCFH no longer processes patient service invoices on behalf of the grantee. //2013//

Initially started in four West Virginia counties, the HAPI Project has expanded to include eight counties, with service components in areas of: oral health services; substance abuse screening and referral; and outreach services utilizing former consumers. The long-term goal of the Project is to decrease the incidence of low birth weight infants born in West Virginia by reducing recurrent low birth weight. It is hoped that resulting data may also show that there is a significant benefit of cost savings through the risk reduction plan for at risk families. Hopefully from this data, RFTS can justify the benefit in expanding the current case management program to include the risk reduction plan for families and allow implementation of a longer period of eligibility for case management to assist at-risk families.

West Virginia's Office of Maternal, Child and Family Health is known for its positive partnerships with the medical community, the University Affiliated Programs, the State Department of Education, and the March of Dimes, among others. These partnerships have resulted in shared initiatives. One initiative is the folic acid campaign, a national March of Dimes assignment, used in West Virginia to advocate for the distribution of this supplement preconceptually to reduce the incidence of neural tube defects. Another initiative made possible was the Smoking Cessation or Reduction in Pregnancy Treatment (SCRIPT) initiative developed in partnership with Richard Windsor and the Office of Epidemiology and Health Promotion, who contributed tobacco funds for the purchase of CO monitors for 188 RFTS care coordinators for use with pregnant women statewide. Another recent initiative, called Kids First, targets health screening for children entering school for the first time using the EPSDT (HealthCheck) protocol. Objectives of the initiative include: to establish a medical home for the child, to allow school systems to focus on providing needed services for children with identified deficits, to assist families in finding

treatment resources, and to promote healthy lifestyle activities. The screening focuses on oral health, vision, hearing, speech and language, and behavior/development. Kids First is an example of high-level collaboration in government. Three Cabinet level agencies, the Department of Education, the Department of Health and Human Resources and the Department of Administration, are working closely together to bring this project to the families of West Virginia. All insurers agreed to pay for the services. Another initiative is the West Virginia Perinatal Partnership that includes stakeholders from across the state. Stakeholders include obstetrical and neonatal physicians, Medicaid, private insurance providers, OMCFH, Vital Statistics staff, the Hospital Association and the March of Dimes, among others. A 2011 Work Plan has been developed.

/2012/ OMCFH provides two representatives, one from the Early Intervention/Part C Program and the other from the Home Visitation/ Early Childhood Comprehensive Syustems Project on the appointed Governor's Early Childhood Advisory Council (ECAC), established under Head Start reauthorization. //2012//

/2014/ WVBTT State Staff participate in other interagency coordinating groups including the Early Childhood Advisory Council (ECAC), established under the HeadStart Act. ECAC subcommittees, with interagency membership including Directors of the WVBTT and HV Programs, are revising Early Childhood Core Knowledge and Core Competencies to be reflective of the needs of professionals working with young children and their families in both center and home based settings.

WVBTT collaborates with various partners across all components of the early intervention system, including child find/public awareness, coordination of funding, professional development, and service delivery.

The West Virginia Early Intervention Interagency Coordinating Council (ICC) is comprised of various state
agencies, early intervention service providers, local community groups, advocacy groups, and parents. The ICC is responsible for advising and assisting DHHR and WVBTT in the overall operation of the early intervention system. //2014//

The Birth to Three/Part C Program partners with a multitude of agencies to assist with child find efforts and to ensure needed services are arranged. WV Birth to Three has institutionalized a variety of strategies for the early identification of infants and toddlers with developmental delay or significant risk factors. WV Birth to Three's interagency agreements with Title V, CHIP, Bureau for Children and Families, Head Start, and Medicaid assist in the early identification and referral of potentially eligible children. West Virginia finds that coordination with primary health care providers and other community partners is important to assure that children potentially in need of early intervention services are identified as early as possible.

WV Birth to Three continues coordination with Title V/CSHCN, Newborn Hearing, and Right From The Start programs to assure that infants failing the newborn hearing screen receive diagnostics, and referral to Part C and Ski *Hi when hearing loss is confirmed. The Birth Score universal newborn screening, conducted on all children born in West Virginia, identifies infants who are born with conditions that may make them at risk for developmental delay. Referrals are made directly to the appropriate Birth to Three Regional Administrative Unit (RAU). Public awareness and child find activities are conducted collaboratively with interagency partners, including Part B preschool, Child Care and Head Start. Examples of this collaboration include the publication and distribution of a quarterly magazine, annual calendars, and developmental wheels to county schools, physicians, Family Resource Networks, medical clinics, early childhood providers, and higher education faculty. The publications include information about how to make a referral to Part C, Part B, Head Start and/or Child Care. The WV Birth to Three Public Information Coordinator has worked closely with WV CHIP to develop parent educational and child find materials, to be distributed collaboratively. The WV Birth to Three Public Information Coordinator

has participated in faith based planning initiatives coordinated through WV CHIP to provide information about WV Birth to Three as a resource for families.

Child find strategies have also included coordination with the Right From The Start and HealthCheck Programs coordinated through the Office of Maternal, Child and Family Health. Local Right From The Start personnel who work directly with high risk mothers and infants are able to identify those children who may be in need of early intervention services. Program Specialists within the HealthCheck Program, in their work with physicians, are able to provide information about the criteria and requirements, and importance of identifying children who may be in need of early intervention services. Recent policy direction by the AAP to its members encouraging early screening for developmental delays and subsequent referral to Part C have also contributed to increases in the number of children served by the Program.

WV Birth to Three staff have coordinated with the Bureau for Children and Families, Child Protective Services, in the development of procedures to assure the referral of children who have experienced substantiated abuse and/or neglect. Training is provided to WV Birth to Three service coordinators and practitioners related to the requirements and coordination with Child Protective Services and Foster Care, as required by the Federal Child Abuse and Protection Act (CAPTA).

/2012/ The West Virginia Department of Health and Human Resources (WVDHHR) on behalf of Governor Earl Ray Tomblin, designated the Office of Maternal, Child and Family Health (OMCFH) as lead agency to coordinate and implement the West Virginia Home Visitation Program (WVHVP).

The goals and objectives include: Collective efforts between state and local stakeholders will expand infrastructure and training capacity; develop and implement a statewide continuum of evidence based home visitation from pregnancy to five years of age; and identify resource agencies. The following is the State Plan framework:

1. Partner with state and local stakeholders to establish an innovative administration providing oversight of operational plans required for implementation with fidelity;
2. Encourage active collaboration and shared learning between multiple models through quarterly state and local continuous quality improvement activities;
3. Conduct focus groups to evaluate awareness of home visitation services and determine both barriers and motivators in home visiting;
4. Design a web based data collection system utilizing uploads from selected models, capacity to collect staffing and training details, and track referral processes;
5. Implement a rigorous evaluation of the Maternal Infant Health Outreach Worker (MIHOW) model as a promising approach;
6. Coordinate cross model trainings for depression screening, injury prevention, preconception counseling, child abuse prevention, domestic violence and SIDS/SUID;
7. Develop a Central Intake System providing single point of entry to appropriate agencies ensuring reduced model competition, decreased duplicative services and ensure continuum of care for clients served.

Community-based home visitation models involved in the WVHVP include: Right From The Start (RFTS); Healthy Families America (HFA); Parents as Teachers (PAT); Head Start; Early Head Start; and Helping Appalachian Parents Initiative (HAPI). //2012//

/2013/ As the lead State agency, the West Virginia Home Visitation Program is charged with coordinating, developing and implementing evidence based home visiting services. The primary focus is to increase infrastructure to expand services to clients residing in identified high risk counties. Included in the activities to build strong organizational and management capacity for implementation are:

1) Establish a Continuous Quality Improvement (CQI) team to identify initial areas to target, incorporate CQI activities in evaluation design, data collection system and collectively review CQI activities with stakeholders.
2) Assure implementation of home visitation service delivery with fidelity by selected models (Parents as Teachers, Healthy Families America, and Maternal Infant and Health Outreach Worker) through ongoing monitoring based upon individual national accreditation standards and collectively review progress of service delivery.
3) Utilize the WVHVP website to provide up to date information on programs, activities, trainings, community resources and data collection processes.

The WVHVP is developing cross model programs standards, core competencies and a Help Me Grow model while integrating home visiting with other social and medical services.

/2014/ New sites in Boone, McDowell and Mason counties, and expansion in Wayne and Cabell counties occurred during the first year based upon the Home Visitation Statewide Needs Assessment. Expansion or implementation in Nicholas, Lincoln and Raleigh counties occurred in year 2 along with efforts to strengthen 16 existing Parents as Teachers sites throughout some of West Virginia's highest risk counties. These efforts should provide outcomes in over 1000 families served by year 3 of the WVHVP. //2013// //2014//

/2013/ The Oral Health Program was influential in the formation of a statewide Oral Health Coalition (OHC) which was recommended in the State Oral Health Plan. The Coalition is comprised of any individual or group with an interest in oral health. The creation of the statewide OHC allows non-traditional oral health stakeholders such as faith-based organizations, primary medical care providers, social service organizations, community programs, consumer advocacy groups, and others with an interest in oral health to have a voice in implementing policy change. The OHP will continue to provide the OHC with support in the form of logistical planning and clerical needs, as well as representation on the Executive Committee.

The West Virginia Department of Health and Human Resources OHP and Bureau for Medical Services worked with the West Virginia University School of Dentistry and their partners to develop a training program for medical personnel and their ancillaries to apply fluoride varnish as a preventative oral health measure. Once properly trained, primary care physicians and their ancillaries will complete oral health evaluations for children three years old and under using the caries risk assessment tool. In addition, the providers will give anticipatory guidance, provide fluoride varnish application twice annually and make dental referrals at age one or within six months of eruption of the first tooth as recommended by the American Dental Association. The program is designed to be completed in two sequential phases by the medical professional. Phase One consists of an on-line training and Phase Two consists of a live face-to-face training led by a professional that has completed the "Train the Trainer" course. //2013//

/2014/ During the 2011-2012 legislative session, the WV Legislature passed the Dental Sealant Bill. This bill expands the scope of practice for Public Health Dental Hygienists, and increases care to WV's most vulnerable population. Public Health Certified Dental Hygienists can now apply dental sealants in public health settings without a prior exam from a dentist. The bill also requires that all children be referred to a dentist within six months of the sealant application. This expansion of practice will increase the number of children who will receive dental sealants and eventually be seen by a dentist.

Oral Health Educators provide oral health education to children and families in all 55 counties through schools, early childhood programs and community health fairs. The curriculum teaches prevention through proper oral hygiene, including instructions on brushing; flossing; choosing healthy foods; tobacco and drug prevention; and the importance of establishing a dental home. During the FY2012, 96,855 children received these educational services.

The OHP is currently undergoing a redesign of the current oral health education system in effort to meet the needs of the citizens. The OHP has contracted with Marshall University to implement a standardized oral health curriculum that can be used in schools and by community groups and to hire full-time Oral Health Coordinators that will be located regionally throughout the State to serve as community oral health resources. By placing the Coordinators in the communities, the Program can reach more people, encourage grassroots involvement and build community relationships. The Oral Health Coordinators will provide oral health education, promote good oral hygiene and work with local water systems on fluoridation.

The OHP has begun working with Marshall University to expand the School-Based Dental Sealant Program. The current program offers dental sealants at school-based health centers in 25 West Virginia counties. To maximize the efforts of the program, the OHP will expand this system statewide. A Dental Sealant Coordinator, contracted through Marshall University, will help facilitate the expansion so that all West Virginia counties are served. //2014//

Adolescent Pregnancy Prevention Initiative (APPI):
/2014/ In 2011, the Adolescent Pregnancy Prevention Initiative (APPI) Director participated in the National Conference of State Legislatures as part of a team of West Virginia professionals that were selected to travel to Colorado for collaboration on teen pregnancy prevention state plans. West Virginia's APPI program was recommended by The National Campaign to Prevent Teen and Unplanned Pregnancy. West Virginia was one of only six states invited to attend this meeting. APPI's Director continues to facilitate this group as the co-chair. APPI's Director also serves as the co-chair of the Adolescent Health Collaborative, a group of individuals representing both state government and private/community organizations that work with and serve the youth of West Virginia.

APPI fosters more positive partnerships through its organization and sponsorship of the Leadership to Prevent Teen Pregnancy Taskforce. This statewide initiative of committed individuals and organizations focuses on encouraging medically accurate, age appropriate, sexuality education and promoting healthy informed reproductive life planning for teens. //2014//

APPI has created a text message line for adolescents to use when they have questions about biology, sex and contraception. The adolescent sends a text message which is converted to email. The email is answered by a specialist within 48 hours of receipt. The response is then converted back to text and sent to the teen. The text message line number is available on the APPI website and at APPI presentations and exhibits.

/2014/ APPI administers the federal Personal Responsibility Education Program (PREP) Grant. In 2010, APPI was selected as the state representative for application for the 5 year Federal PREP Grant. APPI administers and monitors fidelity to evidence-based curricula (EBC) for five (5) sub-grantees who will reach approximately 600 students during this grant cycle. Grantees were selected through a Request for Application process and scored by an independent committee. In order to avoid duplication of services, APPI partners with grantees of the federal Teen Pregnancy Prevention (TPP) grant to ensure a variety of services are being offered in multiple areas to reach the largest possible number of teens.

Requirements to be a sub-grantee for West Virginia specify that PREP facilitators be fidelity-trained by the publisher in one of the following Center for Disease Control and Prevention (CDC) identified evidence-based curricula (EBC):
•Reducing the Risk
•Making Proud Choices

APPI organizes and sponsors this training. All APPI staff members are trained both to teach these curricula and to train other educators to teach these curricula. //2014//

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	109.9	88.5	88.2	78.6	78.6
Numerator	1159	938	918	813	813
Denominator	105435	105976	104060	103456	103456
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
based upon 2011 Hospital Discharge Data, HCA

Notes - 2011
2011 Hospital Discharge Data, HCA

Notes - 2010
2010 Hospital Discharge Data, HCA

Narrative:
WV has one of the highest smoking rates nationally and second hand smoke is a known irritant for asthma. Appropriately so, tobacco monies are also being used to address environmental factors that increase the risk of developing asthma or exacerbate the disease. Although the OMCFH is not the home of the Asthma Initiative, since it is a disease that affects both children and adults, the OMCFH has a role in prevention via education of parents and children, plus a direct clinical care role which includes: 1) addressing maternal smoking during pregnancy and/or early infancy, and 2) provision of asthma therapy for children to include maintaining pulmonary function, normal activity levels, minimizing emergency room visits and hospitalization, and making available medication to control persistent asthma and "quick relief" medication to treat acute symptoms.

As part of a combined effort with the WV Bureau for Public Health's Asthma Education and Prevention Program, the Office of Maternal Child & Family Health (OMCFH), and the WV Department of Education - Office of Healthy Schools, the purchase of valved holding chambers (spacers) for metered dosed inhalers and peak flow meters has been made possible. The purchase itself was done by OMCFH. Data on the number of children currently receiving school nursing services for asthma and having an inhaler at school was provided from the WVEIS-Electronic Health Care Plan (EHCP) site through the WVDE Office of Healthy Schools. This information was the basis for the number of devices purchased -- roughly 6,700 of each. These devices have been shipped to county locations for upcoming distribution to school nurse staff.

Trainings on the distribution and administration of these devices were required to inform and train

the school nurse staff as well as support staff (secretaries, aids, coaches, etc.) in the school system who are authorized to administer medications. The first training event for school nursing staff was conducted via WebEx to discuss the rollout of this initiative. The training used evidenced based curriculum and resources provided by the AEPP Manager as well as experts located within the state.

This initiative is set for full implementation for the upcoming 2013-2014 school year as all pertinent staff will be trained. An evaluation plan is also being developed at this time with some initial collection practices to focus on identifying students who need the devices, tracking who receives the devices, performance of an Asthma Control Test with results tracked, acquiring an Asthma Action Plan for each child with asthma, tracking missed school days, and other yet to be determined data surveillance needs.

The rate of children hospitalized for asthma has decreased from 109.9 in 2008 to 78.6 in 2012.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	97.1	97.4	69.6	67.1	68.7
Numerator	13431	13752	9601	9155	9206
Denominator	13829	14114	13799	13636	13402
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
Fiscal Year 2012 - CMS - 416
9. receiving at least one initial or periodic screen

Notes - 2011
Fiscal Year 2011 - CMS - 416
9. receiving at least one initial or periodic screen

Notes - 2010
Fiscal Year 2010 - CMS - 416
9. receiving at least one initial or periodic screen

Narrative:
The OMCFH administers the mandated Medicaid EPSDT Program (known in WV as HealthCheck). The HealthCheck Program educates families who receive Medicaid about preventive health care for their children and encourages participation in the HealthCheck Program while ensuring the following: 1) children are screened/re-screened according to periodicity tables established by the American Academy of Pediatrics "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition"; 2) medical problems identified by examination are treated/referred; and 3) children/families receive transportation

assistance and help with appointment scheduling.

Per the 2012 CMS-416 -- 9,446 total individuals <1 were eligible for EPSDT 90 continuous days. Of these, 9,206 received at least one initial or periodic screen, or 97.46%. There were 13,402 children under the age of 1 who received Medicaid at any time during 2012. Of those, 9206 or 68.7% received at least one initial or periodic screen. The HealthCheck Program focuses on equipping Medicaid providers with the necessary tools and knowledge to carry out EPSDT screening services. As part of the Governor's Kids First Initiative, all school enterers are required to receive a health screen using EPSDT protocol, regardless of insurance carrier. The denominator above reflects all children eligible for Medicaid and the denominator mentioned in the first sentence of this paragraph reflects those that were eligible for EPSDT for 90 continuous days.

Using a combination of written and oral methods, community-based Outreach Workers effectively inform Early and Periodic Screening, Diagnosis and Treatment eligible individuals (or their families) of the importance of well-child care visits based on the Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, which sets out a series of examinations at specific developmental stages. HealthCheck also supports Bright Futures recommended preventive health care encounters for children ages 0-1.

On March 27, 2012, the Centers for Medicare and Medicaid Services (CMS) flagged the 2010 CMS 416 data reported last year for this indicator. Consequently, the accuracy of the 2010 CMS 416 data specific to this indicator is in question. The WV CMS 416 annual report does not distinguish between children in fee-for-service and those in managed care delivery models. Hence, potential access problems unique to a particular delivery model cannot be assessed.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 03 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	94.1	100.0	100.0	90.0	95.2
Numerator	16	18	9	9	20
Denominator	17	18	9	10	21
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
CHIP 2012 Annual Report, date ending June 30, 2012. Continuous 12 month enrolled children less than or equal to 15 months.

Notes - 2011
CHIP 2011 Annual Report, date ending June 30, 2011. Continuous 12 month enrolled children less than or equal to 15 months.

Notes - 2010
CHIP 2010 Annual Report, date ending June 30, 2010. Continuous 12 month enrolled children less than or equal to 15 months.

Narrative:
The bipartisan Rockefeller-Kennedy-Snowe CHIP Reauthorization Act of 2007 (S.1224) provided significant new federal resources for children's health coverage that enables states to substantially expand the number of children in this country who have health care. The legislation assures states a stable and sufficient source of financing to cover uninsured children. Because of this, WV's previous Governor Joe Manchin lll, signed into legislation, during the 2007 session, CHIP eligibility expansion up to 300 percent of the FPL. A phase-in eligibility of up to 220 percent of the FPL began July 1, 2007. In July of 2008, the eligibility raised to 250% of the FPL. In 2011, eligibity was requested to be raised to 300% of the FPL and was implemented July 1,2012.

Not many infants, under the age of one in WV, are eligible for CHIP. Most infants under age one are insured by Medicaid (eligible at or below 150% FPL) or private insurance.

Of the 21 infants eligible for CHIP, 20 or 95.2% received at least one periodic screen.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	74.3	73.7	72.9	77.9	77.9
Numerator	15977	15638	14872	14592	14592
Denominator	21492	21225	20391	18737	18737
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
based upon 2011 PRAMS data

Notes - 2011
2011 PRAMS data

Notes - 2010
2010 Vital Statistics - calculated by 1st trimester with 11+ visits, 2nd trimester with 6+ visits and 3rd trimester with 1+ visits
numerator does not include unknown trimester care began

Narrative:
Availability of prenatal care providers continues to be problematic. Also, the only board-certified perinatal specialists in WV are located in Charleston, Huntington, and Morgantown, where the tertiary care hospitals are located. Women and babies needing the services of high-risk specialists often have to travel long distances for an appointment. Many do not keep their appointment because of the long distances on difficult WV roads. Telemedicine is being expanded to bring expertise to patients and community-based physicians in rural areas, saving transportation cost and time. In addition, community-based physicians would receive valued

support. Telemedicine also gives health care providers access to continuing education lectures that are given at medical schools. Please see information on the Connect to Care Project under Other Program Activities.

According to WV Vital Statistics, women who began prenatal care in the first trimester increased from 83.1% in 2010 to 83.2% in 2011 (cumulative). In 2010, 25.8% of women had six to ten prenatal care visits, 55.2% had eleven to fifteen prenatal care visits and 12.9% had sixteen or greater prenatal care visits. Cumulative 2011 data suggest 26.7% had six to ten prenatal visits, 53.6% had eleven to fifteen prenatal visits, and 13.1% had sixteen or greater prenatal visits.

Coordination to improve the health of West Virginia's perinatal population is a result of a carefully crafted, highly-interdependent partnership. Tertiary care centers, primary care centers, local health departments, private practitioners and community agencies have worked with the Office of Maternal, Child and Family Health (OMCFH) for more than thirty years to improve the health and well-being of the State's people. In conjunction with its medical advisory boards, OMCFH has designed a system that offers early and accessible health care to low income, medically indigent and underinsured women and children. A successful perinatal care system requires adequately trained professionals to provide complete reproductive health services that include family planning, preconceptual counseling, prenatal care, delivery, newborn care, and care for the woman in the postpartum period.

Early preventive prenatal care and education are recognized as the most effective and cost effective ways to improve pregnancy outcomes. West Virginia's RFTS Program began in 1989 as a partnership between OMCFH and WV Medicaid to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal services to low-income women up to sixty days postpartum and care coordination for Medicaid eligible infants up to one year of age. Right From The Start also provides direct financial assistance for obstetrical care for WV pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 07A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	77.6	81.6	81.2	82.1	95.2
Numerator	160348	174073	178233	181737	208704
Denominator	206729	213390	219576	221328	219150
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
CMS-416 Annual Report Fiscal Year 2012
Total screens received

Notes - 2011
CMS-416 Annual Report Fiscal Year 2011
Total screens received

Notes - 2010
CMS-416 Annual Report Fiscal Year 2010
Total screens received

Narrative:
The CMS-416 does not identify individually those children who received any service. Data is based on number of screens which increased by 27,000 screens in 2012. The number of screens have increased, but not necessarily the number of children receiving a service paid for by Medicaid. For example, one child may have had five screens.

HealthCheck is WV's name for the mandated pediatric Medicaid program, Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Over 200,000 Medicaid-approved children in WV have been eligible to participate in the HealthCheck Program for the past several years. EPSDT's promise to children eligible for Medicaid is the provision of screening services and treatment of all medical conditions discovered during the exams.

HealthCheck Program Specialists are assigned to geographical regions to educate, orient and provide ongoing technical assistance to EPSDT providers and have been especially active in recruiting additional primary care providers for underserved areas. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community is presently at capacity. Program Specialists have also been active in working with local school systems to increase the number of school-based clinics and on site EPSDT evaluations. The number of students using school-based health centers (SBHC) has steadily increased over the past few years. The SBHC's goal is to develop a coordinated system of health care for children that increases access to primary and preventive care, especially for students who are uninsured, who lack a medical home, or who are at risk for health problems.

HealthCheck monitors the utilization of the program to ensure that EPSDT eligible individuals receive health screens per the American Academy of Pediatrics' Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents periodicity schedule and provides follow up to ensure that EPSDT eligible individuals receive medically necessary services to assess/treat conditions that are discovered by personal physicians or primary care providers (PCPs) during initial or periodic HealthCheck screens.

HealthCheck ensures that no less than 95% of EPSDT eligible individuals who are not enrolled in a managed care organization and 90% of children in foster care have a clearly identifiable personal physician or primary care provider (PCP), the foundation of the medical home model, by the end of each month. HealthCheck community-based Program Specialists encourage medical/dental providers to accept and serve Medicaid eligibles and to streamline referral systems to improve client access to services.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	56.0	57.9	59.1	58.0	59.9
Numerator	22778	24237	25541	25410	26312
Denominator	40691	41838	43225	43802	43947
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
Fiscal Year 2012 - CMS - 416
12a any dental services

Notes - 2011
Fiscal Year 2011 - CMS - 416
12a any dental services

Notes - 2010
Fiscal Year 2010 - CMS - 416
12a any dental services

Narrative:
Per 2012 CMS-416 -- 43,947 children ages 6-9 were eligible for Medicaid and 26,312 or 59.9 received any dental service.

The Children's Dentistry Project is a component of the OHP within the Division of Infant, Child and Adolescent Health housed within OMCFH. Medicaid child beneficiaries have financial access to dental services, yet 40% do not routinely seek care.

In FY 2012 WV reported having 208,420 children enrolled in the Title XIX Medicaid, and 22,262 children enrolled in the Title XXI Children's Health Insurance Program. The Board of Dental Examiners reporting having 1245 licensed dentists. Of those, 627 had at least one Medicaid patient and 503 had at least one paid CHIP claim.

In the recent Dental and Dental Hygiene Workforce study that was conducted by the OHP in conjunction with the Board of Dental Examiners and WVU School of Dentistry, findings indicated that over fifty percent of WV dentists accept Medicaid and CHIP patients, seeing an average of 20 Medicaid patients per month. Low reimbursement and broken appointments were primary reasons indicated by the dentists who did not see Medicaid patients.

The OHP is currently working with WV Medicaid to put a system in place that will systematically analyze reimbursement rates for dental services to ensure that providers are compensated at a rate that is comparable for treatment provided. Care coordination to increase incidence of a dental home, encourage usage of dental benefits and decrease the broken appointment rate among Medicaid and CHIP recipients are also being considered by the OHP and its partners.

The OHP has continued to work with Marshall University to expand the School-Based Dental Sealant Program. The current program offers dental sealants at school-based health centers in 27 WV counties. To maximize the efforts of the program, the OHP will expand this system statewide. A Dental Sealant Coordinator, contracted through Marshall University, will help facilitate expansion so that all WV counties are served.

Oral Health Educators provide oral health education to children and families in all 55 counties through schools, early childhood programs and community health fairs. The curriculum teaches prevention through proper oral hygiene, including instructions on brushing; flossing; choosing healthy foods; tobacco and drug prevention; and the importance of establishing a dental home. During the FY 2012, 96,855 children received these educational services.

The OHP is currently undergoing redesign of the current oral health education system in an effort to meet the needs of the citizens. The OHP has contracted with Marshall University to implement a standardized oral health curriculum that can be used in schools and by community groups and to hire full-time Oral Health Coordinators that will be located regionally throughout the State to serve as community oral health resources.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 08 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	9.5	8.1	6.8	8.1	8.1
Numerator	879	748	528	625	601
Denominator	9233	9233	7739	7679	7430
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
numerator is children 16 and under receiving CSHCN services who receive SSI
denominator is children under 16 receiving SSI within the State

Notes - 2011
numerator is children 16 and under receiving CSHCN services who receive SSI
denominator is children under 16 receiving SSI within the State

Notes - 2010
numerator is children 16 and under receiving CSHCN services who receive SSI
denominator is children under 16 receiving SSI within the State

Narrative:
It should be considered that the statistical information shared for this indicator is best described as an estimate because the CSHCN Program data is from calendar 2011, but the WV Supplemental Security Income (SSI) data is from calendar year 2010, which is the most recent data available. Also when comparing historical data, 2010 is the first year in which age 17 and 18 year olds are not included in the numerator for calculation of the annual objective and performance data.

A more accurate snapshot may be offered when considering a specific rehabilitative service currently provided from the CSHCN Program to SSI beneficiaries. For example, Title V funds are utilized for coverage of medical foods. At the end of 2011, there were 236 children less than 16 years old receiving medical foods from the CSHCN Program; 192 of those children are SSI recipients. This offers the conclusion that 81% of the children receiving the rehabilitative service of medical food coverage from the CSHCN Program are SSI beneficiaries.

Nevertheless, at the end of 2012 there were 1,343 children enrolled in CSHCN Program services and 47 children awaiting eligibility determination or diagnostic assessment. Of the enrolled clients, 773 receive SSI; 601 of those children are less than 16 years old. Hence, 57% of the CSHCN enrolled children are SSI recipients and 47% of the CSHCN enrolled are SSI recipients

under 16 years of age. It should be noted, 110 children enrolled in CSHCN Program Services are not eligible for rehabilitative services because of being over-income, but are offered care coordination services. Hence, if these children are not factored into the eligible enrollees for rehabilitative services, then 60% of the children eligible for rehabilitative services in the CSHCN Program are SSI recipients and 44% of the CSHCN eligible for rehabilitative services are SSI recipients under 16 years of age.

The CSHCN Program received a total of 996 referrals directly from the Social Security Administration Disability Determination Unit during the 2012 Calendar Year; a 5% increase from CY 2011 when there were 949 referrals received. There were 481 CSHCN applications mailed out during CY 2012. During CY 2012 there were 259 cases enrolled into the program, of that 259 cases 99 were clients who have SSI. Unfortunately the CSHCN Program does not have the ability to discern what percentage of applications returned were from this population.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2011	payment source from birth certificate	11.1	7.2	9.3

Notes - 2014
only those with known birthweight

Narrative:
WV has struggled with the incidence of low birth weight infants. Birth weight is the single most important predictor of survival. Low birth weight is defined as a weight of less than 2,500 grams at birth and may result from preterm birth (before thirty-seven weeks) or poor fetal growth for a given duration of pregnancy (intrauterine growth retardation) or both. In the United States, most infant deaths are associated with low birth weight. Risk factors for preterm birth and low birth weight include: previous preterm and/or low birth weight birth, multiple births, smoking, unplanned pregnancy, infections, poor nutrition, lack of access to adequate and early prenatal care, harmful substance abuse, and domestic violence.

Right From The Start (the State's perinatal Medicaid home visiting program) provides in-home care coordination to a high risk population of pregnant women and infants. 2011 data show the average birth weight for an infant born to Program participants was 6.97 pounds or 2,976 grams.

WV has the highest smoking rate for pregnant women in the United States. Preliminary data from the WV Health Statistics Center show that the rate of smoking during pregnancy in WV for 2011 was 27.0% compared to the National rate of 9.4% in 2010 (last available national information). Alarming rates of these were 39.5% of the Medicaid insured mothers smoked during pregnancy. 10.1% of the Non-Medicaid insured women in West Virginia reported smoking during pregnancy.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-**	**ALL**

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Infant deaths per 1,000 live births	2011	payment source from birth certificate	8.2	3.4	6.1

Notes - 2014
only those with known Medicaid status

Narrative:
Prematurity/low birth weight is the leading cause of death in the first month of life. In addition to mortality, prematurity is a major determinant of illness and disability among infants, including developmental delays, chronic respiratory problems and vision and hearing impairment. Through enhanced education and intervention, birth outcomes can be improved. Tracking the proportion of births that are preterm and identifying other risk factors such as low-income levels and education affirms that focusing attention on government sponsored patients (i.e., Medicaid, Title V, Title XIX) remains important.

According to Preliminary 2011 WV Vital Statistics, over two out of nine infant deaths (23.1%) was due to SIDS. Nearly one in four (24.8%) were the result of congenital malformations, while 39.7% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birth weight (8.3%). The number of neonatal deaths decreased from 82 in 2010 to 80 in 2011; the neonatal death increased, from 4.0 deaths among infants under 28 days per 1,000 live births in 2010 to 4.3 in 2011. Neonatal deaths comprised 66.1% of all WV resident infant deaths in 2011 compared with 54.7% in 2010. The overall preliminary infant mortality rate for WV in 2011 was 6.1 and 7.3 in 2010 deaths per 1,000 live births whereas the overall preliminary infant mortality rate for the United States in 2011 (latest data available) was 6.2 per 1,000 live births.

Preliminary 2011 WV Vital Statistics data suggests that WV attained a 6.1 infant mortality rate, the lowest ever in the state.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2011	payment source from birth certificate	77.8	90.5	83.2

Notes - 2014
only those with known prenatal care

Narrative:

Fifteen rural healthcare sites have access to specialized medical consultation via live telemedicine with the three WV tertiary hospitals providing high risk prenatal and newborn care. Approximately 255,534 women of child bearing age in fifteen rural WV communities have easier access to specialized maternity and newborn care, eliminating the need to travel far distances. 353,250 rural county residents realize additional benefits from this project through access to medical videoconferencing equipment provided in their local areas.

The WV Perinatal Partnership Maternity Care Provider Shortages Committee is continuing its work to improve access to maternity care and appointed this committee to study the issues.

Refer to State Priorities for additional information.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2011	matching data files	72	84	78

Notes - 2014
2011 PRAMS data

Narrative:
In WV, approximately 60% of all pregnant women receive prenatal care through Medicaid and the Public Employee's Insurance Agency (PEIA). The RFTS Maternity Services Program also provides coverage for additional women. In CY 2012, 748 pregnant women who were denied WV Medicaid applied to RFTS Maternity Services for financial assistance with the cost of their obstetrical care and 397 had a portion of their prenatal care costs covered. Funding for RFTS Maternity Services is provided by federal Title V and WV State appropriations.

WV Vital Statistics 2011 data show 84% non-Medicaid pregnant women accessed prenatal care in the first trimester but only 72% of Medicaid pregnant women for a total of 78%.

In 2012 the WV RFTS Program worked with thirty-eight community agencies throughout WV under contract to provide in-home, evidence-based, best-practice care coordination and enhanced education services to high risk pregnant women and infants. Approximately 188 Designated Care Coordinators (DCCs), who are Registered Nurses and Licensed Social Workers, have been dedicated to the core public health function of assisting with access to early and adequate prenatal health care. In addition to RFTS DCCs, there were 82 obstetricians, nurse practitioners, nurse midwives and family practice physicians in WV and bordering states that have Letters of Agreement with the Program to provide quality obstetrical and delivery care to pregnant women according to American College of Obstetricians and Gynecologists (ACOG)

standards.

The DCCs are specially trained Registered Nurses and Social Workers licensed to practice in WV, and follow ACOG guidelines and protocols identified in the RFTS Program Policy and Procedures Manual that focus on the mother's personal health, quality of care-giving and life-course development. Women voluntarily enroll as early in pregnancy as possible with home visits beginning ideally by the 16th week of pregnancy, and continuing through the first year of the infant's life. DCCs involve the mother's support system including family members, fathers and friends, and help families access other health and human services they may need. Each pregnant woman and family of the infant receives individualized services which are developed jointly with the DCC shared with the family's medical provider. Additional medical and social services offered in the community are also used to assure efficient use of resources.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2011	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2011	300

Narrative:
The percent of poverty level for eligibility in the State's Medicaid progams is 150% for infants (0-1) 133% for children ages 1-5, 100% for children ages 6-18 and 150% for pregnant women. The poverty level for eligibility in the State's SCHIP programs is 300% for infants and children ages 0-19. There is no SCHIP coverage for pregnant women. OMCFH offers maternity coverage for pregnant women up to 188% of the poverty level, coverage for pregnant teens and coverage for the first visit and labs for women who have applied for Medicaid but have not yet received approval.

The Governor of WV, Earl Ray Thomblin, announced in May 2013 that the state would expand Medicaid eligibility. Individuals may apply starting October 1, 2013 for a January 1, 2014 start date.

The expansion of coverage will benefit people who make up to 138% of the FPL. Currently 138% FPL is $15,856 for an individual or $26,951 for a family of three. The expansion of coverage will benefit many people who were not previously eligible, including low income, non-disabled adults without children. It is estimated that more than 99,000 West Virginia residents will be enrolled in Medicaid and WVCHIP by 2018.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2011	 133 100 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2011	 300

Narrative:
The percent of poverty level for eligibility in the State's Medicaid progams is 150% for infants (0-1) 133% for children ages 1-5, 100% for children ages 6-18 and 150% for pregnant women. The poverty level for eligibility in the State's SCHIP programs is 300% for infants and children ages 0-19. There is no SCHIP coverage for pregnant women. OMCFH offers maternity coverage for pregnant women up to 188% of the poverty level, coverage for pregnant teens and coverage for the first visit and labs for women who have applied for Medicaid but have not yet received approval.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2011	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2011	

Notes - 2014
Pregnant women are not covered under CHIP. All uninsured teen pregnancies are covered by Title V.

Narrative:
The percent of poverty level for eligibility in the State's Medicaid progams is 150% for infants (0-1) 133% for children ages 1-5, 100% for children ages 6-18 and 150% for pregnant women. The poverty level for eligibility in the State's SCHIP programs is 300% for infants and children ages 0-19. There is no SCHIP coverage for pregnant women. OMCFH offers maternity coverage for pregnant women up to 188% of the poverty level, coverage for pregnant teens and coverage for the first visit and labs for women who have applied for Medicaid but have not yet received approval.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2014

Narrative:
The OMCFH has had an SSDI grant for many years which has helped build data collection and reporting capabilities. All population based programs, including PRAMS, birth defects surveillance, newborn screening, maternal and infant mortality review, data management and epidemiologists are housed within the Research Division. Epidemiologist capacity has grown from a staff of six since June of 2011 to nine in July 2012. The YRBS is housed within the Health Statistics Center (Vital Statistics) and is located within the Bureau for Public Health as well. There is full cooperation between Vital Statistics and the Research Division for data sharing.

WIC data sharing cooperation has not been achieved as WIC believes they are unable to share their data. Hospital discharge data is utilized, but the discharge data has no identifiers so is unable to be matched.

The OMCFH also has the ability and cooperation from the Immunization Registry to match data.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2014

Narrative:
The YRBS is housed within the Health Statistics Center (HSC) along with Vital records. We do not have direct access to the data, but sharing among the HSC and the OMCFH occurs continuously for numerous projects.

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2012/ 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 2010 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.
/2014/ According to Workforce WV, WV's seasonally adjusted unemployment rate for April 2013 was 6.6%, compared with a national rate of 7.5%. //2014//
• According to the U.S. Census 2005-2009, 81.6% of persons age 25+ are high school graduates compared to 84.6% nationally. This is a six percent increase from the 2000 U.S. Census. However, according to the same data source only 17.1% of persons age 25+ have a bachelor's degree or higher compared to 27.5% nationally.
• Work disability is also a significant problem in West Virginia. The 2010 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.

Former 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 /2013/ and on July 1, 2012 CHIP expanded to 300% FPL. //2013//

/2014/ The Governor of WV, Earl Ray Thomblin, announced in May 2013 that the state would expand Medicaid eligibility. Individuals may apply starting October 1, 2013 for a January 1, 2014 start date.

The expansion of coverage will benefit people who make up to 138% of the FPL. Currently 138% FPL is $15,856 for an individual or $26,951 for a family of three. The expansion of coverage will benefit many people who were not previously eligible, including low income, non-disabled adults without children. It is estimated that more than 99,000 West Virginia residents will be enrolled in Medicaid and WVCHIP by 2018. //2014//

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. Former Governor Joe Manchin III placed emphasis on education and introduced several bills to address the issue. Using American Recovery and Reinvestment Act funds several schools have added "coaches" to assist 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.

Historically, many West Virginians have 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.

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 based on data and help from 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//2012//

B. State Priorities

/2012/ Each current state performance measure was selected because of the health status of the respective population and based on information derived from the Needs Assessment completed in 2010. The new state performance measures are once again based upon the Needs Assessment and have changed only marginally from the 2005 measures.

Although West Virginia has financial stressors and many health care issues such as smoking among pregnant women, infants born prematurely, infants born with low birth weight, obesity and asthma, the WV OMCFH has woven together multiple funding streams to develop a system of care for women, infants, and children, including adolescents and those with special health care needs as well as some services for adults such as dental care and breast and cervical cancer screening that support a life course model. The WV OMCFH has developed strong partnerships across the state with the medical community, private sector, as well as community health centers and local health departments, all in an effort to assure access. Medicaid has purchased services for their beneficiaries at the request of Title V but they, too, are facing financial stressors.

It is clear that the OMCFH cannot support all programs and services that are needed to meet the needs. In response to shrinking resources, the WV OMCFH has advocated for the purchase of those services most critical to the health of maternal and child populations--family planning, prenatal care, support of EPSDT, population based surveillance programs, CSHCN services, etc. all in an effort to support the life course and prevent catastrophic illness. Another strategy that the WV OMCFH has undertaken is reduction of cost wherever possible. ***/2014/ The Family Planning Program, as a partner in the 340B Prime Vendor Program, has assisted in lowering state costs by encouraging the use of Long-Acting Reversible Contraception (LARCs) which the program receives at a greatly reduced rate. LARCs are as effective as surgical sterilization but provide a reversible option for clients who may wish to increase their family size at a later date. This is a major step in reducing the number of unplanned pregnancies that rely on state funding to cover maternity services and continuing healthcare for the child. //2014//*** /2013/ The Family Planning Program has seen a significant increase in the use of Long-Acting-Reversible Contraceptives (LARCs). These more effective forms of birth control are purchased in mass and stored at a government operated warehouse that is supported by multiple programs. //2013// West Virginia is also efficient with resources, often administering programs and services that are used by multiple payor sources such as Title XIX and XXI. To assure that federal resources are maximized, all uninsured children and pregnant women seeking services must apply for Title XIX. If the patient is ineligible for Title XXI or Title XIX, Title V resources may be used to pay for their care.

The West Virginia five year needs assessment is a work in progress throughout the year, every year. In order to ensure that adequate health care is available OMCFH must continually ask customers, clients and providers if their needs are being met and use data to support outcomes. With limited resources, it is essential to target areas that will have the greatest impact in improving overall health outcomes.

Through the participation of OMCFH medical advisory boards, population targeted focus groups, workgroups and other agencies who conducted surveys of shared constituencies throughout the State and use of qualitative and quantitative data, the following priorities were established for the MCH population as follows:

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

1. Decrease smoking among pregnant women

/2014/ WV has the highest smoking rate for pregnant women in the United States. Preliminary data from the WV Health Statistics Center show that the rate of smoking during pregnancy in WV for 2011 was 27.0% compared to the National rate of 9.4% in 2010 (last available national information). Alarming rates of these were 39.5% of the Medicaid insured mothers smoked during pregnancy. 10.1% of the Non-Medicaid insured women in West Virginia reported smoking during pregnancy. There is a small decline trend over the last six years. //2014//

The state's home visiting perinatal program, Right From The Start (RFTS), provides services to Medicaid insured pregnant women and infants. To address the smoking during pregnancy concern, RFTS continues to implement the evidence-based 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 provides services to approximately one-fourth of the pregnant 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. /2013/ During 2011 and continuing in 2012 the Division of Tobacco Prevention and OMCFH co-funded smoking during pregnancy public service announcements as public education and awareness events. //2013//

2. Reduce the incidence of prematurity and low birth weight

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 births in West Virginia, pointing to a need for a more comprehensive examination of these births. The Perinatal Partnership has made recommendations to practicing obstetricians and birthing facilities that elective c-sections should not occur before 39 weeks if not medically indicated. In 2009, there was a 50% improvement in the rate of elective c-sections. ***/2014/ The reductions have been maintained in 2010 and 2011. //2014//***

/2014/ OMCFH was selected to particpate in the National Governor's Association Network: Improving Birth Outcomes. The goal of the WV Learning Network is to reduce elective deliveries, including inductions and c-sections, prior to 39 weeks gestation. While the strategy to be employed is currently under discussion, the core planning team may opt to assess evidence-based maternity payment reforms by WV payors (i.e. discontinuation of coverage for non-medically indicated elective inductions or c-sections prior to 39 weeks. //2014//

3. Reduce the infant mortality rate, focusing efforts on black infants and Sudden Unexplained causes

A significant cause of infant death in WV is SIDS/Sudden Unexplained Infant Death (SUID). 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. OMCFH has joined forces with a community collaborative group "Our Babies-Safe and Sound" to increase public awareness of

the need to provide safe sleeping arrangements for infants. /2013/ OMCFH has assisted financially with public awareness activities such as placement of public service announcements and printing and distribution of patient education materials. //2013// During the 2011 Legislature, legislation was enacted that added review of infant deaths to the existing Maternal Mortality Review Team. Staff are being hired and processes are currently being developed. Findings from a formal review of infant mortality will serve as the basis for future activities. /2013/ Case abstraction and review of infant deaths that occurred in 2011 is underway. A database is currently being purchased and should be installed in 2013. An Advisory meeting will be scheduled in late fall to discuss the chart reviews and first year findings. //2013// ***/2014/ The Infant and Maternal Mortality Review Team has completed three-fourths of the 2011 infant deaths. The preliminary WV infant mortality rate for 2011 is 6.1, while the overall preliminary infant mortality rate for the U.S. in 2011 was 6.2 per 1,000 live births. Analysis has not been completed to determine causes for the decrease. 2012 preliminary vital statistics data indicates that the infant mortality rate has increased from 2011. According to preliminary 2011 WV Vital Statistics data, over two out of nine infant deaths (23.1%) was due to SIDS. Nearly one in four (24.8%) were the result of congenital malformations, while 39.7% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birth weight (8.3%). //2014//***

B. Children and Adolescents

1. Assure that children and adolescents access preventive dental services

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 Program, (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.

/2014/ The Children's Dentistry Project (CDP), a component of the OHP within OMCFH, has children's dental needs as its priority. Dental caries (tooth decay) is the most common chronic disease among U.S. children and is 100% preventable. The OHP and its partners work diligently to reduce the incidence of caries in children and adolescents. The project provides water testing to determine fluoride levels of private water systems, conducts a fluoride rinse project to WV elementary schools, and has a regional network of oral health coordinators who conduct oral health education and fluoride technical assistance statewide.

The OHP continued to work with Marshall University to expand the School-Based Dental Sealant Program. The current program offers dental sealants at school-based health centers in 104 schools, serving 27 counties in West Virginia. To maximize the efforts of the program, the OHP will expand this system statewide. The Dental Sealant Coordinator, contracted through Marshall University, will help facilitate the expansion so that all West

Virginia counties are served.

The OHP continued to work with the WVU School of Dentistry and their partners, to implement a training program for medical personnel and their ancillaries to apply fluoride varnish as a preventative oral health measure. The West Virginia Medical Infant and Child Oral Health Training Program delivers ongoing, evidence-based information that is open to all primary care physician's (PCP) in West Virginia. The Program also provides a source of continuing education credits to participants who complete the training course. Program participants receive a training manual that includes a copy of the presenters PowerPoint presentation, program implementation guide, coding and billing information and templates for West Virginia Medicaid and West Virginia CHIP (Children's Health Insurance Program), and parent education and dental resources. To date, the Program has trained 47 PCPs to apply fluoride varnish. The OHP plans to make the training program a State project to increase awareness of the training in an effort to increase the number of medical providers who participate in the program. //2014//

2. Reduce smoking among adolescents

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), housed within the OMCFH Division of Infant, Child and Adolescent Health, educate youth about the consequences of tobacco use and encourage responsible behavior. 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.

3. Reduce obesity among the state's children less than age 18

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.

There are a multitude of programs in WV trying to combat obesity as described in the Five-Year Needs Assessment and discussion in the performance measures. /2013/ Refer to State Performance Measures 4 and 5 for activities occurring to combat children's obesity within the State. //2013//

4. Decrease the incidence of fatal accidents caused by drinking and driving among high school students

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 that includes several programs targeting underage drinking and drinking and driving.

Both the Adolescent Health Initiative and Adolescent Pregnancy Prevention Initiative target risk behaviors and stress making wise decisions.

5. Increase the percentage of adolescents who wear seat belts

In WV, the Governor's Highway Safety Program (GHSP) encourages the development of local traffic safety initiatives. Approximately 60% of the Section 402 funds received by the GHSP in 2010 were forwarded to Safe Community Programs formed by local government and civic and business groups in eight different areas of the state. Using this approach, the entire state's population is covered by a Safe Community Program. In 2009, WV's seat belt usage rate was 87%. In 2010 it dropped 5% to 82.15%. The GHSP attributes the decrease in usage rate to a lack of stronger legislation. WV's current seat belt law is a secondary enforcement law. /2013/ During the 2012 Legislative session, the seat belt law was introduced as a primary enforcement law, but did not pass. //2013// GHSP also continued the sustained DUI enforcement, and reported more participation in 2010 in the Child Passenger Safety Program. Student trainee attendance for the Motorcycle Safety program was up in 2010 as well.

The Adolescent Health Initiative participated in several health and safety events across West Virginia and distributed information regarding seatbelt usage to adolescents, parents and other community members. The Adolescent Health Initiative Director collaborated with the Governor's Highway Safety Program to launch a statewide campaign that included billboards and electronic seatbelt usage signs. The Adolescent Health Initiative Director also worked with Kanawha Coalition for Health Improvement and the Charleston Police Department to sponsor seatbelt and child safety seat checkpoints throughout the City of Charleston.

6. Reduce accidental deaths among youth 24 years of age or younger

The Violence and Injury Prevention Program participates in events throughout the State specifically addressing childhood injuries relating to motor vehicle crashes. Program staff continue to meet with partners and stakeholders to develop and maintain prevention activities throughout the State. The Program works closely with Emergency Medical Services for children to distribute educational materials and provide skill building for parents and children regarding the risk of injuries from motor vehicle crashes. A full-time coordinator was hired to manage the project. /2013/ In 2012 the WV Legislature passed secondary enforcement laws pertaining to texting and talking on cell phones while driving. These will become primary enforcement laws in 2013. //2013//
/2014/ Talking on a cell phone while driving was passed by the WV legislature in 2013 as a primary enforcement offense. //2014//

C. Children with Special Health Care Needs

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

The CSHCN Program is working with the Medical Advisory Board to: identify and recruit physicians; to ensure that CSHCN clinics are established and/or maintained in areas of need; establish a provider recruitment plan that includes utilization of Family to Family partnership and presentations at medical schools; minimize out of state referrals so that WV infrastructure can be maintained.

CSHCN will continue to work with the WV Chapter of the American Academy of Pediatrics to encourage the medical community to refer children with chronic, debilitating conditions to the CSHCN Program.

CSHCN will continue to collaborate with another office within the Bureau for Public Health, Office of Nutrition Services' Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to assure children who are age eligible to receive WIC services are identified.

State priorities are not necessarily the state performance measures since national performance measures already exist and cover some of the priorities. //2012//

/2012/ Health Disparities:
Although WV is primarily homogenous in population with 93.9% white and 3.4% black, there remains a great disparity in health and economic outcomes, not only among minorities, but among the low-income as well. //2012//

/2014/ The WV Bureau for Public Health is expanding its Minority Health Program to an Office of Minority Health and Health Equity. OMCFH is participating in development of the Office charter, definition of roles/responsibilities and co-funding staffing of the new Office. Involvement with this new Office will improve focus and attention on health disparities in the MCH population. //2014//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	26	43	61	43	65
Denominator	26	43	61	43	65
Data Source	Newborn Metabolic Screening	Newborn Metabolic Screening	Newborn Metabolic Screening	Newborn Metabolic Screening	Newborn Metabolic Screening
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	100	100	100	100	100

Notes - 2012
2012 Occurrence births

Notes - 2011
2011 Occurrence births

Notes - 2010
2010 Occurrence births

a. Last Year's Accomplishments
Newborn metabolic screening is a critical public health function by which all newborns are screened shortly after birth for selected disorders with potentially adverse consequences that can be identified and treated before the illness becomes apparent. For many years, even before mandatory legislation, the Office of Laboratory Services (OLS) worked in tandem with the OMCFH to develop capacity to expand the newborn screening panel. Prior to 2005, WV screened for only five disorders, while in 2007 had the ability to screen for ten disorders and in February, 2009 began screening for all 29 nationally recommended disorders. It is the partnership between the OLS and the OMCFH that has allowed this expansion to occur while also being able to provide follow-up and genetic health services to all infants that are born within WV borders. The WV Newborn Screening Program (NBSP) boasts coordination of services between birthing facilities, insurance companies, West Virginia University (WVU) who provides genetic and cystic fibrosis expertise, as well as with the endocrine, metabolic/genetic and hematology specialists across the state.

In 2012, 97.3% of infants born in the state of WV received newborn screening. Of the 65 infants with a definitive diagnosed condition in 2012, all received timely follow-up and clinical management. In conjunction with the OLS, the NBSP ensures infants are screened before hospital discharge. All abnormal test results are followed by OMCFH staff and confirmed abnormalities receive case management, with assistance from the Genetics Program at WVU. The OMCFH provides, free of charge, regardless of family income, formula for those with confirmed PKU and other nutritional supplements and vitamins indicated for other diagnoses. The OMCFH, using Title V dollars, in the past reimbursed the OLS for all newborn screening specimens. With the passage of Newborn Screening Rules during the 2008 Legislative session, the Bureau for Public Health is now able to bill hospitals for every infant who receives a screen. The cost of the newborn screening system is included in this charge.

With the addition of the 29 disorders, improvements in the data system, laboratory equipment, reagents, and personnel, costs have increased from $47 in 2009 per screen to $100. per screen starting July 1, 2013. Charges are based on actual costs of screening, follow-up by case managers, genetics staff and nutritional supplements from the previous year.

The Genetics Program at WVU provides genetic clinics at 6 strategic locations throughout the state, offering diagnosis, treatment and counseling and was historically funded using Title V dollars. The Genetics Program costs associated with newborn screening are now included in system charges, since they provide medical support for primary practitioners serving affected newborns. WVU Genetics, with NBSP financial support, was able to add an additional geneticist

to work with the State because of the expanded panel.

Educational information on the expanded panel of disorders has been developed for use by physicians and families. The NBSP website is continually updated to include progress on expansion efforts and information on disorders as well as establishing links to supportive information.

Expanding newborn screening incrementally has afforded OMCFH the opportunity to build State laboratory capacity as well as bill hospitals to recoup system costs between expansion phases.

CCHD/Pulse Oximetry Testing for Newborns was passed by the Legislature during the 2012 legislative session and implemented July, 2012 and is collected on the Birth Score form.

WV completed the addition of the case management follow-up module to the existing data package contracted with Neometrics. This has enabled nurse case managers more timely access to the data system for follow-up activities and for surveillance activities by the epidemiologist. Final implementation occurred in May, 2013.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All abnormal test results are followed by OMCFH case management.		X		
2. The Pediatric Genetics Program at WVU provides six subspecialty clinics throughout the State of West Virginia.				X
3. An active advisory committee assists with policy and program development.				X
4. The NBS Program staff work collaboratively with the birthing facilities and State Lab to ensure screening before hospital discharge.				X
5. Formula and supplements for patients with newborn screening disorders are provided free of charge, regardless of income, by OMCFH.		X		
6. Linkage of data between OMCFH and the State Lab creates efficiency.				X
7. Formal relationships have been developed with Schools of Medicine to assure availability of medical experts.				X
8. WV currently screens for 30 disorders (includes hearing and CCHD). SCID to be added in 2013.			X	
9. The Bureau for Public Health generates cost-based revenue by billing the birthing hospital for each live birth for newborn screening.				X
10. WV added a data collection case management module to the existing contract with Neometrics to enhance efficiency. The module should be installed in Sept. 2012.				X

b. Current Activities

It is the goal of the NBSP to screen every newborn in WV for disorders to ensure diagnosis and treatment before the consequences of the disease become apparent ensuring the greatest opportunity to live a normal, productive life. Long-term benefits include a better quality of life for

the child and his/her family and considerable cost savings for the insuring payers and the taxpayers of WV.

WV will be adding SCID to the list of newborn disorders screened when equipment arrives and the validation process at the State Lab has been completed. Continued education and planning for implementation of SCID is ongoing.

Collaboration with the Birth Score Office on collecting outcome data for CCHD is also underway. OMCFH collects screening rates, but identifying outcomes of the infants with a positive screen has been challenging. Medical providers have been reluctant to release information. Since September, 2012, 21 infants have failed screens. The Birth Score Office has outcome data on 10 infants and of the 10, 3 have had surgery to correct heart problems.

WV has an active Advisory Committee made up of pediatric specialists across the State and meets at least two times a year. The Committee makes recommendations that improve newborn screening and follow-up.

c. Plan for the Coming Year

The Office of Maternal, Child and Family Health will maintain its relationships with the State Laboratory, the Newborn Screening Advisory, WVU Genetics Program, birthing facilities, Medicaid, insurance companies and the March of Dimes. The follow-up component of the Newborn Screening Program is housed within OMCFH and currently two fulltime nurses hold these positions.

Processes were developed and will be refined as necessary to purchase supplements needed for those infants diagnosed with a disorder. Partnership with WIC and CSHCN will continue to enable infants to receive nutritional products that he/she may be eligible for beyond that provided for by the Newborn Screening Program.

Screening for SCID will occur in 2013.

The Program will revise and develop policies and procedures and complete a provider manual in 2013-2014.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**20959**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	20429	97.5	1	1	1	100.0

Congenital Hypothyroidism (Classical)	20429	97.5	440	18	18	100.0
Galactosemia (Classical)	20429	97.5	110	20	20	100.0
Sickle Cell Disease	20429	97.5	80	0	0	
Biotinidase Deficiency	20429	97.5	205	7	7	100.0
Cystic Fibrosis	20429	97.5	129	10	10	100.0
Homocystinuria	20429	97.5	0	0	0	
Maple Syrup Urine Disease	20429	97.5	5	0	0	
beta-ketothiolase deficiency	20429	97.5	0	0	0	
Tyrosinemia Type I	20429	97.5	7	1	1	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	20429	97.5	3	0	0	
Argininosuccinic Acidemia	20429	97.5	0	0	0	
Citrullinemia	20429	97.5	3	1	1	100.0
Isovaleric Acidemia	20429	97.5	2	1	1	100.0
Propionic Acidemia	20429	97.5	10	0	0	
Carnitine Uptake Defect	20429	97.5	72	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	20429	97.5	10	2	2	100.0
Multiple Carboxylase Deficiency	20429	97.5	10	0	0	
Trifunctional Protein Deficiency	20429	97.5	0	0	0	
Glutaric Acidemia Type I	20429	97.5	309	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	20429	97.5	72	2	2	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	20429	97.5	7	2	2	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	20429	97.5	0	0	0	

3-Hydroxy 3-Methyl Glutaric Aciduria	20429	97.5	10	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	20429	97.5	0	0	0	
S-Beta Thalassemia	20429	97.5	1	0	0	
Mitrochondrial Acetoacetyl-CoA thiolase Deficiency	20429	97.5	0	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	65	60	60	60	73
Annual Indicator	59.2	59.2	59.2	72.0	72.0
Numerator	41150	41150	41150	50850	50850
Denominator	69567	69567	69567	70609	70609
Data Source	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2009-2010 CSHCN Survey	2009-2010 CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	73	75	75	75	75

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT

comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
The 2009-2010 National Survey-Children with Special Health Care Needs (NS-CSHCN) is a telephone survey conducted by the National Center of Health Statistics at the Centers for Disease Control under the direction and sponsorship of the federal Maternal and Child Health Bureau intended to represent the population of non-institutionalized children ages 0-17 who are classified as having one or more special health care needs (CSHCN). In each state, telephone interviewers screened at least 3,000 households with children to identify CSHCN. In-depth interviews were conducted with the parents of 750 -- 850 CSHCN in West Virginia in 2001, 2005-2006 and again in 2009-2010.

According to the 2009-2010 NS-CSHCN, 72% of West Virginia children with special health care needs age 0 to 18 years have families that partner in decision making at all levels, and are satisfied with the services they receive. This is 1.7% above the 2009-2010 national average, and an increase of 12.8% since the 2005-2006 NS-CSHCN performance measure data.

The West Virginia Children with Special Health Care Needs (CSHCN) Program ensures a key element of comprehensive care coordination with families at the center of the process and there are mechanisms to include family involvement in systems improvement. Parents or legal guardians of children enrolled in the CSHCN Program are involved in the Level of Need Assessment (LONA) by a face-to-face, in-home interview to determine what services the family needs and wants. The Care Plan then explicitly organizes the family's needs and wants to help the family play a part in health care services.

During calendar year 2011, 925 LONA and 824 care plans were developed and/or updated with family involvement. The initial LONA assesses eleven functional areas which include: 1) medical, adherence and insurance; 2) nutrition; 3) housing; 4) financial; 5) transportation; 6) legal; 7) daily living and other basic needs; 8) safety of self and others; 9) coping strategies; 10) development, education and vocation; 11) support systems and relationships. Holistic and analytical scoring methods are utilized to define top priorities that will be addressed on the care plan. Care plans, combined with a medical summary, are outlined for six-month service periods.

To assure continuum of comprehensive care coordination and building the medical home, copies of care plans are shared with all members of the medical care team including the family, PCP,

other providers, agencies and organizations involved in the care of the child. A central record containing all pertinent medical information is maintained; the record is accessible to families, but confidentiality is preserved.

The CSHCN Care Coordinator shares information among the child, family and specialist while making referrals as needed. Families are linked to family support groups, parent-to-parent groups and other family resources. When a child is referred for a consultation or specialty care, the CSHCN Nurse Case Manager assists the child and family in understanding clinical issues. The CSHCN Nurse Case Manager evaluates and interprets the specialists' recommendations for the child and family and, in consultation with them and subspecialists, implements recommendations that are indicated and appropriate. The plan of care is coordinated with educational and other community organizations to ensure that special health needs of the individual child are addressed. Families of children with special health care needs have the opportunity to lead the care coordination team and are encouraged to be proactive participants. To do so, the CSHCN care team provides information about the condition and access to necessary resources.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration with Marshall University in Parent Partners in Education (PPIE) funding results in parent advocates placed in Cabell-Huntington Hospital PICU and Pediatric Clinic.		X		
2. Culture competency training of staff "The Culture of Poverty" and "Home Visit Safety."				X
3. Parent/Professional Collaboration Conference sponsored by OMCFH and Marshall University Pediatrics.				X
4. Parents participate as part of the care coordination team for development of individual care plans in Part C and CSHCN Programs.		X		X
5. Copies of Care Plans and updates are given to the child's parent.		X		X
6. Care Notebook and Resource Manual were revised with the assistance of the Parent Network Specialists and families and distributed to families and applicants.		X		X
7. On-going training of Birth To Three practitioners beyond their professional licensure is required.				X
8. Paid Parent Coordinators, one in each of the 8 Birth to Three Regions are available to families, and 6 Parent Network Specialists.		X		X
9. All BTT participants self select practitioner offering services.		X		
10. The WV CSHCN Program in 2013 will fund expansion of residency training in delivery of chronic care to those with special health care needs to WVU/CAMC campus.				X

b. Current Activities

The West Virginia Children with Special Health Care Needs (CSHCN) Program continues to ensure a key element of comprehensive care coordination with families at the center of the process including mechanisms to ensure family involvement in systems improvement. Parents or legal guardians of children enrolled in the CSHCN Program are involved in the Level of Need Assessment (LONA) by a face-to-face, in-home interview to determine what services the family needs and wants. The Care Plan then explicitly organizes the family's needs and wants to help the family play a part in health care services.

The CSHCN Program policy and procedure as well as staff expectations were revised to reflect that all newly enrolled children will have the initial LONA and care plan completed in their home. The goal of utilizing the new LONA, medical summary and care plan for previously enrolled children, to create consistency in service delivery and fully implement the redesigned CSHCN Program care coordination model, is to conduct a minimum of six (6) home visits per month upon annual anniversary review.

As a result of the need to address intricate dynamics, including multiple parental and caregiver involvement in the decision making and service provision, of children placed in foster care, the CSHCN Program created an addendum to the Level of Need Assessment specifically targeting the foster care population.

c. Plan for the Coming Year

The LONA foster care addendum assesses functional areas of placement and permanency as well as emotional and behavioral coping strategies of the child and caregiver. Furthermore, the Child Protective Service agency serving as the child's guardian is invited to the in-home interview to assist in developing the child's care plan, but the foster parent or kinship/relative placement implements the care plan objectives and goals.

Partnering with families, and ensuring the family perspective, in decision making at all levels of the CSHCN Program is demonstrated through the participation of Parent Network Specialists (PNS) and families in: 1) developing individualized, family-centered care plans; 2) the CSHCN Program Medical Advisory Board; 3) quarterly staff meetings with work sessions dedicated specifically to program tools, policies and procedures; and 4) surveys.

To ensure resource and referral information is responsive to family needs, the Parent Network Specialist project, in cooperation with the CSHCN Program, continues to update the Care Notebook. CSHCN Program Care Coordinators continue to develop and update an electronic resource library accessible to all CSHCN Program staff members including regional, state and national resources addressing topics of medical, social and educational services available to families.

The 2013 CSHCN Program work plan includes goals of developing up to four (4) family education tools specifically defined by families to help them care for their child. A parent survey has been developed, and will be administered to families via phone or face-to-face contact (i.e. home visit or clinic appointment), to prioritize what parents define as needs in attaining the best care possible for their child. The survey seeks a yes, no, I don't know or not applicable response to topics including: tracking medications; emergency planning; approval process and obtaining durable medical equipment; arranging and reimbursement for non-emergency medical transportation; legal guardianship; transition options; teaching children self-advocacy skills; and education plans. The survey also offers a comment section for parents to identify other needs. CSHCN will also finalize Policy and Procedure revisions which reinforces family's involvement in the care coordination process.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012

Annual Performance Objective	58	58	55	55	50
Annual Indicator	50.5	50.5	50.5	46.7	46.7
Numerator	35100	35100	35100	33000	33000
Denominator	69567	69567	69567	70609	70609
Data Source	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2009-2010 CSHCN Survey	2009-2010 CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	50	50	50	50	50

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

According to the 2009-2010 NS-CSHCN, 46.7% of West Virginia children with special health care needs age 0 to 18 years receive coordinated, ongoing, comprehensive care within a medical home. This is 3.7% above the 2009-2010 national average. Even so, West Virginia has experienced a decline of 3.8% since the 2005-2006 NS-CSHCN performance measure data which also is consistent with national average decline of 4.1%. It is significant to note that receiving effective care coordination when needed is the weakest component of children with special health care needs receiving care in the medical home. Considering the CSHCN Program redesigned its care coordination services model throughout 2011, it is premature in the redesigned model's ability to specifically address this performance measure. However, with exploration of the CSHCN Program providing care coordination services directly in offices of primary care physicians, CSHCN Program care coordination focus on supporting the medical home via methods such as submitting all medical records to the Primary Care Provider, CSHCN Program staff becoming more skilled and competent in implementing the redesigned care coordination model as well as creating consistent care coordination models between care coordinators stationed in primary and specialty providers via the Tri-State Children's Health Improvement Consortium project, the State of West Virginia can make strides in improving the quality of this measure.

Information about a child's primary care provider is collected by the Systems Point of Entry (SPE) during initial intake. During calendar year 2011, 885 children who enrolled in CSHCN Program services had an identified medical home defined as a usual source for sick and well care with a personal provider. This represents 72% of the enrolled children identifying having a medical home when seeking CSHCN Program services. Furthermore, the 2009-2010 NS-CSHCN indicates, 92.1% of West Virginia children with special health care needs age 0 to 18 years have a usual source for sick or well care with a personal provider.

SPE service coordinators link children without an identified medical home to the state's expansive network of community health centers and to primary practice clinicians for medical care. All children receiving benefits through the WV Medicaid Program, including those participating in the CSHCN Program, choose a primary care physician. This lends to the impression that assessibility is not a barrier, but instead individual components of the medical home may affect the performance data, and hence are targeted areas of the CSHCN Program redesigned care coordination model. These individual components are: having no difficulty with receiving needed referrals; receiving family-centered care; and receiving effective care coordination when needed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 95% of WV children have insurance coverage (Medicaid, CHIP, private carrier)		X		X
2. State CSHCN Program provides extensive care coordination		X		
3. Medicaid, CHIP, PEIA and commercial carriers are requiring use of a medical home				X
4. The U.S. Scorecard ranked WV number 8 for percent of children who have a medical home			X	
5. The U.S. Scorecard ranked WV number 1 for percent of children whose personal doctor or nurse follows up after receipt of specialty care services		X		

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Informational materials, including a CSHCN Program Brochure, Provider List, and Poster, have been developed and distributed in primary care and specialty provider offices to explain and promote the advantages of the CSHCN Program providing care coordination services in the medical home to the children, families and physicians.

A pilot project with Summersville Pediatrics, which the CSHCN Program plans to continue past the pilot stage, provides care coordination services during well-child exams of children enrolled in the CSHCN Program, and those receiving rehabilitative services of medical foods. Aside from direct assistance to the family, and supporting the medical home, this pilot improves the system of care for CSHCN through education of the physician, multidisciplinary-concurrent service provision, and improved efficiency (i.e. dietary assessment conducted by a Registered Dietitian concurrently with the well-child exam; utilizing Inter-Qual criteria for durable medical equipment identified through the well-child exam; completion of certificate of medical necessity during the well-child exam, etc).

The heightened emphasis on patient-centered medical homes also promotes a team approach for optimal care of patients. Such an approach assures whole patient orientation, follows evidence-based guidelines, and implements continuous quality improvement.

c. Plan for the Coming Year
A CSHCN Screener developed by CAHMI was piloted in 2012. The CSHCN Assessment Unit will continue to complete the screener. Fostering Healthy Kids will launch in Kanawha County July 2013. Kanawha County has the largest foster care population in the state.

The CSHCN Assessment Unit will continue to process WV Health Check Well Child Exams in conjunction with the FHK pilot project.

The CSHCN Nutrition clinical services staffed by a Registered Dietician, was piloted in a pediatrician's office in the fall of 2012. This was the first collaboration between CSHCN and a pediatric medical home provider. During this clinic the clients received a HealthCheck Well Child Exam as well as a Nutritional Evaluation for needed medical foods. This expedites medical food authorizations and delivery of services. This service will continue past the pilot stage.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	65	65	65	65	65
Annual Indicator	64.2	64.2	64.2	62.0	62.0
Numerator	44650	44650	44650	43800	43800
Denominator	69567	69567	69567	70609	70609

Data Source	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2009-2010 CSHCN Survey	2009-2010 CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	65	65	65	65	65

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the 2009-2010 NS-CSHCN, 62% of West Virginia children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. This is 1.4% above the 2009-2010 national average. Even so, West Virginia has experienced a decline of 2.2% since the 2005-2006 NS-CSHCN performance measure data which is slightly higher than the national average decline of 1.4%.

The Systems Point of Entry (SPE) Project, housed within OMCFH, is a telephone hot-line and referral service that identifies families that do not have Medicaid, CHIP or private insurance

coverage at the time an application to participate in the CSHCN Program is made. Families without resources to pay for medical services must apply for Title XIX and Title XXI, and must be denied by these sources, prior to Title V payment initiation.

During calendar year 2011, 91% of the children enrolled in the WV CSHCN Program have public insurance; 87% have Medicaid and 4% have CHIP. Five percent report having private insurance and 6% report having no insurance. (It should be noted some children may be eligible for more than one insurance plan so totals do not add up to 100%). There are three managed care organizations (MCO) that administer benefits through the WV Medicaid Managed Care system. However, recipients of Supplement Security Income and children placed in foster care have public insurance benefits administered by the WV Medicaid state agency. As a result of this structure, benefit packages vary even though a family is entitled to public insurance. The CSHCN Program Nurse Case Manager assures families are informed about insurance coverage and benefit eligibility, including benefit packages of each WV Medicaid MCO, so the family is educated about their options when making choices to best care for their child.

To assure that families have the best available coverage for their child's medical care, the CSHCN Program requires all applicants to first apply for Medicaid and CHIP at their local Department of Health and Human Resources (DHHR) Office. Verification of their application is done through receipt of written notice given to the family and/or by accessing RAPIDS, the Medicaid eligibility data system. Information submitted to the DHHR office during this process is also used as the determinant of a child's financial eligibility for the CSHCN Program.

In addition to Title V coverage for treatment, testing and services for children that do not qualify for public health insurance and with a family income at or below 200% of the federal poverty level, the CSHCN Program provides coverage of medical foods for children enrolled in the program without adequate private and/or public insurance coverage. The CSHCN Program currently has 12 children with Title V insurance coverage, and 282 children receiving medical food coverage (0.9% and 21.0% of the enrolled CSHCN Program caseload respectively).

The CSHCN Program continues to administer the Kids First Hearing Project via funds donated by Mountain State Blue Cross/Blue Shield (private insurer) to provide hearing aid services and supplies for children 3, 4, 5 or 6 years of age who lack insurance coverage for this benefit. During calendar year 2011, 77 children were served in the Kids First Hearing Project.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 95% of WV children have insurance coverage (Medicaid, CHIP, Private carrier)		X		
2. CSHCN requires Medicaid and CHIP applications, to ensure Title V resources are used as last resort		X		X
3. Coordination between CSHCN and Social Security Administration facilitates access to SSI		X		
4. CHIP approved expansion of eligibility to 300% FPL				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Patients receiving medical treatment and/or care coordination through the CSHCN Program have their health care financed by Medicaid, CHIP, private insurance or Title V funds. Families with income of 200% of the Federal Poverty Level or below may be eligible for Title V sponsored services if they have an eligible/covered diagnosis. The Program does not have sufficient resources to act as an insurer for every chronic debilitating condition. For example, Title V does not provide payment for treatment of asthma or diabetes. Continued financial eligibility is determined on a yearly basis using a computer generated letter asking families to reapply for Medicaid and CHIP to assure Title V funds are used as payor of last resort. The care coordinator reviews financial information as well as determines continued medical eligibility.

Regardless of insurance coverage, the CSHCN Program will provide health assessments and diagnostic evaluations with a pediatric specialist in a CSHCN Program Clinic at the request of a parent or physician to assist in early identification and treatment of a chronic, debilitating condition; the CSHCN Program will schedule up to two free medical exams, including testing in a CSHCN Program clinic.

c. Plan for the Coming Year

Building on outreach efforts for the past year, CSHCN will continue efforts to make potential recipients aware of services available through CSHCN. To expand CSHCN outreach efforts, the DHHR Office of Management Information Systems will identify approved or denied Medicaid beneficiary children (age 0-20) who have a disability. The system will generate a monthly report to use in CSHCN outreach efforts by the Systems Point of Entry unit. The SPE unit will mail identified families information about available CSHCN Program services and care coordination. This will augment population based surveillance efforts and children identified as a consequence of an EPSDT screen.

Additional informational materials, including a CSHCN Annual Report and CSHCN Fact Sheet, will be developed for a physician awareness campaign. The CSHCN Fact Sheet will highlight the current income guidelines and specifically highlight the eligibility process. The CSHCN Annual Report focuses on how the CSHCN direct services supports the medical system of care, encourages best practice standards to influence pediatric practice for all children, and builds state infrastructure.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	90	90	67
Annual Indicator	89.7	89.7	89.7	66.5	66.5
Numerator	62420	62420	62420	46950	46950
Denominator	69567	69567	69567	70609	70609
Data Source	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2009-2010 CSHCN Survey	2009-2010 CSHCN Survey
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	67	67	67	67	67

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the 2009-2010 NS-CSHCN, 66.5% of West Virginia children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. This is 1.4% above the 2009-2010 national average. Unfortunately, this MCHB core outcome indicator is not comparable over NS-CSHCN survey years.`

In CY 2011 an informational pamphlet was given to each family at the time of enrollment. The pamphlet provided information about the CSHCN Program, eligibility criteria for continued service, services offered including aspects of care coordination and a listing of the patient/family rights and responsibilities.

To improve the system of care, expand population-based MCH services and build the medical home model, the CSHCN Program partners with specialty, multi-disciplinary clinics or private practices throughout WV to provide care coordination services for any children, adolescents and adults with special health care needs. The CSHCN Program Nurse Case Manager and Social Work Care Coordinator are members of the multi-disciplinary team to implement care coordination in the clinic or practice.

In efforts to ensure children can receive quality care within one hour drive from their home, facilitate communication with a child's medical home, and expand care coordination services to a broader population of children with special health care needs, the CSHCN Program supports providers and practices with care coordination services by partnerships with: 1) West Virginia University to conduct six (6) specialty clinics in eight (8) locations throughout the state in the areas of cardiology, cleft and craniofacial surgery, genetics, myelodysplasia, and neurology; 2) Charleston Area Medical Center to conduct two (2) specialty clinics in Charleston WV in the areas of cystic fibrosis as well as cleft and craniofacial surgery; and 3) Marshall University to conduct two (2) specialty clinics in Huntington WV in the areas of spina bifida and cardiology. Ultimately, the CSHCN Program provides a Nurse Case Manager and Social Work Care Coordinator for care coordination services in each of these clinics; services are available to any child scheduled in the clinic on the designated date the CSHCN team attends.

In calendar year 2012, the CSHCN Program provided care coordination services in 208 partnership clinics. In these clinics, the CSHCN Program Nurse Case Managers and Care Coordinators provided services to 482 children enrolled in the CSHCN Program and 1002 patients of the clinics that are not enrolled in the CSHCN Program. Likewise, during calendar year 2012, 813 children enrolled in the CSHCN Program received services in a CSHCN-sponsored clinic.

In addition to contact in clinic settings, CSHCN care coordination teams made 605 face-to-face visits in homes or other sites excluding clinics. In calendar year 2012, 2,685 resources and/or referrals, by a CSHCN nurse or social worker, were provided to or for CSHCN Program clients and families.

WV BTT received from the U.S. Department of Education the highest ranking possible for it's administration of Part C which includes evaluation of timely service delivery, parent knowledge of rights and responsibilities, parent satisfaction and measured child performance milestones.

The CSHCN Quality Initiative Workgroup will establish infrastructure and resources to support Quality Improvement in the processes by which Care Coordination is delivered to CSHCN clients throughout West Virginia. The use of a strategic planning process, multilevel participation in the development of goals and objectives for quality improvement will be developed. Through a process of internal quality review, CSHCN can effectively determine operational compliance with State and Federal guidelines. For year 2013 the workgroup, through strategic planning, will ensure field staff will conduct a quality monitoring report monthly, and report to the Quality Workgroup, the Quality Workgroup will review each service level quality monitoring report. Should concerns be identified, a strategic planning process for the development of goals, objectives, and action plans for problem resolution will be conducted with all staff.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Parents participate in policy and procedures development for WV Birth to Three, Hearing Screening and CSHCN.		X		
2. Collaboration with WV Medicaid to optimize resources and plan efficient use of funds.				X
3. CSHCN collaborates with other OMCFH programs to				X

coordinate needed services efficiently.				
4. CSHCN Nursing Director participates on Medicaid policy committee sharing input from families.				X
5. CSHCN Program Advisory includes medical providers, service providers, and parents.		X		X
6. Survey of BTT parents reflect satisfaction and child performance improvement.				X
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN quality assurance component was strengthened by continuation of an internal process designed to monitor staff documentation in enrolled patient records. Each month the CSHCN Director of Nursing and the Director of Social Services review a portion of each of their assigned staff's work using an Internal Chart Review form, which identifies important elements in care management and case recording. This process identifies areas that need improvement and serves as a basis to identify staff training needs and evaluation. The system serves to augment the periodic clinic/field office site visits completed by the CSHCN Director of Nursing and the Director of Social Services. An electronic data system was developed by OMCFH's Division of Research, Evaluation and Planning for recording and tracking of completed reviews. This allowed the CSHCN nurses and social workers to track response times from the time of inquiry, to the time of authorization and then to the delivery of patient equipment or services.

c. Plan for the Coming Year

The CSHCN Program differentiates itself from other programs/payers by continuing to emphasize the importance of care coordination services. Nurses and social workers are trained to view the family as a whole and assess their needs, both medical and social, and link them with available resources and community services.

The Parent Network Specialists (PNS) will continue to provide resource information, support families in dealing with educational issues, and plan regional workshops to include information on transition services. The PNS will continue to develop parent support groups in their assigned areas.

The ability to serve more children with special health care needs and support the medical system of care will require continued partnerships with hospitals, clinics and private providers with the CSHCN Program offering the care coordination services while the medical management of the clinic patients remain with the provider.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	41.3	42	43	43	43
Annual Indicator	41.3	41.3	41.3	41.6	41.6

Numerator	28700	28700	28700	29400	29400
Denominator	69567	69567	69567	70609	70609
Data Source	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2009-2010 CSHCN Survey	2009-2010 CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	43	43	43	43	43

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the 2009-2010 NS-CSHCN, 41.6% of West Virginia youth with special health care received the services necessary to make transition to all aspects of adult life, including adult health care, work and independence. This is 1.6% above the 2009-2010 national average, and an increase of 0.3% since the 2005-2006 NS-CSHCN performance measure data.

Transition services are provided to all children, age 14-21 enrolled in the CSHCN Program, in collaboration with parents, education specialists and other interested parties. Transition screening tools for middle adolescents and young adults are completed by the client and/or family to develop a transition care plan focused on the effective and efficient organization and utilization of resources as well as seek to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural and social needs. During calendar year 2011, 204 transition tools were completed with 849 transition services provided to clients and families enrolled in the CSHCN Program.

The CSHCN Program continued to seek and allow training of CSHCN staff and contracted employees to build skill and competence in the area of transition services. Topics included: 1) alternatives to guardianship, 2) wills and special needs trusts, 3) "Help Yourself -- Chronic Disease Self-Management Programs", 4) pre-existing condition insurance plan program, 5) overview of Social Security Administration Disability Determination Services and understanding the benefits, and 6) keeping Social Security benefits on track with community work incentive. The Level of Need Assessment (LONA) completed in the home to help families define their needs and wants assesses readiness and reaction to transition in the healthcare section, education section, and coping strategies section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN offers transition services to all Program participants beginning at age 14.		X		
2. WVU Center for Excellence in Disabilities has a transition advisory.		X		
3. Marshall University School of Medicine is collaborating with Title V on transition programming.		X		
4. Participants are encouraged to access Vocational Rehabilitation counseling in schools.		X		
5. WV established required certification for interpreters for the deaf.				X
6. Division of Rehabilitation Services has Cooperative Agreements with all 55 county school systems.				X
7. Throughout WV, rehabilitation counselors are assigned to work with public and private schools.				X
8. Rehabilitation counselors assist students with disabilities in developing individualized plans for employment.		X		
9.				
10.				

b. Current Activities

The CSHCN electronic data system produces reports identifying adolescents 14 through 21 years of age as a tracking system for social workers and nurses. These reports are produced on a monthly basis and used by CSHCN staff when determining need for frequency of contact with clients in providing transition services.

School transition is an area where progress is actively occurring including: statewide and district level workshops and forums; transition targeted teleconferencing; transition assessment resource development; focus on improving achievement; attention to differences in graduation and dropout rates for students with disabilities and all students; efforts to increase collaboration and coordination with WV Division of Rehabilitative Services (DRS), Office of Maternal, Child and Family Health/Children with Special Health Care Needs (OMCFH/CSHCN) and the Department of Education (DOE); development of inclusive educational models and strategies to improve access; and the opportunity to progress in the general education curriculum.

The CSHCN Program continues work with Dr. Shannon Browning from the Marshall University Joan C. Edwards School of Medicine, Pediatrics Department to provide care coordination services in a transition clinic. Transition planning and care coordination is provided by the CSHCN staff to patients 14 through 20. This clinic is highlighted in a newly developed provider listing brochure to promote services statewide.

c. Plan for the Coming Year

The OMCFH has representation on the State Developmental Disabilities Council and shares data and programmatic information that can be used to pursue system change, increase service or support availability or otherwise promote positive and meaningful outcomes. Several examples include coordinated advocacy for the passage of an expanded newborn screening legislation, coordination with Vocational Rehabilitation on policy and practice to promote self-determination and transition planning for youth, and CSHCN Program staff participation in advocacy training and public policy development.

A greater emphasis will be placed on transition services by collaboration between state and local school systems, Division of Rehabilitation Services, medical care providers, social service agencies and the CSHCN Program. Transition screening forms will be revised and updated to better determine the needs of the adolescent and their family.

While there are a number of services and programs that are designated to assist people with disabilities in various facets of training and employment assistance, central easy access to these services across agencies and providers is lacking. A forum where stakeholders can work together to bring about change is needed.

A team of stakeholders continues to assist with the core design of the strategic planning process. This team consists of representatives from: The Bureau for Medical Services, Goodwill Industries of KYOWVA, WV Developmental Disabilities Council, Workforce WV, People's Advocacy Information and Resource Services Center, Bluefield State College, Office of Special Education Assistance, WV Mental Health Planning Council, Job Accommodation Network, the Center for Excellence in Disabilities (CED) and Division of Rehabilitative Services (DRS). Technical assistance is provided by the program staff of CED.

Varieties of assessments across different groups continue to be completed. The voices heard within the state from a wide audience (education, business, advocates and people with disabilities and their families) provides positive feedback, challenges and ideas for improvement.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	95	95	96	71	75
Annual Indicator	77.0	65.0	70.3	74.6	69.8
Numerator	21420	18380	20500	19800	14180
Denominator	27811	28270	29181	26553	20322
Data Source	2008 Immunization Data	2009 Immunization Data	2010 Immunization Data	2011 Immunization Data	2012 National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	70	70	70	70	70

Notes - 2012
2012 National Immunization Survey
4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Haemophilus influenzae type b (Hib) vaccine, and 3 or more doses of hepatitis B vaccine.
+/- 5.8

Notes - 2011
National Immunization Survey
2011 State Division of Immunization Services - individual immunizations: (DTaP-4: 84%, IPV-3: 92%, MMR-1: 90%, Hib-3: 92%, Hep B-3: 89%, and VAR-1 (chickenpox): 89%)

Notes - 2010
2010 National Immunization Survey
2010 State Division of Immunization Services - individual immunizations: (DTaP-4: 78.8%, IPV-3: 88.6%, MMR-1: 89.2%, Hib-3: 82.3%, Hep B-3: 88.3%, VAR-1: 86.9%)

a. Last Year's Accomplishments
The State's Division of Immunization Services is housed in the Office of Epidemiology and Prevention Services, Bureau for Public Health. This division works closely with local health departments, WIC, hospitals, the private practicing medical community, and other early childhood programs in an effort to get children fully immunized. The current immunization coverage rates from the National Immunization Survey (NIS) for children 19 through 35 months of age in West Virginia: 74% had been immunized for DTaP-4, 92% for IPV-3, 87% for MMR-1, 75% for Hib-3 and 86% for Hep B-3, and 88% for VAR-1 (chickenpox). The Division of Immunization Services worked with the WV Higher Education Policy Commission from 2006-2008 to develop a list of recommended immunizations for college enterers. WVCHIP enrollment materials and information were included in the State's Newborn Immunization Program packets to new mothers through the Right From The Start Coordinators.

In 2012, WV remained 44th among the states in overall immunization coverage of 2 year-old children at 62%.

There is a different measurement rate used now which includes the PCV13 (pediatric pneumococcal vaccine) in the coverage rate that was not included last year. That is only partly why the overall coverage rate is lower; the other reason is that fewer kids are getting vaccinated by age two. There are very disturbing drops in coverage in DTaP-4, MMR and Hep B-3.

In accordance with federal regulations and the Bright Futures standard, appropriate immunizations must be provided. In making certain that primary care providers are familiarized with the Bright Futures standard of care and medical home approach to comprehensive primary care, HealthCheck Program Specialists routinely emphasized the importance of assessing immunization status at each initial and periodic screen and (as a strategy to reduce fragmentation of care) administering vaccine(s) at the time of visit in medical home.

HealthCheck mailed individual letters to the parent(s) of HealthCheck clients on the clients' 11th birthday to raise awareness among beneficiaries of the importance of adolescent immunizations.

HealthCheck makes available to all health professionals (without charge) Vaccine Administration Records.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In 2011, WV remained 36th in the nation for completion of regularly scheduled immunizations coverage rates for 2 year old children.		X		
2. The EPSDT/HealthCheck Program encourages providers to offer immunizations as part of health care.				X
3. The RFTS Program collects data on whether or not infant participants (who are up to 12 months) are up to date on immunizations.				X
4. All women giving birth in WV receive an information packet including an immunization schedule before leaving the birthing facility.		X	X	

5. WV does not allow non-medical exemptions for immunizations.		X		X
6. Partnered with West Virginia's Immunization Network (WIN) to promote adolescent immunizations.		X		
7. Partnered with West Virginia's Immunization Network (WIN) to promote adolescent immunizations.		X		
8.				
9.				
10.				

b. Current Activities

The Division of Immunization Services is working to increase the number of providers who regularly report to the immunization registry, the West Virginia Statewide Immunization Information System (WVSIIS). Of the 405 providers of immunizations enrolled in the Vaccines for Children (VFC) Program, all are enrolled and have reported at least once to WVSIIS, but only 80-85% report regularly to the Registry. A Certificate of Immunization has been developed. The Certificate of Immunization has helped to improve preschool and school-age immunization levels by establishing a standard process by which children are given documents certifying receipt of age-appropriate immunizations. A uniform Certificate of Immunization will enable the consolidation of all valid immunization dates on one document that can be utilized by schools, child care centers and in other settings. The certificate is a tool used by the Division of Immunization Services as an ongoing effort to increase preschool and school immunization levels in West Virginia. VFC Providers in WV may now order vaccines online via the WVSIIS. Additionally, providers may manage inventory and generate vaccine usage reports, coverage rates, and reminder/recall messages from the registry.

c. Plan for the Coming Year

All women giving birth in WV receive an information packet including an immunizations schedule before leaving the birthing facility. WV does not allow either religious or philosophical exemptions to immunization requirements.

The Division of Immunization Services and the West Virginia Immunization Network (WIN), a statewide coalition of more than 200 public and private sector members who work to protect West Virginia's residents from vaccine-preventable diseases, have collaborated to implement the "Take Your Best Shot" campaign targeting adolescents for HPV, MCV, Tdap, chickenpox and Hep B vaccinations in 38 counties, up from 32 counties in 2011.

During the 2012 Legislative Session, the WV Legislature passed a resolution to study nonmedical exemptions to school immunization requirements. A public hearing as part of this study was held on Monday, June 25, 2012 at 5pm in the House Chamber.

States, where nonmedical exemptions are allowed, have seen reductions in their immunization rates and outbreaks of vaccine-preventable diseases as a result of these exemptions. Thus, the West Virginia Immunization Network (WIN) strongly opposes allowing nonmedical exemptions to school immunization requirements.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012

Annual Performance Objective	19	19	20	22	21
Annual Indicator	23.2	24.7	21.0	18.9	18.9
Numerator	779	814	690	615	615
Denominator	33640	32984	32903	32570	32570
Data Source	2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	2011 Vital Statistics	based upon 2011 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	18	18	18	18	18

Notes - 2012
based upon 2011 Vital Statistics

Notes - 2011
2011 Vital Statistics

Notes - 2010
2010 Vital Statistics

a. Last Year's Accomplishments
The Adolescent Pregnancy Prevention Initiative (APPI) influences and supports teens as they explore and determine responsible sexual and reproductive options for the future. Through the development, oversight and coordination of evidence based activities, APPI is able to influence WV's youth to make healthier choices. Last year, APPI conducted nearly 700 presentations reaching over 20,000 students. This included conducting evidence-based curricula within a variety of settings and presenting information in public school classrooms. In addition to providing resources for public school educators, APPI also administers a federal grant, the Personal Responsibility Education Program (PREP), which reaches students who are most at risk with the same prevention messages and evidence based materials through the use of community partners. The goal of both APPI and PREP is to reduce the number of pregnancies among adolescents using an abstinence-based approach while providing information and access to contraceptive services.

APPI Specialists work with family planning clinics and health departments to aid in the creation of teen friendly services at these facilities and provide input on ways to increase teen traffic.

APPI is the primary contact for state agencies and community groups regarding teen pregnancy prevention. As a result, APPI participates in at least 130 health related fairs and conferences annually. APPI staff is often requested to conduct presentations during these same events.

APPI conducted 700 presentations for students during last school year, which included, state mandated medically accurate comprehensive sexuality education as required by the Health Content, Standards and Objectives of the West Virginia Department of Education. APPI staff presented to 15,000 students in the 2012-2013 school year; and distributed 60,000 pieces of literature to parents and professionals across the state.

The Adolescent Health Initiative (AHI) administers West Virginia's Title V State Abstinence Education Grant Program. The AHI's vision for FY2012 included a comprehensive approach centered on an evidence-based curriculum program but also included extracurricular activities, media marketing, community-based events and parent trainings.

The AHI achieved the following objectives last year:
• OBJECTIVE I: Provided an abstinence curriculum (Promoting Health Among Teens) program to over 3,000 adolescents within the public school systems of the 12 counties noted in the following activities.
• OBJECTIVE II: Reinforced abstinence education to youth (12-18), young adults, parents, and other community members through at least 50 outreach activities per year across the State.
• OBJECTIVE III: Implemented at least 15 parent education activities per year to encourage parent/youth communication about the benefits of delaying sexual activity for youth.
The AHI's accomplishments last year include:
• Participated in statewide meetings for the Leadership to Prevent Teen Pregnancy Task Force;
• Sponsored a "night at the ballpark" in Bluefield, WV and provided attendees with information about abstinence, parental communication, etc;
• Developed posters and banners to provide health information to the community and raise awareness about available health resources;
• Sponsored a Life Skills Camp in Mercer County, WV;
•Sponsored a five day Teen Institute camp in Romance, WV. The camp is designed to teach middle school youth how to make positive life decisions and avoid risk behaviors;
• Sponsored a two day Teen Institute in Mason County, WV;
• Worked with Mission WV, a local non-profit, in applications for Teen Pregnancy Prevention, PREP and Community Based Abstinence Education federal funding;
• Provided educational information to over 700 parents and other adults on teen risk behaviors, building self-esteem, communication and healthy relationships;
• Developed a Public Service Announcement (PSA) encouraging parents to talk to their teens about sex. The PSA aired in up to 67,850 homes with 175,732 potential viewers in southern West Virginia;
• Facilitated community-based teen pregnancy prevention meetings in several WV counties;
• Provided trainings for teens and parents on "sexting" and it's social, emotional and legal impacts;

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Adolescent Pregnancy Prevention Specialists conducted numerous community education and outreach activities on a regional/local level.		X		
2. Conducted school presentations at WV schools distributing over 100,000 pieces of literature and participated in 75 health related community events, fairs and confernces.		X		
3. Recognized and promoted "National Teen Pregnancy Prevention Month".			X	
4. Recognized and promoted “Let’s Talk Month”.			X	
5. Free family planning services are available at 163 locations.		X		

6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Adolescent Health Initiative (AHI) and the Adolescent Pregnancy Prevention Initiative (APPI) continue to work together to address teen risk factors such as alcohol, drugs, tobacco and early sexual activity. Using evidence based curricula AHI and APPI partner with federal grantees to provide both in-school and community based education for teens and parents statewide. APPI serves as the state's lead in teen pregnancy prevention, providing resources and facilitating trainings for educators, parents and teens. AHI assists by also providing services that include alcohol, drug and tobacco prevention, violence prevention, as well as life skills and character development education. AHI programs provided parent seminars on how to effectively communicate with teens regarding healthy choices and teenage behavior trends.

APPI has organized and supported the Leadership to Prevent Teen Pregnancy Taskforce since 2000. This group is a statewide initiative of committed individuals and organizations that focus on encouraging medically accurate, age appropriate, sexuality education and promoting healthy informed reproductive life planning for teens. The goal is to reduce the number of unplanned, unwanted teen pregnancies. AHI grantees, staff and director are active members of the LPTP Taskforce.

c. Plan for the Coming Year
AHI and APPI will continue to work together to provide resources for parents, schools and communities seeking to increase protective factors and reduce adolescent risk behavior. AHI will provide trainings on topics such as adolescent brain development/decision making, the over-sexualization of youth in the media and in society, and the dangers of social media. AHI will continue to provide the evidence-based abstinence curriculum, Promoting Health Among Teens within select counties.

APPI will continue to work in public schools and with community organizations statewide to provide comprehensive sexuality education with a focus on the prevention of teen pregnancy and the education of youth and parents about the importance of reproductive life planning.

APPI also will work closely with Title-X Family Planning providers and clinics to assist in making facilities "teen friendly". APPI staff and Family Planning Specialists will work together to help clinics and providers understand the special needs of adolescent patients. APPI will assist clinics in planning events and activities to attract teens to clinics to receive services.

The Adolescent Health Initiative will continue to serve as a statewide resource for schools and communities seeking to increase protective factors and reduce adolescent risk behavior. The AHI will provide trainings on topics such as adolescent brain development/decision making, the over-sexualization of youth in the media and in society, and the dangers of social media.

The AHI will continue to educate parents, youth and communities about the importance of teen pregnancy prevention including its economic and societal impacts, particularly in rural areas entrenched in generational poverty. The AHI will also provide information about the legal impacts of early sexual behavior such as the age of sexual consent and "sexting."

The AHI will continue to provide within the public the evidence-based abstinence curriculum, Promoting Health Among Teens within school system and to other youth serving, after school

community groups in coming year.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	30	57	57	30	30
Annual Indicator	56.1	56.6	29.0	29.0	29.0
Numerator	11500	11600	8250	8250	8250
Denominator	20485	20485	28416	28416	28416
Data Source	Health Care Authority	CMS 416	ASTDD	ASTDD	ASTDD
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	30	30	30	30	30

Notes - 2012
based upon 2010 Oral Health random sample
denominator is estimated number of third graders in state

Notes - 2011
based upon 2010 Oral Health random sample
denominator is estimated number of third graders in state

Notes - 2010
2010 Oral Health random sample
denominator is estimated number of third graders in state

a. Last Year's Accomplishments
The WV Oral Health Program hired a Dental Sealant Coordinator through Marshall University to develop and implement a statewide dental sealant plan. The plan was designed to build upon the WV-School-Community Partnership Program with the goal of increasing the number of third grade children receiving protective sealants. In the past year the number of children receiving sealants increased by 37% 649 in 2010-2011 compared to 887 in 2011-2012).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Six mobile dental clinics were held providing preventive services and two clinics were Missions of Mercy providing		X		

preventative and restorative dental services at no charge.				
2. Six local health departments offer dental education and four provide preventative oral services.		X		
3. CDP provides oral health education which includes information on sealants.			X	
4. 18 community-based dental clinics where dental services are provided free or at reduced cost.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OHP works with 29 communities in WV that received grant funding though a partnership between the Appalachian Regional Commission (ARC) and the Claude Worthington Benedum Foundation. The goals of the program are to increase the number of children receiving preventative dental services, such as sealants and fluoride treatments, and to increase the number of children with a dental home. In the 2011-2012 school year, a total of 4359 children in 27 counties from 104 schools received an initial screening. Of those children, sealants were prescribed for 3016 children with 887 children having sealants applied.

c. Plan for the Coming Year

OHP will continue the expansion of the Sealant Program statewide. The Program plans to add six new schools in the State that will provide dental sealants to at risk children. The program also plans to create a school based dental sealant policy and procedure manual that will indicate the State guidelines for school-based sealant programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	3.9	4.5	3	1.5	3.5
Annual Indicator	3.5	1.9	3.8	2.5	2.5
Numerator	11	6	12	8	8
Denominator	316986	318634	319121	317471	317471
Data Source	2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	2011 Vital Statistics	based upon 2011 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	2.5	2.5	2.5	2.5	2.5

Notes - 2012
Based upon 2011 Vital Statistics

Notes - 2011
2011 Vital Statistics

Notes - 2010
2010 Vital Statistics

a. Last Year's Accomplishments
Due to the positive partnerships established over the previous year, the Violence and Injury Prevention Program (VIPP) was asked to provide technical assistance to numerous public and private agencies regarding motor vehicle safety for children ages 0-14. The Program distributed, upon request, educational materials and other resources to schools, county health departments, community centers, law enforcement agencies, and various other organizations. The VIPP continued to strengthen its relationship with the Governor's Highway Safety Program, and now receives the most up to date crash statistics specific to WV, as well as current and future prevention initiatives planned throughout the State.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Department of Education/Health Education Assessment Project to calculate student health knowledge of seat belts and other safety issues.		X		
2. The EPSDT Program provides anticipatory guidance to parents regarding childhood injuries.		X		
3. Adolescent Health Coordinators and others provide classroom injury prevention instruction.		X		
4. Home Visitation Program and RFTS Program promote infant/toddler car seat and seat belt usage with children		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
On June 1, 2013, WV legislation changed the offense of failure to wear a safety belt to a primary offense, to require that all passengers regardless of age be restrained by a seat belt or child passenger safety device system. This allows officers to stop a motorist for not wearing a safety belt even without observing another violation.

The VIPP partnered with the WV Director of the Governor's Highway Safety Program and provided a track of training workshops for participants at a two day Statewide meeting of

prevention professionals. As a result of this collaboration and positive support, a workgroup focused on preventing childhood injuries has been established and is in the process of developing a strategic plan of action to reduce deaths of children ages 0-14 as they relate to motor vehicle crashes. This group is part of the State Violence and Injury Prevention Coalition that will meet in August 2013 to decide upon specific priorities, target areas of need, and plan prevention activities accordingly.

c. Plan for the Coming Year

The VIPP plans to continue to strengthen the partnership with the Governor's Highway Safety Program, as well as other Motor Vehicle Related Professions, to raise awareness of and provide further education on the enforcement of the primary seatbelt law and collaborate in future prevention activities. There will be a section of the VIPP's State Strategic Plan that will focus on motor vehicle safety. Specific goals, objectives and actions necessary to achieve success will be included as well as benchmarks and measures of effectiveness.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	60	35	35	35	29
Annual Indicator	34.0	25.9	26.2	28.1	28.1
Numerator	7310	5500	5350	5730	5730
Denominator	21492	21225	20391	20391	20391
Data Source	2008 PRAMS	2010 NIS Breastfeeding Report Card	2011 NIS Breastfeeding Report Card	2012 NIS Breastfeeding Report Card	based upon 2012 NIS Breastfeeding Report Card
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or				Final	Provisional

Final?					
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	29	29	29	29	29

Notes - 2012
based upon 2012 NIS Breastfeeding Report Card

Notes - 2011
2012 NIS Breastfeeding Report Card

Notes - 2010
2011 NIS Breastfeeding Report Card

a. Last Year's Accomplishments
The West Virginia Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is dedicated to informing families about the importance of breastfeeding - both as the optimal source of nutrition and for a child's improved growth and development. WIC provides breastfeeding promotion and encouragement for pregnant women who are considering how best to care for their babies. WIC also provides on-going breastfeeding information and support for new mothers after baby has arrived.

WIC is dedicated to building support for the practice of breastfeeding among entire communities - health care providers, employers, neighbors, churches. WIC publishes Breastfeeding Update, a newsletter for health care professionals with clinically useful breastfeeding information. Social marketing research for the WIC Program has shown that support from those in their communities gives women the confidence and pride to begin and continue to breastfeed their children.

While the latest data on breastfeeding indicates that a low percentage of women choose to breastfeed their infants, this should not be taken as an indication of little effort on the part of the State's Bureau for Public Health or, in particular, the Office of Maternal, Child and Family Health (OMCFH). All pregnant women participating in the RFTS Program, the state's Medicaid perinatal home visiting program, receive information about the benefits of breastfeeding their infants. DCCs offer breastfeeding education and support to prenatal participants through sixty days postpartum and to breastfeeding mothers of eligible infants until their infant reaches age one year.

Educational tools such as videos, DVDs, brochures, "The Pregnancy Workshop" and medical models were available to RFTS DCCs for use on home visits to promote breastfeeding. A DVD player was used by each RFTS DCC in order to more effectively provide client education in their homes.

RFTS DCCs have had access to the use of standardized step-by-step prenatal curriculum which includes education on breastfeeding. The curriculum is entitled "The Pregnancy Workshop" and "Planning A Healthy Pregnancy" has been available to each DCC at no cost. In 2010, it was decided that the RFTS Program would benefit from more standardized, evidence-based curriculum. Therefore, the OMCFH purchased the evidence-based "Partners for a Healthy Baby" curriculum developed by Florida State University. All RFTS providers were trained on how to use the curriculum in 2011 and it has been implemented statewide.

RFTS Program participants have experienced a fairly steady increase in the number of moms who choose to breastfeed their infants at hospital discharge (33%) and those who continue to breastfeed at case closure (16%). In the 2011/2012 National Survey of Children's Health 62.6% reported that they have ever breastfed their child ages 0-5 compared to the Nationwide response of 79.2%.

OMCFH is a member of the WV Breastfeeding Alliance (WVBA) which strives to improve the health of West Virginians by working collaboratively to protect, promote, and educate our community about breastfeeding. A one day conference was held in Charleston on May 18, 2012, titled "Connecting the Pieces: Obesity, Diabetes and Breastfeeding". Over 150 healthcare professionals attended the meeting and learned about the link between breastfeeding and the prevention of disease in later life.

The WVBA also recognizes employers annually with the Breastfeeding Employer Recognition Awards. The two (2) categories are Breastfeeding Supportive Worksite and Outstanding Breastfeeding Supportive Worksite. Businesses that qualified as being Breastfeeding Supportive met the basic criteria as outlined in new federal guidelines from the Department of Labor. Businesses that qualified as Outstanding met that minimum criteria, plus offered additional benefits to moms like a place for milk storage, access to an electric breast-pump, etc., and had a policy in place to inform mothers of this option.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The WIC Program strongly supports and promotes breastfeeding.		X		
2. WIC goals include providing additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physicians' practices in order to keep mothers breastfeeding longer.				X
3. WIC increased income guidelines to allow more women, infants and children to qualify.				X
4. RFTS collects data on prenatals who are breastfeeding at hospital discharge, and how many continue to breastfeed at case closure.				X
5. All women participants in RFTS receive benefits of breastfeeding information.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Pregnant RFTS Program participants are encouraged to breastfeed and are educated on health and socioeconomic benefits such as how human milk meets the specific needs of human babies and changes with growth to offer the best combination of nutrients.

Women are educated about the health benefits for themselves associated with breastfeeding including reduction of postpartum blood loss, increased postpartum weight loss with no return of weight once weaning occurs, possible delay of fertility, need for reduced insulin in diabetic mothers, psychological benefits of increased self-confidence and enhanced mother/infant bonding, reduced risk of breast, ovarian and endometrial cancers, reduced risk of osteoporosis and bone fracture.

The social and economic benefits of breastfeeding for families are emphasized by RFTS Program DCCs such as saving several hundred dollars when the cost of breastfeeding is compared to the cost of using formula. Breastfeeding is convenient and safer because breast milk is always

available at the correct temperature, is sterile, and requires no mixing.

The RFTS Program encourages collaboration with WIC offices statewide to ensure participants continue to receive breastfeeding education and support after case closure. In 2011, the Program continued active involvement with WV WIC in a collaborative strategic planning effort to develop a cross-referral system for service integration and coordination.

In 2012 RFTS staff received certified lactation training.

c. Plan for the Coming Year

Because children are healthier when they are fed breast milk exclusively for the first six months, WIC continues to encourage fully breastfeeding for that time period. The WIC Program provides for an increased food package to breastfeeding women who use no commercial formulas from WIC. We also know that infants are less likely to die from sudden unexplained death syndrome who are breastfed.

Trained WIC nutritionists, board-certified lactation consultants and breastfeeding peer counselors are available at all local WIC clinics to help mothers, and entire families, learn how to have a satisfying and healthy breastfeeding experience.

The WIC Program has board-certified lactation consultants on staff to act as breastfeeding information resources in their communities.

WIC's 2013 State Plan provides for additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and other health care providers in order to assist the medical community in helping the mother to initiate and continue to breastfeed longer.

The RFTS Program will continue to provide educational materials on breastfeeding such as videos, pamphlets, and literature for DCCs to use during home visits. RFTS DCCs promote breastfeeding with each prenatal participant and provide support and referrals as needed. RFTS will continue to train DCCs on the benefits of breastfeeding and how to encourage participants to try breastfeeding as their choice for infant feeding.

RFTS is committed to increasing breastfeeding rates throughout WV and promoting optimal breastfeeding practices. This goal can be achieved through the existing RFTS Program network by supporting breastfeeding mothers, their families, communities, employers, and health care providers by providing education, training, funding, technical assistance, and research.

Women can be encouraged to breastfeed longer into the postpartum period by being educated to seek assistance from local support groups, other mothers who have successfully breastfed and from their local WIC lactation consultants.

The Director of Perinatal Programs and the RFTS RCCs will continue collaborative efforts with staff of the WV Office of Nutrition Services to ensure that local WIC offices refer clients to the RFTS Program and work effectively with DCCs.

OMCFH is working with the Brease Feeding Alliance to sponsor a breast feeding summit for hospital based health care professionals.

OMCFH also funds the WV Perinatal Partnership, Provider Outreach and Education, which includes provider training on lactation support.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	99	99	99.1	99.2	99.2
Annual Indicator	99.0	96.1	96.5	97.4	97.8
Numerator	21233	20461	20051	20421	20695
Denominator	21443	21299	20781	20959	21152
Data Source	Birth Score Office	Birth Score Office	Birth Score Office	Birth Score Office and Vital Stats	Birth Score Office and Vital Stats
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	98	98	98	98	98

Notes - 2012
2012 WVU Birth Score Data - occurrence births screened before hospital discharge and 2012 Vital Stats occurrence births

Notes - 2011
2011 WVU Birth Score Data - occurrence births screened before hospital discharge and 2011 Vital Stats occurence births

Notes - 2010
2010 WVU Birth Score Data - occurrence births screened before hospital discharge

a. Last Year's Accomplishments
The OMCFH contracts with the WVU Birth Score Office (BSO) to administer, collect and analyze information/data submitted by delivering facilities. Newborn hearing screening results at WV birthing facilities are collected on the Birth Score Card (BSC), an instrument designed to capture information on infants who may be at risk of developmental delay or death within the first year of life. The BSO has the capability to compare WV Vital Statistics birth records to determine those infants missed for a birth score assessment and hearing screening as well as determining, from data submitted, which infants failed the hearing screen. In an effort to reduce loss to follow-up, the responsibility for the initial tracking of newborn hearing screening changed effective March 1, 2012 from the the RFTS Program to the BSO who now provides the initial follow-up for those infants who are not screened or failed a screen at birth. Since the BSO is the first agency to receive results of the newborn hearing screen, they are able to contact families in a more timely manner. Previous follow-up was at 63% and evaluation of the effectiveness of the change will occur in 2013. The BSO contacts the parents/guardians of the infant and/or the primary medical provider to facilitate the screening or re-screening of the infant's hearing. If the infant fails the second screening, the BSO sends a referral to the State's Perinatal Program, RFTS, for follow-

up. Comprehensive services for infants and families referred following screening failure are coordinated between the infant's family, medical team, the NHS Coordinator, RFTS and professionals with expertise in hearing loss to assure diagnostic evaluation occurs in a timely manner. Infants identified as having a potential hearing loss begin audiological and medical evaluations before 3 months of age or 3 months after discharge for NICU infants. Infants with hearing loss upon audiological evaluation receive otologic evaluations. The family and child are referred to Ski*Hi, Birth To Three Program (BTT) and Children with Special Health Care Needs (CSHCN) by RFTS DCCs or the primary medical provider. Ski*Hi is funded through the WV Schools for the Deaf and Blind - Ski*Hi Preschool Program. Children ages birth to five who have a documented hearing loss are eligible for Ski*Hi home visits at no cost to the parents. The goal is to identify and provide care to 100% of WV infants needing services.

Birthing facilities in WV continued to utilize the loaner Otoacoustic Emission (OAE) screeners purchased by the NHS Project for use during periods of equipment failure. This provided assistance in the reduction of infants missed before discharge and lessened the chance for infants to be lost to follow-up due to missed screenings. A total of one (1) WV birthing facility utilized the loaner equipment in 2012.

An assessment of Audiological and Ear, Nose and Throat (ENT) provider availability found that WV has seven (7) audiologists and ENT providers capable of diagnosing infants. This ensured that parents, by way of health care professionals and RFTS DCCs, were provided knowledge of the most current audiology services available. Providers were polled periodically and the web-based Audiology Service Availability Guide was updated to ensure the availability of up to date information. Working with an audiologist experienced in infant diagnostics; efforts began to offer users of the Guide a tiered system of audiological practices indicating which practices offer diagnostics versus screening for infants. The goal is to reduce the number of repetitive screenings an infant receives prior to being referred for diagnostic testing. The web-based version of the Audiology Service Availability Guide is linked to the RFTS and NHS Project websites. The Guide includes a map of WV that incorporates county specific service availability as well as those in bordering states.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All WV birthing facilities are required to screen infants for hearing loss before discharge.			X	
2. Infants identified with a hearing loss are referred to the CSHCN Program for assistive devices.		X		
3. OMCFH purchased and maintains diagnostic equipment to assure access/availability as loaner equipment and shared hospital equipment.				X
4. Redesigned and updated NHS website.				X
5. Educational literature is created and distributed to providers and parents.		X		
6. Maintain Advisory Board members per WV state code.				X
7. RFTS DCCS contact families of infants who missed/failed initial screens.	X			
8.				
9.				
10.				

b. Current Activities
The NHS Project is focusing on assuring that 100% of infants born in WV are screened for hearing loss prior to discharge from a birthing facility or within the first month of age. This minimizes the number of infants not screened and decreases the number of cases referred to the BSO and RFTS for follow-up as well as those infants and families lost to follow-up. All thirty-one birthing facilities have a minimum of two trained staff with competence in screening and referral protocols. Border hospitals continue to refer WV newborns to the BSO where all infants not screened/failed screening are being tracked and referred for follow-up services.

WV resident infants born at home receive a follow-up for screening and referral for audiological services if indicated. The NHS Project created and maintains formal relationships with organizations that support newborn hearing screening activities, such as the WV Speech & Language Association.

In 2012, the WV NHS Project Coordinator was asked to continue participation with WV Hands & Voices (WVH&V). Hands & Voices is a nationwide non-profit organization dedicated to supporting families and their children who are deaf or hard of hearing, as well as the professionals who serve them. Hands & Voices is a parent-driven organization that is unbiased towards communication modality or methodology.

c. Plan for the Coming Year
In 2012, the NHS Project was chosen as one of six (6) states and territories to participate in a Community of Learners (COL) with the National Center for Cultural Competence (NCCC) and the National Center for Hearing Assessment and Management (NCHAM) focused on increasing cultural and linguistic competency in early hearing detection and intervention programs. Training on cultural and linguistic competence for service providers in WV was developed with the material learned in this COL and will be presented throughout 2013.

At minimum, it is anticipated that 90% of early intervention practitioners and RFTS DCCs will receive training in addressing intervention for children with hearing loss. Parent information, letters, brochures and resource guides will be available in 2 languages. The Audiology Service Availability Guide will be updated quarterly and a web-based resource directory will be maintained. All children with hearing loss and their families will be connected with local or regional family-to-family support networks. The OMCFH will collaborate with the Commission for the Deaf & Hard of Hearing to increase capacity of trained interpreters serving in the State. The NHS Project will continue to research and implement specific strategies aimed at reducing the number of WV infants and families who are lost to identification and follow-up care through coordination and collaboration with the NHS Advisory Committee, RFTS, birthing facility personnel, audiologists, Early Intervention/Part C, Children with Special Health Care Needs (CSHCN) and primary care providers. Some strategies that will be considered are, improving the timeliness in the receipt of birth records from Vital Statistics sent to the BSO; discussion of how to improve follow-up in remote areas; scripting a culturally competent message for RFTS to use when contacting the family; and evaluating referral processes to increase the availability of family contact information. The success of these strategies will determine the next steps aimed at reducing the number of infants who are either not screened or lost to follow-up.

In 2012, each birthing facility was requested to validate contact personnel and identify issues/concerns with the screening and referral process. Again in 2013, NHS staff, RFTS and the BSO will conduct annual or as needed site visits to the hospitals to discuss compliance issues and review reporting/referral protocols. Through the BSO, NHS will continue to monitor changes in procedure to direct hospital staff to verify contact information and the identity of the primary care provider or clinic for those infants who do not pass or do not receive an initial hearing screen before discharge from their facility.

The NHS Project will continue to convene regular meetings of the NHS Advisory Committee. The

Committee will continue to act as the primary collaborative structure for the NHS Project and address overall goals and future efforts.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4.3	4.2	4.5	4.5	4.5
Annual Indicator	4.5	5.0	5.0	4.7	4.6
Numerator	19057	21300	21300	19900	19800
Denominator	427879	427879	427879	427879	427879
Data Source	2008 CHIP Annual Report	2009 CHIP Annual Report	2010 CHIP Annual Report	2011 CHIP Annual Report	2012 CHIP Annual Report
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	4.5	4.5	4.5	4.5	4.5

Notes - 2012
2012CHIP Annual Report: The 4.65% uninsured total number for children in lower income (=250% FPL) households is an estimate from the most current (2009) US Census Current Population Survey. This data is based on two year rolling averages.

Notes - 2011
2011CHIP Annual Report: The 4.65% uninsured total number for children in lower income (=250% FPL) households is an estimate from the most current (2009) US Census Current Population Survey. This data is based on two year rolling averages.

Notes - 2010
CHIP 2010 Annual Report
Note 1: The most recent estimate for all uninsured children statewide from the U.S. Census Current Population Survey is from 6.3% to 5%. Even a five percent extrapolation at the county level may vary significantly from county to county depending on the availability of employee sponsored insurance. However, it remains our best gross estimate of the remaining uninsured children.

Note 2: It has been estimated that 7 of 10 uninsured children qualify or may have qualified for CHIP or Medicaid in the past, WVCHIP uses the lower estimated limit of 5% as a target number for outreach due to the way census sampling is likely to overstate this rate.

a. Last Year's Accomplishments
In 2012, the most recent U.S. Census data shows West Virginia is among the states with the lowest rates of uninsured children.

Congress passed the Affordable Care Act (ACA) which was signed into law on March 23, 2010. Healthcare reform will impact WVCHIP significantly. While the bill extends CHIP appropriations through 2015, it also increases the federal share for the program from 2016 through 2019. WVCHIP will be virtually 100% federally funded during this time. One major impact of healthcare reform is the increase in the income eligibility limit for children served by the state Medicaid program. Effective January 1, 2014, the upper income limit for Medicaid children will increase to 133% FPL (regardless of the state's decision to expand Medicaid eligibility to the adult population). This increase means many children that are now income eligible for WVCHIP will transfer enrollment to Medicaid (currently estimated at 11,900), some Medicaid children will become eligible for WVCHIP, and some WVCHIP and Medicaid children will become eligible for Advanced Payment Tax Credits (APTC) through the exchange. Other impacts of the ACA are still being determined.

2012 was one of intensive activity for WVCHIP with implementing a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC), supporting work under the "Tri-State Children's Health Improvement Consortium", a multi-state grant focused on improving the quality of health care provided to children, and ongoing activities necessary to implement healthcare reform under the Affordable Care Act (ACA).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State leaders promote SCHIP and increasing enrollment.				X
2. WVCHIP approved expansion of elgibility to 300% FPL.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WVCHIP continues to work with many types of community partners and entities as identified in its State Plan, however, as enrollment has stabilized, efforts to promote public awareness of the program have shifted from an enrollment focus to one of promoting child health awareness and prevention messaging on topics such as childhood health screening, child development, immunizations, and the importance of a medical home.

Based on health insurance survey data from the U.S. Census Bureau's "2010 Annual Social and Economic Supplement," WVCHIP continues to prioritize outreach efforts to the top fifth of our counties in the State with either higher estimated numbers or percentages of uninsured children.

WVCHIP continues to make application and program information available through its 1-877-982-2447 toll-free Helpline, which averages over 1,700 calls a month and mails out about 400

applications a month. Information is also available through the agency's website at www.chip.wv.gov where program guidelines and applications can be downloaded and printed.

WVCHIP turns to the WV Healthy Kids and Families Coalition (WVHKF), a group of community and faith-based organizations able to conduct outreach throughout the State. The WV Council of Churches serves as the fiscal agent for this group which also includes local community health centers, school nurses, child care agencies, and faith based community programs among others.

c. Plan for the Coming Year

The CHIP Annual report incorporates some of the provisions of PPACA, a product of the Health Care Reform ("HCR") Bill. PPACA includes a large number of health-related provisions to take effect over the next several years, particularly, an additional two years extension to CHIPRA reauthorization through September 30, 2015, the expanding Medicaid eligibility starting on January 1, 2014 and an increase in Federal funding participation in FY 2016 through 2019. At this time, the actual timetable of the PPACA is uncertain.

Effective January 1, 2014, Medicaid eligibility will expand to individuals and families with income up to 133% FPL. CHIP has assumed that approximately 11,433 children in WVCHIP Gold will move to Medicaid under the HCR Bill. The CHIP Program will serve the remaining children up to 300% FPL. In addition, the HCR Bill addresses a 23% increase in Federal participation for FY 2016 through 2019, which would make the CHIP Program 100% federally funded starting October 1, 2015, the first day of Federal FY 2016. The benefit structure for current WVCHIP Premium enrollees has significant cost sharing compared to the benefit structure for children of families under 200% FPL.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	23	25	28	28	30
Annual Indicator	27.4	28.1	29.9	30.3	23.2
Numerator	5169	5407	4943	4883	3562
Denominator	18835	19266	16559	16124	15378
Data Source	2008 WIC Data	2009 WIC Data	2010 WIC Data	2011 WIC Data	2012 WIC Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	23	23	23	23	23

Notes - 2012

2012 WIC data

Notes - 2011
2011 WIC data

Notes - 2010
2010 WIC data

a. Last Year's Accomplishments
Budgeting for families, Sesame Street's Healthy Habits for Life multimedia outreach kits, are distributed to WIC families. The kit consists of an original DVD and storybook starring the Sesame Street Muppets, featuring "The Get Healthy Now Show" that encourages parents with the help of their friends, to explore ways to eat and drink so they can play, learn, and grow up healthy. It also includes a guide for parents and caregivers that contain strategies and hands-on activities for everyday and on the go using their food dollar wisely.

The WV WIC program has developed and implemented online nutrition education. The purpose of the website is to help WIC participants learn more about feeding their child such as providing regular meals and snacks, working with picky eaters, creating a positive eating environment, and the roles of the parent and the child in the feeding relationship.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC supports healthy nutrition and breastfeeding.	X			
2. WIC increased income guidelines to allow more women, infants and children to qualify.		X		
3. Since 1974, WIC has combated childhood hunger, low birth weight, under-nutrition, and iron deficiency anemia so that WIC participants have better health outcomes.		X		
4. New WIC food choices encourage breastfeeding and support infant feeding practices recommended by the American Academy of Pediatrics.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WIC participants receive individual and group nutrition education, breastfeeding support, referrals to health care providers, assistance with making healthy lifestyle choices, and help with immunizations. The Special Supplemental Nutrition Program for Women, Infants and Children provides participants with certain healthy foods for free, and offers assistance in planning low-cost healthy meals that include foods high in essential nutrients and vitamins.

State staff have started training local agency vendor liaisons, community outreach liaisons, nutritionists and outreach coordinators through face-to-face visits to authorized vendors. The training and technical assistance have the goal of developing a store specific product list that serves as a reference for cashiers and a participant education tool. In addition, shelf tagging while simultaneously correcting the store computer system offers the ability to facilitate change quickly. This method also allows a direct, hands-on teaching approach for vendors as well as WIC staff in gaining understanding in how the shopping experience can be overwhelming to WIC participants.

c. Plan for the Coming Year
WV WIC continues to partner with the WV Nutrition Network and the Pick A Better Snack promotion. Implementation of the expanded WIC Food Packages will continue to present opportunities to reinforce nutrition messages. Partnership with the National Dairy Council to promote Low Fat Dairy by distribution of Dairy Council Nutrition Education Information and Materials. WV WIC State Office developed a handout about low fat milk-why low fat milk is offered, tips on gradually weaning to lower fat milk and then to skim milk and will continue to use this handout.

Bulletin boards and displays for the clinic and in the community will promote trying a new food. The State Agency will develop nutrition topic tool open discussion questions as an additional resource for promoting trying a new food. Operational assistance funds will be requested to support cooking demonstrations and taste testing during these sessions.

In FY 2013 WV WIC will address obesity, portion sizes and eating healthy with the message "Build a Healthy Plate Wherever You Go". This goal is a new goal for 2013.

The West Virginia WIC Program will work with partners, USDA, NWA to provide nutrition education materials, information, ideas, and recipes to be distributed to WIC Participants.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	26	26	28	27	30
Annual Indicator	28.7	28.9	30.5	28.9	28.9
Numerator	6165	6140	6250	5410	5410
Denominator	21492	21225	20471	18737	18737
Data Source	2008 PRAMS	2009 PRAMS	2010 PRAMS	2011 PRAMS	based upon 2011 PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	28	28	28	28	28

Notes - 2012
based upon 2011 PRAMS

Notes - 2011
2011 PRAMS

Notes - 2010
2010 PRAMS data

a. Last Year's Accomplishments

PRAMS data for 2011 indicates that 28.9% of pregnant women smoke during the last three months of pregnancy.

WV has the highest smoking rate for pregnant women in the United States. Data from the WV Health Statistics Center show that the rate of smoking during pregnancy in WV for 2010 was 26.2% vs. the National rate of 9.4% in 2010. This was a decrease from 27.3% in 2009. Data collected by the Right From the Start Program in 2012 show 29% of pregnant participants had Carbon Monoxide (CO) confirmed rates consistent with that of a smoker. In response WV continued to provide SCRIPT services, the intensive smoking cessation initiative.

During 2012 the RFTS SCRIPT Project continued to collaborate with the WV Division of Tobacco Prevention and the WV Tobacco Quitline to increase Quitline referral, utilization and ultimately, cessation outcomes. In 2011 the WV Tobacco Quitline enrolled 8,074 participants; 269 of these participants were pregnant women. Of the enrolled pregnant women, 91 were Medicaid insured (33.8.1%). During 2012 the WV Tobacco Quitline enrolled 10,354 participants and 318 of these participants were pregnant women. Of the 318 pregnant women enrolled, 146 were Medicaid insured (45.9%). In 2011, 22 pregnant women enrolled in the Quitline were referred from RFTS and in 2012 the number increased to 44.

In 2012-13 home visiting agencies, through the Home Visitation Program, received professional development opportunities on smoking cessation resources to offer clients.

A Mommy Quit for Me Brochure and Tobacco-Free Pregnancy Factsheet were developed and distributed to physicians and facilities that care for pregnant women.

The Division of Tobacco Prevention hosted a Smoking and Pregnancy Expert Panel meeting with numerous policy makers, health care professionals, prevention specialists and educators to begin development of a state level strategic plan for smoking and pregnancy. The draft document has not yet been developed or released for comment.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented the Smoking Cessation Program (SCRIPT) in January, 2002 and is ongoing.				X
2. WV SCRIPT uses the existing home visitation network and protocols in the RFTS Program.				X
3. Information about negative effects of smoking during pregnancy is distributed to all women.			X	
4. SCRIPT is provided to all willing RFTS/HAPI participants.		X		
5. Smoking information is collected in on all RFTS participants.				X
6. All RFTS smokers/former smokers are offered CO Testing.		X		
7. State government maintains Tobacco Quit Line.				X
8.				
9.				
10.				

b. Current Activities

The Tobacco-Free Pregnancy Initiative educates women of child-bearing age as well as those who are pregnant on the dangers of using tobacco and educates healthcare providers on the urgent need for face-to-face tobacco cessation counseling.

Recent studies show a 26.2% smoking rate among pregnant women in WV which is almost triple the 11% national rate.

In addressing this crisis, the Cessation Program is funding several programs focusing on pregnant women. Among them is "Tobacco Free for Baby and Me," housed in the high-risk OB Clinic at Charleston Area Medical Center's Women's and Children's Hospital in Charleston. The program has provided tobacco cessation services and cessation education to scores of pregnant women.

The WV DHHR Office of Maternal Child and Family Health offers tobacco cessation counseling during in-home visits through the Right From the Start Program.

The WV DHHR Women's Infants and Children's (WIC) Program partners with the Cessation Program by distributing cessation educational materials through the 55 clinics throughout West Virginia.

The Division of Tobacco Prevention Cessation Program supports a Tobacco Free Pregnancy Advisory Council as part of the Tobacco Free Pregnancy Initiative. This Council meets several times a year to address the epidemic.

OMCFH is funding a smoking during pregnancy media campaign with the Division of Tobacco Prevention.

c. Plan for the Coming Year

Although the RFTS provides smoking cessation education to numerous low income pregnant women and their families, more than half of WV pregnant women are eligible for this support and for public assistance.

The RFTS Program will continue to provide smoking cessation education and support to pregnant women and their families on the dangers of smoking during pregnancy and the importance of maintaining a smoke free environment. Designated Care Coordinators will continue to use the 5 A's best practice method and a CO monitor to provide a visual message of the dangers of smoking during pregnancy.

OMCFH programs will continue to work with the Division of Tobacco Prevention on the Smoking and Pregnancy State Plan.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance	7.5	6.5	8	8	8

Objective					
Annual Indicator	9.4	9.3	8.3	12.0	12.0
Numerator	11	11	10	14	14
Denominator	116745	117968	120092	117105	117105
Data Source	2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	2011 Vital Statistics	based upon 2011 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	11	11	11	11	11

Notes - 2012
based upon 2011 Vital Statistics

Notes - 2011
2011 Vital Statistics

Notes - 2010
2010 Vital Statistics

a. Last Year's Accomplishments
The The Violence and Injury Prevention Program (VIPP) provided funding for and participated in the planning and implementation of an educational campaign, along with the West Virginia Council for the Prevention of Suicide and the Adolescent Suicide Prevention and Early Intervention Project, that focused on adolescent bullying and how it relates to suicide. In addition, the VIPP provided funding for and co-sponsored a Statewide Suicide Prevention Conference. The VIPP also partnered with the WV Council for the Prevention of Suicide and the ASPEN Project to aid in the implementation of the Jason Flatt Act, passed in March 2012. This act requires teachers to be trained in recognizing the signs of depression and risk factors for suicide.

The VIPP was accepted into the Children's Safety Network's Community of Practice on Youth Suicide Prevention. The VIPP Director was chosen as West Virginia's team leader. The endeavor's end result was the creation of an action plan to reduce suicide among West Virginia youth.

The Adolescent Health Initiative (AHI) partnered with several agencies, community based groups and schools to support evidence based prevention and provide educational opportunities on the topic of teen depression and suicide. In partnership with Westbrook Health Services and the Office of Healthy Schools, the AHI helped develop the educational program Schools Tackling At-Risk Situations. A workbook was created to be included in the schools' existing health class. The lessons include basic information on the topic, warning signs, how to get help, and ways to handle the issues that may lead to a high-risk situation. The topical areas are bullying and peer

pressure, eating disorders, depression, anger and violence, substance abuse, dropping out, suicide and homelessness.

The AHI also assisted in the launch of THE EMPTY CHAIR campaign in collaboration with the Brooke/Hancock advocates for Substance Abuse Prevention. The campaign brings awareness to West Virginia's high rate of prescription drug overdose deaths (many of which are suicides). The campaign also supported the new permanent prescription drug drop off box located at the Hancock County Sheriff's Department. This environmental approach will reduce accessibility of prescription drugs and hopes to impact adolescent suicide.

The 16th Annual Regional Teen Institute featured a workshop on suicide prevention. The workshop featured a 14 year old camp staff member, Lauren. She shared her story about her mother's drug addiction and how it affected her family and herself. She shared her experiences of considering suicide, of cutting herself and of her hard work to recover and heal. She shared her words of hope for others who may be in a similar situation. She also shared her mother has been drug free for 2 years and how the whole family is involved in her recovery.
AHI joined the Putnam Wellness Committee for an information display Winfield High School. The committee worked with Winfield's SADD group and the We Stop Hate group for this event. Display materials included educational materials about Developmental Assets, Healthy Foods Dating and Healthy Relationships, HIV/AIDS, Teen Pregnancy Prevention, Bullying, Depression, Suicide Prevention, etc.

Other suicide prevention activities the AHI participated in:
• Sponsored a Teen Depression/Teen Suicide forum in Wood County, WV;
• Partnered with the Contemporary Youth Arts Company to provide plays with cyber bullying prevention themes;
• Coordinated a Bullying Prevention Workshop featuring best-selling author and international speaker Jodee Blanco;
• Sponsored the social networking workshop, "The Good, The Bad and the Ugly", featuring retired police chief, Jim Holler.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The OMCFH's Adolescent Health Initiative provides community based skill building opportunities regarding adolescent at-risk behaviors.		X		
2. The EPSDT screen contains a behavior assessment instrument used for age 10 and above.				X
3. The WV Council for the Prevention of Suicide is offering workshops across the state on how to recognize the early signs of depression.				X
4. The Council has completed a five year strategic plan for suicide prevention in WV.				X
5. The Council has had 4 suicide assessment instruments published in the book "Innovations in Clinical Practice".				X
6. Adolescent Health Initiative offers worshops on parent-child communication.		X		
7.				
8.				
9.				
10.				

b. Current Activities
The AHI Regional Coordinators have focused on obtaining necessary trainings from various organizations such as, ASPEN program, the REACH program and the Jason Foundation Teacher In-Service Program. The Coordinators are using this training to develop sustainable suicide prevention programs across the state by educating principals, teachers, church groups, and other serving organizations and helping them develop evidence based approaches suitable to their needs.

The AHI has developed a "Drop-in Center" for all high school youth, especially Gay, Lesbian, Bisexual, Transgender, Queer (LGBTQ) youth and their Allies. The center is located in a neighborhood church in West Virginia's capital city, Charleston. It is hoped this center will help prevent depression and suicide in young people, who are bullied or on a path of self-destruction, by showing them there are people who care and want to help.

The AHI is also working to implement suicide prevention awareness activities and workshops into camps, "Teen Issue Days", conferences and other events across the state.

The VIPP Director made an education presentation on teen suicide prevention to the WV Legislature Interim Sessions in October.

In partnership with the WV Council for the Prevention of Suicide and the ASPEN Project, VIPP developed a training for professionals to provide them with knowledge of suicide risk behaviors, prevention strategies, and intervention resources.

c. Plan for the Coming Year
OMCFH funds the Coordinated School Public Health Partnership $250,000 for prevention/education activities including suicide prevention and will continue for this coming year.

The VIPP plans to continue to strengthen the partnership with the WV Council for the Prevention of Suicide and funding of the ASPEN Project and collaborate in future prevention activities. There will be a section of the VIPP's State Strategic Plan that will focus on suicide prevention. Specific goals, objectives and actions necessary to achieve success will be included as well as benchmarks and measures of effectiveness.

The Adolescent Health Initiative will continue to educate schools, parents, youth and communities on bullying, cyber bullying, teen dating violence, youth depression and correlating risk behaviors such as substance abuse and sexual promiscuity. The AHI will also provide trainings to help adults recognize signs that a teen is contemplating suicide and provide resources for assistance.

The AHI will expand its environment approach to developing sustainable community-based suicide prevention programs by providing eight regional trainings across the state, in addition to trainings currently being offered. The AHI will continue to provide technical assistance and provide needed resources to developing programs throughout the coming year.

The AHI will continue developing the "Drop In Center" in Charleston and hopes expand the idea and provide similar support programs for Gay, Lesbian, Bisexual, Transgender, Queer (LGBTQ) youth in other areas of the state.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	98	90	92	65	65
Annual Indicator	65.6	62.1	64.1	78.3	78.3
Numerator	200	195	175	209	209
Denominator	305	314	273	267	267
Data Source	2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	2011 Vital Statistics	based upon 2011 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	79	79	79	79	79

Notes - 2012
based upon 2011 Vital Statistics - calculated on resident births in WV facilities (WVU, CAMC, Cabell-Huntington)

Notes - 2011
2011 Vital Statistics - calculated on resident births in WV facilities (WVU, CAMC, Cabell-Huntington)

Notes - 2010
2010 Vital Statistics - calculated on resident births in WV facilities (WVU, CAMC, Cabell-Huntington)

a. Last Year's Accomplishments
The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates has increased from 64.1% in 2010 to 78.3% in 2011. This may have been as a direct result of the following efforts:

In WV, three hospitals, Cabell-Huntington Hospital, Charleston Area Medical Center, and WVU, provide NICU care. As a result of collaborative efforts among WV providers, bed increases were gained at both WVU and Cabell-Huntington Hospitals. WVU Children's Hospital now houses 39 NICU beds, which is an increase of nine beds and Cabell-Huntington provides 36 NICU beds.

Lack of Maternity care providers was identified in a Key Informant Survey by the Perinatal Partnership as a as a barrier to care. Collaborative efforts with a variety of partner organizations

including FQHCs, nurse midwifery education and training programs and an obstetrical fellow for Family Practice physicians. Two midwifery programs are now available in the State and the first obstetrical fellow will be accepted in 2013. Several FQHCs have added maternity care to their programs.

In November 2012 a Statewide perinatal One Call System (OCS) was established for physicians and hospitals. The OCS allows for quick responses to find intensive care hospital beds for newborn infants or pregnant women needing immediate high risk care. This OCS is a result of collaboration between the Office of Emergency Medical Services and the Perinatal Partnership. Callers to the hotline will not only find a bed, but also be connected with a specialist at the referral center for consultation.

Connect to Care is a telecommunication project linking rural health facilities with tertiary care center housing perinatal specialists. Live telecommunications allows high risk pregnant women and infants and their local health care providers to obtain important medical advice without leaving their own communities and traveling far distances. Fifteen rural healthcare sites are participating with the three (3) WV hospitals providing high risk prenatal and newborn care.

C-sections and labor inductions have increased dramatically in the United States. West Virgnia has higher rates than the rest of the nation. Concerned that many of these inductions and C-sections are not medically necessary and may be resulting in avoidable negative birth outcomes, the West Virginia Health Care Authority, in partnership with the West Virginia Perinatal Partnership and the West Virginia March of Dimes, developed and implemented a collaborative to study and address the issue. The six month project engaged 14 of the state's 30 hospitals that deliver babies. The participating hospitals represented 70% of the total deliveries in the state. Six months after the implementation of the Collaborative, the rate of elective deliveries prior to 39 weeks without a medical indication had decreased by more than 50%. One year after the completion of the Collaborative, the reduction has been maintained. A report summarizing the collaborative is available on the Perinatal Partnership website.

Universal Maternal Risk Screening is conducted at the first prenatal appointment on all West Virginia women. This screening provides a picture for the maternity care provider on the risks associated with this pregnancy. The instrument used, Pregnancy Risk Screening Instrument, is then sent to the Office of Maternal, Child and Family Health where the data is stored, analyzed and reported to the Maternal Risk Screening Advisory Committee. Implemented in January 2011, one full year of maternal risk data has now been received. The data is being used to form public policy and practice changes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. OMCFH advocates that all pregnant women be screened for medical risk conditions so that high risk patient care can be planned.				X
2. OMCFH fiscally supports training teams to encourage early screening and referral.				X
3. Legislation mandating high-risk screening of pregnant women.				X
4. Screening tool developed by Advisory and implemented in January 2011.				X
5. RFTS protocols support high risk patient deliveries at tertiary care.				X
6. Perinatal Partnership advocated for additional NICU beds at				X

tertiary care hospitals. Additional beds were added.				
7.				
8.				
9.				
10.				

b. Current Activities
OMCFH, the Perinatal Partnership and Shenandoah University Midwifery Program partnered in October 2012 on a project to create an Emergency Maternity Services (EMS) Training Course. The target audience for the training will be EMS, paramedics, RNs, PAs, CNAs and other health care professionals. The goal of the course is to prepare first responders and health care professionals to have a plan for pregnant women and how to assist pregnant women giving birth in the event of a catastrophe, such as floods or disasters. The training course is offered through the West Virginia State Emergency Medical Services. Plans are to expand the project in the future to become a "train-the-trainer" course.

The course, Emergency Maternity Care and Communication, is provided in four (4) sections; sections 1, 2, and 4 are online student directed sections, section 3 is hands-on, didactic training over a 2 day period. The course has been offered on three occasions, April 21 &22, 2012, in Flatwoods, WV, October 12 & 13, 2012 in Parkersburg, and April 20 & 21, 2013 in Beckley.

Eight RFTS RCCs make regular visits to OB and pediatric providers in each region to recruit providers to assure WV high risk pregnant women and infants have access to early and adequate health care.

Evaluation of the data collected from maternal risk screening is analyzed and shared with the Maternal Risk Screening Advisory for comments and guidance on next courses of action.

c. Plan for the Coming Year
Previously mentioned initiatives will be evaluated on the effectiveness of the hot-line and transport guidelines, and Maternal Risk Screening surveillance.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	83	82	84
Annual Indicator	79.1	80.0	83.1	83.2	83.2
Numerator	17001	16938	16009	15365	15365
Denominator	21492	21162	19260	18472	18472
Data Source	2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	2011 Vital Statistics	based upon 2011 Vital Statistics
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	84	84	84	84	84

Notes - 2012
Based upon 2011 Vital Statistics
denominator excludes unknown prenatal care

Notes - 2011
2011 Vital Statistics
denominator excludes unknown prenatal care

Notes - 2010
2010 Vital Statistics
denominator excludes unknown prenatal care

a. Last Year's Accomplishments
West Virginia's access to first trimester prenatal care rate has improved from 60-70% in the 1980s to 83.2% in 2011. WV Vital Statistics data show a preliminary rate of 83.2% for women who began prenatal care in the first trimester in 2012.

In 2009, HB 2837 established an advisory council within the WV DHHR, Office of Maternal, Child and Family Health to provide assistance in the development of a uniform maternal risk screening tool. The WV Maternal Risk Screening Advisory Committee agreed to adapt the OMCFH, RFTS Program's Prenatal Risk Screening Instrument, which had been widely used by numerous OB providers throughout the State for years. Members wanted to keep the form simple, one page, user-friendly and electronically compatible.

Implementation of this new process was effective on January 1, 2011 and is fully operational statewide with OMCFH receiving forms daily from providers. Prenatal care providers are required to complete a PRSI on all WV women on their initial obstetrical visit regardless of payment source. Providers must notify the woman of any identified high-risk condition and provide referrals as necessary. All information submitted is confidential and will not be released or disclosed for any reason other than data analysis of at-risk/high-risk pregnancies and planning purposes by public health officials.

In 2011 providers submitted 3,403 completed PRSIs to the RFTS Program as referrals for pregnant women who were potentially eligible to receive in-home targeted case management services. Preliminary data collected from 75% of the PRSIs reveal 76% of the women accessed first trimester prenatal care, an increase from 72% in 2010. The WV PRSI will continue to serve as a referral source to the RFTS Program for low income, government-sponsored pregnant women.

Once the PRSI is received by the RFTS Regional Care Coordinator, the client is referred to a DCC in the local community immediately for the initiation of care coordination services which includes assistance with access to early and adequate prenatal care.

PRAMS data indicated that a barrier to entering prenatal care within the first trimester was not being eligible for Medicaid in a timely manner. As of July 1, 2012, the WV Bureau for Medical Services, Medicaid Program no longer requires proof of pregnancy to be eligible to apply for pregnancy Medicaid. This removes a visit to a healthcare facility to receive documentation of pregnancy and then applying for Medicaid. Removing the required documentation should allow earlier access to prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Free pregnancy testing is available at Family Planning sites statewide.			X	
2. Women who have a positive pregnancy test are assisted with securing health care coverage.		X		
3. Adolescents age 19 years and under are automatically eligible for OMCFH financial assistance under RFTS.		X		X
4. Early prenatal care is strongly encouraged and supported through all family planning efforts.				X
5. OMCFH partners with the March of Dimes to provide education targeting early prenatal care.			X	
6. OMCFH partners with the local DHHRs to encourage referral of pregnant women who are denied Medicaid coverage for obstetrical care services.		X		
7. RFTS receives a monthly print out sent electronically from Medicaid of those women who were denied Medicaid coverage during pregnancy. RFTS notifies the person by phone and/or letter of OMCFH available services.		X		
8.				
9.				
10.				

b. Current Activities

In 2011 providers submitted 11,082 PRSIs and of these 3,403 were referred to RFTS as potentially eligible to receive in-home targeted case management services. Preliminary data collected from 75% of the PRSIs reveal 76% of the women accessed first trimester prenatal care, an increase from 72% in 2010. The WV PRSI will continue to serve as a referral source to the RFTS Program for low income, government-sponsored pregnant women as well as to other home visitation programs across the State.

The Family Planning Program (FPP) is encouraging all providers to discuss a reproductive health plan with their clients of childbearing age. Starting the discussion before a pregnancy encourages the client to obtain optimal health before conception and to think about pregnancy spacing. FPP offers free or low cost pregnancy testing and provides referrals into prenatal care as needed.

c. Plan for the Coming Year

West Virginia's Perinatal Program, Right From The Start (RFTS), will continue to provide comprehensive perinatal services to low-income women up to sixty days postpartum and care coordination for Medicaid eligible infants up to age one year. RFTS will also provide direct financial assistance for obstetrical care for WV pregnant women who are uninsured or underinsured, are above income guidelines for Medicaid coverage, and meet certain qualification

guidelines.

The RFTS Program will continue to provide intense education for participants promoting the importance of access to early and adequate prenatal care, and will continue to be the statewide network through which the March of Dimes provides education, literature to residents and medical providers.

Eight RFTS RCCs will conduct site visits to OB providers to encourage completion of the PRSI and promote access to early and adequate prenatal care. RCCs will continue to recruit providers for each of their regions so that women do not have to travel long distances to access prenatal care. The WV Director of Perinatal Programs and RFTS RCCs will continue to provide training and education to local DHHR office staff and other community agencies statewide on Maternity Services coverage and how to make a referral to the Program.

In July, 2012 the OMCFH implemented use of Teleform technology for the new WV PRSI process which scans data from forms into a file which is then copied to the PRSI web-based data system. This technology minimizes data entry errors and possibilities for infractions with Personally Identifiable Information.

The OMCFH hired a full time epidemiologist who provided a preliminary statewide statistical report for the Maternal Risk Screening (MRS) Advisory Committee to review and discuss. The epidemiologist has taken a different position within OMCFH and will no longer be providing data review for the RFTS Program, but will continue MRS surveillance. An epidemiologist will be hired to provide RFTS Program data review on a full time basis in 2013.

D. State Performance Measures

State Performance Measure 1: *Decrease the percentage of pregnant women who smoke in the last three months of their pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	22	21	20	25	30
Annual Indicator	28.7	28.9	30.5	28.9	28.9
Numerator	6165	6140	6240	5420	5420
Denominator	21492	21225	20471	18737	18737
Data Source	2008 PRAMS	2009 PRAMS	2010 PRAMS	2011 PRAMS	based upon 2011 PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	28	28	28	28	28

Notes - 2012
based upon 2011 PRAMS data - mom smoked last 3 months of pregnancy

Notes - 2011
2011 PRAMS data - mom smoked last 3 months of pregnancy

Notes - 2010
2010 PRAMS data - mom smoked last 3 months of pregnancy

a. Last Year's Accomplishments
Data from the 2010 PRAMS survey indicate that 28.9% of pregnant women smoked during their last three months of pregnancy. Data collected by the Right From the Start Program in 2012 show 29% of pregnant participants had Carbon Monoxide (CO) confirmed rates consistent with that of a smoker. In response WV continued to provide SCRIPT services, the intensive smoking cessation initiative.

During 2012 the RFTS SCRIPT Project continued to collaborate with the WV Division of Tobacco Prevention and the WV Tobacco Quitline to increase Quitline referral, utilization and ultimately, cessation outcomes. In 2011 the WV Tobacco Quitline enrolled 8,074 participants; 269 of these participants were pregnant women. Of the enrolled pregnant women, 91 were Medicaid insured (33.8.1%). During 2012 the WV Tobacco Quitline enrolled 10,354 participants and 318 of these participants were pregnant women. Of the 318 pregnant women enrolled, 146 were Medicaid insured (45.9%). In 2011, 22 pregnant women enrolled in the Quitline were referred from RFTS and in 2012 the number increased to 44.

OMCFH is working with the Division of Tobacco Prevention to c0-fund additional air time for the Smoking and Pregnancy Campaign.

OMCFH also participated in a Smoking and Pregnancy Expert Panel meeing, hosted by the Division of Tobacco Prevention, which is expected to develop into a Strategic Action Plan.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Smoking Cessation Program (SCRIPT) implemented in January 2002 and is ongoing.				X
2. The WV SCRIPT uses the existing home visitation network and protocols in the RFTS Project.				X
3. All pregnant RFTS smokers/former smokers are offered CO Testing and Smoking Cessation.		X		
4. SCRIPT mandated to be offered to all RFTS/HAPI participants.				X
5. Information collected on smoking in RFTS participants.				X
6. PRAMS data is used to report smoking in last three months of pregnancy.				X
7. The negative effects of smoking during pregnancy are distributed universally.			X	
8. State government maintains Tobacco Quit Line.				X
9.				
10.				

b. Current Activities
The Division of Tobacco Prevention's Tobacco-Free Pregnancy Initiative educates women of child-bearing age as well as those who are pregnant on the dangers of using tobacco and educates healthcare providers on the urgent need for face-to-face tobacco cessation counseling.

Recent PRAMS survey results show a 28.9% smoking rate among pregnant women in West Virginia which is almost triple the 11% national rate.

In addressing this crisis, the Cessation Program is funding several programs focusing on

pregnant women. Among them is "Tobacco Free for Baby and Me," housed in the high-risk OB Clinic at Charleston Area Medical Center's Women's and Children's Hospital in Charleston. The program has provided tobacco cessation services and cessation education to scores of pregnant women. A Mommy Quit for Me Brochure and Tobacco-Free Pregnancy Factsheet were developed and available for distribution.

The WV DHHR Office of Maternal Child and Family Health, another Cessation Partner, offers tobacco cessation counseling during in-home visits through the Right From the Start Program.

The WV DHHR Women's Infants and Children's (WIC) Program partners with the Cessation Program by distributing cessation educational materials through the 55 clinics throughout West Virginia.

The Division of Tobacco Prevention Cessation Program supports a Tobacco Free Pregnancy Advisory Council as part of the Tobacco Free Pregnancy Initiative. This Council meets several times a year to address the epidemic.

c. Plan for the Coming Year

Although the RFTS provides smoking cessation education to numerous low income pregnant women and their families, more than half of WV pregnant women are eligible for this support and for public assistance.

The RFTS Program will continue to provide smoking cessation education and support to pregnant women and their families on the dangers of smoking during pregnancy and the importance of maintaining a smoke free environment. Designated Care Coordinators will continue to use the 5 A's best practice method and a CO monitor to provide a visual message of the dangers of smoking during pregnancy.

OMCFH will continue to partner with the Division of Tobacco Prevention as follow up to the Smoking and Pregnancy Expert Panel meeting and development of a State Action Plan.

State Performance Measure 2: *Increase the percentage of the state's children <18 who are Medicaid beneficiaries who have at least one preventive dental service in a 12-month period.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	92	92	42	38
Annual Indicator	38.1	40.4	38.6	37.1	39.6
Numerator	74326	81199	84742	82009	86863
Denominator	194998	201013	219576	221328	219150
Data Source	CMS-416 Fiscal Year 2008 Annual Report	CMS 416 Fiscal Year 2009	CMS 416 Fiscal Year 2010	CMS 416 Fiscal Year 2011	CMS 416 Fiscal Year 2012
Is the Data Provisional or Final?				Final	Final

	2013	2014	2015	2016	2017
Annual Performance Objective	40	40	40	40	40

Notes - 2012
CMS-416 Fiscal Year 2012 Annual Report, 12b Preventive Dental Services
This measure was changed from "Increase the percentage of the state's children <18 who are Medicaid beneficiaries who have at least one primary care visit in a 12-month period" to "have at least one preventive dental service in a 12-month period". Data for 06 and 07 reflect the percentage of those children who were Medicaid beneficiaries who received at least one primary care visit in a 12-month period.

Notes - 2011
CMS-416 Fiscal Year 2011 Annual Report, 12b Preventive Dental Services
This measure was changed from "Increase the percentage of the state's children <18 who are Medicaid beneficiaries who have at least one primary care visit in a 12-month period" to "have at least one preventive dental service in a 12-month period". Data for 06 and 07 reflect the percentage of those children who were Medicaid beneficiaries who received at least one primary care visit in a 12-month period.

Notes - 2010
CMS-416 Fiscal Year 2010 Annual Report, 12b Preventive Dental Services
This measure was changed from "Increase the percentage of the state's children <18 who are Medicaid beneficiaries who have at least one primary care visit in a 12-month period" to "have at least one preventive dental service in a 12-month period". Data for 06 and 07 reflect the percentage of those children who were Medicaid beneficiaries who received at least one primary care visit in a 12-month period.

a. Last Year's Accomplishments
The Oral Health Program and its partners work diligently to reduce the incidence of caries in children and adolescents. The Oral Health Program continues to work with the Healthcheck Program to promote dental homes and regular dental exams. In addition, the Program has worked extensively with the WVU School of Dentistry and key pediatric providers to enhance medical/dental collaborations. The project provides water testing to determine fluoride levels of private water systems, conducts a fluoride rinse project to WV elementary schools, and has a regional network of oral health coordinators who conduct oral health education and fluoride technical assistance statewide.

The OHP continued to work with Marshall University to expand the School-Based Dental Sealant Program. The current program offers dental sealants at school-based health centers in 55 schools, serving 22 counties in West Virginia. To maximize the efforts of the program, the OHP will expand this system statewide. The Dental Sealant Coordinator, contracted through Marshall University, will help facilitate the expansion so that all West Virginia counties are served.

The OHP continued to work with the WVU School of Dentistry and their partners, to implement a training program for medical personnel and their ancillaries to apply fluoride varnish as a preventative oral health measure. The West Virginia Medical Infant and Child Oral Health Training Program delivers ongoing, evidence-based information that is open to all primary care physician's (PCP) in West Virginia. The Program also provides a source of continuing education credits to participants who complete the training course. Program participants receive a training manual that includes a copy of the presenters PowerPoint presentation, program implementation guide, coding and billing information and templates for West Virginia Medicaid and West Virginia CHIP's (Children's Health Insurance Program), and parent education and dental resources. To date, the Program has trained 47 PCPs to apply fluoride varnish. The OHP plans to make the training program a State project to increase awareness of the training in an effort to increase the

number of medical providers who participate in the program.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oral Health State Plan developed.				X
2. New full time State Dental director hired.				X
3. Children's Dentistry Program (CDP) is partnering with Medicaid to encourage increase in use of dental services.				X
4. The Kids First Initiative screens school enterers using HealthCheck protocols.		X		X
5. The CDP partners with Head Start, TANF, WIC and EPSDT to distribute dental awareness information.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Children's Dentistry Project provides water test kits to families for testing fluoride levels of private water systems. The Project provides a fluoride rinse program in schools.

Oral Health Educators provide oral health education to children and families in all 55 counties through schools, early childhood programs and community health fairs.

The OHP is currently undergoing a redesign of the current oral health education system in effort to meet the needs of the citizens. The OHP has contracted with Marshall University to implement a standardized oral health curriculum that can be used in schools and by community groups and to hire full-time Oral Health Coordinators that will be located regionally throughout the State to serve as community oral health resources.

The OHP continued to work with Marshall University to expand the School-Based Dental Sealant Program.

The OHP continued to work with the WVU School of Dentistry and their partners, to implement a training program for medical personnel and their ancillaries to apply fluoride varnish as a preventative oral health measure.

c. Plan for the Coming Year

The OHP will continue to provide services and education to children and families across West Virginia. The newly redesigned Oral Health Coordinator positions will be fully incorporated into their respective regions. These coordinators will focus on oral health education and prevention through sealants, fluoride application, establishment of a dental home, age one initial dental visit, regular brushing and flossing, and routine dental visits.

OHP will continue the expansion of the Sealant Program statewide. The Program plans to add six new schools in the State that will provide dental sealants to at risk children. The program also plans to create a school based dental sealant policy and procedure manual that will indicate the State guidelines for school-based sealant programs.

State Performance Measure 3: *Decrease the rate of infant deaths due to SIDS/SUID.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				18	160
Annual Indicator	20,481.9	150.8	180.7	117.4	117.4
Numerator	34	32	37	22	22
Denominator	166	21225	20471	18737	18737
Data Source	2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	2011 Vital Statistics	based upon 2011 Vital Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	117	117	117	117	117

Notes - 2012
based upon 2011 Vital Statistics - rate per 100,000 births
includes ICD codes R95 only

Notes - 2011
2011 Vital Statistics - rate per 100,000 births
includes ICD codes R95 only

The Annual Performance Objective should be 180 instead of 18.

Notes - 2010
2010 Vital Statistics - rate per 100,000 births
includes ICD codes R95 only

a. Last Year's Accomplishments
In 2011, the WV passed legislation adding infant mortality review to already existing legislation for maternal mortality review that is housed within OMCFH. The Infant and Maternal Mortality Review Team continues to meet regularly. SIDS/SUID continues to be a significant risk to infants in WV. Determined risk factors include co-sleeping and household smoking.

According to the 2010 Legislative Report on SIDS/SUID (most recent available), during calendar year 2010, there were thirty-seven (37) resident infant deaths attributed to SUID in West Virginia. These deaths are identified by WV Health Statistics Center with a death certificate cause of death code R95. Demographics and risk factors include the month of death, county of residence, age at death, sex of child, death by race, the position of the infant when found, type of bedding, smoking status of mother during pregnancy, smoking status in the home, prenatal care information, co-sleeping/bed-sharing information, gestation, birth weight, breast/bottle feeding and birth score. Twenty-three of the deaths were male; 35 were white and 2 were bi-racial; 22 were less than 34 months of age; 30 were of normal birthweight; 30 were full-term; 16 were reported co-sleeping/bed-sharing; 33 reported hazardous bedding; 26 reported maternal smoking during pregnancy; and 28 reported smoking in the home.

OMCFH staff persons serve on Our Babies: Safe and Sound Advisory Committee and work groups and also provided funding support since 2011. Our Babies: Safe and Sound is an

educational campaign, sponsored by the WV Children's Trust Fund, that provides parents and other caregivers of infants under the age of one, as well as expectant parents and professionals, with information and tips on ways to keep babies safe while sleeping, and how to keep your cool when babies cry. The overall goal of the campaign is to help prevent infant injury and death. Our Babies: Safe and Sound is a project of TEAM for West Virginia Children. Campaign materials are based upon the latest state and national research findings, and are intended to be used by parents and other caregivers, community partners, and the general public. The themes of the campaign are Say YES to Safe Sleep and Keep Your Cool.

OMCFH staff persons also serve on the Child Fatality Review Team (CFRT) which reviews infant deaths due to SIDS/SUID among other causes.

In 2011 the RFTS Program conducted 25 quarterly training meetings for their home visiting nurses and social workers and 10 training meetings for Regional Lead Agency staff. Training topics included domestic violence, shaken baby syndrome, safe sleep practices for baby, a safe crib and providing a smoke-free environment for the infant.

The OMCFH mails "Back To Sleep" post cards monthly to families of each live newborn in WV as a reminder of the importance of placing the baby on its back to sleep, putting the baby in a safe crib, not allowing the baby to sleep in the bed with others, avoiding fluffy blankets in the crib, and not exposing the newborn to 2nd hand smoke.

The CFRT coordinator housed within the Office of the Chief Medical Examiner, has attended multiple child protective service worker staff meetings across the state and provided training on identifying safe sleep environments when conducting client home visits. OMCFH staff serve on the CFRT and are involved with the Team in making additional recommendations and submitting a position paper for review by the Commissioner of the Bureau for Public Health.

The Home Visitation Program has provided education and training to the home visitation staff across the state on safe sleep environments for infants.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Legislation to include infant mortality review within the existing maternal mortality review process.				X
2. Participation and funding support for "Our Babies Safe and Sound" committee to reduce infant mortality and morbidity.				X
3. Educational media campaign to reduce SUID and infant mortality by targeting women and men of childbearing age.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A nurse coordinator was hired to oversee the collection of data to present to the Infant and Maternal Mortality Review Team. A data system is being purchased called Bassinett that will allow easy data entry, data reports and surveillance activity. Memorandums of Understanding were modified with the birthing facilities to include the review of infant death records and mother's prenatal and delivery medical records in addition to review of maternal death medical records. The nurse coordinator is currently completing review of the 2011 infant death records and maternal prenatal and delivery records of the infants who died, including SIDS/SUID. An Advisory Committee was held May 20, 2013 to review information and make recommendation as appropriate. The Advisory has added Child Protective Services to the Advisory.

OMCFH staff persons continue to serve on Our Babies: Safe and Sound Committee.

The RFTS Program continues monthly trainings of home visiting staff to encourage families to provide a safe sleep environment for their baby.

The OMCFH continues to mail "Back To Sleep" post cards monthly to families of each live newborn in WV as a reminder of the importance of placing the baby on its back to sleep, putting the baby in a safe crib, not allowing the baby to sleep in the bed with others, avoiding fluffy blankets in the crib, and not exposing the newborn to 2nd hand smoke

c. Plan for the Coming Year

The RFTS Program will continue monthly trainings of home visiting staff to encourage families to provide a safe sleep environment for their baby.

The Right From The Start Program, the State's perinatal home visiting program is planning an educational campaign with their enrollees on safe sleep practices and providing infant sleep sacks in conjunction with the Injury Prevention Program.

OMCFH will continue to mail "Back To Sleep" post cards monthly to families of each live newborn in WV as a reminder of the importance of placing the baby on its back to sleep, putting the baby in a safe crib, not allowing the baby to sleep in the bed with others, avoiding fluffy blankets in the crib, and not exposing the newborn to 2nd hand smoke.

The Infant and Maternal Mortality Review Team will complete reviews of infant deaths for 2011 and 2012 and formulate ideas from the Advisory for activities to reduce infant mortality including SIDS/SUID based on collected data.

OMCFH staff will continue to serve on Our Babies: Safe and Sound Committee.

The OMCFH will ontinue collection and data analysis on infant mortality medical information reviews including those that died from SIDS/SUID.

The Office of Maternal, Child and Family Health has been an ongoing participant in the national Back to Sleep campaign since its inception in 1996 and is now participating in the expanded Safe to Sleep campaign. The Office continues disseminating pertinent, current information about risk factors such as co-sleeping/bed-sharing, early prenatal care, maternal smoking during pregnancy, etc. The Office also continues to make ongoing efforts to provide current, relevant educational material statewide to health care providers as well as parents, grandparents and other caregivers of West Virginia's newborns.

State Performance Measure 4: *Decrease the percentage of high school students in grades 9-12 who are overweight or obese.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	12	12	11	26	30
Annual Indicator	14.5	28.6	28.6	30.6	30.6
Numerator	18200	35900	35900	37400	37400
Denominator	125578	125578	125578	122115	122114
Data Source	2007 YRBS	2009 YRBS	based upon 2009 YRBS	2011 YRBS	based upon 2011 YRBS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	30	30	30	30	30

Notes - 2012
2011 YRBS 16.3% overweight 14.3% obese
denominator total enrolled school year 2010-2011

Notes - 2011
2011 YRBS 16.3% overweight 14.3% obese
denominator total enrolled school year 2010-2011

Notes - 2010
based upon 2009 YRBS
14.4% overweight and 14.2% obese

a. Last Year's Accomplishments
DHHR continues to provide funding for the CARDIAC Project, which is a screening program designed to identify children at risk of heart disease. Currently completing the 15th year of screening, The CARDIAC Project has provided cardiovascular risk education and intervention among children aged 15 years and younger. Between 1998 and 2012 more than 17,199 kindergarten, 50,082 second, 81,156 fifth and 1030 ninth and 444 eighth graders have been screened through in the CARDIAC Project. An additional 4,423 parents and 794 school staff have received free fasting lipid profiles to assess their personal risk. Of the fifth grade students 18.8% of all children were overweight and an additional 28.3% were obese. Over twenty-five percent (25.7%) had abnormal blood lipids, called dyslipidemia. Almost five percent (5.2%) of children had a rash on the back of the neck (AcanthosisNigricans) indicative of possible insulin resistance.

The Adolescent Health Initiative worked with communities across the state to plan, develop and implement evidence based strategies to combat the growing problem of obesity among adolescents in West Virginia. The AHI planned various events as well as long term, sustainable programs based on the community's educational awareness, capacity and readiness. Those include:
• Assisted in the coordination of the Healthy Families Eat Together Dinner in collaboration with the Healthy Families Coalition of Ohio and Marshall Counties;
• A school tomato and gardening project that began at one elementary school became a model throughout the region and the AHI began working with several schools in the southern part of the state to replicate the program;
• Implemented a YBFIT program in the Northern Panhandle of West Virginia. YBFIT (pronounced "why be fit") is a winter wellness opportunity providing nutrition education, physical activity, parenting and relationship education;
• Developed an afterschool program to celebrate National Nutrition Month. The program allowed 84 youths to fix their own healthy, but fun snacks and participate in games and activities which

taught the basics of good nutrition. The youths were given a journal and several fun handouts to encourage them keep track of the fruits and vegetables they ate and keep track of physical activities they participated in during the month. All children who completed their journal were given a prize at the end of the month;
• Facilitated 10 Tips -- Diet & Exercise at the Children's Home of Wheeling. The workshop, designed to increase participants' knowledge of healthy adolescent diet and exercise behaviors, will increase protective factors and reduce risk factors for adolescents from the region residing at the home;
• Formed a weekly community garden project in Mount Hope, WV. The Adolescent Health Initiative obtained grant funding for the project and recruited middle and high school students to plan, grow and harvest the gardens. Families who participate not only keep the fresh vegetables, but receive developmental asset training, recipes, healthy cooking tips, and share vegetables and gardening tips with other participating families;
• Coordinated Energy Express programs in various communities across the state. Energy Express provides free and nutritious lunches to school aged children during the summer.
• Received a Five Promises for Children Foundation grant to offer nutrition education to youth in Marshall County;
• Provided 8 workshops during Camp Healthy Choices in Hardy County, WV;
• Partnered with various Wellness Teams, Children's Health Councils and schools to provide nutrition information and healthy activities.

OMCFH provides $250,000 to Coordinated School Public Health Partnership who address issues of childhood obesity among numerous other areas.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The DHHR Office of Healthy Lifestyles promotes physical activity.			X	
2. Adolescent Health Initiative promotes healthy eating and physical activity.			X	
3. Cardiac Project provides free school-based BMI, BP, etc. for elementary and middle school students.			X	
4. The Kids First Screening Initiative and EPSDT assessments capture BMI.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Planning for this year's weekly community garden project in Mount Hope is currently underway and a similar garden project is now being planned in Webster County. The tomato and garden project is being implemented in five schools this year. The Energy Express summer feeding programs are also on track to be implemented again this year. Other projects for this year include:
• Coordinating family activities and healthy concessions at the October Fall Festival in Marshall County in collaboration with the Marshall County Family Resource Center Advisory Council;
• Partnering with schools in Mingo County to providing nutrition bar with fruits, cheeses and healthy snacks and discuss the importance nutrition and eating healthy foods. The project

demonstrates to middle and high school students you can eat healthy and still enjoy them;
• Partnering with the West Virginia Special Olympics and Chestnut Ridge Hospital to assist with the winter games at Canaan Valley. The games encouraged participation in physical activity and team building activities for the athletes;
• Collaborating with the Taylor County PATCH (Planned Approach to Community Health) to implement the "Cooking Matters, Shopping Matters" for young adults program in Grafton. These events were funded through a grant from Marshall University and a total of 25 adults were taken to Wal-Mart and taught how to compare food costs of vegetables in 3 categories: fresh, frozen, and canned.

c. Plan for the Coming Year
The Adolescent Health Initiative will continue to work with communities across the state to plan, develop and implement evidence based strategies to combat the growing problem of obesity among adolescents in West Virginia. The AHI will work to transition more communities from providing just education and awareness to developing and implementing sustainable programs, developing policy changes and other environmental approaches.

State Performance Measure 5: *Increase the percentage of high school students who participate in physical activity for at least 60 minutes a day, 3 days a week.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	50	50	55	64	72
Annual Indicator	43.0	62.2	62.2	71.4	71.4
Numerator	54000	78100	78100	87200	87200
Denominator	125578	125578	125578	122115	122115
Data Source	2007 WV YRBS	2009 WV YRBS	based upon 2009 WV YRBS	2011 YRBS	based upon 2011 YRBS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	72	72	72	72	72

Notes - 2012
2011 YRBS students who were physically active for at least 60 minutes per day for at least 3 of the last 7 days
denominator total enrolled school year 2010-2011

Notes - 2011
2011 YRBS students who were physically active for at least 60 minutes per day for at least 3 of the last 7 days
denominator total enrolled school year 2010-2011

Notes - 2010
based upon 2009 YRBS students who were physically active for at least 60 minutes per day for at least 3 of the last 7 days

a. Last Year's Accomplishments

The mission of the West Virginia Office of Healthy Lifestyles is to increase the proportion of its people who are at a healthy weight by creating, improving, and communicating opportunities for residents to engage in healthy eating and physical activity behavior.

It is essential that the school environment, which includes the classroom, cafeteria, and school grounds, not only positively affect a child's decision making skills, but also lend power to the messages conveyed to the community on many levels regarding physical activity and healthy eating choices. This coincides with the WV Department of Education's efforts to include physical activity into the regular classroom environment and its implementation of the Let's Move Initiative.

The Adolescent Health Initiative worked with communities across the state to plan, develop and implement evidence based strategies to encourage adolescents and families to have a more active lifestyle and engage in more physical activity. The AHI planned various events as well as long term, sustainable programs based on the community's educational awareness, capacity and readiness. Those include:
• One Adolescent Health Coordinator and certified Zumba instructor exposed hundreds of youth and adults to this fun; group exercise which helps promotes wellness and healthy lifestyles;
• Facilitated the City of Parkersburg's first Community Festival that promoted "car-free" activities with mini-parks set up in the parallel parking spaces on Market Street. The creation of "walkable" events, combined with education and ideas, encourages residents to consider a more active lifestyle;
• Partnered with the YMCA of Southern WV to develop, organize and implement the Get Up, and Get Active Movement to address obesity throughout the region. The program started by organizing several indoor triathlons. Additionally, the AHI obtained two grants for this organization (Saucony, $10,000 and Beckley Area Foundation $1,500);
• Facilitated 10 Tips -- Diet & Exercise at the Children's Home of Wheeling. The workshop, designed to increase participants' knowledge of healthy adolescent diet and exercise behaviors, will increase protective factors and reduce risk factors for adolescents from the region residing at the home;
• Developed the local chapter, Girls on the Run (GOTR) of Southern West Virginia: This GOTR program teaches life skills, character education, and promotes physical activity to girls through "running" and empirically supported curriculum. The program initially began in one school, but the development of a local chapter has allowed the program to expand to 3 schools in the southern part of the state.
• Created the program Prevention of Disordered Eating through Creative Education Initiatives. One project featured a local youth drama team presenting Four Young Women Tell the Truth About Eating Disorders to encourage healthy eating and the importance of a positive self-image. The program was initiated in a high school and a middle school in Boone, Clay, Kanawha, Putnam, Lincoln and Fayette counties;
• Partnered with Wood County Wellness to provide a bike rodeo for youth in the region;
• Implemented a YBFIT program in the Northern Panhandle of WV. YBFIT is a winter wellness opportunity providing nutrition education, physical activity, parenting and relationship education;
• Implemented the PEDAL (Physical Enrichment Daily And for Life) Power program in Calhoun, Pleasants, Ritchie, Roane, Tyler, Wirt, Wood and Jackson Counties. The program promotes a healthy lifestyle and encourages youth and adults to engage in daily physical activity. The program also promotes bicycle safety and helmet usage to prevent childhood traumatic brain injuries.
• Developed an afterschool program to celebrate National Nutrition Month. The program allowed 84 youths to fix their own healthy, but fun snacks and participate in games and activities which taught the basics of good nutrition. The youths were given a journal and several fun handouts to encourage them keep track of the fruits and vegetables they ate and keep track of physical activities they participated in during the month. All children who completed their journal were given a prize at the end of the month;
• The AHI disseminated information on healthy lifestyles, nutrition and exercise at numerous health fairs, "Family Fun Days", Teen Expos, Student Resource Days all across the state.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Legislation requires three periods of physical activity each week (30 minutes in length) during the school year for grade school.				X
2. Legislation requires one semester each year for middle school.				X
3. Legislation requires one class of physical education during high school.				X
4. The WV DHHR Office of Healthy Lifestyles promotes physical activity.				X
5. Home visitation services promote good nutrition and physical activity for all members in the family.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OMCFH invests in the Coordinated School Public Health Partnership and the Community Transformation Grant to address physical activity and nutrition in the schools. Activities focus on teacher training.

Many of the initiatives started this year are on-going and the AHI continues to work with communities to continue and expand their success. Planning for this year's weekly community garden project in Mount Hope is currently underway and a similar garden project is now being planned in Braxton and Webster Counties. The tomato and garden project is being implemented in five schools this year. The Energy Express summer feeding programs are also on track to be implemented again this year. Other projects for the current year include:

• Assisting with the facilitation of the Greenbrier County Teen Wellness Expo presented at Greenbrier East High School. The Expo provides information to students regarding a wide variety of teen issues including Eat This, Not That, Don't Drink Your Calories, and Physical Fitness without a Gym;
• Working with the Civilian Conservation Corps and the Coal Heritage Highway Authority to confirm and final plans for the Boy Scout Community Service projects planned for the Fayette County area in July. Several of the projects will assist in creating opportunities for families and children to be more active together. These include working on the renovation of a youth center and clearing an abandoned rail line for a walking/cycling trail

c. Plan for the Coming Year

The Adolescent Health Initiative will continue to work with communities across the state to plan, develop and implement evidence based encourage adolescents and families to have a more active lifestyle and engage in more physical activity. The AHI will work to transition more communities from providing just education and awareness to developing and implementing sustainable programs, developing policy changes and other environmental approaches.

The West Virginia Office of Healthy Lifestyles developed in 2005 "West Virginia Everyday…A

statewide plan to improve physical activity and nutrition" which included the following objectives addressing physical activity in the school setting:

Objective A: Increase the number of school staff and administration, parent organizations and community leaders aware of the contribution of proper nutrition and physical activity to the maintenance of lifelong healthy weight and encourage positive role modeling among the same.

Objective B: Increase the number of schools with policies and/or environmental changes geared towards improving nutrition (more fruits & vegetables, less sugar-sweetened beverages, more low-fat and fat-free milk) in school vending machines, a la carte and school meal programs and fundraising events.

Objective C: Increase the proportion of schools that offer age-appropriate and culturally sensitive instruction in physical education (PE) classes that help students develop the knowledge, attitudes, skills and behaviors to
adopt, maintain and enjoy a physically active lifestyle.

Objective D: Increase the number of schools that provide opportunities for physical activity that help students develop the knowledge, attitudes, skills and behaviors to adopt, maintain, and enjoy a physically active lifestyle
by 2010.

The West Virginia Department of Education receives funding from CDC's Division of Adolescent and School Health to: Conduct the Youth Risk Behavior Survey; implement effective policies, programs, and practices to avoid, prevent, and reduce sexual risk behaviors among students that contribute to HIV infection, sexually transmitted diseases (STDs), and pregnancy; and promote coordinated school health policies, programs, and practices with an emphasis on physical activity, nutrition, and tobacco use prevention.

The AHI will continue to work with the Coordinated School Public Health Partnership/School Wellness Coordinators and OMCFH will continue to help fund the Partnership.

State Performance Measure 6: *Decrease the percentage of high school students who smoke cigarettes daily.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	18	17.5	17	9	10
Annual Indicator	19.4	17.7	17.7	12.0	12.0
Numerator	24300	22200	22200	14700	14700
Denominator	125578	125578	125578	122115	122115
Data Source	2007 WV YRBS	2009 WV YRBS	based upon 2009 WV YRBS	2011 YRBS	based upon 2011 YRBS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	10	10	10	10	10

Notes - 2012

2011 YRBS students who ever smoked cigarettes daily, at least one every day for 30 days denominator total enrolled school year 2010-2011

Notes - 2011
2011 YRBS students who ever smoked cigarettes daily, at least one every day for 30 days denominator total enrolled school year 2010-2011

Notes - 2010
based upon 2009 YRBS students who ever smoked cigarettes daily, at least one every day for 30 days

a. Last Year's Accomplishments
The percentage of high school students who smoke cigarettes daily continues to decline from 19.4% in 2008 to 12% in 2011. With the highest smoking percentage in the nation this is a hopeful trend. Significant reductions may be attributed to the youth empowerment program, RAZE, combined with strong local clean indoor air regulations and active anti-tobacco youth "crews".

The Adolescent Health Initiative partnered with several county boards of education to develop Title IV Safe and Drug Free Schools plans to address the problem of tobacco, alcohol and substance use within the public schools. All AHI staff participated in community-based substance abuse prevention coalitions, which also address the issue of tobacco use among teens. The AHI facilitated several community forums on tobacco, alcohol and substance use including meth, inhalants, synthetic drugs and the growing abuse of energy drinks among youth. The AHI also disseminated information on tobacco, alcohol and substance use at numerous health fairs, "Family Fun Days", Teen Expos, Student Resource Days all across the state. Other accomplishments include:

• Assisted in the launch of the Isn't It About Time? Snuff out Tobacco in Brooke and Hancock Counties campaign in collaboration with the Brooke/Hancock Advocates for Substance Abuse Prevention. By bringing awareness to the lack of comprehensive clean indoor air regulations in both Brooke and Hancock Counties and supporting local businesses who implement clean indoor air policies independently in addition to supporting local RAZE activities, the coalition hopes to impact the priority adolescent health outcome of tobacco use. This is a Centers for Disease Control and Prevention recommended intervention of Mass Media Campaign with Additional Interventions Reducing Tobacco Use Initiation;
• Awarded $5,000.00 from the West Virginia Division of Tobacco Prevention for the Brooke/Hancock Advocates for Substance Abuse Prevention Coalition. Funding will support the Centers for Disease Control and Prevention recommended strategy of public education and advocacy campaigns for tobacco-control policies. The coalition plans to increase public knowledge of both the hazards of passive smoking and the need for and effectiveness of tobacco-control policy. The coalition also plans to increase public support and support among target populations for tobacco-control policy. As a result, the coalition will increase the number of tobacco-free community parks and venues in Brooke and Hancock counties. The coalition hopes this environmental and policy change will impact the adolescent health outcome of Tobacco Use, decreasing social accessibility, as well as reducing exposure, ultimately decreasing tobacco-related morbidity and mortality in Brooke and Hancock counties.

According to the Coordinated School Health Third Quarter Report dated May 17, 2013, County Wellness meetings were held in 15 of 55 counties this quarter bringing the three quarter total to 46.

Regarding the topic of tobacco prevention the following activities occurred:
RESA 2 trained 3 school staff from RESA 2 on the Not-On-Tobacco cessation program.
RESA 4 worked with Braxton County High School to begin a tobacco cessation program as an intervention aligned with Policy 4373.

RESA 5 connected ALA's Tony Richards with the Juvenile Drug Court for a future visit and presentation to at-risk youth.
RESA 7 provided technical assistance to the Buckhannon Upshur High School Raze crew in Upshur County and the Washington Irving Middle School Raze crew in Harrison County.
RESA 8 received Not-On-Tobacco training.

The AHI's newest coordinator attended the Not on Tobacco (NOT) training event sponsored by the American Lung Association. The training session was presented by Mr. Tony Richards and featured a curriculum that is designed to assist adolescents in quitting their use of tobacco. The curriculum is designed to last for ten sessions with a group of at least three participants. She is now certified in this curriculum and can facilitate programming.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WV DHHR and Department of Education have strong anti-tobacco programs which include a brand and promotional campaign designed with advice from youth in this age group.		X		X
2. RAZE is West Virginia's teen led anti-tobacco movement.		X		X
3. Smoking bans in all public and government buildings and state vehicles throughout WV.				X
4. As of January 2009, all 55 counties have clean indoor air regulations.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Division of Tobacco Prevention will continue to support the RAZE campaign and work with the Coordinated School Public Health Partnership School Wellness Coordinators.

The AHI will support this campaign by providing information to educate families on the problem of tobacco, alcohol and drug use among teens. The AHI is continually working with schools and communities to address these issues. The AHI also works with the regional and state Governor's Substance Abuse Task Force groups to assist with the implementation of their statewide plan to address alcohol, illegal drugs and tobacco use.

The AHI also assisted in the facilitation of the Region VI Healthy Parks Initiative in collaboration with the Tobacco Prevention coalitions of Brooke and Hancock, Ohio, Marshall, and Wetzel counties. Coalition members plan to increase the number of tobacco-free community parks and venues in the region. Brooke and Hancock Coalition members are currently developing a 'Tobacco Use and Opinion' survey in collaboration with the Brooke County Health Department to be accessed on both the Brooke County Health Department website and the Hancock County Health Department website.

c. Plan for the Coming Year
The AHI will continue to work with local substance abuse coalitions, schools and communities to provide information, technical assistance and resources to address the problem of substance

use, including tobacco and alcohol.

According to the Coordinated School Health Third Quarter Report dated May 17, 2013, the RSWSs continue to be involved with the Governor's Substance Abuse Task Force and with the BBHHF Data Planning Teams on a regional level.

State Performance Measure 7: *Decrease the percentage of high school students who drink alcohol and drive.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	9.5	9	8.5	7	6
Annual Indicator	9.8	7.5	7.5	6.7	6.7
Numerator	12300	9400	9400	8200	8200
Denominator	125578	125578	125578	122115	122115
Data Source	2007 WV YRBS	2009 WV YRBS	based upon 2009 WV YRBS	2011 YRBS	based upon 2011 YRBS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	6	6	6	6	6

Notes - 2012
2011 YRBS students who drove a car or other vehicle one or more times during the past 30 days when they had been drinking alcohol
denominator total enrolled school year 2010-2011

Notes - 2011
2011 YRBS students who drove a car or other vehicle one or more times during the past 30 days when they had been drinking alcohol
denominator total enrolled school year 2010-2011

Notes - 2010
based upon 2009 YRBS

a. Last Year's Accomplishments
The percentage of high school students who drink alcohol and drive continues to see a downward trend from 9.5% in 2008 to 7% in 2011.

Due to the positive partnerships established over the previous year, the Violence and Injury Prevention Program (VIPP) was asked to provide technical assistance to numerous public and private agencies regarding teen drinking prevention. The Program distributed, upon request, educational materials and other resources to schools, county health departments, community centers, law enforcement agencies, and various other organizations. The VIPP Director also provided numerous presentations and staff developments across the State regarding alcohol use among teens and healthy choices.

The Adolescent Health Initiative partnered with several agencies, community based groups and schools to support evidence based prevention and provide educational opportunities on the adolescent drinking and/or driving. In partnership with Westbrook Health Services and the Office

of Healthy Schools, the AHI helped develop the educational program Schools Tackling At-Risk Situations. A workbook was created to be included in the schools' existing health class. The lessons include basic information on the topic, warning signs, how to get help, and ways to handle the issues that may lead to a high-risk situation. The topical areas are bullying and peer pressure, eating disorders, depression, anger and violence, alcohol use, substance abuse, dropping out, suicide and homelessness.

The AHI also assisted in the launch of THE EMPTY CHAIR campaign in collaboration with the Brooke/Hancock advocates for Substance Abuse Prevention. The campaign brings awareness to West Virginia's high rate of adolescent drinking and prescription drug abuse in West Virginia. This environmental approach will reduce accessibility of prescription drugs and bring awareness to the consequences of underage drinking. It is hoped this will reduce the number of incidences of adolescent drinking and drugged driving.
Other activities the AHI participated in include:
• Sticker Shock campaigns were held in Kanawha and Marshall Counties. The campaigns involved youth and adult volunteers placing stickers on alcoholic beverages in area retail stores. The stickers warn the purchaser of the risks of the providing alcohol to minors;
• Teen Institutes were held in Jackson and Mingo counties to develop leadership skills and self-esteem in middle school students to enable them to avoid peer pressure to engage in drinking alcohol or using drugs;
• Partnered with local law enforcement and the Governor's Highway Safety Program to provide sobriety checkpoints;
• Partnered with local law enforcement to provide SOBER's simulated DUI course in several high schools across the state;
• Implemented a "Communities Mobilizing for Change on Alcohol" program in Kanawha County;
• Partnered with community substance abuse prevention coalitions and law enforcement to conduct "Beer Sting", "Shoulder-Tap" and "Cops in the Shop" operations to identify area merchants who sell alcohol to underage adolescents. Merchants caught selling alcohols to minors were given the opportunity for staff to receive free training in lieu of paying a fine;
• Assisted several high schools with providing Project Graduations and After Prom events. These events provide a safe and fun alternative to youth going to parties after prom and graduation;
• Partnered with community coalitions and law enforcement to offer Public Service Announcements that aired on the CW Network;
• Presented information on activities being carried out in Upshur County related to Drug/Alcohol Prevention and Red Ribbon Week.
• Assisted with the Harrison County Safety Day at the Bridgeport Country Club. Thirty youth from four counties participated and learned about mini prevention programs they can do for their peers and students back in their home county. Seatbelt safety, drinking and driving, etc. were presented.
• The AHI facilitated several community forums on tobacco, alcohol and substance use including meth, inhalants, synthetic drugs and the growing abuse of energy drinks among youth. The AHI also disseminated information on tobacco, alcohol and substance use at numerous health fairs, "Family Fun Days", Teen Expos, Student Resource Days all across the state.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Students Against Destructive Decisions (SADD) works with communities to establish local chapters.		X		
2. Adolescent Health Initiative promotes healthy decision making.			X	
3. State alcohol distribution policy protects youth.				X
4. Govenor's Highway Safety Program initiatives.				X

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The VIPP convened a tw0 day Statewide meeting, with topics of discussion on youth and high risk behaviors. As a result, a workgroup of professionals was formed with the focus being Youth and High Risk Behaviors. This workgroup met and developed a preliminary list of target issues for prevention efforts as part of the State VIPP Coalition that will meet in August 2013 to finalize specific goals, priorities and actions to reduce the instances of adolescent alcohol use.

The Adolescent Health Initiative maintains the ongoing initiatives that discourage drinking and driving among youth. The AHI continues to provide information at various outreach opportunities to educate families on the problem of tobacco, alcohol and drug use among teens. The AHI is continually working with schools and communities to address these issues. These include:

• Assist in the planning and facilitation of the Greenbrier County Teen Wellness Expo presented at Greenbrier East High School. The Expo provided information to students regarding a wide variety of teen issues including understanding Alcohol Addiction from the Alcoholics Anonymous Model. Students evaluated the event and the overwhelming response was positive;
• Helped create an informal handout regarding the use, misuse and abuse of alcohol for the Prevention Group at the Governor's Regional Substance Abuse Task Force. The intent is for local Substance Abuse Coalitions to use it as a teaching tool and to increase awareness regarding alcohol use.

c. Plan for the Coming Year
The VIPP plans to continue the positive partnerships with other professionals in the field of teen drinking prevention. There will be a section of the VIPP's State Strategic Plan that will focus on teen drinking prevention. Specific goals, objectives and actions necessary to achieve success will be included as well as benchmarks and measures of effectiveness. The VIPP will strengthen efforts in outreach so that statewide prevention activities may be coordinated and implemented.

The Adolescent Health Initiative will continue to develop and expand existing efforts to reduce adolescent drinking and driving. The AHI will work to identify new, innovative and effective strategies for implementation across the state. The AHI will continue to work with local substance abuse coalitions, schools and communities to provide information, technical assistance and resources to address the problem of substance use, including tobacco and alcohol.

State Performance Measure 8: *Decrease the number of high school students who never or rarely wear a seatbelt when riding in a car driven by someone else.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	14	13.5	13	13	13
Annual Indicator	16.4	14.0	14.0	13.8	13.8
Numerator	20600	17600	17600	16800	16800

Denominator	125578	125578	125578	122115	122115
Data Source	2007 WV YRBS	2009 WV YRBS	based upon 2009 WV YRBS	2011 YRBS	based upon 2011 YRBS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	13	13	13	13	13

Notes - 2012
2011 YRBS students who never or rarely wore a seat bealt when riding in a car driven by someone else
denominator total enrolled school year 2010-2011

Notes - 2011
2011 YRBS students who never or rarely wore a seat bealt when riding in a car driven by someone else
denominator total enrolled school year 2010-2011

Notes - 2010
based upon 2009 YRBS
never 5.4% and rarely 8.6%

a. Last Year's Accomplishments
The number of high school students who never or rarely wear a seatbelt when riding in a car driven by someone else has continued to slowly decline from 16.4 in 2008 to 13.8 in 2011.

During the 2013 legislative session, not wearing a seatbelt was passed as a primary offense, allowing law enformcement to stop drivers for not wearing a seatbelt.

The VIPP was asked to provide technical assistance to numerous public and private agencies regarding motor vehicle safety for high school students. The Program distributed, upon request, educational materials and other resources to schools, county health departments, community centers, law enforcement agencies, and various other organizations. The VIPP continued to strengthen its relationship with the Governor's Highway Safety Program and the West Virginia Department of Education, and now receives up to date information regarding student behaviors as they relate to the usage of seatbelts, as well as current and future prevention initiatives planned throughout the State.

The Adolescent Health Initiative participated in several health and safety events across West Virginia and distributed information regarding seatbelt usage to adolescents, parents and other community members. Additionally, the AHI:

• Sponsored the PEDAL (Physical Enrichment Daily And for Life) Power program in Calhoun, Pleasants, Ritchie, Roane, Tyler, Wirt, Wood and Jackson Counties. The program promotes a healthy lifestyle and encourages youth and adults to engage in daily physical activity. The program also promotes bicycle safety and helmet and seatbelt usage to prevent unintentional injuries.
• Partnered with local law enforcement to develop Public Service Announcements on the dangers of drinking and driving and not wearing seatbelts. The ads aired on the CW Network during prom and graduation season;
• Partnered with local law enforcement to host seatbelt safety checkpoints;
• Assisted with the Harrison County Safety Day at the Bridgeport Country Club. Thirty youth from four counties participated and learned about mini prevention programs they can do for their peers and students back in their home county. Seatbelt safety, drinking and driving, etc. were

presented.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WV Department of Transportation promotes seat belt use.				X
2. WV Department of Public Safety sponsors the "Click It or Ticket" campaign and has put an emphasis on enforcement of seat belt usage laws.				X
3. WV state law requires seat belt use.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The VIPP partnered with the WV Director of the Governor's Highway Safety Program and provided a track of training workshops for participants at a two day Statewide meeting. As a result, a workgroup focused on preventing injuries and deaths among high school students has been established and is in the process of developing a strategic plan of action to increase seatbelt usage in high school students.

The AHI collaborates with regional partners and the VIPP to provide presentations to educate youth and parents, and distribute informational literature about unintentional injury, drinking and driving and the use of seatbelts.

The AHI partnering with Charleston Police to develop a community-wide information and enhanced enforcement campaign to encourage seat belt use, helmet use and discourage teens from driving impaired. Discussion also underway to better enhance the enforcement of laws prohibiting the sales of alcohol and tobacco products to minors.

The AHI collaborated with community leaders and the Mingo County Delbarton Fire Department to implement efforts to decrease the number of who don't wear seatbelts. The objective was to seek to reduce motor vehicle and other related unintentional injuries/deaths among youth utilizing community based environmental approaches.

The AHI is working with Mrs. Jane Shuman, From The Willy Foundation to implement the WAS Challenge (Wear A Seatbelt) and their leadership training for youth in schools in Boone and Clay Counties.

c. Plan for the Coming Year

The VIPP plans to continue to strengthen the partnership with the Governor's Highway Safety Program and the West Virginia Department of Education to collaborate in future prevention activities. It is anticipated that the Program will work the Highway Safety partners to educate youth and the public about the new seat belt law. In addition, there will be a section of the VIPP's State Strategic Plan that will focus on motor vehicle safety. Specific goals, objectives and actions

necessary to achieve success will be included as well as benchmarks and measures of effectiveness.

The AHI will implement a minimum of 16 community-wide enhanced enforcement initiatives designed to encourage increased seatbelt and helmet usage. The AHI will continue to participate in local and state safety events.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	9.5	9.1	9.2	9.3	9.3
Numerator	2050	1941	1882	1749	1749
Denominator	21492	21225	20471	18737	18737
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
based upon 2011 Vital Statistics

Notes - 2011
2011 Vital Statistics

Notes - 2010
2010 Vital Statistics

Narrative:
There were a total of 1,749 low birth weight babies (those weighing less than 2,500 grams or 5 1/2 pounds) born to West Virginia residents in 2011, 9.3% of all births according to preliminary 2011 data from WV Vital Statistics. There has been no significant change in low birth weight babies in the last five years.

West Virginia has higher rates than the rest of the nation for c-sections and labor inductions. Concerned that many of these inductions and C-sections are not medically necessary and may be resulting in avoidable negative birth outcomes, the WV Health Care Authority, in partnership with the WV Perinatal Partnership and the WV March of Dimes, developed and implemented a collaborative to study and address the issue. The six month project engaged 14 of the state's 30 hospitals that deliver babies. The participating hospitals represented 70% of the total deliveries in the state. Six months after the implementation of the Collaborative, the rate of elective deliveries prior to 39 weeks without a medical indication had decreased by more than 50%. One year after the completion of the Collaborative, the reduction has been maintained.

Refer to State Priorities section for additional narrative.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	8.0	7.4	7.6	7.5	7.5
Numerator	1670	1518	1503	1361	1361
Denominator	20826	20543	19854	18136	18136
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
based upon 2011 Vital Statistics

Notes - 2011
2011 Vital Statistics

Notes - 2010
2010 Vital Statistics

Narrative:
There was a total of 1,361 low birth weight singleton babies (those weighing less than 2,500 grams or 5 1/2 pounds) born to West Virginia residents in 2011, 7.5% of all births according to preliminary 2011 Vital Statistics data.

West Virginia had higher rates than the rest of the nation for c-sections and labor inductions. Concerned that many of these inductions and C-sections are not medically necessary and may be resulting in avoidable negative birth outcomes, the WV Health Care Authority, in partnership with the WV Perinatal Partnership and the WV March of Dimes, developed and implemented a collaborative to study and address the issue. The six month project engaged 14 of the state's 30 hospitals that deliver babies. The participating hospitals represented 70% of the total deliveries in the state. Six months after the implementation of the Collaborative, the rate of elective deliveries prior to 39 weeks without a medical indication had decreased by more than 50%. One year after the completion of the Collaborative, the reduction has been maintained.

Refer to State Priorities section for additional narrative.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012

Annual Indicator	1.4	1.5	1.3	1.4	1.4
Numerator	305	314	273	267	267
Denominator	21492	21225	20471	18737	18737
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
based upon 2011 Vital Statistics

Notes - 2011
2011 Vital Statistics

Notes - 2010
2010 Vital Statistics

Narrative:
The percent of WV live singleton births weighing less than 1,500 grams was 1.4% for 2011. HB 2837, the Uniform Maternal Screening Act, passed during the 2009 WV legislative session, established an advisory council within the WV DHHR, Office of Maternal, Child and Family Health to assist in developing a uniform maternal risk screening tool. Now developed, all health care providers offering maternity services are required to utilize the tool in their examinations of any pregnant woman, maintain confidentiality and notify the woman of any high-risk condition which they identify along with any necessary referral.

This uniform approach simplifies the process, standardizes procedures and identifies pregnancies that need more in-depth care and monitoring. Additionally, uniform application provides measurable data regarding at-risk and high-risk pregnancies. This allows public health officials to analyze conditions that are most frequently observed and develop methodology to address concerns. In 2011, about 50% of the pregnant women received a maternal risk screen. Information was analyzed and presented to the Advisory. In 2012 there were a total of 11,489 perinatal risk screening forms completed representing approximately 61% of the 2012 preliminary resident births.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	1.2	1.1	1.0	1.1	1.1
Numerator	248	218	204	194	194
Denominator	20826	20543	19854	18136	18136
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
based upon 2011 Vital Statistics

Notes - 2011
2011 Vital Statistics

Notes - 2010
2010 Vital Statistics

Narrative:
The percent of WV live singleton births weighing less than 1,500 grams was 1.1% for 2011. HB 2837, the Uniform Maternal Screening Act, passed during the 2009 WV legislative session, established an advisory council within the WV DHHR, Office of Maternal, Child and Family Health to assist in developing a uniform maternal risk screening tool. Now developed, all health care providers offering maternity services are required to utilize the tool in their examinations of any pregnant woman, maintain confidentiality and notify the woman of any high-risk condition which they identify along with any necessary referral.

This uniform approach simplifies the process, standardizes procedures and identifies pregnancies that need more in-depth care and monitoring. Additionally, uniform application provides measurable data regarding at-risk and high-risk pregnancies. This allows public health officials to analyze conditions that are most frequently observed and develop methodology to address concerns. In 2011, about 50% of the pregnant women received a maternal risk screen. Information was analyzed and presented to the Advisory. In 2012 there were a total of 11,489 perinatal risk screening forms completed representing approximately 61% of the 2012 preliminary resident births.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	9.8	5.3	7.5	4.4	4.4
Numerator	31	17	24	14	14
Denominator	316986	318634	319121	317471	317471
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012

based upon 2011 Vital Statistics and 2010 Census population 0-14

Notes - 2011
2011 Vital Statistics and 2010 Census population 0-14

Notes - 2010
2010 Vital Statistics and 2010 Census population 0-14

Narrative:
The Violence and Injury Prevention Program partnered with West Virginia University's Injury Control Research Center to develop a comprehensive report on the burden of injury in West Virginia. It is the hope of the Program that the release of this report will assist the Program in developing a strategic plan in partnership with a broad variety of stakeholders. Unintentional Injuries among children under the age of fourteen remain the leading cause of death in West Virginia, and much more needs to be done to address this continuing problem. In addition, West Virginia's Governor led efforts to pass a law during the 2012 Legislative session that will ban texting and driving effective in June 2012 and restrict cell phone usage in July 2013. The 2013 Legislature made not wearing a seat belt a primary offense.

Analysis on the reduced number of deaths due to unintentional injuries has not occurred at this time.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	3.5	1.9	3.8	2.5	2.5
Numerator	11	6	12	8	8
Denominator	316986	318634	319121	317471	317471
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
based upon 2011 Vital Statistics and 2010 Census population 0-14

Notes - 2011
2011 Vital Statistics and 2010 Census population 0-14

Notes - 2010
2010 Vital Statistics and 2010 Census population 0-14

Narrative:

Because the number of deaths is small it is difficult to establish a trend, however the rate per 100,000 deaths decreased to 2.5 in 2011 and the number of high school students who never or rarely wear a seatbelt when riding in a car driven by someone else has continued to slowly decline from 16.4 in 2008 to 13.8 in 2011.

The WV Legislature passed the cell/texting law as a primary offense during the 2012 legislative session. The seatbelt law was strengthened during the 2013 legislative session becoming a primary offense.

The Adolescent Health Initiative is a positive youth development program with a team of 8 Coordinators located throughout the state. These Coordinators offer young people, parents, and other significant adults in a child's life skill building sessions on conflict resolution, communication, increased awareness of the harmful consequences of risk behaviors, and strategies to develop self-reliance and improve responsible decision making. These skill building sessions help increase protective factors in an adolescent's life helping them to avoid risky behaviors such as substance/alcohol use, early/unsafe sexual activity, not using a seatbelt, driving while impaired, or other negative outcomes such as depression, unhealthy relationships and suicide.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	34.3	34.5	19.8	27.2	27.2
Numerator	78	83	47	65	65
Denominator	227161	240529	237296	238820	238820
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
based upon 2011 Vital Statistics and 2010 Census population 15-24

Notes - 2011
2011 Vital Statistics and 2010 Census population 15-24

Notes - 2010
2010 Vital Statistics and 2010 Census population 15-24

Narrative:
The death rate from unintentional injuries due to motor vehichle accidents among youth aged 15 through 24 dramatically increased in 2011 from 2010, but still remains below the 2008 and 2009 rates.

West Virginia has several programs in place to address the safety of drivers and occupants aged

15 to 24: Graduated Driver's Licensing Programs; High Visibility Law Enforcement activities; and public awareness education and events.

APPI is a strong partner with the West Virginia Department of Education. The Initiative supports the belief that improving health-related decision making and reducing risk behaviors can only occur as a result of educating teens with refusal and delay tools. APPI presentations are structured to include development of refusal skills and delay tactics which could be used to avoid unsafe circumstances such as not using a seat belt, driving while impaired and cell phone use during driving. Specialists have adapted techniques from Reducing the Risk, an evidence-based curriculum as the basis for this skill development.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	278.0	268.0	190.5	242.2	242.2
Numerator	915	882	608	769	769
Denominator	329137	329137	319121	317471	317471
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
based upon 2011 Hospital Discharge data, HCA
Use caution with interpretation of ECODE data. ECODEs are under reported in this dataset.

Notes - 2011
2011 Hospital Discharge data, HCA
Use caution with interpretation of ECODE data. ECODEs are under reported in this dataset.

Notes - 2010
2010 Hospital Discharge data, HCA
Use caution with interpretation of ECODE data. ECODEs are under reported in this dataset. There were 46,144 non-fatal diagnoses of injury vs. 32,303 ECODES, this is a difference of 13,841 with no ECODE reported.

Narrative:
The West Virginia Violence and Injury Prevention Program provides coordination of prevention activities throughout the State. By serving on the Violence and Injury Prevention Advisory Board, several OMCFH staff are able to coordinate each other's Program activities so that injuries in every age group may be properly addressed. Much more work is needed to be done, but positive partnerships have developed and Programs are coordinating their efforts now more than ever in order to work toward preventing injuries among children under the age of fourteen.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	40.4	36.5	36.7	43.8	43.8
Numerator	133	120	117	139	139
Denominator	329137	329137	319121	317471	317471
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
based upon 2011 Hospital Discharge Data - HCA
Use caution with interpretation of ECODE data. ECODEs are under reported in this dataset.

Notes - 2011
2011 Hospital Discharge Data - HCA
Use caution with interpretation of ECODE data. ECODEs are under reported in this dataset.

Notes - 2010
2010 Hospital Discharge Data - HCA
Use caution with interpretation of ECODE data. ECODEs are under reported in this dataset. There were 46,144 non-fatal diagnoses of injury vs. 32,303 ECODES, this is a difference of 13,841 with no ECODE reported.

Narrative:
The Governor's Highway Safety Program saw more participation in the Child Passenger Safety Program (CPS), and held numerous events promoting the importance of keeping all children properly restrained.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	81.1	84.0	217.9	240.3	240.3
Numerator	558	578	517	574	574
Denominator	688401	688401	237296	238820	238820
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
denominator in years prior to 2010 has been misreported - had include all ages through 24, not just 15-24 year olds
based upon 2011 Hospital Discharge Data - HCA
Use caution with interpretation of ECODE data. ECODEs are under reported in this dataset.

Notes - 2011
denominator in years prior to 2010 has been misreported - had include all ages through 24, not just 15-24 year olds
2011 Hospital Discharge Data - HCA
Use caution with interpretation of ECODE data. ECODEs are under reported in this dataset.

Notes - 2010
denominator in years prior to 2010 has been misreported - had include all ages through 24, not just 15-24 year olds
2010 Hospital Discharge Data - HCA
Use caution with interpretation of ECODE data. ECODEs are under reported in this dataset.
There were 46,144 non-fatal diagnoses of injury vs. 32,303 ECODES, this is a difference of 13,841 with no ECODE reported.

Narrative:
In 2010, West Virginia's seatbelt usage rate was 82.15%, down from 87% in 2009. WV's usage rate for 2011 is 85%, and the Governor's highway safety program attributes the increase to more citizens getting the Click it or Ticket message through a strong media campaign and law enforcement actively enforcing the seatbelt law. A primary seat belt law was passed in the 2013 legislature.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	15.3	17.4	19.3	20.6	23.2
Numerator	935	1065	1124	1167	1315
Denominator	61043	61043	58233	56565	56565
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
Office of Epidemiology and Prevention Services, Division of STD, HIV and Hepatitis

Notes - 2011
Office of Epidemiology and Prevention Services, Division of STD, HIV and Hepatitis

Notes - 2010
DSDC STD Unit

Narrative:
Chlamydia infections in West Virginia disproportionately affect women in the early reproductive stage of life. In CY 2012, 57.0 percent (N=2,726) of all reported infections occurred in women aged 15 to 24 years, with 29.5 percent (N=1,411) occurring in women aged 20 to 24 years and 27.5 percent (N=1,315) occurring among women aged 15 to 19 years. Men aged 20 to 24 years ranked third with 13.1 percent (N=628) of reported infections, followed by women aged 25 to 29 years with 8.2 percent (N=391). A similar pattern was found in CY 2011 when 57.3 percent (N=2,456) of reported infections occurred in women aged 15 to 24 years. Women aged 20 to 24 years accounted for 30.0 percent (N=1,284) of all reported infections, followed by women aged 15 to 19 years with 27.3 percent (N=1,172). Men aged 20 to 24 years ranked third with 12.5 percent (N=536) of cases, followed by women aged 25 to 29 years with 8.4 percent (N=358).

Chlamydia infections have occurred in all races and ethnic groups in West Virginia. However, non-Hispanic Blacks have consistently been disproportionately affected. Despite accounting for approximately 3.4 percent of the state's population, non-Hispanic Blacks represented 18.1 percent (N=865) of the infections reported in CY 2012 compared to 18.5 percent (N=792) in CY 2011. Overall, there was a 9.2 percent increase in cases reported for non-Hispanic Blacks from CY 2011 (N=792) to CY 2012 (N=865). The increase in cases was greatest among non-Hispanic Whites who experienced a 33.8 percent increase during the same time period (N=2,572 and 3,442, respectively).

The analysis of West Virginia morbidity data, utilizing the CDC's STD*MIS application, and partner services activities for CY 2012 led to no additional changes in case assignment criteria for Chlamydia and gonorrhea. The following criteria remain for cases initiated to the field for DIS investigation and partner services: all pregnant females and all patients age 14 and under who test positive for Chlamydia regardless of testing source and all gonorrhea cases.

In CY 2011 and CY 2012, the STD Data Manager worked with the state's Office of Technology to provide the DIS with a secure internet gateway for accessing the STD*MIS application. The DIS have noted quicker response time and fewer connectivity issues.

The Division collaborates and shares STD data with other public health programs on a regular basis: the HIV Prevention Program, Ryan White Part A, Part B and HIV Care Programs, the Division of Perinatal and Women's Health, HIV Prevention Community Planning Group, local health departments, Department of Corrections, Community-Based Organizations, Faith-based Organizations, Division of Substance Abuse, Division of Mental Health, Board of Education programs as well as several other community service agencies. Annual STD data reports are also posted on the Division website for provider and public information.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	5.0	5.4	5.8	6.5	7.1
Numerator	1481	1584	1652	1841	2032
Denominator	294987	294987	283748	284680	284680
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
Office of Epidemiology and Prevention Services, Division of STD, HIV and Hepatitis

Notes - 2011
Office of Epidemiology and Prevention Services, Division of STD, HIV and Hepatitis

Notes - 2010
DSDC STD Unit

Narrative:
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Chlamydia infections have occurred in all races and ethnic groups in West Virginia. However, non-Hispanic Blacks have consistently been disproportionately affected. Despite accounting for approximately 3.4 percent of the state's population, non-Hispanic Blacks represented 18.1 percent (N=865) of the infections reported in CY 2012 compared to 18.5 percent (N=792) in CY 2011. Overall, there was a 9.2 percent increase in cases reported for non-Hispanic Blacks from CY 2011 (N=792) to CY 2012 (N=865). The increase in cases was greatest among non-Hispanic Whites who experienced a 33.8 percent increase during the same time period (N=2,572 and 3,442, respectively).

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In CY 2011 and CY 2012, the STD Data Manager worked with the state's Office of Technology to provide the DIS with a secure internet gateway for accessing the STD*MIS application. The DIS have noted quicker response time and fewer connectivity issues.

The Division collaborates and shares STD data with other public health programs on a regular basis: the HIV Prevention Program, Ryan White Part A, Part B and HIV Care Programs, the Division of Perinatal and Women's Health, HIV Prevention Community Planning Group, local health departments, Department of Corrections, Community-Based Organizations, Faith-based Organizations, Division of Substance Abuse, Division of Mental Health, Board of Education programs as well as several other community service agencies. Annual STD data reports are also posted on the Division website for provider and public information.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	20571	18498	983	42	213	6	829	0
Children 1 through 4	82885	74958	3392	136	586	32	3781	0
Children 5 through 9	105299	96438	4043	172	789	33	3824	0
Children 10 through 14	108716	100193	4241	227	765	27	3263	0
Children 15 through 19	117105	107652	5676	265	797	42	2673	0
Children 20 through 24	121715	112012	5944	242	1483	60	1974	0
Children 0 through 24	556291	509751	24279	1084	4633	200	16344	0

Notes - 2014

Narrative:
Children ages 0-24 make up approximately 30% of WV's population. White children make up 92% of the population, black 4.3%, more than one race 2.9% and Asian .8%.

Refer to the State Overview for additional population information.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	20299	272	0
Children 1 through 4	80717	2168	0
Children 5 through 9	103022	2277	0
Children 10 through 14	106683	2033	0
Children 15 through 19	114947	2158	0
Children 20 through 24	119362	2353	0
Children 0 through 24	545030	11261	0

Notes - 2014

Narrative:
Of the 556,291 total children ages 0-24 only 11,261 (2%) are Hispanic or Latino.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY	**Total**	**White**	**Black or**	**American**	**Asian**	**Native**	**More**	**Other and**

Total live births	**All Races**		**African American**	**Indian or Native Alaskan**		**Hawaiian or Other Pacific Islander**	**than one race reported**	**Unknown**
Women < 15	24	20	3	0	0	0	1	0
Women 15 through 17	615	573	32	0	0	0	9	1
Women 18 through 19	1668	1582	72	1	0	0	12	1
Women 20 through 34	14803	14110	496	12	43	91	45	6
Women 35 or older	1626	1535	52	3	9	23	3	1
Women of all ages	18736	17820	655	16	52	114	70	9

Notes - 2014

Narrative:
Of the 18,736 total live births in 2011, 95% were born to White mothers, 3.5% born to Black mothers, and approximately 1.5% born to AINA, Asian Pacific Islander or more than one race reported.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	23	1	0
Women 15 through 17	607	8	0
Women 18 through 19	1649	19	0
Women 20 through 34	14658	145	0
Women 35 or older	1596	30	0
Women of all ages	18533	203	0

Notes - 2014

Narrative:
Of the 18,939 live births to WV residents, 406 or 2% were to women of hispanic or latine origin. The bulk of these births occur in the Eastern Panhandle close to Washington, D.C. OMCFH programs offering services in that area of the state offer public health educational brochures in Spanish.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY	**Total**	**White**	**Black or**	**American**	**Asian**	**Native**	**More than**	**Other and**

Total deaths	**All Races**		**African American**	**Indian or Native Alaskan**		**Hawaiian or Other Pacific Islander**	**one race reported**	**Unknown**
Infants 0 to 1	121	112	8	0	0	0	1	0
Children 1 through 4	17	17	0	0	0	0	0	0
Children 5 through 9	13	13	0	0	0	0	0	0
Children 10 through 14	19	19	0	0	0	0	0	0
Children 15 through 19	66	61	5	0	0	0	0	0
Children 20 through 24	136	129	7	0	0	0	0	0
Children 0 through 24	372	351	20	0	0	0	1	0

Notes - 2014

Narrative:
Of the 121 infant deaths 93% were white, and 7% black. Deaths to children ages 1-14 were 100% white. Of children ages 15- 19, 93% were white and 7% black. Of children ages 20-24, 95% were white and 5% black. This is roughly representative of the racial population in WV.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	120	1	0
Children 1 through 4	17	0	0
Children 5 through 9	13	0	0
Children 10 through 14	19	0	0
Children 15 through 19	66	0	0
Children 20 through 24	135	1	0
Children 0 through 24	370	2	0

Notes - 2014

Narrative:
Of deaths to children ages 0-24, .5% are hispanic or latino, 95.5% are not hispanic or latino. WV has a very low hispanic or latino population.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	434576	397739	18335	842	3150	140	14370	0	2011
Percent in household headed by single parent	30.9	24.2	50.1	30.9	12.9	25.0	43.8	27.5	2010
Percent in TANF (Grant) families	4.9	4.9	0.0	0.0	0.0	0.0	0.0	0.0	2012
Number enrolled in Medicaid	173390	162813	6782	24	520	30	2701	520	2012
Number enrolled in SCHIP	37608	35323	1475	8	102	17	570	113	2012
Number living in foster home care	7178	5922	715	15	20	17	470	19	2012
Number enrolled in food stamp program	131406	131406	0	0	0	0	0	0	2012
Number enrolled in WIC	39149	34673	1506	110	101	36	2723	0	2012
Rate (per 100,000) of juvenile crime arrests	986.0	787.0	171.0	0.5	2.1	0.0	0.0	26.0	2011
Percentage of high school drop-outs (grade 9 through 12)	1.7	1.7	2.2	1.4	1.2	0.0	0.0	0.0	2012

Notes - 2014
2012 Census American Community Survey
household type children under 18
male no wife present and female no husband present
household type by race

not broken down by race

CHIP annual report - fiscal year ending June 30, 2012
race calculations based roughly on CHIP percentage
only includes children 0-18

CHIP annual report - fiscal year ending June 30, 2012
race calculations based roughly on CHIP percentage
only includes children 0-18

not broken down by race

2012 WIC Data

Criminal Justice Statistical Analysis Center
Asian and Pacific Islander calculated as one under Asian
More than one race not reported
Previously calculated as rate per each race population - now calculated as rate by total population

reported as rate
FY 2012

AFCARS report ending data 03-2013

Narrative:
For the above numbers TANF and the food stamp program have difficulty breaking down the demographics so there is a zero for those fields.

Forty-one percent of all white children ages 0-19 are enrolled in Medicaid, while 37% of all black children ages 0-19 are Medicaid enrolled.

Nine percent of white children ages 0-19 are enrolled in WVCHIP while 8% of black children are enrolled in WVCHIP.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	425668	8908	0	2011
Percent in household headed by single parent	69.1	30.9	0.0	2010
Percent in TANF (Grant) families	0.0	0.0	4.9	2012
Number enrolled in Medicaid	0	0	173390	2012
Number enrolled in SCHIP	0	0	37608	2012
Number living in foster home care	76	6022	152	2012
Number enrolled in food stamp program	0	0	131406	2012
Number enrolled in WIC	37908	1241	0	2012
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	986.0	2011
Percentage of high school drop-outs (grade 9 through 12)	98.0	2.0	0.0	2012

Notes - 2014
2012 Census American Community Survey
household type children under 18

male no wife present and female no husband present
household type by race

not broken down by ethnicity

not broken down by ethnicity

not broken down by ethnicity

not broken down by ethnicity

2012 WIC Data

not broken down by ethnicity

reported as rate

Narrative:
Some fields were unable to be identified by ethnicity such as TANF, Medicaid, SCHIP, Food Stamps and juvenile crime arrests. 1.4% of non-hispanic children 0-19 years of age are foster care while close to .9% of hispanic children ages 0-19 are in foster care.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	8784
Living in urban areas	202038
Living in rural areas	237175
Living in frontier areas	0
Total - all children 0 through 19	439213

Notes - 2014

Narrative:
Most of WV is rural with population centers such as Charleston, the State's Capital in the center of the state, Huntingon, in the western part of the state where Marshall University is located, Morgantown, in the northern part of the state where WVU is located and Martinsburg, in the eastern panhandle close to D.C. Approximately half (48%) of the state's children live in urban/metropolitan areas, while approximately half (52%) live in rural areas.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1799960
Percent Below: 50% of poverty	8
100% of poverty	21
200% of poverty	40

Notes - 2014

Narrative:
According to the WV Center on Budget and Policy and the WV Healthy Kids Coalition poverty rates for children have remained consistently high (around 23%). Meanwhile, the poverty rate for seniors has declined from nearly 40 percent in 1969 to 10% in 2011. The poverty rate of working-age West Virginians has also declined over the last five decades.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	439213
Percent Below: 50% of poverty	15
100% of poverty	23
200% of poverty	22

Notes - 2014

Narrative:
According to the WV Healthy Kids and Families Coalition, three in 10 West Virginia kids under age six live in poverty; tens of thousands more live right on the edge. More than one in four of all WV children lives below the federal poverty line, the 13th highest poverty rate in the Nation. They want for food, child care, and their parents' time. Research in brain development shows that social, emotional and cognitive development are shaped in early childhood and have lifelong effects. Poor kids are five times more likely to have children outside marriage, twice as likely to be arrested, and nearly three times as likely to have severe health problems. Poor kids also end up earning incomes less than half those of their counterparts.

According to the 2011 American Community Survey, 25.8 percent of related WV children (94,852) under the age of 18 live in poverty compared with 22.2 percent of U.S. children and more than one in 10 lives in deep poverty which means living on less than $11,406 annually for a family of four with two children.

With the increase in the numbers of children living in poverty in WV and in homes where there is increased substance abuse and/or domestic violence, there is an urgent need to have appropriately trained home visitors, teachers, child care providers, child welfare workers, administrators, policymakers and technical assistance/training providers who are knowledgeable and skilled in evidence-based practices for promoting social-emotional competence and preventing challenging behaviors. Over the past several months, the Early Care and Education and Early Childhood Advisory Council (ECAC) and the WV Home Visitation Progam contacted with Wisconsin Alliance for Infant Mental Health (W-AIMH) to assist early childhood stakeholders in determining how WV could proceed with infant and early childhood mental health competencies and endorsements. ECAC selected the Wisconsin contractor due to their extensive work with implementing the Michigan's Association for Infant Mental Health (MI-AIMH). After thorough review and extensive discussion, the committee made a formal recommendation to approve the use of ECAC funds to purchase MI-AIMH.

The adopted Michigan competencies will be integrated into the various infant mental health efforts within WV. The Endorsement will serve as a framework for early childhood providers across service delivery areas. The system will provide a framework for WV to move forward with

early infant mental health efforts. This activity will strengthen the WV Early Childhood Care System's efforts in developing a coordinated and comprehensive early childhood system. The endorsement system will provide a framework for what WV is already doing. The support from Michigan along with all the materials and the learning community with the League of States will assist in a successful implementation of infant and early childhood competency and endorsement system.

F. Other Program Activities

/2012/ The WV OMCFH has been expanding programs due to the influx of federal funds and reorganization and has outgrown the capacity portion of the application. Additional programs and activities of interest are listed within this section.

Connect to Care Project:
Connect to Care is a telecommunications project linking rural health facilities with tertiary care centers housing perinatal specialists. Live telecommunications allows high risk pregnant women and infants and their local health care providers to obtain important medical advice without leaving their own communities and traveling far distances. Connect to Care also allows for medical and nursing education at the rural sites and access for obstetrical referrals. Connect to Care is currently a pilot program. Fifteen rural health care sites are participating with the three West Virginia hospitals providing high risk prenatal and newborn care. The project is funded by a Rural Utilities Service Grant from the U.S. Department of Agriculture and matching funds from eighteen partnering West Virginia hospitals and community health centers. Technical assistance and training for this project is being provided by Charleston Area Medical Center Health Education and Research Institute, a partner organzation of the West Virginia Perinatal Partnership. Dr. Luis Bracero, maternal fetal medicine specialist and member of WVPP's Central Advisory Council serves as Principle Investigator for the Project. //2012// /2013/ A series of live webcasts were provided for healthcare professionals and stored on the Perinatal Partnership website. //2013//

/2013/ Birth To Three/ Early Intervention/Part C:
In 2012, the ECAC (with Title V, WVBTT and HV as Governor appointed members) will be co-sponsoring with the WV Center on Civic Life, Community Dialogues across the state to encourage communities to engage in conversations about the importance of positive experiences during a child's first three years of life -- and the life-long health and other impacts of negative experiences.

WVBTT uses a rigorous survey to gather input from all families of children as they exit the BTT, regarding impact of early intervention services. The information is used to report on three national Family Outcomes for Part C and guides program improvement strategies.

WVBTT in collaboration with the WV Dept of Ed, sponsors annual Camp Gizmo, a week-long camp for families and professionals to problem solve how assistive technology can support children with significant developmental delays. WVU and Wheeling Jesuit also send students from the Speech Pathology and Physical Therapy programs to participate in the camp for academic credit. This experience encourages many of the students to pursue careers working with young children.

WV CHIP is now partnering with OMCFH and WVBTT to provide reimbursement for Part C early intervention services. //2013//

/2013/ Focus Groups, APPI/FPP, November 2010

Purpose: To understand the health behaviors of young adults 29-29 years of age in regard to unplanned pregnancies. Discussion included accessing the knowledge of various sexual health issues, motivation factors that encourage or deter the use of contraception and to determine if there was a preferred format for learning about these topics.

In November 2010, six (6) groups were conducted consisting of women and men between the ages of 19-29. Increased sex education was the most discussed topic of all the groups. Many of the adults stated they had few opportunities to learn about more than just the biological aspects of sex. Most remembered only have a classroom discussion about sexuality once or twice from 7th to 12th grade. STD prevention was a higher priority than pregnancy prevention for both groups. It was difficult for the groups to talk about pregnancy in a negative way and more stated pregnancy was a blessing.

Focus Groups, APPI, November 2011

Purpose: These focus groups were developed to address the recent increase in births to 15-17 year olds in WV. Discussion included decision making regarding contraception, needs teens have to obtain contraception, why some teens are choosing to have unprotected sex and messaging that could resonate with teens to use protection.

In November 2011, six (6) groups were conducted consisting of women and men that became parents between the ages of 15-17 or were to become parents between the ages of 15-17. Again, education was the most discussed issue. Participants stated the need for more inclusive and frequent sex education. Teens perceived contraception to not be easily accessible whether due to its cost, lack of transportation or embarrassment. Some of the participants planned their pregnancy to escape abuse (physical, sexual or emotional) in their home. Alcohol and other substances were contributors to careless decision making with many participants. The majority felt invincible "it won't happen to me". Although all participants stated they loved their children, they wished they had delayed sexual activity and parenting. //2013//

G. Technical Assistance

West Virginia needs technical assistance to improve capacity to address racial, ethic, economic and health disparities as well as cultural competence.

The WV Bureau for Public Health is establishing an Office of Minority Health and Health Equity.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	6371254	6377017	6377020		6325547	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	9401284	10131796	9053003		9016996	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	14500000	11081640	14500000		16395813	
7. Subtotal	30272538	27590453	29930023		31738356	
8. Other Federal Funds *(Line10, Form 2)*	16202177	13575995	19384764		22246565	
9. Total *(Line11, Form 2)*	46474715	41166448	49314787		53984921	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2012		FY 2013		FY 2014	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1574996	352383	215762		840055	
b. Infants < 1 year old	1996409	557969	2117463		1839132	
c. Children 1 to 22 years old	2922797	3320940	3523572		3720936	
d. Children with	18690072	16591096	20306274		21046070	

Special Healthcare Needs						
e. Others	4329757	5931331	2937030		3401792	
f. Administration	758507	836734	829922		890371	
g. SUBTOTAL	30272538	27590453	29930023		31738356	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	97260		113470		66392	
c. CISS	0		0		0	
d. Abstinence Education	589861		360236		287835	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	5174915		5741190		5052925	
j. Education	2152956		2151649		2170499	
k. Home Visiting	0		2242401		2853360	
k. Other						
ARREST	949966		452000		899955	
COMM. BASED INT SYS					140000	
Family Planning	2430093		2382499		1072124	
NEWBORN HEARING					172263	
Oral Hth Workforce					500000	
PREP (APPI)			278827		262382	
Preventative Block					326782	
TANF	1666640		2000000		3235867	
TITLE XIX			3225244		5206181	
Community Based Sys	105000		150000			
Preventative Health			287248			
Early Home Visit	883550					
Title XIX	2151936					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	1942176	1478383	2091034		1748131	
II. Enabling Services	18985147	15847030	19331002		21028194	
III. Population-Based Services	6522132	5518846	5520445		5742630	
IV. Infrastructure Building Services	2823083	4746194	2987542		3219401	
V. Federal-State	30272538	27590453	29930023		31738356	

Title V Block Grant Partnership Total						

A. Expenditures

Please reference notes contained with forms 3, 4 and 5 for a dicussion of budgeted estimates and actual expenditures.

B. Budget

The Office of Maternal, Child and Family Health has done a good job of leveraging resources. The Block Grant Title V, serves as the foundation but the Office also administers Family Planning funded by Title X, TANF, Title V, State funds; Title XV Breast and Cervical Cancer Screening Program; Part C/IDEA, funded by the Department of Education; Childhood Lead Prevention Program, Title V funded; EPSDT, funded by Title XIX; Children with Special Health Care Needs, funded by Title XIX and Title V; Right From the Start funded by Title XIX and Title V; Adolescent Pregnancy Prevention Initiative funded by state dollars; Injury Prevention funded by CDC and PRAMS, funded by CDC and Title V. All of these funding streams augment what is purchased with Title V monies. Like many states across the country, the WV OMCFH has moved away from the sole focus of purchasing or providing individual health services and has placed attention and fiscal resources on developing a system of care.

Sequestration:

• In 2013, federal agencies and programs that fund maternal and child health services experienced automatic across-the-board cuts up to 8.2% under sequestration. While the actual cuts have not been determined for all federally funded programs, the Office of Maternal, Child and Family Health will be directly impacted by the federal budget sequestration. In total, OMCFH estimates a loss of nearly $750,000 in federal grant funds. These cuts negatively impact the ability to deliver critical services to mothers and babies in need and disproportionately impact low-income and uninsured families. Specific to Title V MCH Block Grant cuts, OMCFH plans to utilize prior year re-appropriated State appropriations/General Revenue funds to maintain core services funded through the Block. New planned initiatives will be delayed until funding is available and currently funded special projects may be reduced.

State Budget cuts:

• In addition to the negative impact of the federal sequester, the FY 2014 WV State budget reduction left OMCFH with nearly $490,000 less in State Appropriations/General Revenue for services, activities and projects targeted to MCH populations. OMCFH plans to utilize prior year re-appropriated State appropriations/General Revenue funds to maintain core services and offset the loss of federal funds, but has initiated processes to reduce expenditures in numerous areas.

WV Medicaid Expansion to 138% FPL:

• On Thursday, May 2, 2013, Governor Earl Ray Tomblin joined by U.S. Sen. Rockefeller, President and CEO of United Health System Tom Jones, and CEO of Thomas Health Systems Steve Dexter, announced the decision to expand Medicaid in West Virginia to 138% FPL.

• Following the ACA Supreme Court decision, West Virginia leveraged a competitively bid actuarial modeling contract to analyze the impact of many ACA reforms and Medicaid expansion on West Virginia. In total, the Report indicated that the Medicaid expansion will provide insurance coverage to approximately 91,500 West Virginians, significantly reducing the number of uninsured West Virginians.

• Individuals with private insurance will see reductions in the amount of subsidies they provide associated with the delivery of uncompensated care.

A large number of individuals will qualify for Medicaid that have substance abuse and behavioral health needs; thus the State will draw down significant federal funds to treat these problems that are now addressed with State funds

• The State will end the disincentive to current Medicaid enrollees from working -- under expansion impoverished families can work to the middle class and no longer fear losing insurance coverage.
• The total Medicaid expansion costs for West Virginia will be approximately $375.5 million from FY 2014 through FY 2023, an average of $37.55 million per year over the 10 year period. Expansion results in approximately $5.2 billion in federal dollars coming into the state from FY 2014 through FY 2023, or an average of $520 million per year over the 10 year period.
• Cost of care will be covered by 100% federal funds for first three years, capturing majority of pent-up demand, with $1.267 billion federal dollars at a cost of only $15 million in state administrative match dollars. When the match rate is fully applied in 2020, Feds will pay $9 for every $10 spent on the expanded population for cost of care.
• The State will be helping working West Virginians -- i.e., those with income levels from 17% to 138% of FPL obtain insurance. In addition, the expansion creates financial security for working families that experience medical hardships.

Because of the low median income of WV families, the need for services has been great but resources have been limited. The State Legislature routinely supports the Office of Maternal, Child and Family Health, but over the years this commitment has not kept pace with the demand for services and escalating cost.

The OMCFH provides leadership for many of the health care services and systems of care provided in the state. Medicaid, CHIP and others are purchasers/payers, but the OMCFH and its staff recruit clinicians, establish state policy and care protocols, monitor provider behavior, complete care coordination and offer skill building opportunities, all using the resources identified above to improve WV's health care system.

The WV OMCFH administers EPSDT on behalf of Medicaid, for children not enrolled in an HMO, and has done so for approximately 30 years. The Bureau for Medical Services supports the Program by paying for individual health services for children and administrative support for salaries of the MCFH team administering EPSDT. The OMCFH develops, distributes, and purchases anticipatory guidance which is used by the participating providers. OMCFH also is responsible for bringing together members of the medical community to provide guidance as it relates to pediatric care, not just EPSDT, but newborn hearing screening, newborn screening, children with special health care needs, birth defects, lead poinsoning, etc. OMCFH uses many of the programs cited to identify children who are ultimately referrred to The Children with Special Health Care Needs Program (CSHCN). The CSHCN Program, financed under Medicaid and Title V, not only serves children who have diagnosed chronic and debilitating conditions but arranges assessment for children referred by their primary care/medical home. All of these efforts are commitments to primary and preventive care of the state's children and ultimately have a tie-in to CSHCN when indicated.

Using the statutory authority under Title V that allowed for cost based reimbursement for Medicaid beneficiaries and the authority vested in Title V to be responsible for all populations, OMCFH embarked upon an ambitous redesign plan for the Birth to Three/Part C system. This redesign allowed the State of WV to implement a system change in alignment with Part C requirements and to obtain financing necessary to support the system. This system is designed to serve children who are developmentally delayed or at risk of developmental delay, but the many programs administered by the Office serve as a referral conduit. Referral sources include the Birth Score screening that is completed on every baby born in WV to screen for developmental delay or identify those at risk of post neonatal death, the Birth Defects Surveillance System, Newborn Screening and Newborn Hearing Screening programs, and of course EPSDT. This system change has been in the process for several years and has resulted in families having an opportunity to select a provider of service, improved financing for the system, and assurance that families are served by appropriately credentialed personnel. OMCFH has used Title V connections and fiscal resources to secure support from the medical community including developing physician training programs, offering skill building around the early detection of

developmental delay, and to champion messages to their colleagues that the early identification of children who are at risk are important to all.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.