# Maternal and Child Health Services Title V Block Grant

# West Virginia

# FY 2021 Application/ FY 2019 Annual Report

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# Table of Contents

## I. General Requirements

## I.A. Letter of Transmittal

STATE OF WEST VIRGINIA
**DEPARTMENT OF HEALTH AND HUMAN RESOURCES**
**Bureau for Public Health**
Office of Maternal, Child and Family Health

**Bill J. Crouch**
**Cabinet Secretary**

**Ayne Amjad, MD, MPH**
**Commissioner & State Health Officer**

September 1, 2020

Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18-31
Rockville, Maryland 20857

Dear Grants Management Officer:

The West Virginia Department of Health and Human Resources, Office of Maternal, Child and Family Health is pleased to submit the following reports:

1. Application for Funds under the Title V Maternal and Child Health Services Block Grant for Fiscal Year 2021.

2. Fiscal Year 2019 Annual Report of Activities funded by the Maternal and Child Health Block Grant.

We are appreciative of the availability of federal funding that makes community-based health care more available and accessible to women, infants, and children and children with special health care needs in West Virginia.

Please direct questions and/or concerns regarding programmatic responsibilities to Kathryn Cummons, Director, Division of Research, Evaluation and Planning, Office of Maternal, Child and Family Health, at (304) 414-0534. Questions and/or comments regarding the business management responsibilities should be directed to Larry Easter, Director, Division of Grant Administration and Reporting, at (304) 558-3378.

Sincerely,

Tara L. Buckner
Chief Financial Officer

James Jeffries, Director
Office of Maternal, Child and Family Health

TLB/JEJ/vc

Enclosures

350 Capitol Street, Room 427 • Charleston, West Virginia 25301 • 304-558-5388 • 304-558-2183 (fax) • dhhr.wv.gov

## I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

## I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

## I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

## II. Logic Model

*Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.*

## III. Components of the Application/Annual Report

## III.A. Executive Summary

### III.A.1. Program Overview

Enacted in 1935 as part of the Social Security Act, the Title V Maternal and Child Health Program is the Nation's oldest Federal-State partnership. For over 80 years, the Title V Maternal and Child Health program has provided a foundation for ensuring the health of the Nation's mothers, women, children, youth, including children and youth with special health care needs, and their families. Title V converted to a Block Grant Program in 1981.

The Title V Maternal and Child Health program seeks to:

1. Assure access to quality care, especially for those with low-incomes or limited availability of care
2. Reduce infant mortality
3. Provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at-risk pregnant women)
4. Increase the number of children receiving health assessments and follow-up diagnostic and treatment services
5. Provide and ensure access to preventive and childcare services as well as rehabilitative services for certain children
6. Implement family-centered, community-based, systems of coordinated care for children with special health care needs; and
7. Provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

State Maternal and Child Health agencies apply for and receive a formula grant each year. In addition to the submission of a yearly application/annual report, State Title V programs are also required to conduct a statewide, comprehensive Needs Assessment every five years. States and jurisdictions use their Title V funds to design and implement a wide range of maternal and child health and children with special health care needs activities that address National and State needs.

Unique in its design and scope, the Maternal and Child Health Block Grant to States program:

1. Focuses on the entire maternal and child health population
2. Encompasses infrastructure, population-based, enabling, and direct services for the maternal and child health population
3. Requires a unique partnership arrangement between Federal, state, and local entities
4. Requires each state to work collaboratively with other organizations to conduct a statewide, comprehensive Needs Assessment
5. Based on the findings of the Needs Assessment, requires each state to identify priorities to comprehensively address the needs of the MCH population and guide the use of the Maternal and Child Health Block Grant funds; and
6. May serve as the payer of last resort for direct services for the maternal and child health population that are not covered by any other program.

It is the goal of Title V to assure availability of a comprehensive quality, accessible maternal and child health system that will positively affect pregnancy outcomes and promote positive health status for infants, children, adolescents, and children with special health care needs by involving multiple stakeholders across West Virginia. The Title V Needs Assessment identifies needs based on data/outcomes and partners with community and 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; and collaborate with community resources, government agencies, families, and other stakeholders to identify resources essential for healthy families such as childcare services, healthcare, and economic support. The vision of the WV Office of Maternal, Child, and Family Health (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.

WV uses a systematic method in developing a working framework for carrying out the required five-year Needs Assessment using epidemiological and qualitative approaches to determine priorities incorporating data, clinical, cost-effectiveness, and patient, provider, and stakeholder perspectives. WV also looks at available capacity in determining health interventions and attempts to make explicit what health benefits are being pursued. This approach tries to balance the clinical, ethical, and economic considerations of need—what should be done, what can be done, and what can be afforded when determining evidence-based health interventions.

Once the Needs Assessment is completed, interventions developed and implemented, evaluation of the effectiveness of the interventions is conducted and, if needed, changed as indicated using evaluation recommendations. Partners are involved in this process since many partners are involved in the intervention strategies. Data collection and analysis for maternal, infant, and child health outcome are shared with stakeholders across state and local government, as well as with the Centers for Disease Control and Prevention (CDC) and the Health Resources Services Administration (HRSA).

The WV 2020 Needs Assessment identified the following priority areas for securing better health outcomes for mothers, infants, children, and adolescents:

1. Smoking in pregnancy and smoke exposure in the home
2. Infant mortality
3. Preterm birth
4. Injury – specifically bullying and suicide (attempted)
5. Substance use in pregnancy and in youth/teens
6. Breastfeeding initiation and duration
7. Medical home
8. Obesity in children
9. Oral health in pregnancy
10. Transition

The findings of the 2020 WV Title V Five Year Needs Assessment supported the struggles WV has with positive health outcomes in part due to pervasive poverty, chronic disease, an aging population, and employment security. Behaviors identified that contribute to poor health outcomes consist of; high percentage of adults that smoke, obesity across all age groups, and increasing drug abuse. These combined issues affect the ability to reduce infant mortality, premature births, and low birthweight.

The OMCFH views care coordination as an essential function for the efficient management of the multifaceted issues surrounding the care of children with special health care needs within the context of the medical home. The medical home is the optimal approach for family centered care coordination. Correspondingly, the increasing number of children with special health care needs, complexity of care, and the efforts necessary to educate about the medical home bring about more onus for care coordination.

For WV Medicaid managed care contracts, a child is defined as having special health care needs through her/his participation in the Maternal and Child Health Services Title V Block grant for children with special health care needs. This definition has served to facilitate a symbiotic relationship between Medicaid managed care organizations and OMCFH, thus empowering ongoing collaboration to support the medical home as a focus of care coordination, and for Children with Special Health Care Needs (CSHCN) Program clients in particular, to facilitate shared plans of care that clearly communicate needs, goals, and negotiated strategies to achieve those goals.

Moreover, as a component of the statutorily required managed care quality strategy, OMCFH coordinates with the WV Medicaid agency and contracted managed care organizations to assess the quality and appropriateness of care and services furnished to children with special health care needs.

The OMCFH involves multiple stakeholders across WV to develop and support interventions that will achieve positive results. These partnerships collaborate around data collection activities, evaluate availability of care, service utilization, and quality of health services for the maternal and child health populations. The Office maximizes the use of funding streams from state and federal dollars to administer population-based surveillance and service systems, work in partnership with other agencies to not duplicate services, provide safety-net services for gaps in the delivery system, support home visitation services that strengthen families, and provide capacity for data collection and analysis. Allocation of resources is based on need that takes into consideration other available resources,

population served, and desired outcomes.

The Office has historically engaged in collaboration with multiple partnerships and leverages its relationships and federal and non-federal funds to accomplish objectives outlined in its State Action Plan. Key partnerships include the Perinatal Partnership, academic institutions, medical facilities, advisory boards, health care providers, the Department of Education, and the families served by its Programs. The OMCFH has grant agreements with West Virginia University (WVU), Marshall University (MU) and the Perinatal Partnership, West Virginia's Perinatal Quality Collaborative.

With assistance from stakeholders and OMCFH staff, WV developed the following performance measures under the five population domains. These have been updated to reflect the 2020 Title V Application/Annual Report submission.

**Women/Maternal Health**

Decrease the percentage of cesarean section deliveries in low-risk first births from 27.6% in 2018 to 25% by 2025. WV has seen improvement in overall C-section rates but needs to continue to support education efforts to physicians and hospital administration.

Increase the percentage of women who had a dental visit during pregnancy from 35.6% in 2018 to 45% by 2025. It is important for pregnant women to have a dental visit due to the health implications of decaying teeth and gum disease.

Decrease the percentage of women who smoke during the last 3 months of pregnancy from 24.7% in 2018 to 20% by 2025. This has long been an issue in WV and has led to higher than national average preterm births, low birthweight and Sudden Unexplained Infant Deaths (SUID).

Address substance use in pregnancy by increasing provider, family and general public awareness of harmful effects.

**Perinatal/Infant Health**

Increase the percentage of infants ever breastfed from 68.6% in 2016 to 74% by 2025. Breastfeeding has increased over the past few years, but more improvement is necessary to maximize important health benefits.

Increase the percentage of infants exclusively breastfed through six months from 20.2% in 2016 to 24% by 2025. Breastfeeding has continued to increase over the past few years, but additional improvement is necessary to maximize health benefits.

Increase the percentage of infants placed to sleep on their backs from 86.6% in 2017 to 90% in 2025. Safe sleep remains an issue for WV infants and is a significant factor in the State's infant mortality rate.

**Child Health**

Reduce the percentage of children in households where someone smokes from 22.2% in 2017 to 18% by 2025. WV ranks first or nearly first every year in the percentage of residents who smoke.

Address substance use in youth/teens by increasing provider, family and general public awareness of harmful effects.

Decrease obesity rates in children, ages two through four, from 16.6% (WIC data 2016) to 14.4% by 2025.

**Adolescent Health**

Reduce the percentage of adolescents, ages 12-17, who report being bullied from 29.1% in 2017 to 22% by 2025. Bullying is becoming more prevalent with the use of social media.

Increase the percentage of adolescents with and without special health care needs who receive services necessary to make transitions to adult health care from 20.2% (CSHCN) and 20% (non-CSHCN) in 2016 to 40% for both populations by 2025.

Address substance use in youth/teens by increasing provider, family and general public awareness of harmful effects.

**CSHCN**

Increase the percentage of children with special health care needs, that have a medical home from 45.2% in 2018 to 52% by 2025. WV's rates are higher than the national average, but significant improvement is needed for children with special health care needs.

Increase the percentage of adolescents with and without special health care needs who receive services necessary to make transitions to adult health care from 20.2% (CSHCN) and 20% (non-CSHCN) in 2016 to 40% for both populations by 2025.

### III.A.2. How Federal Title V Funds Support State MCH Efforts

Federal block grant funds are used to establish and guide maternal and child health priorities and concerns in WV. WV remains committed to its mothers and children through continued support of OMCFH and its programs. Generally, federally funded positions have been exempt from hiring freezes and position sweeps, so the Block Grant along with other federal funds enable WV to maintain its workforce and continue moving forward. WV also leverages its partnerships to provide staffing for public health awareness, clinics, and case abstraction activities. WVOMCFH has been creative in using vacant positions to reallocate to positions with higher salaries and increased responsibilities often working across Divisions within the Office. During the Pandemic, OMCFH staff provided technical assistance with data collection efforts to other Offices.

WV uses block grant resources to implement many of its programs and projects, especially those that are not specifically mandated by State law. For example, block grant funds assure support for breastfeeding, adolescent health, injury prevention, maternal mortality and children with special health care needs. While these programs are broadly supported, little or no state funds are allocated for their operations. Block grant funds assure infrastructure and support for these vital activities, while state funds are prioritized for efforts required by law. This strategy allows block grant funds to complement the efforts supported by the State.

### III.A.3. MCH Success Story

For more than two decades, the Office of Maternal, Child and Family Health (OMCFH) and WV University School of Medicine's Department of Pediatrics have worked together to administer a birth score system, i.e. Project WATCH, to identify newborn infants at risk for post-neonatal mortality, debilitating conditions and developmental delays. Data are collected on every infant born in WV birthing hospitals/facilities as well as most home births. Since late 2016, discrete surveillance data have been collected to calculate the incidence of neonatal abstinence syndrome (NAS) in West Virginia via a standardized case definition. This ongoing NAS surveillance has been essential to informing public health-related efforts aimed at prevention, but individual level information about infants diagnosed with NAS was not being shared with pediatric or family medicine providers.

Effective January 2020, primary care providers began receiving notifications of their infant patients' NAS diagnosis. Correspondingly, and in coordination with the *Perinatal Partnership*, (WV's perinatal quality collaborative), Project WATCH is facilitating ongoing educational outreach and training for maternity care, pediatric and family medicine providers throughout the state to highlight opportunities for treatment and prevention for mothers and infants as well address primary concerns regarding the management of NAS.

https://www.wvdhhr.org/mcfh/files/Policy_Project_Watch_Information_Transfer_12312019.pdf

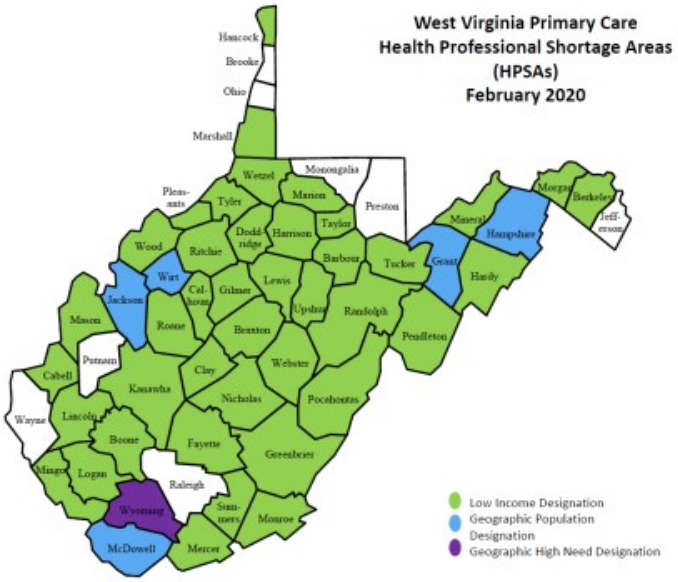
### III.B. Overview of the State

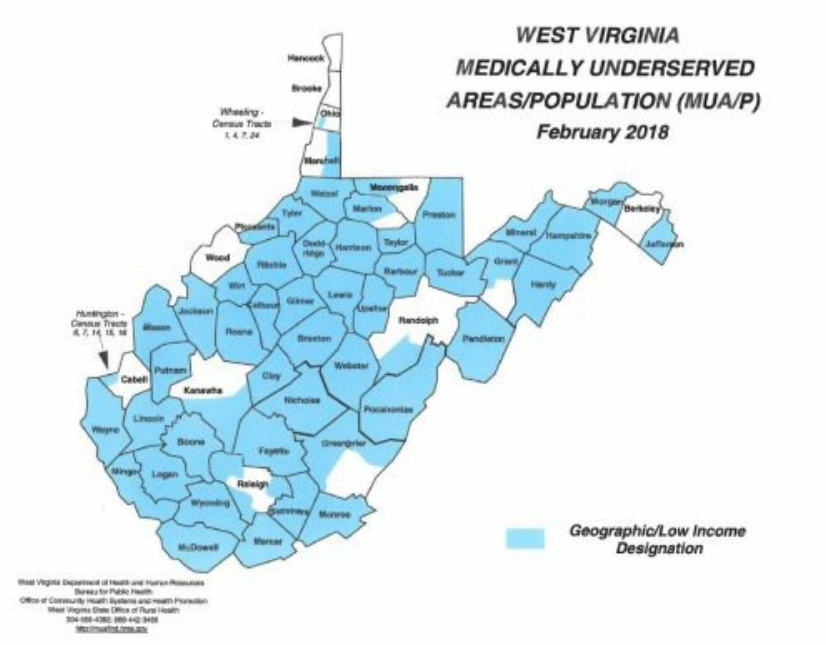
The OMCFH is the WV Title V agency and housed within the Bureau for Public Health (BPH) under the umbrella of the DHHR. This structure lends itself to easily interact and collaborate with the Bureau for Children and Families, the Bureau for Medical Services (Medicaid), the Bureau for Behavioral Health, the Office of Nutrition Services (WIC), and the Health Statistics Center (Vital Statistics) to name a few. The Office also administers the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program and houses epidemiologists from the West Virginia Board of Pharmacy, West Virginia's prescription drug monitoring program (PDMP) authority, and the Office of Drug Control Policy. The latter two strategic alliances facilitate the use of the PDMP as a public health surveillance tool via the most relevant and sustainable analysis and dissemination of actionable data to drive public health action in the State. In addition, the Office provides administrative oversight for the Department of Education's Part C/Early Intervention Program and Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

WV, the second most rural state in the nation, is the only state located entirely within the area known as Appalachia. Even so, WV 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 (WVU) is located, provides access to Washington, D.C. and Baltimore, MD. Interstate 68 also connects with I-79S, providing access to Charleston, WV, the state capitol and I-79N providing access to Pittsburgh, PA. 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.

WV 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 WV the highest elevation of any state east of the Mississippi River.

WV reached its population peak a half century ago with 2,005,552 residents counted in the 1950 US Census. The State's population has not exceeded the 2 million mark since then but has fluctuated between 1.7 and 1.9 million depending on the State's economy. Charleston, the state capitol and largest city, and Huntington are the only cities with populations nearing 50,000 people. WV is the 41st largest and the 38th most populous state in the country. Two-thirds of the State's 1.8 million people live in communities with less than 2,500 residents; 44 of the 55 counties in WV are federally designated as non-metropolitan by the Federal Office of Management and Budget and 51 counties are designated fully or in part as Health Professional Shortage Areas (HPSA) and/or Medically Underserved Areas.






Appalachia is distinguished by mountainous terrain, geographic isolation, and a history of economic underdevelopment. Although conditions in Appalachia have improved in recent years, these improvements have not benefited all communities equally. Isolated, rural areas continue to experience the most adverse social, economic, and educational deficits, resulting in significant health disparities in the incidence, prevalence, mortality, burden of chronic diseases, and their risk factors, as well as access to care. Not surprisingly, WV consistently ranks in the top three nationally in adults self-reporting their general health as either “fair” or “poor”. Data indicates that 18% of individuals could not afford needed health care services and approximately 21.4% of adult West Virginians do not have a specific primary care physician (PCP) or health care provider.

WV's population is mostly homogeneous with little racial or ethnic diversity. The 2019 Census population estimates for WV reported that 93.5% of WV residents are White, 3.6% Black, 0.3% American Indian and Alaska Native, 0.8% Asian, and 1.8% were more than one race. The Hispanic population was reported as 1.7%.

WV has one of the oldest median ages (42.8 years) and percent of people age 60 and older in the nation according to 2019 US Census population estimates data. Although the population has fluctuated between 1.7 and 2.0 million over the last 50 years, the number of births has declined from 50,000 births in 1950 to 19,006 tentative births in 2019. Because of its older population, WV 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 73.4% compared to 66.9% nationally. Almost 85% of individuals age 65 and older own their home.

According to America’s Health Rankings, WV ranked poorly in 2018 across several health measures, including overall health, obesity, and physical inactivity. Perhaps most concerning is a decline in its rank in overall health from 41st in 2011 to 46th in 2017, however in 2018 there was a rebound to 44$^{th}$. A major contributor to WV’s poor overall health is obesity. Obesity is a major risk factor for many diseases and chronic conditions including heart disease, cancer, Type 2 diabetes and stroke. In 2018, the percent of obese adults reached 38.1%; WV ranked 50th in obesity. A key factor to reducing and preventing obesity and other related chronic conditions is regular exercise (physical activity). Unfortunately, WV ranks low in this important lifestyle behavior. Again, according to America’s Health Rankings in 2018, WV was ranked 43rd with 31.6% of the population reporting being physically inactive. Other health issues affecting the state include high rates of diabetes and smoking. The percentage of the adult population who has been told by a health professional that they have diabetes increased from 4.7% in 1996 to 15% in 2017. In 2018, WV ranked 50th in terms of smoking with 26% of the adult population indicating that they currently smoke daily. This

percentage has remained fairly stable over the past 10 years, unaffected by the numerous public health interventions to reduce smoking although, according to the 2018 WV Pregnancy Risk Assessment Monitoring System (PRAMS) data, smoking during the last three months of pregnancy has increased to 24.9% after decreasing from 22.8% in 2016 to 18.6% in 2017.

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 with each having a level III Neonatal Intensive Care Unit. There are currently 23 birthing hospitals in the State. Currently, there is one standalone children's hospital located in Charleston, WV called Women and Children's Hospital under the CAMC umbrella. An additional Children's Hospital is under construction at WVU located in Morgantown, WV and is scheduled to open in 2021. There are limited pediatric specialists in WV with most located at one of the three tertiary care centers. The OMCFH contracts with WVU Pediatrics/Genetics to provide six (6) satellite clinics throughout the state to provide services for children with special health care needs. The Newborn Screening Program has an active Advisory Committee involving pediatric specialties that include pulmonology, hematology, genetic specialists, immunology and Cystic Fibrosis.

According to HRSA.gov there are 52 Rural Health Clinics in WV and 243 Federally Qualified Health Center (FQHC) sites providing services in the State. Six percent of WV residents lack health insurance (Kaiser, 2017) and according to the 2018 National Survey of Children's Health only 5.4% of WV residents lack health insurance. According to the Economic Research Service, the average per capita income for WV residents in 2018 was $40,873 and rural per capita income lagged at $37,003. Estimates from 2018 indicate a poverty rate of 19.3% exists in WV.

Congress passed the Patient Protection and Affordable Care Act (ACA) which was signed into law on March 23, 2010. Healthcare reform dramatically impacted health programs and services in WV. 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, aged zero to one, increased to 158% Federal Poverty Level (FPL) and children aged six through 18 increased to 133% FPL, while the WV Children's Health Insurance Program's (WVCHIP) eligibility is 300% FPL. This increase caused many children that were income eligible for WVCHIP to transfer enrollment to Medicaid. Approximately 5,482 children moved from WVCHIP coverage to Medicaid coverage through June 30, 2014. In addition, some Medicaid children became eligible for WVCHIP, and some WVCHIP and Medicaid children became eligible for Advanced Payment Tax Credits (APTC) through the marketplace. Medicaid eligibility for pregnant women also expanded to 158% FPL. WVCHIP has implemented a number of changes in order to comply with the ACA. The most notable activities include:

• Transitioning income eligibility determination to one based on Modified Adjusted Gross Income – effective October 1, 2013;
• Dropping the waiting period required before a child becomes eligible for WVCHIP;
• Redesigning the premium program to comply with regulations regarding premium collections and program enrollment; and
• Transitioning WVCHIP kids in families with incomes up to 133% FPL to the Medicaid program.

Other eligibility standards for Medicaid in WV also changed significantly. With the dependent child requirement dropped and increased income limits, virtually any legal resident making less than 138% of the FPL qualifies for Medicaid coverage. This means that a single person can make up to $17,256, a two-person household, $23,352, a three-person household $29,448 and a four person household $35,544. The new guidelines eliminate the asset test previously required for non-disabled adults and the elderly. Individuals in these categories with assets that exceed around $4,000 in value, even including cars or retirement savings, were previously ineligible for traditional Medicaid coverage, regardless of their income. Under expansion, these assets are no longer considered, and eligibility is based strictly on income. In July of 2019, WVCHIP began covering all pregnant women between 139% and 300% of the Federal Poverty Level (FPL). Title V provided coverage for prenatal visits and $1,000 towards delivery costs for those pregnant women up to 188% of the FPL. In response to the new WVCHIP coverage, Title V will cover premium payments for pregnant women who are unable to pay to ensure coverage continues six months postpartum and will provide prenatal care, pharmacy, and up to $5,000 on labor and delivery charges for pregnant women between 301% to $325% of the FPL.

Economic hardship, especially in early childhood, has been shown to put children at risk for developing special health care needs later in life. This supports the need to ensure all children have adequate health insurance to allow for preventive measures and early intervention to attempt to mitigate potential issues before they develop. According

to the National Survey of Children's Health (NSCH), the rate of uninsured children under the age of 18 continues to decline. According to the 2003 survey, 6.6% of WV children were uninsured. The most recent survey (survey year 2018) found that 5.4% of WV children are uninsured, lower than over half of the other states, but according to the 2019 WVCHIP Report there are only 3.4% children currently uninsured. As the ACA was fully implemented, the prevalence of uninsured children continued to decrease.

The ACES Coalition of West Virginia includes over 400 different organizations and individuals working together to improve the health and well-being of all West Virginians by reducing the impact of Adverse Childhood Experiences (ACEs) and preventing their occurrence. The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and later-life health and well-being. The Coalition is working to apply that study and additional ACEs research findings in WV.

The OMCFH is participating in integration of services with emergency medical personnel, Child Protective Services, community health centers, school counselors, and others to develop a culture supportive of interventions using a trauma-informed approach. A trauma informed approach comprises six basic elements that are applied to all activities and interactions with agency clients and with agency workers (Fallot & Harris, 2009). These core elements are safety, trustworthiness, choice, collaboration, empowerment, and cultural relevance (Proffitt, 2010). These philosophical principles help to shape the culture of assault service programs and the services provided to survivors of ACEs or trauma.

To address health access challenges, the OMCFH and its partners encourage the use of community health centers by low-income and/or uninsured individuals where free services or sliding fee payment is available. WV is largely dependent on the community health center network, with their core of family physicians to serve not only medically underserved geographical areas, but also the uninsured and those that have recently been insured. However, because of Medicaid expansion, the number of physicians needed to serve previously uninsured individuals has increased and rates of medical school students choosing family practice to serve in underserved areas is decreasing (Chen et al, 2014). So far, little progress has been made to address this national shortage.

The OMCFH has been acknowledged for its positive partnerships across the State including the medical community, the University System, the State Department of Education, and the Perinatal Partnership. The OMCFH is known for its willingness to engage and participate alongside stakeholders in designing systems of care to serve the maternal and child health population. The Office knows that resources are scarce, and WV cannot afford to duplicate existing systems that are working well. The OMCFH also understands that it must join other stakeholders to achieve goals.

The OMCFH has established partnerships with FQHCs, free clinics, private practicing physicians, local health departments, and hospital-based clinics to ensure access to high quality medical services for all WV residents. The OMCFH also supports a network of parents who are employed by the Center for Excellence in Disabilities (CED) at West Virginia University. These Parent Network Specialists offer parent-to-parent support for families with children who have disabilities.

The Office continues to hold contracts and formalized agreements, both internal and external, to the DHHR for direct services offered throughout the State. The Office also has in place many systems with partnerships that contribute to the early identification of persons potentially eligible for services. These population-based systems include the Birth Score Program, birth defect surveillance system, newborn metabolic screening, newborn critical congenital heart defects screening, childhood lead poisoning screening and newborn hearing screening. These systems rely upon partnerships to conduct the screenings, and report findings to the OMCFH to ensure appropriate follow-up and surveillance activities.

There are several State laws and policies that guide WV's Title V Program. These laws include but are not limited to:

a. Children with Special Health Care Needs: Provides specialty medical care, diagnosis, treatment and health care coordination for children with special health care needs and those who may be at risk of disabling conditions. Staff provide care coordination, develop and monitors treatment plans and assist families with scheduling and transportation for medical care. Title V funds are used as payor of last resort. *(WV Code § 49-4-3)*
b. West Virginia Birth to Three: Provides therapeutic and educational services for children age zero-three years and their families who have established, diagnosed handicaps, developmental delay or are at risk due to biological factors. The goal is to prevent disabilities, lessen effects of existing impairments, and improve

developmental outcomes. These services are provided by community-based practitioners. *(WV Code §16-5k, P.L. 99-457/Part H)*

c. HealthCheck (EPSDT): Educates Medicaid-eligible families about preventive health care for children and encourages their participation in the program while ensuring the following: 1) children are screened and re-screened according to periodicity tables established by the American Academy of Pediatrics; 2) medical problems identified by examination are treated or referred; 3) children/families receive transportation assistance; and 4) help with appointment scheduling. (*Medicaid 42 FR §§441.50 – 441.62*)
d. Oral Health Program: Provides statewide coordination for oral health activities including planning, school-based sealants, fluoride efforts, workforce shortages, and community involvement. (*WV §16-41*)
e. Right From The Start (RFTS): Arranges care for government sponsored obstetrical populations and children up to age one (Title V, Title XIX, Title XXI) that meet pre-established medical criteria. State staff have responsibility for care protocol development and dissemination; provider recruitment; and system development that assures patient access to quality, comprehensive, timely care. RFTS services are provided through a community-based network of nurses, social workers, and physicians. *(WV §9-5-12)*
f. Birth Score: Population-based surveillance project that is administered by WVU in partnership with OMCFH to identify infants at risk of post-neonatal death in the first year of life and to provide appropriate interventions for those determined at risk. *(WV Code §16-22B)*
g. Newborn Hearing Screening: All children born in WV are screened at birth for the detection of hearing loss. Children who fail the screen are followed and assisted in obtaining further diagnostic care to assure that children with a loss receive appropriate medical intervention. *(WV Code §16-22A)*
h. Women's Right to Know: The Women's Right to Know (WRTK) requires informed consent for an abortion to be performed, requires certain information to be supplied to women considering abortion, and establishes a minimum waiting period after women have been given the information. The law specifies exception for medical emergencies and requires physicians to report abortion statistics. Further, the WRTK law requires DHHR to publish printed information and develop a website on alternatives to abortion. *(WV Code § 16-21-1)*
i. Maternal Risk Screening: Maternal Risk Screening is a comprehensive and uniform approach to screening conducted by maternity care providers to discover at-risk and high-risk pregnancies. The law provides for better and more measurable data regarding at-risk and high-risk pregnancies. The law requires DHHR, BPH, OMCFH to convene the Maternal Risk Screening Advisory Committee annually and provide administrative and technical assistance to the Committee as needed. A Prenatal Risk Screening Instrument (PRSI) was created to be used by all maternity care providers and is to be submitted to OMCFH at the first prenatal visit. The uniform maternal screening tool is confidential and shall not be released or disclosed to anyone including any state or federal agency for any reason other than data analysis of high-risk and at-risk pregnancies for planning purposes by public health officials. Data is housed within OMCFH. *(WV Code § 16-4E)*
j. Family Planning Program: Arranges for comprehensive physical examination, lab testing, counseling, and education, as well as contraceptive services to persons of childbearing age. Provides technical assistance and establishes operational standards for medical providers. *(WV Code §16-2B)*
k. Breast and Cervical Cancer Screening Program: Promotes early detection of breast and cervical cancer through screening, follow-up services, and education to low-income women. Available in all 55 WV counties through county health departments and primary care centers – a total of 132 sites. *(WV Code §16-33)*
l. Newborn Screening Program: All infants born in WV are tested for 30 disorders that include SCID, CCHD, newborn hearing, and NAS and includes follow-up services. The Program also provides for some special nutritional needs as a payor of last resort. Children who are positive are referred to the Division of Infant, Child, and Adolescent Health, Children with Special Health Care Needs Program, for support services. *(WV Code §16-22)*
m. Lead Screening: This Project is a collaborative effort between two Offices in the Bureau for Public Health, the OMCFH and the Office of Environmental Health Services (OEHS). The mission is to determine the extent of childhood lead poisoning and identify potential areas that may have more lead poisoning episodes. All laboratories that collect blood lead samples are required by statute to send results to OMCFH. The OEHS provides assessment of home and environment for residences of children with elevated blood lead levels. The CSHCN Program provides care coordination to children with elevated levels, and who qualify for the CSHCN Program. Additionally, a referral to the OEHS will be made for home assessments. *(WV Code §16-35-4a)*
n. Infant and Maternal Mortality Review Panel: The Infant and Maternal Mortality Review Panel evaluates maternal and infant deaths to understand the diverse factors and issues that contribute to deaths that are preventable. The panel identifies and implements interventions to address these problems. *(WV Code §48-*

*2SA)*

## III.C. Five-Year Needs Assessment Summary (as submitted with the FY 2021 Application/FY 2019 Annual Report)

### III.C.2.a. Process Description

**Goals, Framework and Methodology**

The Needs Assessment is used to evaluate competing factors which impact health delivery services from the program level and drives activities to improve the health status of the maternal and child health population. The goal of the West Virginia Title V Needs Assessment is to assure availability of a comprehensive quality, accessible maternal and child health system that will positively affect pregnancy outcomes, which ultimately results in positive health status for infants, children, adolescents and children with special health care needs by involving multiple stakeholders across the State. Staff of the MCH Epidemiology Unit, housed in the Division of Research, Evaluation and Planning, were responsible for the development of the 2020 Needs Assessment. The Office has numerous community partners and is involved and actively participates on several agency boards, advisory committees, work groups and study groups. The Epidemiology Unit was responsible for collecting, analyzing and reporting data compiled in the Needs Assessment. These findings were used to determine West Virginia's priorities, set performance measures, develop the state action plan and incorporate evidence-based measures.

**Assessing MCH Populations**

For this Needs Assessment OMCFH included input from program staff, advisories, stakeholders, colleagues, families and residents relating to improving the health status among West Virginians.

**Stakeholder Involvement**

The Office utilized both a formal and informal process for involving stakeholders in the 2020 Needs Assessment process. The Office both coordinates and participates on numerous advisory boards throughout the year. Stakeholder input is continuously sought for program planning and quality improvement.

**Quantitative and Qualitative Methods**

The OMCFH used both qualitative and quantitative methods to assess the strengths and needs of each of six identified population domains. Qualitative methods included, regional community meetings, focus groups with families regarding Home Visitation Programs, the review of multiple documents reporting the findings of stakeholder and advisory groups, and focus groups with stakeholders regarding national and state performance measures. Quantitative methods included administration and review of multiple surveys and data sets. While the Office primarily relied upon established surveillance systems such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS), other surveys were also utilized.

**Interface of Needs Assessment Data, the State's Priority Needs and Action Plan**

The Office of Maternal, Child and Family Health compiled input from its stakeholders and staff to help select West Virginia's National Performance Measures. During the data collection period, needs assessment input was solicited to identify and understand West Virginia's priority needs. The Epidemiology Unit with direction from leadership formalized a list of priority needs based upon data findings. The list of priority needs was then utilized to select national performance measures and create state performance measures to aid in the development of West Virginia's State Action Plan.

### III.C.2.b. Findings

#### III.C.2.b.i. MCH Population Health Status

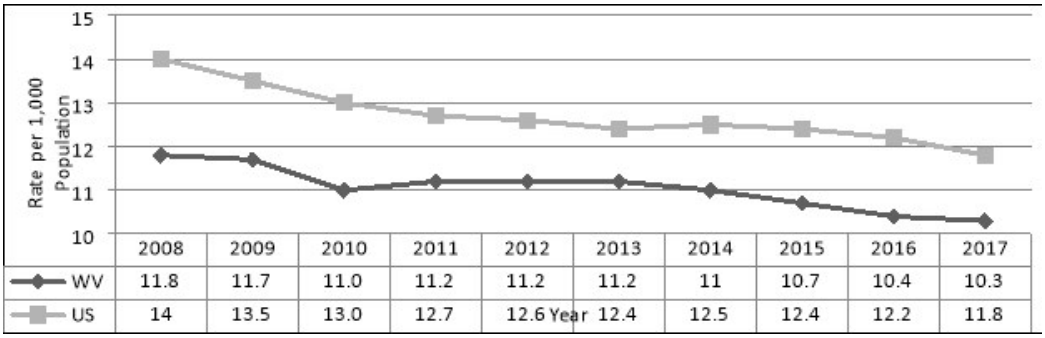
**Women/Maternal Health**

While progress has been made in recent decades, women and girls in West Virginia, continue to experience challenges. Far too many female residents are vulnerable to both economic and health related challenges such as poverty, limited access to childcare and elder care, gender wage gaps, limited access to health care and poor health.

**Pregnant Women, Mothers, and Infants Up to Age 1**

West Virginia's resident live birth rate in 2017 was 10.3 live births per 1,000 population, which was less than the national 2017 birth rate of 11.8. West Virginia's birth rate has been below the national rate since 2008 and continued its decline in tandem with the national rate. Birth certificate data shows there were 18,675 births in West Virginia in 2017.

West Virginia and United States Birth Rates, 2008-2017

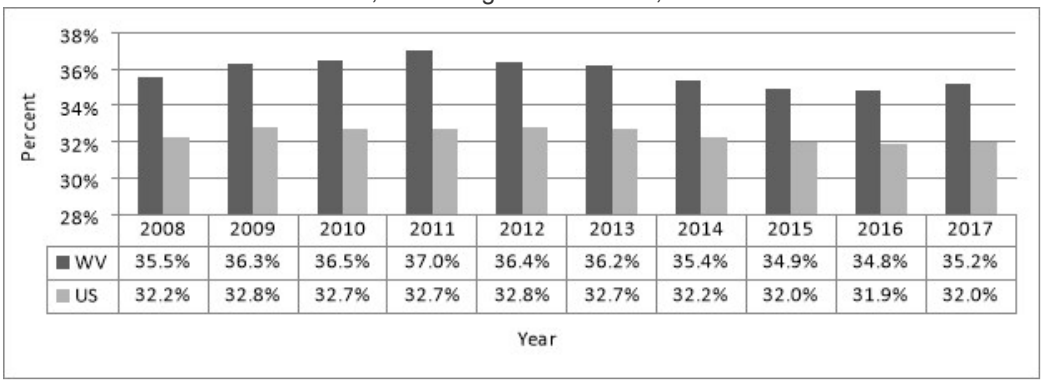



Data source (WV): West Virginia Health Statistics Center, Vital Statistics Center. (National): CDC Wonder

**Delivery Method**

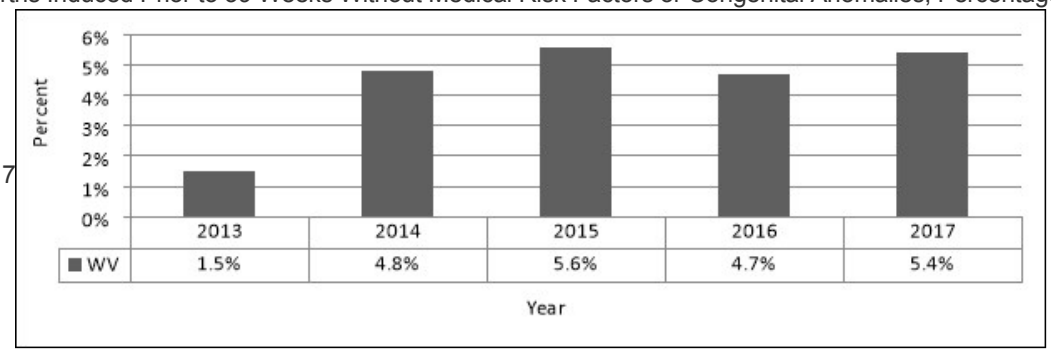
The proportion of cesarean deliveries in WV peaked in 2011 at 37.0% of all births, though that percent has decreased to around 35.0% in recent years. The proportion of caesarean sections in the U.S. has remained steady at around 35.0% since 2014. As with most negative birth outcomes, the proportion of cesarean delivery is greater in West Virginia than in the U.S., and there has been little change to that disparity over the last decade.

WV Resident Cesarean Deliveries, Percentage of Live Births, 2008-2017




Data source (WV): West Virginia Health Statistics Center, Vital Statistics Center. (National): CDC Wonder

WV Singleton Births Induced Prior to 39 Weeks Without Medical Risk Factors or Congenital Anomalies, Percentage of Live Births, 2013-2017




Notes: Previous c-sections were added to the parameters of medical risk factors in 2014. Percentages are calculated excluding the unknown values.

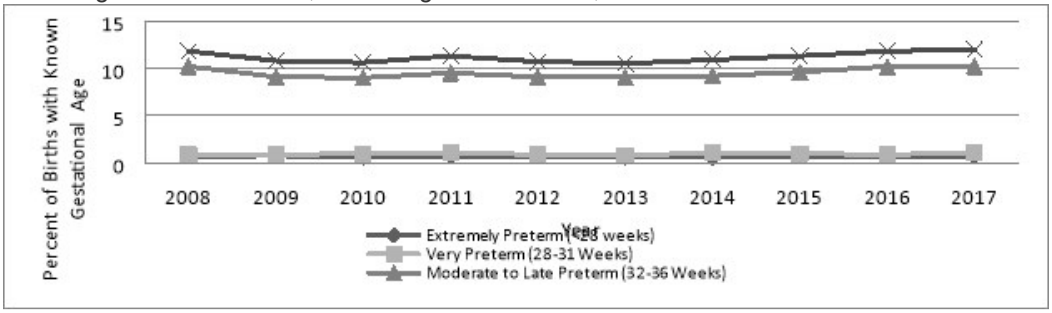
Data source: West Virginia Health Statistics Center, Vital Statistics Center

**Premature birth**

By 2016, WV returned to the 2008 percentage of preterm births, after a period of relatively small decline from 2009 to 2013. These changes in preterm births are driven primarily by changes in moderate to late-preterm births, those that occur at 32 through 36 weeks gestation. In 2010, the percent of moderate to late preterm births was 9.0% and by 2017 it had increased to 10.2% From 2008 to 2017, the extremely preterm birth percentage ranged from 0.8% to 0.6% and the very preterm birth percentage ranged from 0.8% to 1.1%.

The West Virginia Health Statistics Center examined birth certificate data from singleton births from 2008 through 2017 to determine the scope of the problem of late-preterm birth in the State. There was a small decrease in overall preterm births from 2009-2013, but the proportion of preterm births returned to 2008 levels by 2017 (12.0%).

West Virginia Preterm Births, Percentage of Live Births, 2013-2017




Data Source: West Virginia Health Statistics Center, Vital Statistics Center

**Infant Mortality**

Infant mortality is the result of a complex set of biological and social factors, and infant deaths have long been viewed as an important indicator of a population's health. While the rest of the Nation has shown a steady decline in the rate of infant mortality since 2008, West Virginia's rate has remained slightly above the national average for each of the last 10 years.

2008-2017 National and WV Resident Infant Mortality Rate, Per 1,000

| Year | WV | U.S. |
|---|---|---|
| 2008 | 7.7 | 6.6 |
| 2009 | 7.8 | 6.4 |
| 2010 | 7.3 | 6.1 |
| 2011 | 6.8 | 6.1 |
| 2012 | 7.3 | 6.0 |
| 2013 | 7.5 | 6.0 |
| 2014 | 7.1 | 5.8 |
| 2015 | 7.0 | 5.9 |
| 2016 | 7.3 | 5.9 |
| 2017 | 7.0 | 5.8 |

Data source: (WV) West Virginia Health Statistics Center, Vital Statistics Center, (National) CDC Wonder

The three leading causes of infant death in West Virginia are in line with the leading causes of infant death in the U.S.: prematurity, birth defects, and sudden unexplained infant death.

**Maternal Smoking**

Tobacco use remains high across all WV populations, but most alarmingly in pregnant women. Maternal smoking during pregnancy can result in multiple adverse consequences for the neonate, such as preterm birth, low birth weight, and birth defects of the lip and mouth (CDC, 2019). According to WV Vital Statistics, the rate of smoking during pregnancy in WV for 2018 was 23.7% (preliminary). A decline in maternal smoking can be seen across multiple data sources, including PRAMS, MRS, and Vital Statistics, indicating the robustness of that decline across the varied populations sampled. In 2018, 38.1% of women insured by Medicaid smoked during pregnancy, while 11.5% of non-Medicaid insured women smoked during pregnancy.

WV Resident Smoking During Pregnancy, Percentage of Live Births, 2014-2018

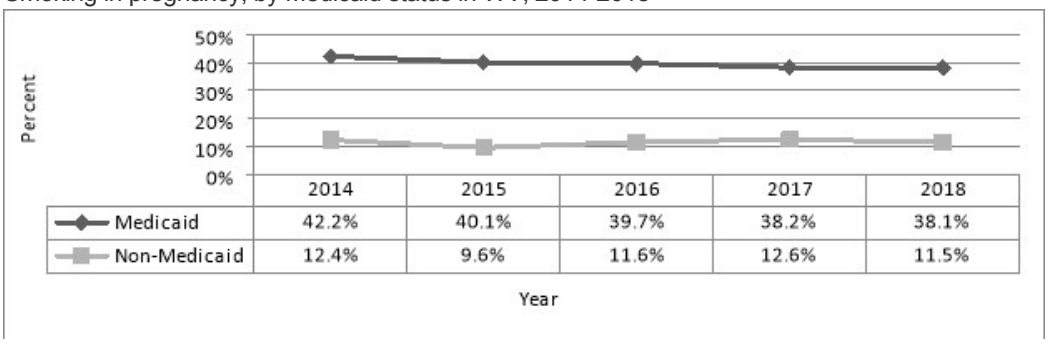
| Smoking status during pregnancy | 2014 | 2015 | 2016 | 2017 | 2018* |
|---|---|---|---|---|---|
| Smoked | 27.9% | 25.3% | 25.4% | 24.7% | 23.7% |
| Did not smoke | 72.1% | 74.7% | 74.6% | 75.3% | 76.3% |

Data source: WV Health Statistics Center, Vital Statistics System

*2018 statistics are preliminary

Note: Percentages are calculated excluding the unknown values.

Smoking in pregnancy, by Medicaid status in WV, 2014-2018



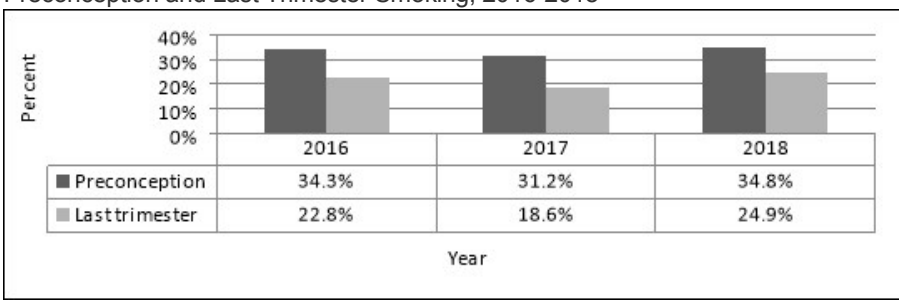

Data source: WV Health Statistics Center, Vital Statistics System

*2018 statistics are preliminary

Note: Percentages are calculated excluding the unknown values.

PRAMS examined the smoking habits of WV women before and during pregnancy. Respondents were asked if they smoked any cigarettes in the three months prior to pregnancy and the last three months of pregnancy. Those mothers who responded they smoked during either time-periods were asked additional questions about their smoking habits the perinatal period. While 24.9% of women in 2018 smoked during the last trimester of pregnancy, this is lower than the 34.8% of women that reported smoking in the three months before pregnancy.

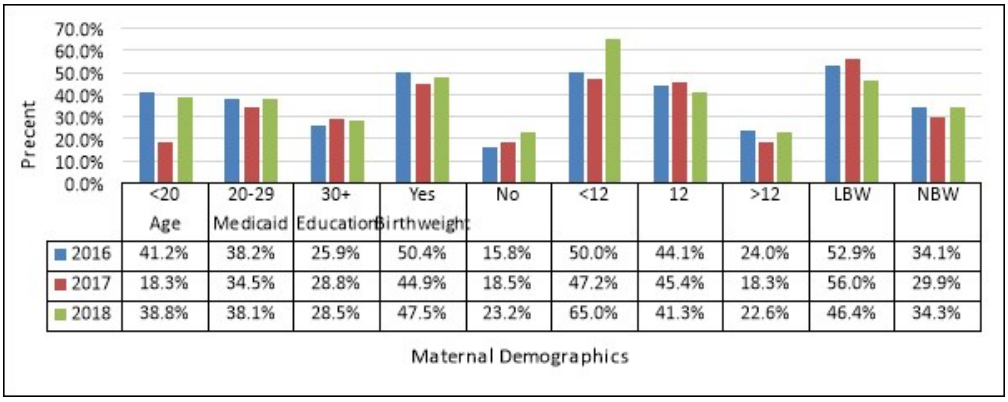
Preconception and Last Trimester Smoking, 2016-2018




Data source: WV PRAMS

Maternal smoking three months before pregnancy is most common among mothers less than 29-years of age, those who receive Medicaid, and those with less than a high school degree; an alarming 65% and 55% of those mothers without a high school degree reported smoking in the 3 months before pregnancy and the last trimester of pregnancy, respectively, in 2018. A higher percentage of mothers who had a low birth weight newborn reported preconception smoking that those with a normal birth weight newborn. Though fewer women reported smoking in the last trimester of pregnancy, the demographic trends are similar to those who reported smoking before pregnancy.

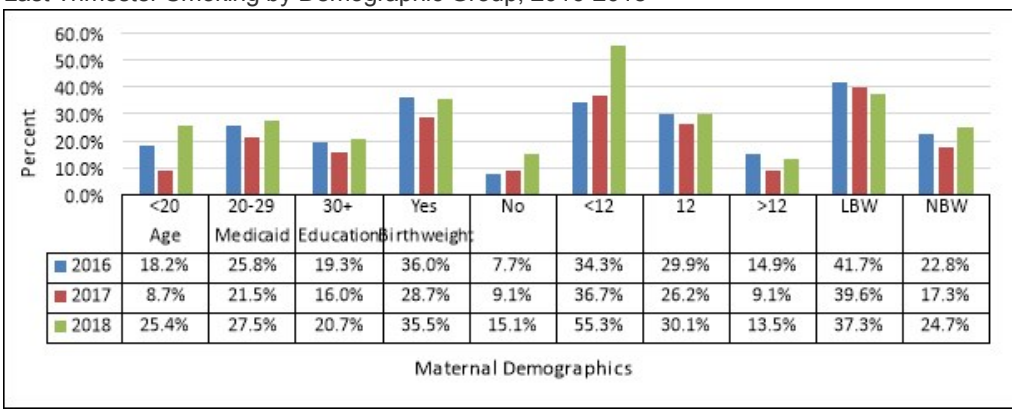
Preconception Smoking by Demographic Group, 2016-2018




| | <20 Age | 20-29 Medicaid | 30+ Education | Yes Birthweight | No | <12 | 12 | >12 | LBW | NBW |
|---|---|---|---|---|---|---|---|---|---|---|
| 2016 | 41.2% | 38.2% | 25.9% | 50.4% | 15.8% | 50.0% | 44.1% | 24.0% | 52.9% | 34.1% |
| 2017 | 18.3% | 34.5% | 28.8% | 44.9% | 18.5% | 47.2% | 45.4% | 18.3% | 56.0% | 29.9% |
| 2018 | 38.8% | 38.1% | 28.5% | 47.5% | 23.2% | 65.0% | 41.3% | 22.6% | 46.4% | 34.3% |

Data source: WV PRAMS

Last Trimester Smoking by Demographic Group, 2016-2018




| | <20 Age | 20-29 Medicaid | 30+ Education | Yes Birthweight | No | <12 | 12 | >12 | LBW | NBW |
|---|---|---|---|---|---|---|---|---|---|---|
| 2016 | 18.2% | 25.8% | 19.3% | 36.0% | 7.7% | 34.3% | 29.9% | 14.9% | 41.7% | 22.8% |
| 2017 | 8.7% | 21.5% | 16.0% | 28.7% | 9.1% | 36.7% | 26.2% | 9.1% | 39.6% | 17.3% |
| 2018 | 25.4% | 27.5% | 20.7% | 35.5% | 15.1% | 55.3% | 30.1% | 13.5% | 37.3% | 24.7% |

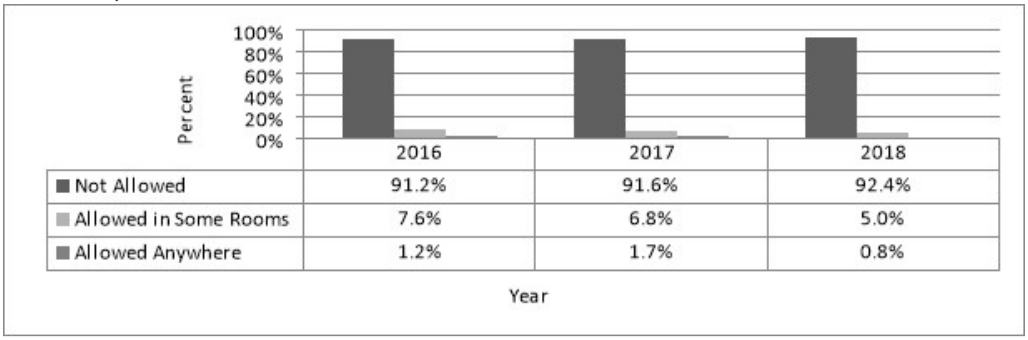
Data source: WV PRAMS

**Infant Smoke Exposure**

Infants are particularly vulnerable to the effects of second- and third-hand smoke because they are still developing physically, have higher breathing rates than adults, and have little control over their indoor environments and thus cannot escape exposure to smoke. Infants exposed to high doses of secondhand smoke, are at greater risk of developing serious health effects such as asthma, pneumonia, ear infections, and SUID.

PRAMS data showed that the number of homes with infants where smoking was allowed remained stable between 2016 and 2017. In 2018, smoking was allowed in at least part of the home in less than 6% of homes.

Smoke Exposure in the Home, 2016-2018




| | 2016 | 2017 | 2018 |
|---|---|---|---|
| Not Allowed | 91.2% | 91.6% | 92.4% |
| Allowed in Some Rooms | 7.6% | 6.8% | 5.0% |
| Allowed Anywhere | 1.2% | 1.7% | 0.8% |

Data source: WV PRAMS

**Maternal Substance Use**

Substance use and overdoses are national public health issues but are particularly widespread in WV. OMCFH funded early research into and service provision to address the opioid crisis. In 2009, a “Cord Blood Drug Study” was sponsored by the OMCFH using Title V funds to assess the prevalence of maternal substance abuse. According to the study, the prevalence

of drug use in pregnancy appeared to be increasing, based on increasing numbers of infants diagnosed with NAS. Eight hospitals across WV collected cord blood samples anonymously from infants and all samples were tested for methamphetamine, cocaine, cannabinoids, opiates, methadone, benzodiazepines, buprenorphine, and alcohol. Evidence of drugs or alcohol was found in 19% of the samples. This study supported the theory that WV had a greater number of women using drugs and/or alcohol during pregnancy than was previously estimated. In 2011, the OMCFH partnered with the Perinatal Partnership to develop the Drug Free Moms and Babies (DFMB) project, in order to support pregnant and postpartum women on their journey to recovery from Substance Use Disorder (SUD).

The federal Child Abuse Protection and Treatment and Comprehensive Addition and Recovery Acts (CAPTA/CARA) of 2016 requires WV Hospitals to report a newborn that is affected by maternal substance use to the child welfare system. While SUD alone is not cause for removal, Child Protective Services is required to open a case, which may eventually result in infant or child removal from the home and placement into state care. Thus, maternal substance use impacts the foster care system, which has been overwhelmed by the effects of the opioid crisis and currently serves over 7,000 children at any given time.

In 2017, MRS indicated 7.2% of pregnant respondents reported a problem with drugs or alcohol currently and 9.1% reported problem with drugs or alcohol in the past. MRS also found that, of those PRSIs submitted in 2017, 2.8% reported current opioid abuse treatment and 2.7% reported previous opioid abuse treatment.

The Birth Score program tracks the rates of intrauterine substance exposure (IUSE) and signs of NAS in infants. The percent of infants with IUSE has hovered just below 15% from 2017 to 2019; the percent of infants born with signs of NAS has remained close to 5%.

IUSE and Signs of NAS among Infants born to WV Residents, 2017-2019

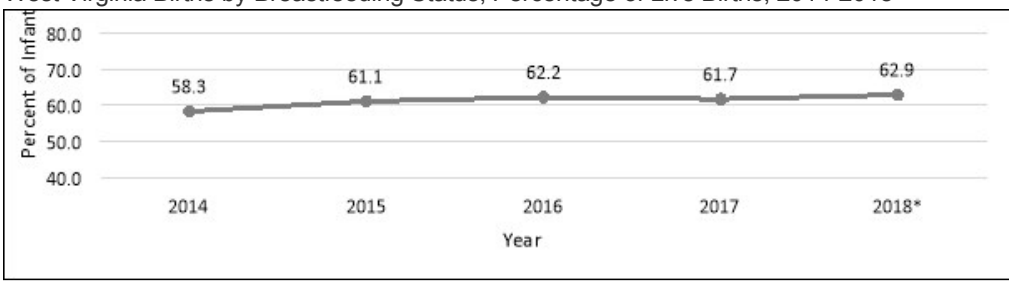
| | IUSE | | NAS | |
|---|---|---|---|---|
| | N | % | N | % |
| 2017 | 2,265 | 14.3 | 802 | 5.1 |
| 2018 | 2,148 | 14.3 | 737 | 4.9 |
| 2019 | 2,052 | 13.4 | 862 | 5.6 |

Data source: West Virginia Birth Score Program, 2020

**Breastfeeding**

Breastfeeding rates have increased in WV; between 2014 and 2018, the percentage of infants breastfed at discharge from the hospital increased from 58.3% to 62.9%.

West Virginia Births by Breastfeeding Status, Percentage of Live Births, 2014-2018




*2018 data is preliminary

Data source: West Virginia Health Statistics Center, Vital Statistics Center.

The U.S. Breastfeeding Report Card reports that WV's outcomes regarding breastfeeding, continue to increase, but still trail behind the U.S. as a whole.

Percentage of Children Who Were Breastfed, WV and U.S., 2009-2016

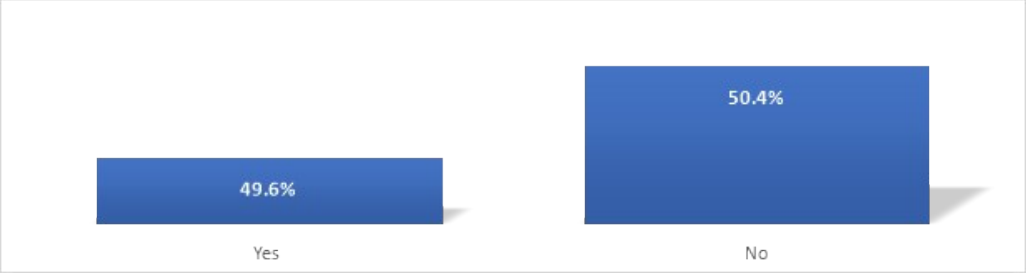
| | Ever breastfed | | Breastfeeding at 6 months | | Breastfeeding at 12 months | | Exclusive breastfeeding at 3 months | | Exclusive breastfeeding at 6 months | |
|---|---|---|---|---|---|---|---|---|---|---|
| | WV | U.S. | WV | U.S. | WV | U.S. | WV | U.S. | WV | U.S. |
| 2012 | 62.3 | 80.0 | 34.3 | 51.4 | 17.7 | 29.2 | 27.8 | 43.3 | 11.5 | 21.9 |
| 2013 | 64.6 | 81.1 | 35.8 | 51.8 | 18.3 | 30.7 | 32.6 | 44.4 | 14.1 | 22.3 |
| 2014 | 65.4 | 82.5 | 33.0 | 55.3 | 20.2 | 33.7 | 36.8 | 46.6 | 19.0 | 24.9 |
| 2015 | 68.6 | 83.2 | 40.1 | 57.6 | 24.3 | 35.9 | 36.3 | 46.9 | 20.2 | 24.9 |
| 2016 | 68.2 | 83.8 | 36.5 | 57.3 | 25.5 | 36.2 | 34.5 | 47.5 | 15.2 | 25.4 |

Source: CDC National Immunization Survey (NIS), 2009-2016

**Prenatal, Antenatal, and Postnatal Care for Mothers**

PRAMS data in 2018 shows about half mothers received teeth cleanings prior to pregnancy, but there exists the remaining 50.4% that do not partake in visiting the dentist as part of prenatal care.

Percentages of mothers receiving teeth cleanings prior to pregnancy, West Virginia, 2018




Data Source: WV PRAMS

**Obesity**

Healthy lifestyles need to be promoted among all individuals, especially in a state with such a high burden of overweight and obesity like West Virginia. Pediatric overweight and obesity initiates a pattern that continues into adulthood which puts individuals at increased risk of diseases such as cardiovascular disease and diabetes. These behaviors are also taught, so children of adults who are overweight and obese may learn this practice, perpetuating the cycle further.

The obesity puts children at risk for developing heart disease, high blood pressure, cancer, asthma and diabetes. These obesity-related conditions, and the resulting burden on finances, quality of life, life expectancy, and the health care system, may be prevented by intervening early with children and adolescents by promoting a healthy lifestyle.

WV WIC rates in 2-4 year olds was 14.4% in 2010. WV was only one of three states that had increasing obesity rates (from 14.4% in 2010 to 16.4% in 2014). In 2016, even though obesity rates in this population were still increasing, the increase was at a much lower velocity (ie 16.4% up to 16.6%). The results are reported as WV had a 2.2% increase in prevalence (14.4% to 16.6%).

**Child/Adolescent Health**

Improving the health of children helps to ensure the health of future generations. In addition to physical and mental health, numerous factors influence children's health including: socioeconomic factors, insurance, access to health care, and education. Details regarding the physical and mental health of children are discussed in more detail in the Children with Special Health Care Needs section.

Leading Causes of Death, by Age Group West Virginia 2015-2017

| Rank | <1 | 1-4 | 5-9 | 10-14 | 15-19 | 20-24 |
|---|---|---|---|---|---|---|
| 1 | Congenital Anomalies 100 | Unintentional Injury 27 | Unintentional Injury 15 | Unintentional Injury 18 | Unintentional Injury 93 | Unintentional Injury 263 |
| 2 | Short Gestation 51 | Congenital Anomalies **** | Congenital Anomalies **** | Suicide **** | Suicide 31 | Suicide 61 |
| 3 | SIDS 43 | Homicide **** | Malignant Neoplasms **** | Congenital Anomalies **** | Homicide 15 | Homicide 32 |
| 4 | Unintentional Injury 19 | Malignant Neoplasms **** | Homicide **** | Malignant Neoplasms **** | Malignant Neoplasms **** | Malignant Neoplasms 12 |
| 5 | Two Ties 15 | Five Tied **** | Heart Disease **** | Homicide **** | Congenital Anomalies **** | Heart Disease 10 |

**** indicates that cell values range from 1-9 and are suppressed for data confidentiality purposes
Data source: National Center for Health Statistics (NCHS), National Vital Statistics System

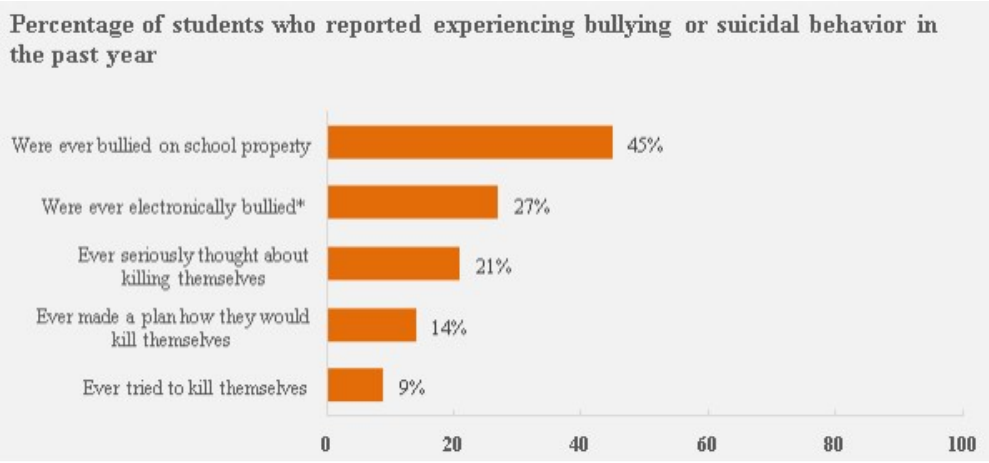
Adolescent health spans many areas, from mental, physical and reproductive health to substance abuse to relationships. The choices made and behaviors adopted during these years affect adolescents' overall wellbeing and, potentially, their health throughout their lives.

Adolescents often exhibit risky behaviors that can have immediate and prolonged detrimental health effects. Numerous adult diseases and causes of premature death can be attributed to risky behaviors in adolescence. Additionally, risky behaviors such as unprotected sex and bullying can lead to adolescents not meeting their full potential as adults. The Youth Risk Behavior Survey is a biannual survey of middle and high school students to assess risky behaviors in these populations.

**Middle School**

The 2017 YRBS middle school survey was completed by 2,089 students in randomly selected classrooms within 49 randomly selected public middle schools in West Virginia during the spring of 2017. The school response rate was 98% and the student response rate was 78%. The results are representative of all students in grades 6-8.

### Bullying and Suicidal Behaviors




The 2017 West Virginia Youth Risk Behavior Survey revealed the following rates of bullying and suicidal behaviors reported by WV middle school students.

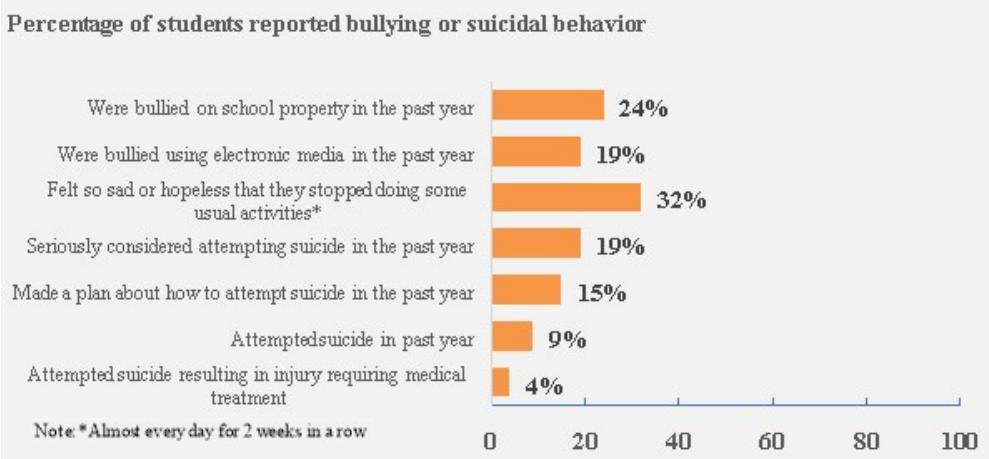
*Data source: West Virginia Department of Education Trends in the West Virginia Youth Risk Behavior Survey, 2017: Middle School 2018 Fact Sheet.*

**High School**

The 2017 YRBS was completed by 1,563 students in 35 randomly selected public high schools in West Virginia during the spring of 2017. The school response rate was 100%, the student response rate was 78%, and the overall response rate was 78%. The results are representative of all students in grades 9-12.

Note: *Through e-mail, chat rooms, instant messaging, web sites, or texting

The 2017 West Virginia Youth Risk Behavior Survey revealed the following rates of bullying and suicidal behaviors were reported by WV high school students.




**Children with Special Health Care Needs Health**

The federal Maternal and Child Health Bureau (MCHB) administers the National Survey of Child's Health (NSCH) to provide robust state-level data about the status of children's health. This survey was revised in recent years to incorporate the National Survey of Children with Special Health Care Needs. Due to the significant redesign and methodology changes, the 2016 data has been established as the new baseline and users are advised to compare to previous year's data with caution. Multi-year estimates are generated to provided more accurate estimates, which is especially important for small states like West Virginia. The combined 2017/2018 survey estimates there were 88,838 CSHCN in the state of West Virginia, or 23.8% of the total child population. West Virginia has the second highest prevalence of CSHCN in the country.

The state of West Virginia does an excellent job of insuring children, with 94.3% of CSHCN reporting being covered by health insurance at the time of the 2017/2018 survey and 91.6% reporting having consistent coverage for the past 12 months.

Only 45.2% of CSHCN in West Virginia report receiving coordinated, ongoing, comprehensive care within a medical home. Both nationally and in West Virginia, rates of receiving all needed care coordination are falling behind the other components of the medical home measure.

| | 2016/2017 | | 2017/2018 | |
|---|---|---|---|---|
| | WV | U.S. | WV | U.S. |
| CSHCN receiving coordinated, ongoing, comprehensive care within a medical home | 47.9% | 43.2% | 45.2% | 42.7% |
| Medical Home Components | | | | |
| CSHCN with at least one personal doctor or nurse | 84.6% | 79.8% | 83.2% | 80.0% |
| CSHCN with a usual source for sick care | 84.4% | 83.0% | 80.6% | 81.9% |
| CSHCN who received family-centered care | 86.1% | 82.4% | 87.1% | 82.6% |
| Children who had no problem getting referrals to doctors or services (state-level CSHCN estimate not available) | 75.2% | 77.9% | Unavailable due to survey changes | |
| CSHCN who received needed effective care coordination, among those who needed care coordination | 59.0% | 61.8% | 56.3% | 73.5% |

Data source: National Survey of Children with Special Health Care Needs

While not a component of the medical home measure, transition services are integral to ensuring youth with special health

care needs (YSHCN) are receiving services in a well-functioning system. Upon reaching adulthood, these youth face changing insurance, health care providers, and potentially losing community services and supports they have depended on. While all components of transition are lacking, the most profoundly lacking is pediatric health care providers taking the time to discuss and prepare the YSHCN to shift to adult health care providers.

| | 2016/2017 | | 2017/2018 | |
|---|---|---|---|---|
| | WV | U.S. | WV | U.S. |
| YSHCN who received services necessary for transition to adult health care, ages 12 - 17 | 14.5% | 16.7% | 20.2% | 18.9% |
| Components of Transition | | | | |
| YSHCN who had the chance to speak privately (without their parents or another adult in the room) with a doctor or other health care provider at their last preventive check-up | 39.4% | 45.8% | 43.6% | 47.0% |
| YSHCN whose doctor actively worked with them to gain skills to manage his/her health and health care | 57.5% | 63.0% | 65.0% | 66.8% |
| YSHCN whose doctor actively worked with them to understand the changes in health care that happen at age 18 | 32.3% | 31.1% | 32.9% | 34.4% |
| YSHCN whose doctors discussed the shift to providers who treat adults, if needed | 12.6% | 17.3% | 18.8% | 20.0% |

Data source: 2016/2017 National Survey of Children with Special Health Care Needs

Families are the CSHCN's primary caregivers and it is integral to engage them in the health care planning for CSHCN. Families can provide insight into the reality of the daily issues and barriers the CSHCN face. As such, the family, and CSHCN when they are developmental capable and of age, should be engaged by their health care providers at every possible opportunity. As mentioned, 87.1% of CSHCN in West Virginia report receiving family-centered care. The data is encouraging, especially considering 89.1% of CSHCN report their child's doctors and health care providers usually or always make them feel like a partner in decision making.

**III.C.2.b.ii. Title V Program Capacity**

**III.C.2.b.ii.a. Organizational Structure**

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 (DHHR). A Cabinet Secretary is appointed by the Governor to administer DHHR. The Office is responsible for the administration of all Title V Programs in West Virginia as well as numerous other Programs funded by the state of West Virginia and its national partners.

The OMCFH is constituted of three divisions, plus a Quality Assurance/Monitoring Team, Early Intervention IDEA/Part C, 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.

*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 Home Visitation Program, Family Planning Program under which the Adolescent Pregnancy Prevention Initiative is housed; the Breast and Cervical Cancer Screening Program; WISEWOMAN; the Birth Score Program and Perinatal Programs which include Right From the Start.

*Division of Infant, Child and Adolescent Health (ICAH):* 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. ICAH programs include the Children with Special

Health Care Needs Program, the Oral Health Program, HealthCheck (EPSDT), the Adolescent Health Initative, and the Violence and Injury Prevention Program.

*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. There are currently 16 epidemiologists assigned to different Programs within OMCFH and four 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, the Newborn Hearing Project and the universal Maternal Risk Screening. 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.

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. Most 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. 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. The OMCFH uses a leadership team management approach with the Office Director, Division Directors and Quality Assurance Monitoring Director actively participating in decision-making and strategic planning.

The Office participates in West Virginia's civil service employment system that is governed by its Division of Personnel (DOP). DOP works with agencies to establish, criteria for personnel classifications, develop registers of qualified applicants and assures that agencies follow established policies and procedures. Recently, DOP has also been working with the Office to develop plans for the recruitment and retention of certain employment classifications including nurses and epidemiologists. While the Office recruits its workforce from throughout the US, it is difficult to retain employees that are not from West Virginia because of lower than average salaries. As a result, retention efforts often focus on facilitating career goals, maintaining connections to family, and State benefits (including health insurance, generous leave policies, and an employer sponsored pension plan).

In order to improve workforce capacity, OMCFH leadership actively participates in activities sponsored by the Association of Maternal and Child Health Programs (AMCHP) including the annual conference, webinars and regional discussions. Staff also have the opportunity to participate in various DHHR workgroups through the Secretary's Health Innovation Collaborative, Leadership Institute, new manager Boot Camp, and the Bureau for Public Health's Quality Improvement Initiative.

The Office provides ongoing support for staff to attend professional development opportunities both in-state and out-of- state to assure the understanding and knowledge of evidence-based practice. These events support professional staff in maintaining necessary credentials related to their field. Opportunities include the Women's Health Conference, Public Health Conference, KidStrong Conference, Celebrating Connections, Rural Health Conference, the State social worker conference, various National Program meetings and other local training programs.

**III.C.2.b.ii.b. Agency Capacity**

**Statewide System of Services**

The 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.

OMCFH continues to ensure a statewide system of services that reflect the Title V principles of comprehensive, community-based, coordinated, family-centered care. Examples of this work include: actively tracking health professional shortage areas and recruiting professionals in underserved areas; providing statewide family centered care coordination services for children with special health care needs; developing and implementing maternal risk screening tools, expanding services through home visiting where appropriate, leading efforts to implement trauma informed screening in pediatric practices, increasing utilization of developmental screening tools and assuring prenatal care is offered to all women regardless of their ability to pay.

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 actually receive both state and federal resources.

**Other State Agencies and Private Organizations**
The OMCFH works in close coordination with the State Medicaid agency, the Bureau for Medical Services (BMS). BMS provides funding support for many OMCFH Programs including Right From The Start, the State's medical case management program for pregnant women and infants to age one; HealthCheck, West Virginia's EPSDT Program; Breast and Cervical Cancer Case Management Services and the Children With Special Health Care Needs Program.

In 2009, the Office began collaborating with the Bureau for Children and Families to assure adequate health care services to children in foster care. What began as a pilot project to ensure all foster children received a timely EPSDT screening upon entry into foster care, has evolved to ensuring all foster children in the state receive adequate medical care. The EPSDT screening exam form has been modified to incorporate a two-question trauma screening tool, the Abbreviated PTSD Checklist. The CSHCN Program and HealthCheck will develop a provider training on the value of completing these trauma screening questions. The Office has determined that foster children fit the federal definition of CSHCN due to the trauma they experience and their increased risk of developing a special health care need as a result. This makes all foster children categorically eligible to receive services from the CSHCN Program. The CSHCN Program care coordination teams will complete a care plan for all foster children. This care plan incorporates a psychotropic medication review to ensure appropriate prescription and management of these medications. Care coordination services will be provided in collaboration with Aetna, the managed care organization contracted by BMS to be the health insurance provider for all foster children in West Virginia.

In February 2006, with support from the Claude Worthington Benedum Foundation and encouragement by then First Lady Gayle Manchin, a group of health care professionals convened at the Governor's Mansion to collaborate and address the poor health of mothers and babies in West Virginia. The state had some of the worst health outcomes in the country related to low birth weight, infant mortality, and teen pregnancy.

As a result of this meeting, the participants created the West Virginia Perinatal Partnership to work together for their shared interest of improving the health of mothers and babies in West Virginia, as well as have a positive impact on their environments, their family situations and their futures. The Partnership engaged various partners and contributing organizations through the 2006 Key Informant Survey and hosted the first Perinatal Summit. A Central Advisory Council was established to help organize subcommittees to address a variety of issues which had been identified. The members of the Central Advisory Council included rural providers, chairs and directors of perinatal health care organizations, deans and representatives from the state's three medical schools, the Office of Maternal, Child and Family Health and payers of care in West Virginia. The Partnership has become recognized throughout the state for its effectiveness in bringing together individuals and organizations involved in all aspects of perinatal care. The Office has supported the work of the WV Perinatal Partnership to implement the Drug Free Moms and Babies Project, and to implement a smoking cessation in pregnancy project.

**State Support for Communities**
West Virginia's Adolescent Health Initiative is a project developed and coordinated by the Infant, Child and Adolescent Division, Office of Maternal, Child and Family Health. The vision of the Project is to promote optimal physical, emotional, cognitive, social, and spiritual well-being for children and youth throughout West Virginia. Its mission is to support community collaborative efforts designed to develop the assets youth need to thrive and become successful across the State of West Virginia.

Formal work with the Adolescent Health Initiative (AHI) began in 1988. The OMCFH funds a dedicated network of eight regional Adolescent Health Coordinators across the State of West Virginia. The Initiative is designed to introduce, develop, train, and provide needed technical assistance to youth, parents, teachers, health care professionals, other regional networks, and civic groups with focused attention on improving adolescent health indicators while building asset-rich communities.

**Coordination of Health Components of Community-Based Systems**
The OMCFH embraces the principles of comprehensive, community-based, coordinated, family centered care, and works continuously to assure coordination with the health components of community-based systems. When possible, the Office works to involve family members at all levels of decision making. Parents actively participate in most of the advisory committees that the Office coordinates and/or participates in including, but not limited to the Children with Special Health Care Needs Medical Advisory Board, Newborn Hearing Screening Advisory Board, the Developmental Disabilities Council, the Commission to Study Residential Placement and the Commission for the Deaf and Hard of Hearing. The Office frequently works to identify parents to participate in the advisory groups of other agencies.

In addition, OMCFH uses Title V funds to support the involvement of parents of children with special health care needs. These parents play an active role in establishing policy for the Children with Special Health Care Needs Program, training of staff and families, assisting families with identified needs and assuring that family voices are ever present in decision making.

On a broad level the Office coordinates access to comprehensive health and related services through the medical home using the principles and guidelines established by the American Academy of Pediatrics. The primary vehicle for this coordination is through OMCFH's EPSDT Program, called HealthCheck. The HealthCheck Program promotes regular preventive medical care and the diagnosis and treatment of any health problem found during a screening. Medical providers provide children regular check-ups, screenings and preventive services based on a schedule established by medical, dental and other health care experts, including the American Academy of Pediatrics. Medical providers also treat children when they are sick or refer them to an appropriate specialist if they need to see one.

While HealthCheck is funded by the Bureau for Medical Services (Medicaid), nearly all Title V Programs follow HealthCheck recommendations and guidelines. Programs utilize the HealthCheck Program to distribute educational messages to providers and families. For example, the Oral Health Program utilized the HealthCheck infrastructure to educate providers on the importance of age one dental visits. In addition, the Children with Special Health Care Needs Program utilizes HealthCheck's established Policies and Procedures to assist families in accessing services not currently covered within the Medicaid plan.

The Children with Special Health Care Needs Program also works to assure access to comprehensive health and related services through the medical home. In 2010, the Program made a conscious decision to begin integrating their care coordination activities with the team of health care providers working with each enrolled child. With permission from the families, the eleven care coordination teams share information across providers and coordinate multi-disciplinary discussion when necessary.

The Office promotes early and continuous screening, evaluation and diagnosis via a number of its Programs. These Programs include HealthCheck, Breast and Cervical Cancer Screening, Family Planning, and WISEWOMAN, supported by Medicaid and the Centers for Disease Control and Prevention as well as its Title V Programs including Oral Health, Newborn Screening, and Children with Special Health Care Needs Programs. The Office relies on the combined infrastructure of these Programs to promote newborn screening, well-child visits, cancer screening, cardiovascular screening, preventive oral health services and other important services.

West Virginia has experienced a high degree of success in the implementation of the Affordable Care Act. Record numbers of residents have health insurance (94%), but the issue of adequate insurance remains troubling for many families. West Virginia's Medicaid Plan does not provide coverage for expensive medical foods needed by many children with special health care needs. As a result, OMCFH utilizes Title V funds to assure that families have access to these life sustaining products.

#### III.C.2.b.ii.c. MCH Workforce Capacity

OMCFH currently maintains 156 professional, technical and administrative support positions and 18 temporary contract positions. In addition, the Office maintains five paid parent 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. Biographical sketches of the Office Director and Senior Management:

**James Jeffries**, MS-Title V Office Director

**Education:**

Master of Science, Mountain State University, Beckley, WV, 2006

Bachelor's Degree, Physical Education, WV Institute of Technology, Montgomery, WV, 1991

**Professional:**

Director, Division of Infant, Child and Adolescent Health Division (2013-2018)

Director, HealthCheck Program, OMCFH (2009-9/2013)

Director, Quality Assurance Monitoring, OMCFH (2008-2009)

Quality Assurance Monitor, OMCFH (1998-2008)

**Kathryn G. Cummons,** MSW, LICSW, ACSW-Director, Division of Research, Evaluation and Planning,

**Education:**

Master of Social Work, West Virginia University, 1988

Bachelor of Social Work, West Virginia University, 1974

**Professional:**
Director, Division of Research, Evaluation and Planning, OMCFH (2000-Present)
Clinical Social Worker, Comprehensive Psychological Services (1999-2000)
Clinical Social Worker, Charleston Area Medical Center (1989-1990) and (1998-1999)
Director of Social Work Services and Discharge Planning, CAMC (1990-1998)
Administrator, Northern Tier Youth Services, Foster Care (1984-1989)
Supervisor, Lutheran Youth and Family Services, Residential Treatment (1981-1984)

**Teresa Marks,** MS– CSHCN Director; Director, Division of Infant, Child and Adolescent Health
**Education:**
Healthcare Administration, MS, Marshall University, 2019
Secondary Education, BA, Marshall University, 2001
**Professional:**
Director, Division of Infant, Child and Adolescent Health, OMCFH (2019-Present)
Director, Division of Perinatal and Women's Health, OMCFH (2018-2019)
Program Director, West Virginia Oral Health Program, OMCFH (2014-2018)
Workforce Coordinator, West Virginia Oral Health Program, BPH (2013-2014)
Program Coordinator, WV Asthma Education and Prevention Program, BPH (2012-2013)
Program Assistant, WV Cardiovascular Health Program, BPH (2010-2012)
Director of Education, Sylvan Learning Center (2007-2008)
Service Coordinator, Autism Services Center (2006-2007)
Director of Education, Sylvan Learning Center (2003-2006)
Teacher, Chesapeake (Ohio) Union Exempted Village School District (2001-2003)

**Aimee S. Bragg**, LNHA, Director, Division of Perinatal & Women's Health
**Education**:
Bachelor of Science, Health Services Administration, 1993
**Professional**:
Director, Division of Perinatal & Women's Health, OMCFH (2019-Present)
Assistant Administrator/HR Director, Jackie Withrow Hospital, BHF/DHHR (2005-2019)
Administrator, Heartland of Keyser, HCR Manor Care (2000-2002)
Assistant Administrator/HR Director, Heartland of Beckley, HCR Manor Care (1997-2000)

**Melissa Baker**, MA – MCH Epidemiologist, PI/Director PRAMS
**Education:**
Public Health Distance Education, Johns Hopkins University, Baltimore, MD, 1997/98
Master of Arts, Marshall University, Huntington, WV, 1989
Bachelor of Arts, Marshall University, Huntington, WV, 1987
**Professional:**
MCH Epidemiologist, PI/Director PRAMS, OMCFH (2002-Present)
PRAMS Coordinator, OMCFH (1996-2002)
Legislative Analyst, WV Legislature (1991-1996)

**Mechanisms for Culturally Competent Approaches**

**Ensure Training**
Staff from the OMCFH ensures the provision of training in areas of cultural and linguistic competence whenever possible. The Office maintains the ability to provide continuing education units for nurses and social workers and utilizes this to incentivize training when possible. The Office has offered numerous training opportunities on poverty and cultural competence via staff meetings, provider training, and conferences. These events reach internal staff, family leaders, medical professionals and community grantees.

**Collaboration with Diverse Groups**
The Office collaborates with a broad group of stakeholders throughout West Virginia. This network includes community leaders, church pastors, and family advocacy groups. The Office provides training and participates in strategic planning activities throughout each year.

**Securing Resources**
The Office works to provide technical and financial support to meet the unique needs of culturally diverse groups. The Office provides financial support and staffing support for grant development to various agencies and community groups when possible.

**Develop and Implement Performance Standards**
The Office works diligently to establish standards and training for clinical health providers to assure culturally competent practices.

**Provide Policies and Guidelines**
The OMCFH maintains policies and guidelines that support culturally competent practice, particularly in its clinical services programs. However, the Office needs to develop internal policies for its staff.

**III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination**

The Office of Maternal, Child and Family Health has demonstrated an ongoing commitment to build, sustain and expand partnerships to work collaboratively and to coordinate services with other organizations.

**Other MCHB Investments**
The Office receives and manages the State System Development Initiative (SSDI) Grant. Staff assigned to this Project are housed within the Division of Research, Evaluation and Planning. The Office is also responsible for implementing the Maternal, Infant, and Early Childhood Home Visiting Grants (MIECHV). This Program reports directly to the Office Director and heavily coordinates its services with Right From the Start, HealthCheck, Birth To Three and Violence and Injury Prevention. In addition, the Home Visitation Program is merged with the Early Childhood Systems of Care Grant to assure that efforts are well coordinated. Externally, the Office works closely with West Virginia University to implement West Virginia's Healthy Start Grant as part of the Right From the Start Program.

**Other Federal Investments**
The OMCFH is responsible for a number of other federal programs including: PRAMS, Breast and Cervical Cancer Screening, WISEWOMAN, Family Planning, Personal Responsibility Education Program, Prescription Drug Overdose, Rape Prevention Education, Sexual Assault Prevention, Lead Prevention, and various oral health grants.

**Other HRSA Programs**
The OMCFH works closely with the Division of Primary Care to leverage work with Federally Qualified Health Centers. Many of the Centers receive grant funds from the Office and nearly every center receives technical support for clinical services.

**State and Local MCH Programs**
West Virginia is a small state with regard to population. Therefore, the OMCFH is the only Program designated as an MCH Program in West Virginia.

**Other Programs within DHHR**
The Office works with the Health Statistics Center to obtain critical data from vital registration. The Office also works with the Office of Environmental Health Services to assure water fluoridation, the Office of Chief Medical Examiner to review maternal and infant deaths, the Office of Laboratory Services to assure tracking and follow-up of newborn screening, the Office Epidemiology and Prevention Services to identify and treat sexually transmitted diseases, and the Office of Emergency Medical Services to meet the requirements of children with special health care needs in emergency situations.

**Other Governmental Agencies**
The Office works closely with the Bureau for Children and Families on foster care initiatives and with the Bureau for Behavioral Health on several activities. In addition, the Office partners very closely with the Bureau for Medical Services to implement EPSDT, provide medical case management services to pregnant women, and to assure health care coordination of children with special health care needs.

**Public Health and Health Professional Educational Programs**
Under the leadership of the Bureau for Public Health, the Office has partnered with West Virginia University and Marshall University's Public Health Programs.

**Family/Consumer Partnerships and Leadership Programs**

The OMCFH participates in several family/consumer partnerships programs. All of the Parent Network Specialists and several OMCFH staff have completed the Partners in Policy Making Training, and intensive multi-session training. Both the Birth to Three and Home Visitation Programs maintain advisory groups with parents and parents with children with special health care needs to address the issues that families and children face in early childhood.

### III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

West Virginia OMCFH used data and information provided from various programs, advisories, data sources and stakeholders to inform the priority needs selection for the 2020 Needs Assessment. Priority needs were selected based upon the findings from collected data and ranking of selected National Performance Measures by staff and stakeholder groups. Capacity, existing resources, feasibility and potential impact were all considered when selecting the priority needs.

The Office engaged several stakeholder groups in the selection process. These groups included but were not limited to the Perinatal Partnership, the Pediatric Medical Advisory Board, communities across the state and staff. This method for input assured that equal input was given for all population groups. Once the process was completed, epidemiology staff compared the results to other data resources available to assure that the selected priorities were aligned with the larger efforts of West Virginia's Public Health System. While some differences in opinion were noted across stakeholder groups, strong consensus was achieved. In addition, while the identified needs are aligned with the larger public health focus in West Virginia, Title V remains unique in its focus on the maternal and child health population groups. Based upon these finding West Virginia has chosen the following priority need areas for 2020-2025:

1. Smoking in pregnancy and smoke exposure in the home
2. Infant mortality
3. Preterm birth
4. Injury – specifically bullying and suicide (attempted)
5. Substance use in pregnancy and in youth/teens
6. Breastfeeding initiation and duration
7. Medical home
8. Obesity in children
9. Oral health in pregnancy
10. Transition

To address these needs, West Virginia has selected the following National Performance Measures by domain:

NPM 2. Low risk cesarean delivery (Women/Maternal Health)
NPM 4. Breastfeeding (Perinatal/Infant Health)
NPM 5. Safe Sleep (Perinatal/Infant Health)
NPM 9. Bullying (Adolescent Health)
NMP 11. Medical Home (Children with Special Health Care Needs)
NPM 13. Oral Health (Women/Maternal Health)
NPM 14. Smoking (Women/Maternal Health, Child Health)

In addition, West Virginia will develop the following State Performance Measures:

SPM 1. Transition (Adolescent Health, Children with Special Health Care Needs)
SPM 2. Substance use in pregnancy (Women/Maternal Health)
SPM 3. Substance use in youth/teens (Child Health, Adolescent Health)
SPM 4. Obesity in children (Child Health)

### III.D. Financial Narrative

| | 2017 | | 2018 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $6,056,026 | $5,949,753 | $6,056,026 | $6,055,416 |
| State Funds | $11,261,253 | $13,319,286 | $13,485,615 | $10,983,296 |
| Local Funds | $0 | $0 | $0 | $0 |
| Other Funds | $0 | $556,775 | $0 | $0 |
| Program Funds | $15,351,809 | $17,056,389 | $20,399,917 | $19,589,153 |
| SubTotal | $32,669,088 | $36,882,203 | $39,941,558 | $36,627,865 |
| Other Federal Funds | $27,818,810 | $23,763,813 | $24,853,776 | $22,849,741 |
| Total | $60,487,898 | $60,646,016 | $64,795,334 | $59,477,606 |

| | 2019 | | 2020 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $6,056,026 | $6,055,641 | $6,056,584 | |
| State Funds | $13,264,963 | $12,629,175 | $13,341,754 | |
| Local Funds | $0 | $0 | $0 | |
| Other Funds | $0 | $0 | $0 | |
| Program Funds | $19,282,861 | $19,526,885 | $0 | |
| SubTotal | $38,603,850 | $38,211,701 | $19,398,338 | |
| Other Federal Funds | $27,964,391 | $22,293,910 | $33,256,949 | |
| Total | $66,568,241 | $60,505,611 | $52,655,287 | |

| | 2021 | |
|---|---|---|
| | Budgeted | Expended |
| **Federal Allocation** | $6,176,181 | |
| **State Funds** | $13,272,503 | |
| **Local Funds** | $0 | |
| **Other Funds** | $0 | |
| **Program Funds** | $21,193,138 | |
| **SubTotal** | $40,641,822 | |
| **Other Federal Funds** | $29,431,884 | |
| **Total** | $70,073,706 | |

**III.D.1. Expenditures**

The Office of Maternal, Child and Family Health (OMCFH) expects to allocate over $70,000,000 in resources for FY 2021. These funds are comprised of State, Federal, and private resources. Title V Block Grant funds in the amount of $6,176,181 are used to provide the foundational structure for the OMCFH. Specifically, the funds are used to assure access to quality care, reduce infant mortality, ensure access to prenatal care, ensure access to preventive and child care services for certain children, implement family-centered, community-based care for children with special health care needs, and provide toll-free hotlines for assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX. While there are some non-traditional programmatic areas within the Office, the Block Grant assures that the Office stays true to focusing on the entire maternal and child health population, maintains its unique partnerships with Federal, State, and local entities and serves as the payer of last resort for direct services not covered by any other program.

Each year, the State Legislature allocates funds to the Office to assist in meeting the match and maintenance of effort requirements for the Title V Block Grant. The remaining funds are generated through program income. The maintenance of effort for WV totals $4,362,527. The Office expects to be allocated $13,272,503 in State funds and will generate $21,193,138 in program income. The total state match provided is $34,465,641. Program income is comprised of payments from insurance providers (including Medicaid and WVCHIP) and hospitals for newborn screening. There are some variations noted in the OMCFH budget from year to year. These variations are because the Office budgets current FY appropriations, but annual spending reflects re-appropriated funds from previous years. Overall, state appropriated funds have remained relatively stable.

The OMCFH meets with the Bureau for Public Health's Central Finance Unit each month to monitor expenses and assure compliance. The Office apportions approximately 35% for preventive and primary care for children and 30% for children with special health care needs which is in compliance with the 30% - 30% requirement. At each meeting, the Leadership Team discusses allocations to funding categories, administration, and maintenance of effort. Currently, the Office is operating at approximately 7.5% for administrative costs, complying with the 10% limit.

The Office served over 320,000 women and children during CY 2019 and over 15,000 pregnant women received OMCFH-sponsored services. This included provision of prenatal care for low-income uninsured women, maternal risk screening and referral at the first prenatal visit, and referral of women with positive pregnancy tests to home visitation programs. Over 16,000 infants received newborn screening services and Birth Score referrals and over 240,000 children ages 1 through 21 years of age received Help Me Grow referrals, childhood lead screenings, outreach for adolescent health, oral health services, or family planning services. Nearly 50,000 children with special health care needs received referrals or other services through Birth to Three or the Children with Special Health Care Needs Program.

**III.D.2. Budget**

The Title V Needs Assessment and its findings provide the operational structure for the day to day activities of the OMCFH. State priorities include preterm birth, breastfeeding, infant mortality, bullying and teen suicide, medical home for children with special health care needs, oral health during pregnancy, smoking during pregnancy and exposure in the household, transition to adult care, addressing substance use during pregnancy and in youth/teens and childhood obesity. These priorities drive the work of the Office and its funding decisions. This is achieved by assuring that project work plans and grant agreements align with its needs assessment and action plan on an annual basis.

Specifically, MCH Block Grant funds support a skilled MCH workforce, programs to reduce cesarean deliveries, reduce smoking during pregnancy, increase breastfeeding, mail safe sleep materials and provides staff support for the work to address Neonatal Abstinence Syndrome (NAS). Block grant funds also support West Virginia's Adolescent Health Initiative to address bullying, mental health and other child and adolescent health priorities. Children with special health care needs are supported through braided funding from Medicaid. The MCH Block Grant typically supports clinical services not covered by any other funding source while Medicaid pays for the majority of the Program's staff and their associated expenses.

In general, state funds are used to support activities mandated by WV law such as support for the Birth Score Instrument and Birth to Three. State funds are also prioritized for use in areas where the Office has the potential for earned income like newborn screening, genetics services, and Birth to Three. This strategy serves to maximize the resources available to serve women, children, and children with special health care needs. The MCH Block Grant is an essential pillar of West Virginia's funding strategy to meet the needs of its population.

In addition to the Title V Block Grant, the Office receives numerous grants from a wide variety of sources including SSDI, Abstinence Education, Early Childhood Comprehensive Systems, Maternal Infant Early Childhood Home Visitation, Universal Newborn Hearing Screening, and Oral Health. The Office also manages a number of Cooperative Agreements from the Centers for Disease Control and Prevention including PRAMS, Oral Disease Prevention, Childhood Lead Poisoning Prevention, Breast and Cervical Cancer Screening, and WISEWOMAN.

Other funding sources include Title X for Family Planning and the Administration for Children and Families for the Personal Responsibility Education Program. The Office receives Title XIX funds for EPSDT, Children with Special Health Care Needs, case management services for women with breast or cervical cancer, and Right From the Start.

## III.E. Five-Year State Action Plan

### III.E.1. Five-Year State Action Plan Table

**State: West Virginia**

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

**III.E.2. State Action Plan Narrative Overview**

**III.E.2.a. State Title V Program Purpose and Design**

The Office of Maternal, Child and Family Health (OMCFH) is the Title V agency in West Virginia (WV). While the Office brings together under one umbrella a variety of programs and projects, its leadership uses its available resources and partnerships to optimize health across the lifespan, for all people. DHHR leadership rely on the Office to provide a crosswalk between public health and its child welfare, behavioral health, and Medicaid systems on a broad range of topics related to maternal and child health. In addition, the Office's infrastructure combined with its utilization and access to data makes it a go-to place for high priority special projects.

The Office places great value on its partnerships and leverages its relationships to accomplish many of the goals outlined with its State Action Plan. Key external partnerships include the State's Perinatal Partnership (Perinatal Collaborative), academic institutions, medical and programmatic advisory boards, health care providers, the Department of Education, and the families served by its Programs. OMCFH actively convenes medical and programmatic advisory boards but also serves in leadership roles for many external groups. For example, staff serve on the Perinatal Partnership's Central Advisory Council, the Executive Committee of the Developmental Disabilities Council, and the Steering Committee of the State's cancer coalition, Mountains of Hope.

The Title V funded Children with Special Health Care Needs (CSHCN) Program functions to support family-centered, coordinated, ongoing comprehensive care for children and youth with special health care needs within a medical home. CSHCN Program Care Coordinators (Nurses and Social Workers) work to facilitate a team approach to health care, with coordination across multiple services and settings, in accordance with the National Consensus Standards for Systems of Care for Children and Youth with Special Health Care Needs. The following care coordination functions are provided for all clients enrolled CSHCN Program:

- Advocating family-centered, coordinated, ongoing comprehensive care within a medical home.
- Ensuring an appropriate written care plan.
- Promoting communications within the medical home team and ensuring defined minimal intervals between said communications.
- Supporting and/or facilitating (as appropriate) care transitions from practice to practice and from the pediatric to adult systems of care.
- Supporting the medical home's capacity for electronic health information and exchange; and
- Facilitating access to comprehensive home and community-based supports.

In WV, OMCFH has a major role in establishing standards, policies, and procedures for health care services, interpreting standards to providers, providing education to enhance implementation, promoting quality of care, and assessing progress. The State Medicaid Agency has commissioned managed care organizations to provide comprehensive health services to West Virginia Medicaid members, including children receiving Supplemental Security Income (SSI) Medicaid. The West Virginia Medicaid Managed Care Program's management of children with special health care needs is closely integrated with the CSHCN Program. Moreover, the OMCFH and contracted managed care organizations have agreed to a Memorandum of Understanding (MOU) to establish roles and responsibilities between the OMCFH and contracted managed care organizations for the purposes of providing coordination of services to promote prompt access to high-quality child health services for children eligible for benefits under Titles V and XIX of the Social Security Act. Said MOU, which remains in full force and effect for the duration of the contract between OMCFH and each Managed Care Organization (MCO), stipulates that "*as a component of its statutorily required managed care quality strategy, MCO will make available summary reporting data to OMCFH, including the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), to enable the Title V agency to monitor and evaluate its quality initiatives, including care*

*furnished to CSHCN*."

As a result of the opioid crisis, the Office has developed several innovative practices in recent years and is planning new work for Fiscal Year 2021. As a result of the Pandemic the Office has developed innovative practices to continue to provide all services offered to clients with some deviation from in-home provision. Communication with families using Skype and Zoom has proved invaluable. The Office utilized its legislatively mandated Birth Score Instrument to establish a surveillance system for neonatal abstinence syndrome in October 2016. This data collection tool continues to mature, evolve and transform as more is learned about NAS. The Birth Score data collection will be used by the Office and its academic partners to study NAS associated birth defects, infant mortality, as well as impacts to its service programs like Birth to Three, Home Visitation, and foster care. This information will inform public health policy, resource allocation, and evidence-based practices across the State.

In addition, this data illustrates the need to recommend, assist and guide high risk women to delay pregnancy until they are ready. The Office will continue to offer comprehensive reproductive health care services to persons in correctional facilities and those seeking syringe exchange in harm reduction clinics. This work is grounded in the best available evidence for reproductive health, but provision of these services in new settings require innovation, quality assurance monitoring, and program evaluation.

The Office integrates into its work the core public health functions of assessment, assurance, and policy development. OMCFH routinely reviews incidence rates and maps available data for program planning.

In addition, the Office actively works to manage resources and develop organizational structure, implement and evaluate programs, and inform and educate the public. Examples of this work include:

- Implementation of over 25 ongoing Programs and projects that meet the needs of maternal and child health populations.
- Maintenance of an active Quality Assurance Monitoring Unit that routinely evaluates the quality of care provided by its Title X, early intervention, and breast and cervical cancer screening program providers; and
- Deployment of a network of public health educators that provide education on a wide range of topics including teen pregnancy, comprehensive sex education, women's health, developmental screening, substance abuse, oral health, injury prevention, and bullying.
- Enhancing the review process and data collection for Infant and Maternal Mortality.

**III.E.2.b. Supportive Administrative Systems and Processes**

**III.E.2.b.i. MCH Workforce Development**

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. Most 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 156 staff in professional, technical and administrative support positions and 18 temporary positions. In addition, the Office maintains five paid parent 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. Its leadership has over 50 years of combined experience in Title V specific roles. The OMCFH uses a leadership team management approach with the Office Director, Division Directors and Quality Assurance Monitoring Director actively participating in decision-making and strategic planning. Below are brief biographical sketches of the Office Director, Senior Management, and key staff:

**James Jeffries**, MS-Title V Office Director
**Education:**
Master of Science, Mountain State University, Beckley, WV, 2006
Bachelor's Degree, Physical Education, WV Institute of Technology, Montgomery, WV, 1991
**Professional:**
Director, Division of Infant, Child and Adolescent Health Division Director, Title V CSHCN Director, OMCFH/BPH (2013-2018)
Director, HealthCheck Program, OMCFH/BPH (2009-9/2013)
Director, Quality Assurance Monitoring, OMCFH/BPH (2008-2009)
Quality Assurance Monitor, OMCFH/BPH (1998-2008)

**Kathryn G. Cummons,** MSW, LICSW, ACSW-Director; Division of Research, Evaluation and Planning,
**Education:**
Master of Social Work, West Virginia University, 1988
Bachelor of Social Work, West Virginia University, 1974
Minors in Psychology and Speech
**Professional:**
Director, Division of Research, Evaluation and Planning, OMCFH/BPH (2000-Present)
Clinical Social Worker, Comprehensive Psychological Services (1999-2000)
Clinical Social Worker, Charleston Area Medical Center (1989-1990) and (1998-1999)
Director of Social Work Services and Discharge Planning, CAMC (1990-1998)
Administrator, Northern Tier Youth Services, Foster Care (1984-1989)
Supervisor, Lutheran Youth and Family Services, Residential Treatment (1981-1984)

**Teresa Marks,** MS– Title V CSHCN Director; Division of Infant, Child and Adolescent Health, Division Director
**Education:**
Healthcare Administration, MS, Marshall University, 2019
Secondary Education, BA, Marshall University, 2001
**Professional:**
Director, Division of Infant, Child and Adolescent Health, OMCFH (2019-Present)
Director, Division of Perinatal and Women's Health, BPH (2018-2019)
Program Director, West Virginia Oral Health Program, BPH (2014-2018)

Workforce Coordinator, West Virginia Oral Health Program, BPH (2013-2014)
Program Coordinator, WV Asthma Education and Prevention Program, BPH (2012-2013)
Program Assistant, WV Cardiovascular Health Program, BPH (2010-2012)
Director of Education, Sylvan Learning Center (2007-2008)
Service Coordinator, Autism Services Center (2006-2007)
Director of Education, Sylvan Learning Center (2003-2006)
Teacher, Chesapeake (Ohio) Union Exempted Village School District (2001-2003)

**Aimee S. Bragg**, LNHA, Director; Division of Perinatal & Women's Health
**Education**:
Bachelor of Science, Health Services Administration, 1993
**Professional**:
Director, Division of Perinatal & Women's Health, OMCFH (2019-Present)
Assistant Administrator/HR Director, Jackie Withrow Hospital, BHF/DHHR (2005-2019)
Administrator, Heartland of Keyser, HCR Manor Care (2000-2002)
Assistant Administrator/HR Director, Heartland of Beckley, HCR Manor Care (1997-2000)

**Melissa Baker**, MA, MCH Epidemiologist, PI/Director PRAMS
**Education:**
Public Health Distance Education, Johns Hopkins University, Baltimore, MD, 1997/98
Master of Arts, Marshall University, Huntington, WV, 1989
Bachelor of Arts, Marshall University, Huntington, WV, 1987
**Professional:**
MCH Epidemiologist, PI/Director PRAMS, OMCFH/BPH (2002-Present)
PRAMS Coordinator, OMCFH/BPH (1996-2002)
Legislative Analyst, WV Legislature (1991-1996)

The Office participates in West Virginia's civil service employment system that is governed by its Division of Personnel (DOP). DOP works with agencies to establish, criteria for personnel classifications, develop registers of qualified applicants and assures that agencies follow established policies and procedures. Recently, DOP has also been working with the Office to develop plans for the recruitment and retention of certain employment classifications including nurses and epidemiologists. While the Office recruits its workforce from throughout the United States, it is difficult to retain employees that are not from West Virginia because of lower than average salaries. In July 2019, salaries for all epidemiology classifications within BPH were increased in hopes of retaining existing staff and recruiting more easily for vacancies as they become open. Retention efforts often focus on facilitating career goals, maintaining connections to family, and State benefits (including health insurance, generous leave policies, and an employer sponsored pension plan).

In order to improve workforce capacity, OMCFH leadership actively participates in activities sponsored by the Association of Maternal and Child Health Programs (AMCHP) including the annual conference, webinars and regional discussions. Additional staff are also encouraged to participate in specific activities offered by AMCHP, specifically Program Managers/Coordinators and Epidemiologists.

Staff also have the opportunity to participate in various Department of Health and Human Resources workgroups through the Secretary's Health Innovation Collaborative, Leadership Institute, new manager Boot Camp, and the Bureau for Public Health's Quality Improvement Initiative. In addition, the Bureau for Public Health's Commissioner and State Health Officer requires participation by the Office Director in monthly Bureau level leadership team meetings.

The Office provides ongoing support for staff to attend professional development opportunities both in-state and out-of- state to assure the understanding and knowledge of evidence-based practice. These events support professional staff in maintaining necessary credentials related to their field. Opportunities include the Women's Health Conference, Public Health Conference, KidStrong Conference, Celebrating Connections, Rural Health Conference, the State social worker conference, various National Program meetings including Council of State and Territorial Epidemiologists (CSTE), CityMatCH, MCH Epi and other national, state and local training programs.

Challenges have included state level position sweeps and retirements. The Office has been creative in using vacant positions to reallocate to positions requiring higher educational levels with higher salaries. These positions can often be shared between Divisions. Generally, federally funded positions have been exempt from these restrictions, so the Block Grant along with other federal funds enable WV to maintain its workforce and continue moving forward. OMCFH has been able to assist other Offices during the Pandemic with developing data collection tools, data entry, technical assistance for local health departments, contact tracing, syndromic surveillance, follow-up with pregnant women diagnosed with COVID-19 and their infants and identifying and providing surveillance for children with MIS-C.

In addition, to utilizing federal funds to maintain adequate staffing, the Office also embeds personnel employed by its partners. For example, personnel from West Virginia University, the Board of Pharmacy, the Office of Drug Control Policy and other local community agencies are located within the OMCFH main office. In some instances, this has even allowed former OMCFH personnel to be promoted to other positions in those agencies while they continue to function as OMCFH staff.

**III.E.2.b.ii. Family Partnership**

The Office of Maternal, Child and Family Health (OMCFH) acknowledges the essential role that family participation (FP) plays in its programs. Studies demonstrate that engaging families as equal partners in their child's health care decision-making reduces unmet health needs, problems with specialty referrals, out-of-pocket expenses, and improves patient physical and behavioral function.

The OMCFH embraces the principles of comprehensive, community-based, coordinated, family centered care within a medical home, and continuously works to assure coordination with the health components of community-based systems. OMCFH Programs emphasize the medical home as a team-based approach to care that is led by a primary care clinician and/or subspecialist, and in which the family is a core member. Family strengths are respected in the delivery of care, extended family members are included in decision-making according to the family's wishes and family driven goals are incorporated into plans of care.

The OMCFH promotes parent peer supports through longstanding partnerships with the West Virginia University Center for Excellence in Disabilities (WVUCED) and the Parent Partners in Education (PPIE) at the Marshall University School of Medicine in the administration of services and supports for special need children populations. Through these collaborations, children with special needs and their families have an opportunity to participate in the design of community-based programs which promotes the possibility for independence, productivity and self-determination. Via a contractual arrangement with the WVUCED and PPIE, the OMCFH uses Title V funds to support four community-based Parent Network Specialists, two Parent Teachers and a pool of Parent Trainers. Those providing parent peer supports must have at least one child with a special health care need. This collaboration has established successful family-based and family led initiatives for youth and their families. During 2019-2020, those providing parent peer supports worked to empower other parents to take on leadership roles within their communities, encouraged participation in support groups, assisting and supporting parents in navigating the educational system, to decrease isolation, and to deliver parents' perspectives to service providers.

The WVUCED Parent Network Specialists (PNS) are certified in all seven courses of the Strengthening Families Protective Factors Framework and trained as Circle of Parents® facilitators. They provide information & resources on the various Triple P Stepping Stones parenting education opportunities, encourage social connections through Circle of Parents support group/parent networking services, extend information about local community events that are inclusive and promote health and fitness, and provide individualized assistance in building advocacy skills within community settings, such as school and afterschool care. The PNS also provide opportunities for families to receive training in topics such as: health and wellness, navigating the medical home, parenting skills, building positive social connections, self-advocacy, educational systems, access to vocational training, and preparing for transitions. PNS are represented at each quarterly meeting of the OMCFH Family Advisory Committee and report the experiences of the families they serve.

Effective June 1, 2018, the WVUCED became West Virginia's Family-to-Family Health Information Center (WV F2F HIC). The goal of WV F2F HIC is to promote optimal health for children and adults with special health care needs by helping families, health professionals, and communities' partner in facilitating access to cost-effective, quality care.

The PPIE Project at Marshall University School of Medicine train pediatric and family practice residents and medical students using the Project DOCC (Delivery of Chronic Care) curriculum. The PPIE Parent Teachers facilitate the trainings and coordinate a pool of Parent Trainers who provide information regarding the early identification of children with special needs, the importance of the medical home for the special needs population, the availability of community resources and how to access them, and the importance of vaccinations as related to care within a well-functioning system. Project DOCC residents and medical students are introduced to several children with different

needs in their own home and community using a video training and then attend a student lecture presentation by those parents they met in the video. The last component, the parent interview, provides opportunity for the residents and medical students to ask questions and the Parent Trainers discuss one-on-one, the shared decision-making model of the patient/family centered medical home.

Through facilitation by the WV CSHCN Administration and the guidance of the PPIE Parent Teachers, The Graduate Medical Student Family Experience Simulation, parent teacher curriculum was developed through the WVU Center for Simulation Training Education and Patient Safety (STEPS) by adapting the 1994 curriculum of Project DOCC. WVU STEPS is the primary simulation center at the West Virginia University Health Sciences Center and the Graduate Medical Student Family Experience Simulation curriculum is now included. This training was developed by parents and is parent led.

The CSHCN Program Administration developed a Transition and Medical Home Improvement Team. Each team is a subcommittee of the CSHCN Medical Advisory Board (MAB). A parent of a child with a special health care need is a member of the CSHCN MAB and each subcommittee. Through parent participation as advisors the CSHCN Program gains understanding of the family/parent/individual perspective on issues, needs, and services. Promoting partnerships and engagement ensures a voice for families and individuals with special health care needs to improve the system of care.

The OMCFH developed a Family Advisory Committee to embrace family perspectives. This family Advisory Committee is comprised of parents/caregivers of clients who engage in OMCFH Programs. Family leaders, in coordination with OMCFH staff, set meeting agendas and hold quarterly meetings. Families review new policies, education materials and reports. The Family Advisory Committee discuss policies that families find problematic, assist strategic planning, participate in the needs assessment, help develop the Block Grant application, and provide advice on the budget. Family Advisory Committee meetings are open to all parents/caregivers of clients who engage OMCFH Programs.

For 2020-2021, Parent Network Specialists will continue to cultivate parent leaders, connect families, build informal support systems for families, and ensure a parent voice for systemic changes. The OMCFH will continue to work in partnership with the WVUCED and serve as a partner involved in the WV F2FHIC network to enable accomplishments in three OMCFH priority areas: (1) ensuring all children are connected to a medical home; (2) ensuring that adolescents requiring care have the necessary services in order to transition to adult health care; and (3) ensuring that all children have access to adequate insurance coverage. This approach will provide valuable opportunities for families to be involved in activities directly pertaining to the planning and implementation of their health care and that of their children. Families will also contribute to the long-term training of health providers on the need to incorporate families into the medical decision-making model and to state discussions about this model.

The OMCFH works to involve family members at all levels of decision making. Parents actively participate in advisory committees including, but not limited to the Children with Special Health Care Needs Medical Advisory Board, Newborn Hearing Screening Advisory Board, the Developmental Disabilities Council, the Commission to Study Residential Placement, and the Commission for the Deaf and Hard of Hearing.

The OMCFH participates in several family/consumer partnerships programs. Specifically, the Office Director serves on the Developmental Disabilities Council and its Executive Committee. This council's membership is comprised of persons with disabilities, parents/families of persons with disabilities, and state agencies with the ability to influence the system of care. The Council provides regular leadership training for members and families. In addition, the Office Director serves on the Commission for the Deaf and Hard of Hearing which is comprised of people who are deaf and/or hard of hearing. Both the Birth to Three and Home Visitation Programs maintain advisory groups that

have parents and parents of children with special health care needs to address issues that families and children face in early childhood.  All the groups give input into the policies implemented by OMCFH Programs.

**III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts**

State Systems Development Initiative

In West Virginia, the quantitative and qualitative collection, analysis, and use of public health data are critical components of effective surveillance, evaluation and development of population, and evidence-based strategies. Each of these components are fundamental to the development of an infrastructure that addresses the health of children and those with special needs, women of child-bearing age, and their infants at the state and local levels. Data analysis is a central component of the efforts to identify maternal, child and family health needs; design appropriate program interventions; manage and evaluate those interventions; and monitor progress toward achieving goals and outcomes. One of the primary goals of the State Systems Development Initiative (SSDI) is to ensure the ability to access policy and program relevant information and data to expand Title V data capacity for its Five-year needs assessment and annual performance measure reporting.

The ability to collect and analyze data to improve evidence-based decision making is the focus of policy and program formulation at the national, state and local levels. Decisions surrounding the allocation of dollars are increasingly focused on outcome and system performance measures driven by the best data available.

The SSDI Project is housed within the Division of Research, Evaluation and Planning (Research Division) of the Office of Maternal, Child and Family Health (OMCFH), West Virginia's Title V agency, located in the WV Bureau for Public Health (WVBPH). The Research, Evaluation and Planning Division is responsible for submission of the Title V Annual Report/Application and the Title V Five-year Needs Assessment, making it a natural fit for the SSDI Project. The Project Director for SSDI is the Director of the Division of Research, Evaluation and Planning. This ensures that SSDI grant funds are used to advance West Virginia's data capacity. WV has chosen to support surveillance systems development to address data needs related to emerging MCH issues (birth defects that may be caused by the Zika virus, maternal mortality, and childhood lead poisoning as state specific measures). Neonatal Abstinence was also listed as an emerging issue and although it is a growing concern in WV, it is being addressed through the Violence and Injury Prevention Program and the Division of Perinatal and Women's Health.

**Goals:**

1. Build and expand State MCH data capacity to support Title V MCH Block Grant Program activities and contribute to data driven decision making in Maternal and Child Health (MCH) programs, including assessment, planning implementation and evaluation.
2. Advance the development and utilization of linked information systems between key MCH datasets in the state and
3. Support surveillance systems development to address data needs related to emerging MCH issues (e.g., the Zika virus, maternal mortality and/or lead poisoning prevention).

**Progress to Date**:

In the last few years, the OMCFH was able to add two CDC data systems to capture birth defects caused by the Zika Virus and maternal mortality using the MMRIA and one HRSA data system to capture infant mortality using the FIMR data base. The Zika project has ended but data was entered for 2016, 2017 and 2018. The MMRIA and FIMR data systems are currently up and running and data is being entered. The new version of the FIMR data system was released for data entry as of June 5, 2018 and updated versions have been added.

WV has seen an increase in maternal deaths due to the drug epidemic over the last few years and continues to track

the data.

By leveraging the CDC Zika funds, WV was able to contract nursing staff to provide active case ascertainment in reviewing medical record information for birth defects for 2016, 2017 and 2018. WV currently has a passive system with only diagnostic codes being sent in by hospitals.

WV also leveraged the CDC Zika award to develop a web-based data system to capture submission of the Prenatal Risk Screening Instrument completed by prenatal providers. This screening instrument captures information about exposure to the Zika Virus among other risks associated with pregnancy.

Over the years, access to SSDI funds has given the WV OMCFH the ability to expand and develop data systems to further surveillance efforts. Using grant dollars from federally sponsored Programs, the OMCFH currently has 14 epidemiologists, giving Programs increased capacity for data collection efforts, surveillance and data analysis to drive programmatic efforts.

The OMCFH agreed to follow pregnant women and their infants who tested positive for COVID-19 and the process is still under construction.

In July 2020 with SSDI assistance, the OMCFH built a data base to capture data on people who were seen at community COVID-19 testing events across the state. These community testing events will continue as long as the need to identify persons infected with the disease remains a priority. Data entry staff housed within the Research Division are assisting with entry of the data. This effort is in partnership with the Office of Epidemiology and Prevention Services who oversee infectious diseases.

**III.E.2.b.iv. Health Care Delivery System**

The WV Title V agency is well-known for its ability to leverage relationships and resources to maximize services available to the State's residents. The agency is responsible for grants and cooperative agreements from numerous federal funders and generates revenue through the provision of services like Birth to Three and Newborn Screening. The agency is also supported by Medicaid and State general revenue. This complex funding system enables the Office to help ensure access to quality health care and needed services for its maternal and child populations.

In WV, both the Title V and Medicaid agencies reside in DHHR and are physically located in the same office building. OMCFH facilitates an annual review and renewal of the required Title V-Medicaid Inter-Agency Agreements (IAA). Medicaid has designated a formal point of contact for the Office to assure coordination and continuity of operations. This point of contact reaches out to the office via routine walk-throughs and check-ins assuring that they are informed of OMCFH issues and concerns. When ideas or issues are identified, they then facilitate follow-up with appropriate Medicaid staff in a timely manner.

This partnership extends to significant financial support of many OMCFH operations. Medicaid is a funder for Children with Special Health Care Needs, Birth to Three, HealthCheck, Right From The Start, and Breast and Cervical Cancer Screening. This allows the Office to leverage resources, but also assures additional coordination between the two agencies via program specific MOUs. This establishes a collaborative environment whereby the agencies work together to develop policy for service delivery which extends to other operations like oral health, maternity services, and newborn screening.

The Office approaches outreach from a systems perspective. For example, the social security administration routinely provides a list of children who have applied for social security. In turn, the Office reaches out with enrollment packages for Children with Special Health Care Needs services. The Office also works with the Health Statistics Center to use birth certificate information to complete a monthly mailing to new parents with targeted outreach information. HeathCheck staff routinely contact families enrolled in fee-for-service Medicaid to facilitate the administrative components of Early and Periodic Screening, Diagnosis and Treatment (EPSDT), including scheduling of well-child exams. Likewise, nine (9) community based HealthCheck Regional Program Specialists serve to equip West Virginia's Medicaid providers with the necessary tools and knowledge to carry out EPSDT services consistent with the standard for pediatric preventive health care, i.e. Bright Futures, as well as provide ongoing technical assistance to facilitate the enable the purpose of EPSDT. In addition to these activities, staff often attend community baby showers and other events to share information about the services provided by OMCFH and Medicaid.

Like many states, WV has commissioned managed care organizations (MCOs) to provide health services to its Medicaid members. Approximately 80% of all Medicaid members are enrolled in Mountain Health Trust (MHT), the WV Medicaid managed care program. More information about MHT is available at the following link: https://dhhr.wv.gov/bms/Members/Managed%20Care/Pages/default.aspx.

Through its Pediatric Medical Advisory Board and HealthCheck Program, the Office has always set standards for the State's EPSDT Program, this role has remained and, in some areas, expanded with the State's utilization of MCOs. Earlier this year, children and youth in the foster care system and individuals receiving adoption assistance transitioned from a fee for service environment to Medicaid managed care with Aetna Better Health of West Virginia receiving the contract for the specialized managed care program. The Title V Director has been involved in every aspect of this transition. Likewise, the Title V CSHCN Director and Title V Children with Special Health Care Needs Nursing Director continue to work with Aetna Better Health of West Virginia on a weekly basis to facilitate successful implementation of an electronic health record (EHR) system to include, at a minimum, the child/youth's chronic health problems, allergies, medications, psychosocial and family histories, trauma history, developmental and immunization

information, and shared plan of care that simplifies implementation of key functions of the medical home, including but not limited to, comprehensive care coordination, communication, and patient- and family-centered care. WV's strong Title V-Medicaid partnership continues to bring about reduced fragmentation and to deliver needed supports and services for this population in the most integrated, appropriate, and cost-effective way possible.

Since the Title V Block review last year, OMCFH has sought to further strengthen the partnership between Title V and Medicaid by focusing on population domains beyond CSHCN. For example, The Breast and Cervical Cancer Screening Program (BCCSP) is working with the OMCFH Medicaid MCO Liaison to share information regarding Patient Navigation in order to help women enrolled in Medicaid to overcome any barriers they may face in receiving breast and cervical cancer screening and/or follow up.

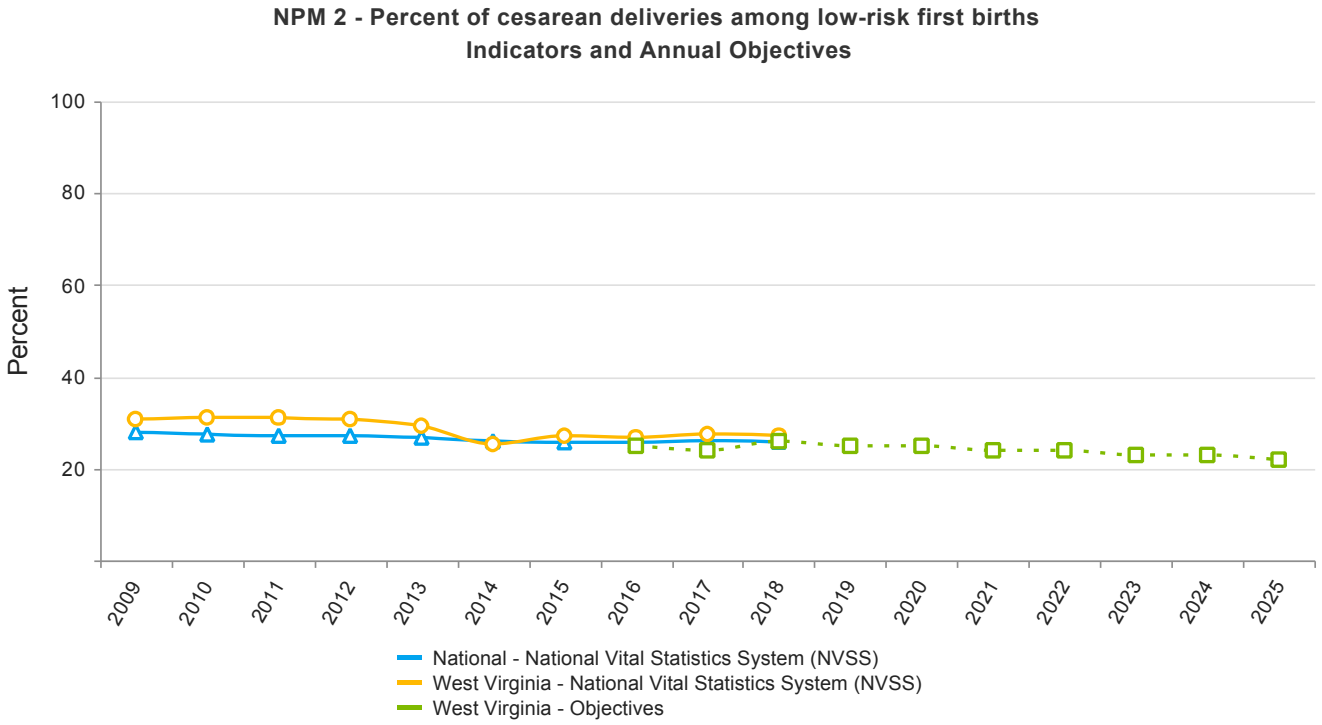
### III.E.2.c State Action Plan Narrative by Domain

#### Women/Maternal Health

#### Linked National Outcome Measures

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations | SID-2017 | 66.8 | NPM 2<br>NPM 14.1 |
| NOM 3 - Maternal mortality rate per 100,000 live births | NVSS-2014_2018 | 15.6 | NPM 2<br>NPM 14.1 |
| NOM 4 - Percent of low birth weight deliveries (<2,500 grams) | NVSS-2018 | 9.4 % | NPM 14.1 |
| NOM 5 - Percent of preterm births (<37 weeks) | NVSS-2018 | 11.8 % | NPM 14.1 |
| NOM 6 - Percent of early term births (37, 38 weeks) | NVSS-2018 | 29.7 % | NPM 14.1 |
| NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths | NVSS-2017 | 6.6 | NPM 14.1 |
| NOM 9.1 - Infant mortality rate per 1,000 live births | NVSS-2017 | 7.0 | NPM 14.1 |
| NOM 9.2 - Neonatal mortality rate per 1,000 live births | NVSS-2017 | 4.0 | NPM 14.1 |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births | NVSS-2017 | 2.9 | NPM 14.1 |
| NOM 9.4 - Preterm-related mortality rate per 100,000 live births | NVSS-2017 | 155.3 | NPM 14.1 |
| NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births | NVSS-2017 | 176.7 | NPM 14.1 |
| NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year | NSCH-2017_2018 | 12.9 % | NPM 13.1 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2017_2018 | 90.1 % | NPM 13.1<br>NPM 14.1 |

## National Performance Measures




| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Vital Statistics System (NVSS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 25 | 24 | 26 | 25 |
| Annual Indicator | 27.2 | 27.0 | 27.6 | 27.3 |
| Numerator | 1,766 | 1,652 | 1,654 | 1,598 |
| Denominator | 6,498 | 6,116 | 5,989 | 5,845 |
| Data Source | NVSS | NVSS | NVSS | NVSS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 25.0 | 24.0 | 24.0 | 23.0 | 23.0 | 22.0 |

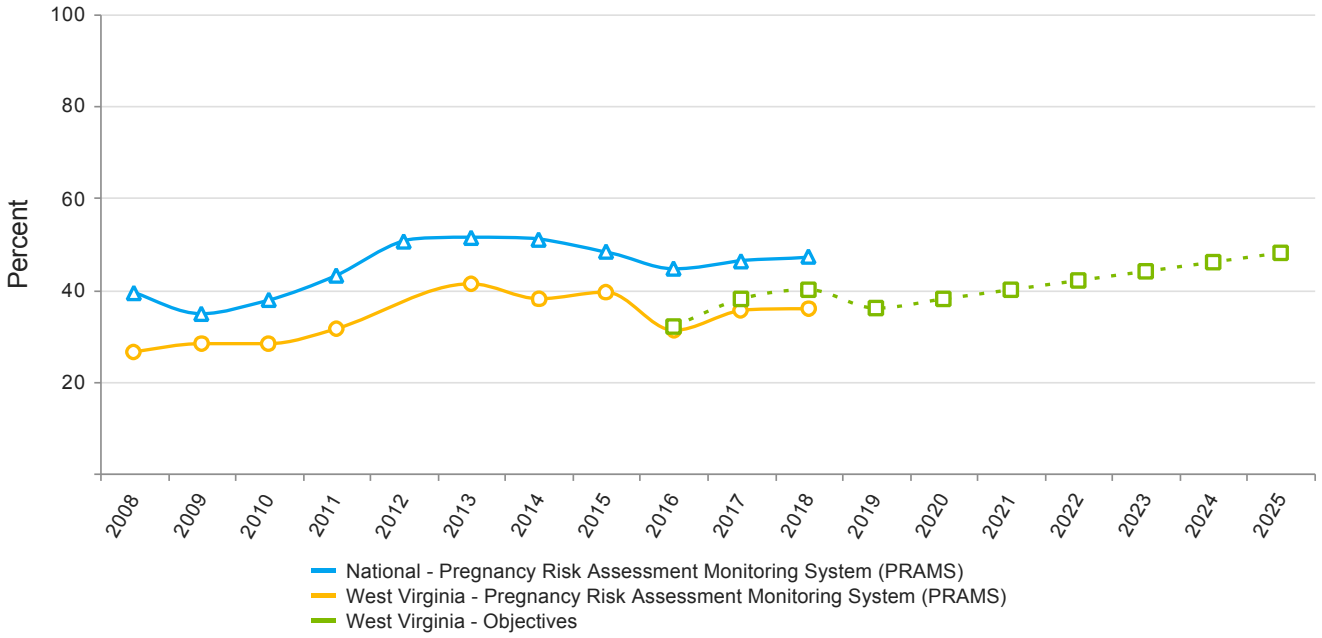
**Evidence-Based or –Informed Strategy Measures**

**ESM 2.1 - Number of first time pregnant women who have participated in the Lamaze International Evidence Based Labor Support Workshop.**

| Measure Status: | Active |
|---|---|
| **State Provided Data** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 100 |
| Numerator | |
| Denominator | |
| Data Source | Perinatal Partnership |
| Data Source Year | 2021 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 100.0 | 200.0 | 250.0 | 300.0 | 350.0 |

**NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy**
**Indicators and Annual Objectives**




| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 32 | 38 | 40 | 36 |
| Annual Indicator | 37.9 | 39.3 | 35.6 | 36.0 |
| Numerator | 6,464 | 6,554 | 5,622 | 5,633 |
| Denominator | 17,066 | 16,685 | 15,797 | 15,656 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2014 | 2015 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 38.0 | 40.0 | 42.0 | 44.0 | 46.0 | 48.0 |

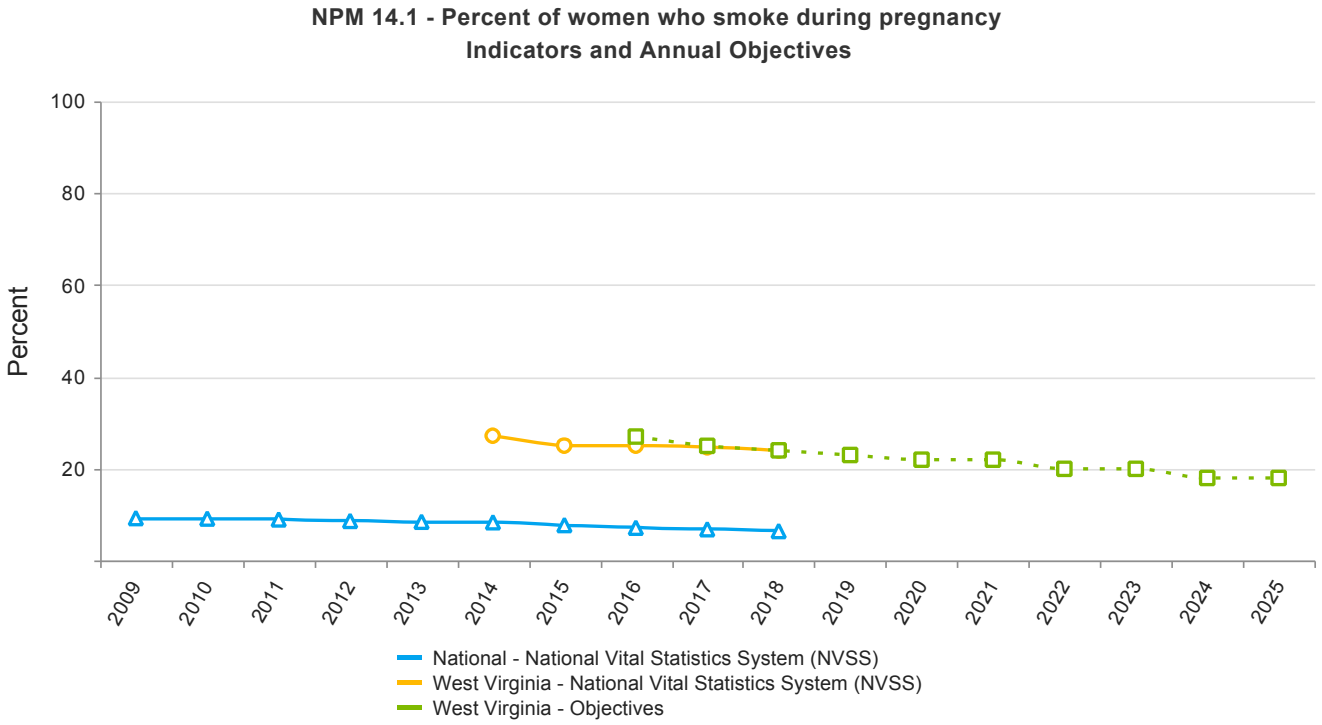
**Evidence-Based or –Informed Strategy Measures**

**ESM 13.1.1 - Establish a curriculum for WVU School of Dentistry on dental care for pregnant women.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Oral Health Program |
| Data Source Year | 2019 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 60.0 | 60.0 | 60.0 | 60.0 | 60.0 |




| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Vital Statistics System (NVSS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 27 | 25 | 24 | 23 |
| Annual Indicator | 25.2 | 25.1 | 24.7 | 23.9 |
| Numerator | 4,902 | 4,591 | 4,590 | 4,337 |
| Denominator | 19,469 | 18,305 | 18,551 | 18,138 |
| Data Source | NVSS | NVSS | NVSS | NVSS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 22.0 | 22.0 | 20.0 | 20.0 | 18.0 | 18.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 14.1.1 - Number of health care workers who have had Help2Quit maternity care provider training**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 150 | 350 | 350 |
| Annual Indicator | 148 | 334 | 44 | 217 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Perinatal Partnership | Perinatal Partnership | Perinatal Partnership | Perinatal Partnership |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 300.0 | 300.0 | 320.0 | 320.0 | 340.0 | 340.0 |

**ESM 14.1.2 - Percent of women enrolled in HV who reported using any tobacco products at enrollment and were referred to tobacco cessation within 3 months of enrollment.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2017 | 2018 | 2019 |
| Annual Objective | | | 60 |
| Annual Indicator | | | 41.5 |
| Numerator | | | 85 |
| Denominator | | | 205 |
| Data Source | | | WV Home Visitation Program (HFA, EHS, PAT, RFTS) |
| Data Source Year | | | 2019 |
| Provisional or Final ? | | | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 50.0 | 55.0 | 60.0 | 65.0 | 70.0 | 75.0 |

**State Performance Measures**

**SPM 2 - Increase identification of pregnant women using substances during pregnancy.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 61 |
| Numerator | |
| Denominator | |
| Data Source | WV PRSI |
| Data Source Year | 2018 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 65.0 | 70.0 | 75.0 | 80.0 | 85.0 |

**State Action Plan Table**

State Action Plan Table (West Virginia) - Women/Maternal Health - Entry 1

### Priority Need

Decrease preterm and low birthweight infants.

### NPM

NPM 2 - Percent of cesarean deliveries among low-risk first births

### Objectives

The Division of Perinatal and Women's Health will provide guidance through the Perinatal Partnership's education efforts to impact the number of cesarean section deliveries in low-risk first births from 27.6% in 2018 to 22% by 2025.

### Strategies

i. Provide evidence-based labor support education for nurses in birthing facilities.

ii. Provide Lamaze childbirth education.

iii. Promote childbirth education for first-time mothers statewide.

iv. Provide increased public awareness about risks of labor induction and cesarean section deliveries that are not medically indicated.

v. Conduct best practice updates for maternity care providers on the recommendations of the American College of Obstetrics and Gynecologists and the Society for Maternal Fetal Medicine.

| ESMs | Status |
|---|---|
| ESM 2.1 - Number of first time pregnant women who have participated in the Lamaze International Evidence Based Labor Support Workshop. | Active |

### NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

## State Action Plan Table (West Virginia) - Women/Maternal Health - Entry 2

### Priority Need

Increase dental care specifically during pregnancy.

### NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

### Objectives

The Oral Health Program and the Division of Perinatal and Women's Health will increase the percentage of women who had a dental visit during pregnancy from 35.6% in 2018 to 48% by 2025.

### Strategies

i. Continue oral health surveillance of perinatal population through the Basic Screening Survey (BSS) to inform program and policy development.

ii. Establish a data sharing agreement with Medicaid and CHIP to monitor pregnant women use of available dental services.

| ESMs | Status |
|---|---|
| ESM 13.1.1 - Establish a curriculum for WVU School of Dentistry on dental care for pregnant women. | Active |

### NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

## State Action Plan Table (West Virginia) - Women/Maternal Health - Entry 3

### Priority Need

Decrease smoking specifically among pregnant women and decrease smoke exposure among children in the household.

### NPM

NPM 14.1 - Percent of women who smoke during pregnancy

### Objectives

The Division of Perinatal and Women's Health will work to decrease the percentage of women who smoke during pregnancy from 24.7% in 2018 to 18% by 2025.

### Strategies

i. Offer evidence-based training to maternity care providers to promote tobacco cessation during each prenatal visit.

ii. Offer evidence-based cessation curriculums to pregnant women via home visitation services.

iii. Continue to seek out innovative evidence-based strategies to support women in quitting tobacco products before, during and after pregnancy.

iv. Follow-up with maternity care providers after receipt of evidence-based training to assess increase of tobacco cessation with pregnant women.

| ESMs | Status |
|---|---|
| ESM 14.1.1 - Number of health care workers who have had Help2Quit maternity care provider training | Active |
| ESM 14.1.2 - Percent of women enrolled in HV who reported using any tobacco products at enrollment and were referred to tobacco cessation within 3 months of enrollment. | Active |

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

## State Action Plan Table (West Virginia) - Women/Maternal Health - Entry 4

### Priority Need

Address substance use in pregnancy and in youth/teens.

### SPM

SPM 2 - Increase identification of pregnant women using substances during pregnancy.

### Objectives

The Division of Perinatal and Women's Health will work to increase the identification of pregnant women using substances through increased completion of the PRSI form.

### Strategies

i. Use RFTS RLA to educate providers on accurate and complete submission of the PRSI form.

ii. Support transition from paper PRSI form to electronic data collection system.

iii. Inform providers of compliance rate in submission of PRSI forms.

**2016-2020: National Performance Measures**

**2016-2020: State Performance Measures**

**2016-2020: SPM 3 - Rate of infants born with neonatal abstinence syndrome.**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 54 | 50 | 45 |
| Annual Indicator | 55.6 | 51.2 | 49.6 | 55.5 |
| Numerator | 182 | 962 | 901 | 1,028 |
| Denominator | 3,272 | 18,797 | 18,174 | 18,526 |
| Data Source | Birth Score Program | Birth Score Program | Birth Score Program | Birth Score Program |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

## Breastfeeding

Twenty-four Lactation consultants were provided a significantly discounted rate for participation in the GOLD Lactation online conference. 10 were IBCLC and 14 were CLC credentialed. A planning meeting was held with Mid-Atlantic Mother's Milk Bank to discuss ideas for increasing donor milk usage in WV. Topics discussed included contact with the WV MCOs to discuss coverage of donor milk for certain preterm neonates including a new project to promote the use of donor milk for substance exposed infants. The Partnership conducted a survey of WV birthing facilities that included questions on breastfeeding polices and support. The WV Breastfeeding Alliance was instrumental in updating nurse managers regarding infant feeding and practice guidelines during the COVID-19 pandemic.

Engaged in a contract with ZipMilk to establish and maintain a directory of lactation resources in WV.

## Preterm Delivery

**Provide evidence-based labor support education for nurses in birth facilities.**

The Kick-off meeting of the Preterm Birth Reduction committee was held in January 2020. Dr. Holls presented WV data and discussed the past efforts to combat the PRT problem including the *First Baby Initiative* to reduce cesarean sections among nulliparous women, education on the use of progesterone treatment and training sonographers on cervical length assessment. The second meeting was cancelled due to the pandemic and the challenges of provider preparation of their obstetrical units as they were meeting the virus head-on.

Provided Lamaze evidenced based labor support (EBLS) training for intrapartum nurses and staff to reduce the rate of nulliparous, singleton, vertex, term babies via cesarean delivery. Fifteen nurses representing four hospitals participated in Lamaze's Evidenced Base Labor Support. Two other trainings were scheduled but cancelled due to the pandemic. "The Impact of Nursing Care on Birth Outcomes: Tracking Performance to Outcomes" was presented at the Perinatal Summit during the lecture focused on nurses' Cesarean Section rates.

**Provide Lamaze childbirth education courses to increase the number of childbirth instructors.**

The DPWH continued to provide funding to the WV Perinatal Partnership to conduct statewide Lamaze childbirth education workshops. The target audience is uncertified childbirth educators, nurses and others interested in providing childbirth education. Individuals trained will be strongly encouraged to share their knowledge by providing childbirth education. Due to COVID-19 pandemic some activities have been delayed. There is funding set aside for this project to purchase Lamaze Learning Guide and seats for the Lamaze Certified Childbirth Educator (LCCE) credential for 14 participants.

Fifteen nurses representing 4 hospitals participated in Lamaze's Evidence Based Labor Support. A Lamaze 3-day seminar will be offered in October 2020 due to the cancellation of face to face instruction. This may be one of the first in the nation to be offered in a virtual format. Online Lamaze EBLS course is not yet offered via web-based training. Labor support materials for use with patients in several hospitals who have received an EBLS workshop and plan on continue this program in 2020-2021.

**Promote childbirth education for first-time mothers statewide.**

RFTS provided childbirth education through both home visits and group childbirth education through enhanced

services. Currently there are 26 licensed nurses or social workers in RFTS trained to provide enhanced services to pregnant women. Enhanced services can be provided to any Medicaid eligible pregnant woman regardless if she enrolls in the home visiting component of RFTS.

A PRSI referral is made to RFTS for any Medicaid eligible pregnant mom and to a MIECHV funded home visiting program for non-Medicaid eligible women. First time pregnant women are a priority for MIECHV funded programs.

Since COVID19, all home visiting programs have transitioned to virtual visits. During the transition the State team worked with State partners, Medicaid, National models and federal funders to ensure a smooth transition to virtual visits. Childbirth education has continued with all programs through approved virtual platforms. Many programs have developed private Facebook pages for expectant moms to participate with other expectant moms and share experiences. This has developed into a strong support system for women during quarantined times and helped with the absence of group education activities.

**Provide increased public awareness about the risks of labor induction and cesarean section deliveries that are not medically indicated.**

The Kick-off meeting of the Preterm Birth Reduction committee was held in January 2020. Dr. Holls presented WV data and discussed the past efforts to combat the PRT problem including the *First Baby Initiative* to reduce cesarean sections among nulliparous women, education on the use of progesterone treatment and training sonographers on cervical length assessment. The second meeting was cancelled due to the pandemic and the challenges of provider preparation of their obstetrical units as they were meeting the virus head-on.

Provided outreach education to 3 delivering hospitals with over 1,000 births, on the standardized approach to obstetric triage to prioritize the woman's urgency for provider evaluation using the Maternal Fetal Triage Index (MFTI). Wheeling Hospital, United Hospital Center, and Berkeley Medical Center were provided the MFTI education course. Each hospital is currently in the implementation stage, which takes months to accomplish. We require a presentation from each hospital related to their "Lessons Learned" upon completion of the implementation stage.

The Premature Birth Team of WV held a meeting in January 2020. OMCFH Title V representatives attended *Prioritizing Action in Preterm Birth* in March 2020 and brought information from the webinar series to the team which includes partners from WV Vital Statistics, WV Perinatal Partnership, obstetric physicians, and third-party insurance representatives. While the team did not continue meeting after the onset of COVID restrictions, the Special Projects Consultant with our Collaborative conducted research into benefits of doula care and the potential of engaging payer groups for available reimbursement options. This information will be included in future agendas to determine how the OMCFH may be able to reduce low risk first time cesarean births.

**Infant Mortality**

Count the Kicks materials were provided to all home visiting programs to share with pregnant women. In addition, promoting the Count the Kicks app with women. All home visitors were provided the opportunity for continued professional development in Count the Kicks during the Safe Sleep annual competencies training on improving birth outcomes. Ninety-one home visitors were trained during the virtual event.

Over 24,555 pieces of educational materials to WV providers were distributed. 277 expectant parents have downloaded the Count the Kicks phone app. Over 1,141 West Virginians have visited the Count the Kicks website

to get more information on kick counting. 64% of visitors are viewing on mobile devices. A local television station ran a story about the launch of CTK in WV and CTK WV Ambassador presented at the WV Perinatal Summit. 10,000 magnets with CTK Dr. Seuss type logo were ordered for distribution to physician offices to share with the OB patients in the last trimester of pregnancy.

**Conduct best practice updates for maternity care providers on the recommendations of ACOG and the Society for Maternal Fetal Medicine.**

An intermediate Fetal Monitoring 2-day session was held at Princeton Community with 8 participants and 2 instructors completing the course. Camden Clark Medical Center had 5 participants and 1 instructor completing. An online Advance Fetal Monitoring Course has been developed and is scheduled. Plans are underway to hold an Instructor Training Course.

**Oral Health Continue oral health surveillance of perinatal population through Basic Screening Survey to inform program policy and development.**

During the last year, the Oral Health Program maintained its surveillance system for children and pregnant women to assess progress and assure evidence-based program planning. In addition, the Program continued to provide training to help dentists become more comfortable in providing dental care to pregnant women. This work was completed in conjunction with the WV Healthy Start/HAPI Project, as well as partners in home visitation and prenatal care programs. In addition, the Program has continued to work with insurance providers to increase dental coverage for pregnant women. As a result of this effort, adults including the perinatal population will have access to comprehensive oral health services beginning January 1, 2021.

**Provide education to medical and dental care providers on national consensus statement 2012.**

The Oral Health Program has continued to educate both medical and dental providers on the 2012 National Consensus Statement for Oral Health Care during Pregnancy. The program utilized training materials and resources from the National Maternal & Child Oral Health Resource Center to educate providers on the best practices related to oral health and pregnancy.

**Smoking**

**Offer evidence-based training to maternity care providers to promote tobacco cessation during each prenatal visit.**

Over 200 health care providers have been trained, provided technical assistance and resources, facilitated information sharing and provided support to multiple groups working on tobacco cessation. A pediatric provider tool kit on tobacco/nicotine cessation was developed and a consistent and unified message among stakeholders regarding the important of tobacco/nicotine cessation was promoted.

Program staff have worked from home since mid-March. Activities have successfully adapted to needed virtual platforms and trainings have transitioned to either WebEx or Zoom. The Help2Quite trainings can now be offered through a variety of modalities upon provider preference, including webinars, in-person and hybrid options.

**Offer evidence-based cessation curriculums to pregnant women via home visitation services.**

Home visiting programs continued to conduct an assessment of prenatal and postpartum client's smoking status and

exposure to environmental smoke exposure as routine Program protocol. Documentation of client interest in smoking cessation and/or reduction was completed and the client was provided opportunity to participate in SCRIPT. The SCRIPT Program Procedures (P) includes:

- Assessment and biochemical confirmation of self-reported CO levels at the 1st visit and once during 3rd trimester,
- A tailored patient guide (5th-6th grade reading level), "A Pregnant Women's Guide to Quit Smoking",
- A tailored 8 minute counseling video, "Commit to Quit: During and After Pregnancy",
- A trained provider (DCC) delivering SCRIPT methods during a home visit and systematic reinforcement by all providers (MD's/RN's),
- Promotion of QUITLINE counseling sessions and
- Encouragement of a non-smoking home policy and partner social support to reinforce quit attempts and cessation.

For women who may not want to participate in SCRIPT, the WVHVP is compiling a list of evidence-based smoking cessation strategies and referral sources to provide families. Home visitation programs have found to have better success with smoking rates by including multiple strategies for families to find the best option for that individual to reduce or quit smoking. The WVHVP will continue to work with other OMCFH perinatal programs to maintain a resource list for home visitors to better assist with appropriate referrals for families. SmokeFree Moms and the WV Quit Line are two resources readily available to meet families' needs.

**Continue to seek out innovative evidence-based strategies to support women in quitting tobacco products before, during and after pregnancy.**

The Partnership trained over 200 health care providers, provided technical assistance and resources, facilitated information sharing and provided support to multiple groups working on tobacco cessation in the state, developed a pediatric provider toolkit on tobacco/nicotine cessation; and promoted a consistent and unified message among key stakeholders regarding the importance of tobacco/nicotine cessation among the target population.

In continuous efforts to broaden our reach of stakeholders working on perinatal cessation issues, we added several new members to the Advisory Council this year. They included the Coalition for Tobacco Free WV, The American Lung Association, and the American Heart Association. These groups are focused on tobacco control for the general population, but they have expressed interest and willingness to work with us to address special considerations for the perinatal population through this project.

Project staff also participate on related statewide groups to ensure consistent and unified messages are promoted. Project staff participated in the March 11, 2020 public health meeting to develop a statewide strategic plan for addressing tobacco. Project staff participate on the monthly calls of the Coalition for Tobacco Free West Virginia.

The Help2Quit tobacco cessation project will provide support for women to stop using tobacco products before, during and after pregnancy. The WV Family Planning Program asks about tobacco use on the Patient Data Form and tracks referrals to tobacco cessation providers. The OMCFH will monitor tobacco cessation on the 7 providers sites that participated in the Certified Tobacco Treatment Specialist (CTTS) training in May 2019. An evaluation of the success of a CTTS within the provider sites increases tobacco cessation by patients.

The WV Perinatal Partnership distributed over 75 "Up in Smoke" posters and 1000 "Up in Smoke" patient handouts to obstetric, family practice and pediatric providers, along with March of Dimes materials on smoking and pregnancy. Planned and facilitated four Tobacco Free Families Advisory Council meetings and added the Coalition

for Tobacco Free WV, the American Lunch Association and the American Heart Association to the Advisory Council.

A pediatric provider toolkit was developed in collaboration with the WV Chapter of the AAP, including motivational interviewing tools, resources for parents, nicotine replacement therapy (NRT) dosing guidelines for adults, NRT guidelines for adolescents, research and resources related to vaping and other emerging nicotine harms, and coding to bill for screening and counseling.

Dr. Lefeber was elected to represent the state as the West Virginia E-Cigarette Champion for the American Academy of Pediatrics. Dr. Lefeber will receive training on vaping and on an evidence-based curriculum for addressing e-cigarette use.

**Follow-up with maternity care providers after receipt of evidence-based training to assess increase of tobacco cessation with pregnant women.**

Follow-up with provider sites trained in Help2Quit, the 5A's and 5R's of tobacco cessation will continue to assess if training has changed how smoking cessation is provided, if it has increased and any suggestions for future trainings. Technical assistance and refresher training will be available.

The COVID-19 pandemic has affected some of the follow up in a number of ways. It has impacted the ability to communicate with health care providers to schedule training, provide resources and offer technical assistance. Maternity and pediatric providers have been focused on learning as much as they can about the novel coronavirus and keeping up with the latest research. Clinicians have been forced to develop new policies and procedures to keep their staff and their patients safe. Seeking new skills and resources about an ongoing health issues has not been a priority and getting their attention to address smoking cessation has been a challenge.

**Substance Use Disorder**

The Family Planning Program has continued to promote the utilization of LARCs for those seeking contraceptive services, especially those with substance use disorder. Collaboration with harm reduction clinics helps speak to those with the disorder as they engage professionals to aid them in recovery. Currently there are three harm reduction clinics participating and providing access to Family Planning services, including long acting reversible methods of contraception.

Since June of 2018 collaboration with the Division of Corrections and Rehabilitation has provided 2,278 inmates access to a family planning provider. All 2,278 inmates have received education about reproductive health and contraceptive methods, including LARCs.

- 1,616 pregnancy tests were completed.
- 740 women of childbearing age were provided at least one method of contraception.
- 2019 – 2020 65 inmates preparing for release at Lakin received a two part training conducted as part of Family Planning's community outreach and education, which dealt with healthy relationships, birth control methods and sexually transmitted infections with a strong emphasis in LARC efficacy and connections to Family Planning services and service sites..

The Family Planning Program was instrumental in development of the 2017 LARC Initiative Toolkit which is still being used and shared with providers. This toolkit is designed to highlight the importance and benefits of immediate postpartum LARC and help providers navigate institutional barriers to implementation. Over the past decade there has been a dramatic increase in NAS incidence in the United States, with West Virginia having some of the highest

reported rates. Primary prevention of NAS includes decreasing unintended pregnancies among those patients with drug addiction, which includes promotion of LARC methods. In women enrolled in substance abuse programming throughout the state, immediate postpartum LARCs, as with other populations, can decrease the risk of short interval pregnancy.

A STABLE course was held at Wheeling Hospital in September 2019 with nurses from both Wheeling and Reynolds hospital in attendance. All participants received the training books. Additional STABLE courses trainings had to be canceled due to the COVID-19 pandemic. Plans to transition to a virtual platform is ongoing.

The "Eat, Sleep, Console" scheduled for Princeton Community Hospital as a pilot for the state, postponed due to pandemic. Yale university is under contract to provide technical assistance and guidance to Princeton Community Hospital moving forward with the implementation of the innovative approach.

**PRSI**

The PRSI made strides in becoming a web-based tool. The system is now in development and testing has begun. The goal is to improve completion and submission of the PRSI. Technical assistance will be provided during the transition period.

**Maternal Mortality**

Partnered with hospitals and birth facilities to hold three workshops on Emergency OB Simulations with low fidelity equipment to support the "Patient Safety Bundles" as recommended by the Alliance for Innovation on Maternal Health and ACOG and AWHONN. The kick-off for the Hypertension Bundle was delayed to give hospitals time to adjust their policies and procedures in anticipation of COVID positive mothers. "In the shadows of Preeclampsia" by the CEO of the Preeclampsia Foundation was presented at the 2019 Perinatal Summit.

Twenty-three hospitals signed onto the AIM Patient Safety Initiative working on process and structure measures at their facilities based upon the patient safety checklists. Each facility attending the simulation train-the trainer sessions received a free Mama Natalee simulation model to continue regular drills at their facilities. The rate of maternal morbidity among hemorrhage cases, excluding those that only received 1-2 units of blood, has decreased from a high of 9% in 2015 to the current rate at the end of 2018 of 4.5%.

Addressed Maternal Safety in Rural Emergency Departments related to the recognition and timely treatment of common obstetric complications in three rural emergency departments. Provided outreach education to three delivering hospitals with over 1,000 births on the standardized approach to obstetric triage to prioritize the woman's urgency for provider evaluation using the Maternal Fetal Triage Index.

- Assigned case ascertainment of one hundred thirty-three (133) 2017 infant mortality cases. 7/1/2019-6/30/2020:
- Completed case ascertainment/medical record review of 133 (100%) of 133 assigned cases (2017).
- Assisted in alleviating backlog of 2016 infant death cases; 28 additional cases assigned, for 161 total infant cases completed.
- Average case completion rate 2.38 cases/week.
- Obtained birth/death certificates for 2017 infant death cases.
- Developed Master Infant Mortality 2017 tracking system using 2017 Infant Mortality spreadsheet prepared by Health Statistics Center, Division of Vital Statistics.
- Generated letters of request for medical records from birthing hospitals and smaller facilities that referred

care to larger Level III tertiary care centers.

**Decrease preterm and low birthweight infants**

**Provide evidence-based labor support education for nurses in birthing facilities.**

As part of the SOW with the Perinatal Partnership the following will occur in coordination with OMCFH:

Provide 3 Lamaze Evidence-Based Labor Support (EBLS) training for intrapartum nurses and staff to reduce the rate of nulliparous, singleton, vertex, term babies born via cesarean delivery.

**Provide Lamaze childbirth education.**

As part of the SOW with the Perinatal Partnership the following will occur in coordination with OMCFH:

Provide Lamaze Childbirth Education Instructor training to support labor and reduce the rate of low-risk cesarean delivery to ensure adequate number of instructors.

**Promote childbirth education for first-time mothers statewide.**

As part of the SOW with the Perinatal Partnership the following will occur in coordination with OMCFH:

Provide “Spinning Babies” one day workshop to train certified nurse midwives, nurses and childbirth educators on the use of positioning to facilitate birth.

**Conduct best practice updates for maternity care providers on the recommendations of the American College of Obstetrics and Gynecologists and the Society for Maternal Fetal Medicine.**

As part of the SOW with the Perinatal Partnership the following will occur in coordination with OMCFH:

Facilitate Grand Rounds on Implicit Bias in Racial and Impoverished Families in each of the obstetrics and gynecology residency training programs.

Provide fetal monitor instruction for clinicians to utilize standardized methods in the assessment of the fetal heart rate status, including interpretation, documentation using the National Institute of Child Health and Human Development (NICHD) terminology, and encouraging methods that promote freedom of movement. One Instructor course, one Advanced course and 2 Intermediate courses.

**Increase dental care specifically during pregnancy**

**Continue oral health surveillance of perinatal population through the Basic Screening Survey (BSS) to inform program and policy development.**

Due to Covid and guidance from the Center for Disease and Control (CDC), the Basic Screening Survey (BSS) has been postponed until further notice. We are continuing to have monthly calls with the CDC for updates and guidance. The Oral Health Program is working with the West Virginia University School of Dentistry (WVU SoD) to develop a pediatric residency program and continuing education opportunities for current oral health workforce and non-dental providers who work with the pediatric and perinatal populations. The continuing education will include pediatric and perinatal best practice. Education on these topics should increase the number of pregnant women who are referred for dental care during pregnancy and increase the number of pregnant women receiving dental services.

**Establish a data sharing agreement with Medicaid and CHIP to monitor pregnant women use of available**

**dental services.**

As of January 1, 2021, all adults including the perinatal population will have access to comprehensive oral health services. Until now, West Virginia had an emergency only benefit for adults. Lack of adult oral health services in pregnant women results in premature delivery, low birth weight, gingival issues, as well as several other issues for mother and baby. Oral health may be considered an important part of prenatal care, given that poor oral health during pregnancy can lead to poor health outcomes for the mother and baby. We have a current agreement in place with Medicaid and CHIP to monitor pregnant women use of available dental services.

**Decrease smoking specifically among pregnant women and decrease smoke exposure among children in the household.**

The OMCFH has a subrecipient grant agreement with the Perinatal Partnership and as part of their Statement of Work (SOW) the Partnership will facilitate training for obstetrical and pediatric tobacco cessation champions, Continue to identify, train, and support pediatric health care providers on best practice smoking /vaping cessation interventions to address second and third hand smoke exposure, coordinate tobacco cessation and prevention efforts with Our Babies Safe and Sound and other statewide groups to address clean air initiatives and participate on the Coalition for a Tobacco Free WV and other statewide group efforts.

**Offer evidence-based training to maternity care providers to promote tobacco cessation during each prenatal visit.**

As part of the SOW with the Perinatal Partnership the following will occur in coordination with OMCFH:

Provide training and intervention programs specifically for obstetrical and pediatric providers to reduce smoking before, during, and after pregnancy. Continue to identify, train and support providers on best practice tobacco/nicotine cessation interventions during pregnancy, promote a consistent and unified message about cessation of smoking in pregnancy, provide training and technical assistance to healthcare and public health providers on helping women quit using tobacco before, during, and after pregnancy, advertise and connect with health care providers to attend trainings, develop a recognition plan for physician practices that participate in training as leaders addressing smoking before, during and after pregnancy. The Perinatal Partnership will also secure continuing education credits for participation in the workshops, provide technical assistance to providers and their practices receiving Help2Quit trainings, provide technical assistance to OMCFH home visitation programs on tobacco prevention and cessation strategies, coordinate with the WV Quitline to reduce barriers to enrollment and increase participation of pregnant and postpartum women.

**Offer evidence-based cessation curriculums to pregnant women via home visitation services.**

Home visitation programs will utilize evidence-based curriculums that align with each of the home visiting models (RFTS, Parents as Teachers, Healthy Families America, and Early Head Start Option) to 2000 pregnant women annually. Each model will utilize the approved handouts and activities addressing maternal mental health, prenatal care, referrals for community resources and supports, breastfeeding, safe sleep, and substance use. Targeted populations will be low income, pregnant women under 21 years of age, smokers, and women with substance use disorder. However, home visiting services will be available to any woman requesting home visiting. Each home visitor will be required to complete model specific curriculum training before adding women to their caseload.

To build training capacity for home visitors using evidence-based cessation curriculums to pregnant women, in-state model curriculum trainers will be established. Having in-state certified trainers in each model will reduce out-of-state training expenses, increase ability to have more trainings as needed and improved technical assistance for new home visitors within the State. Utilizing the curriculum and in-state trainers will maximize the support for pregnant

women and in turn improve prenatal outcomes.

**Continue to seek out innovative evidence-based strategies to support women in quitting tobacco products before, during and after pregnancy.**

As per the their Statement of Work the Perinatal Partnership will facilitate the Tobacco Free Families Advisory Council and collaborate with the federal-state *MOMS* initiative, utilize the "Perinatal All Topics Workgroup" (workgroup of the WV Perinatal Partnership, Medicaid Managed Care Organizations and DHHR leadership) to continue to examine smoking cessation benefits for pregnant and postpartum women, and families with young children, develop Help2Quit program training schedule and deliver training, and explore opportunities with Right From the Start and other home visitation programs to implement evidence-based smoking cessation programs, such as Baby and Me Tobacco Free.

**Follow-up with maternity care providers after receipt of evidence-based training to assess increase of tobacco cessation with pregnant women.**

In order to assess the tobacco cessation efforts the number of obstetrical and pediatric providers who receive training and increased knowledge to provide best practice smoking cessation interventions to patients of childbearing age, pregnant patients, and new parents will be used, qualitative analysis/evaluation of the training program will be determined, quarterly meetings of the Tobacco Free Families Advisory Council meeting information, including agendas, participants and minutes will be recorded and quarterly updates of perinatal tobacco statistics and related data, including progress towards reduction of maternal smoking and 2nd hand exposure will be determined.

**Address substance use in pregnancy and in youth/teens**

**Use RFTS RLA to educate providers on accurate and complete submission of the PRSI form.**

The Right From the Start (RFTS) case management home visiting model will utilize the Regional Care Coordinators (RCCs)to conduct at least one site visit to each practicing obstetrical provider annually (at a minimum) in the assigned region to ensure obstetrical providers are completing the PRSI during initial examination of women. The RCC will provide technical assistance to practicing obstetrical providers to ensure proper completion and submission of the PRSI.

RCCs will be provided training on the new PRSI system and completion of the PRSI form. The number of practicing obstetrical providers in each region will be identified. A goal of 60% completion rate of visits to OB providers will be established for year one to establish a baseline. An increase of 10% each year for the next three years will be expected.

**Support transition from paper PRSI form to electronic data collection system.**

The RCCs will support physicians and help when needed to ensure successful completion of the on-line data system. The Epidemiologist assigned to the PRSI, will communicate with Local Data Solutions to ensure that any changes that need to occur with the electronic data system are communicated to the RCCs and providers.

**Inform providers of compliance rate in submission of PRSI forms.**

The epidemiologist assigned to the Maternal Risk Screening program will develop reports to inform providers of their number of submissions and error rates.

**Perinatal/Infant Health**

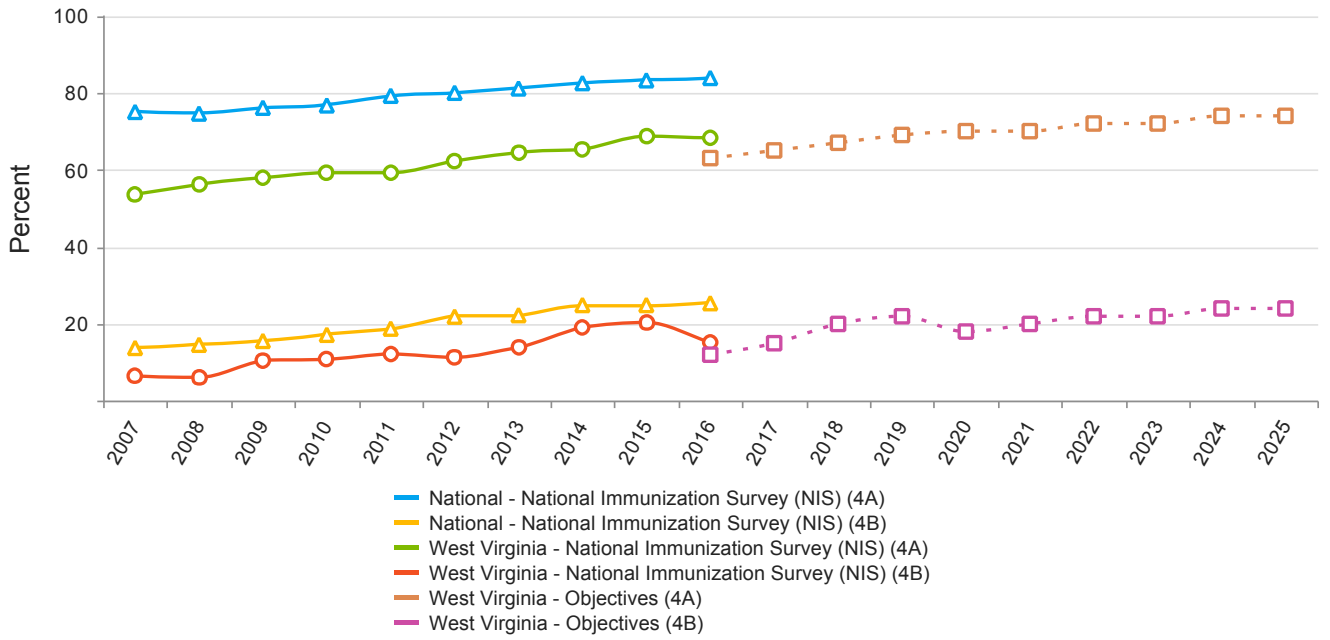
**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 9.1 - Infant mortality rate per 1,000 live births | NVSS-2017 | 7.0 | NPM 4<br>NPM 5 |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births | NVSS-2017 | 2.9 | NPM 4<br>NPM 5 |
| NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births | NVSS-2017 | 176.7 | NPM 4<br>NPM 5 |

## National Performance Measures

### NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

### Indicators and Annual Objectives




### NPM 4A - Percent of infants who are ever breastfed

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 63 | 65 | 67 | 69 |
| Annual Indicator | 64.6 | 65.4 | 68.6 | 68.2 |
| Numerator | 12,784 | 12,994 | 12,974 | 12,736 |
| Denominator | 19,786 | 19,882 | 18,907 | 18,666 |
| Data Source | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 70.0 | 70.0 | 72.0 | 72.0 | 74.0 | 74.0 |

**NPM 4B - Percent of infants breastfed exclusively through 6 months**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 12 | 15 | 20 | 22 |
| Annual Indicator | 14.1 | 19.0 | 20.2 | 15.2 |
| Numerator | 2,748 | 3,708 | 3,610 | 2,790 |
| Denominator | 19,557 | 19,555 | 17,857 | 18,401 |
| Data Source | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 18.0 | 20.0 | 22.0 | 22.0 | 24.0 | 24.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 4.1 - Number of birthing facilities designated Baby-Friendly under the EMPower initiative**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 1 | 5 | 5 |
| Annual Indicator | 0 | 2 | 4 | 5 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Baby Friendly USA | Baby Friendly USA | Baby Friendly USA | Baby Friendly USA |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 6.0 | 6.0 | 8.0 | 8.0 | 10.0 | 10.0 |

**ESM 4.2 - Percent of infants who are breastfeeding at time of discharge from a birthing facility**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 65 | 67 | 65 |
| Annual Indicator | 65.2 | 64.5 | 64.9 | 64.9 |
| Numerator | 11,859 | 11,514 | 11,465 | 11,465 |
| Denominator | 18,179 | 17,865 | 17,662 | 17,662 |
| Data Source | Vital Statistics | Vital Statistics | Vital Statistics | Vital Statistics |
| Data Source Year | 2016 | 2017 | 2018 | 2018 |
| Provisional or Final ? | Final | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 66.0 | 68.0 | 70.0 | 72.0 | 74.0 | 74.0 |

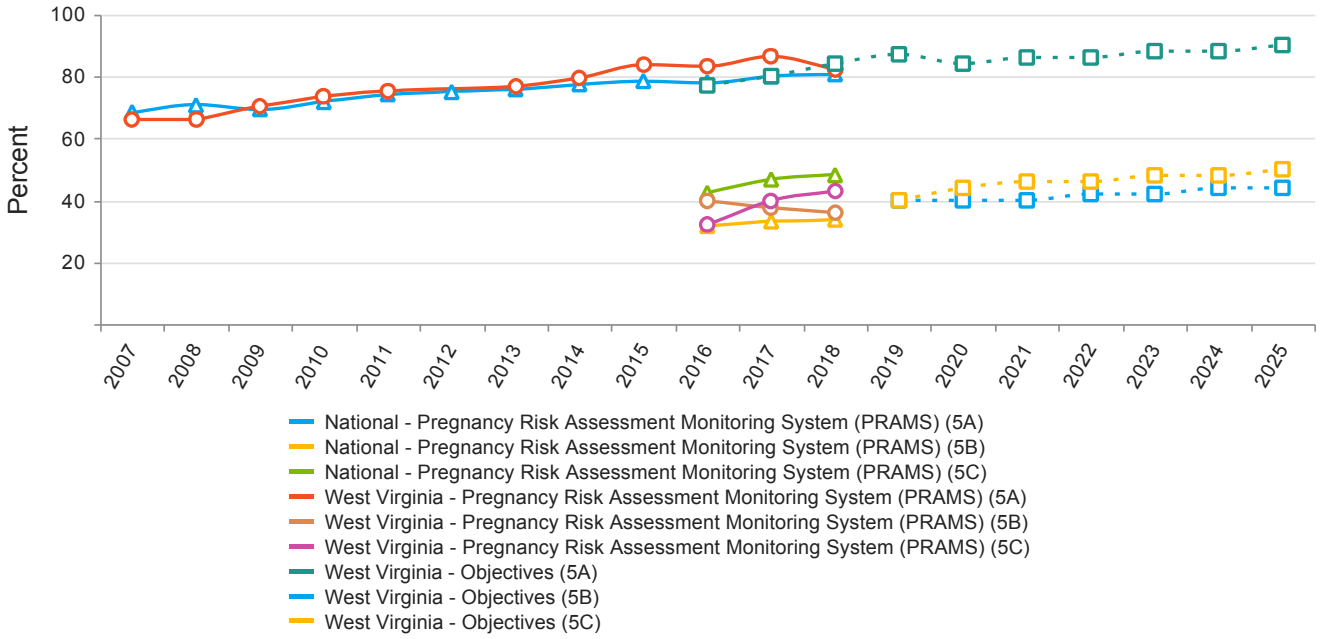
**ESM 4.3 - Percent of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 5 | 9 | 13 |
| Annual Indicator | 8.7 | 8.8 | 11.1 | 11.7 |
| Numerator | 2 | 18 | 74 | 160 |
| Denominator | 23 | 204 | 668 | 1,367 |
| Data Source | WV Home Visitation Program (HFA, PAT, EHS) | WV Home Visitation Program | WV Home Visitation Program (HFA, EHS, PAT, MIHOW, | WV Home Visitation Program (HFA, EHS, PAT, RFTS) |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 12.0 | 14.0 | 16.0 | 18.0 | 20.0 | 22.0 |

**NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding Indicators and Annual Objectives**




**NPM 5A - Percent of infants placed to sleep on their backs**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 77 | 80 | 84 | 87 |
| Annual Indicator | 79.5 | 83.7 | 86.6 | 82.0 |
| Numerator | 13,573 | 14,091 | 13,445 | 12,495 |
| Denominator | 17,071 | 16,839 | 15,534 | 15,245 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2014 | 2015 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 84.0 | 86.0 | 86.0 | 88.0 | 88.0 | 90.0 |

**NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface**

| Federally Available Data | | |
|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | |
| | **2018** | **2019** |
| Annual Objective | | 40 |
| Annual Indicator | 37.7 | 36.1 |
| Numerator | 5,742 | 5,401 |
| Denominator | 15,239 | 14,977 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 40.0 | 40.0 | 42.0 | 42.0 | 44.0 | 44.0 |

**NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding**

| Federally Available Data | | |
|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | |
| | **2018** | **2019** |
| Annual Objective | | 40 |
| Annual Indicator | 39.8 | 43.1 |
| Numerator | 6,129 | 6,470 |
| Denominator | 15,392 | 15,017 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 44.0 | 46.0 | 46.0 | 48.0 | 48.0 | 50.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 5.1 - Percent of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 90 | 95 | 100 |
| Annual Indicator | 92 | 100 | 100 | 100 |
| Numerator | 23 | 25 | 25 | 25 |
| Denominator | 25 | 25 | 25 | 25 |
| Data Source | Our Babies Safe and Sound | Our Babies Safe and Sound | Our Babies Safe and Sound | Our Babies Safe and Sound |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

**ESM 5.2 - Percent of families enrolled in a home visitation program who received safe sleep education from a trained home visitation provider on the first visit after child's birth**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 72 | 86 | 86 |
| Annual Indicator | 71.1 | 83.9 | 61.9 | 75 |
| Numerator | 27 | 177 | 599 | 804 |
| Denominator | 38 | 211 | 968 | 1,072 |
| Data Source | WV Home Visitation Program (HFA, PAT, EHS, MIHOW)) | WV Home Visitation Program | WV Home Visitation Program (HFA, EHS, PAT, MIHOW, | WV Home Visitation Program (HFA, EHS, PAT, RFTS) |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 80.0 | 82.0 | 84.0 | 86.0 | 88.0 | 90.0 |

**ESM 5.3 - Percent of infants enrolled in a home visitation program that are always placed to sleep on their backs, without bed-sharing or soft bedding**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 75 | 78 | 80 |
| Annual Indicator | 77.1 | 76.8 | 55 | 74.8 |
| Numerator | 199 | 730 | 820 | 1,554 |
| Denominator | 258 | 951 | 1,492 | 2,077 |
| Data Source | WV Home Visitation Program (HFA, PAT, EHS, MIHOW)) | WV Home Visitation Program | WV Home Visitation Program (HFA, EHS, PAT, MIHOW, | WV Home Visitation Program (HFA, EHS, PAT, RFTS) |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 80.0 | 82.0 | 84.0 | 86.0 | 88.0 | 90.0 |

**State Action Plan Table**

State Action Plan Table (West Virginia) - Perinatal/Infant Health - Entry 1

| Priority Need |
| --- |
| Increase breastfeeding, both initiation and continuation. |

| NPM |
| --- |
| NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months |

| Objectives |
| --- |
| The Division of Perinatal and Women's Health will work with partners to increase the percentage of infants ever breastfed from 68.6% in 2016 to 74% by 2025. |
| The Division of Perinatal and Women's Health will work with partners to increase the percentage of infants exclusively breastfed through six months from 20.2% in 2016 to 24% by 2025. |

| Strategies |
| --- |
| i. Use evidence-based curriculums to promote breastfeeding, especially during home visits. |
| ii. Collaborate with WIC to assure that all women receive evidence-based breastfeeding education. |
| iii. Offer evidence-based provider training. |
| iv. Provide support to hospitals working to become baby friendly. |
| v. Offer certified lactation training to WV providers to increase breastfeeding support after hospital discharge. |

| ESMs | Status |
| --- | --- |
| ESM 4.1 - Number of birthing facilities designated Baby-Friendly under the EMPower initiative | Active |
| ESM 4.2 - Percent of infants who are breastfeeding at time of discharge from a birthing facility | Active |
| ESM 4.3 - Percent of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age | Active |

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

## State Action Plan Table (West Virginia) - Perinatal/Infant Health - Entry 2

### Priority Need

Decrease infant mortality with an emphasis on Sudden Unexplained Infant Death (SUID).

### NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

### Objectives

The Office of Maternal, Child and Family Health will work with partners to increase the percentage of infants placed to sleep on their backs from 86.6% in 2017 to 90% by 2025.

### Strategies

i. Mail Back to Sleep materials to all families with a birth record.

ii. Offer evidence-based provider training.

iii. Utilize evidence-based curriculums to educate families on safe sleep environments.

iv. Work with hospitals to develop safe sleep policies.

| ESMs | Status |
|---|---|
| ESM 5.1 - Percent of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education | Active |
| ESM 5.2 - Percent of families enrolled in a home visitation program who received safe sleep education from a trained home visitation provider on the first visit after child's birth | Active |
| ESM 5.3 - Percent of infants enrolled in a home visitation program that are always placed to sleep on their backs, without bed-sharing or soft bedding | Active |

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

**2016-2020: National Performance Measures**

**2016-2020: State Performance Measures**

**2016-2020: SPM 3 - Rate of infants born with neonatal abstinence syndrome.**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 54 | 50 | 45 |
| Annual Indicator | 55.6 | 51.2 | 49.6 | 55.5 |
| Numerator | 182 | 962 | 901 | 1,028 |
| Denominator | 3,272 | 18,797 | 18,174 | 18,526 |
| Data Source | Birth Score Program | Birth Score Program | Birth Score Program | Birth Score Program |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

## Breastfeeding

**Use evidence-based curriculums to promote breastfeeding, especially during home visits.**

RFTS utilized the Partnering for a Healthy Baby curriculum with pregnant women enrolled. Parents as Teachers and Healthy Families America utilized the National model approved evidenced based curriculum for prenatal care. Home visitors were required to complete breastfeeding education. Documentation is completed in the data collection system on breastfeeding and education provided.

Additional training on breastfeeding and women enrolled in a Medication Assisted Treatment program was provided. In addition, home visiting partnered with the West Virginia University IMPACT project targeted women identified with substance use disorder and infants diagnosed with substance use exposure on the most current ACOG and AAP recommended guidelines on breastfeeding.

Twenty-four Lactation consultants were provided a significantly discounted rate for participation in the GOLD Lactation online conference. 10 were IBCLC and 14 were CLC credentialed. A planning meeting was held with Mid-Atlantic Mother's Milk Bank to discuss ideas for increasing donor milk usage in WV. Topics discussed included contact with the WV MCOs to discuss coverage of donor milk for certain preterm neonates including a new project to promote the use of donor milk for substance exposed infants. The Partnership conducted a survey of WV birthing facilities that included questions on breastfeeding polices and support. The WV Breastfeeding Alliance was instrumental in updating nurse managers regarding infant feeding and practice guidelines during the COVID-19 pandemic.

**Collaborate with Women's Infant and Children (WIC) to assure all women receive evidence-based breastfeeding education.**

The updated WIC manual has information and referral processes for home visiting services along with information on enhanced services on breastfeeding education that can be provided through Right From the Start. The RFTS registered dieticians serve a dual role in some counties as both the WIC consultant and the RFTS enhanced services provider. Educational brochures are distributed to families enrolled in home visiting on WIC services and appropriate referrals and follow-up completed by the home visitor.

Each local home visiting program coordinates referrals and community outreach activities with WIC including coordinated baby showers, referrals/resources and breastfeeding education.

**Offer evidence-based provider training.**

The DPWH will continue to provide funding to the WV Perinatal Partnership to conduct statewide Lamaze childbirth education workshops. The target audience is uncertified childbirth educators, nurses and others interested in providing childbirth education. Individuals trained will be strongly encouraged to share their knowledge by providing childbirth education. Due to COVID-19 pandemic some activities have been delayed. There is funding set aside for this project to purchase Lamaze Learning Guide and seats for the Lamaze Certified Childbirth Educator (LCCE) credential for 14 participants.

Fifteen nurses representing 4 hospitals participated in Lamaze's Evidence Based Labor Support. A Lamaze 3 day seminar will be offered in October 2020 due to the cancellation of face to face instruction. This may be one of the first in the nation to be offered in a virtual format. Online Lamaze EBLS course is not yet offered via web-based training. Labor support materials for use with patients in several hospitals who have received an EBLS workshop and plan on continue this program in 2020-2021.

**Provide support to hospitals to become baby friendly.**

OMCFH and the Perinatal Partnership provided training and education for hospitals, medical schools, and nursing schools through the work of the WV Breastfeeding Alliance. Breastfeeding initiation rates among hospitals, breastfeeding educational materials distributed, the number of certified lactation education opportunities and social media presence increased between 2018 and 2020. Development of a model policy to address the current landscape toward improvement of lactation benefits in WV is underway.

**Offer certified lactation training to WV providers.**

Twenty-four Lactation consultants were provided a significantly discounted rate for participation in the GOLD Lactation online conference. 10 were IBCLC and 14 were CLC credentialed. A planning meeting was held with Mid-Atlantic Mother's Milk Bank to discuss ideas for increasing donor milk usage in WV. Topics discussed included contact with the WV MCOs to discuss coverage of donor milk for certain preterm neonates including a new project to promote the use of donor milk for substance exposed infants. The Partnership conducted a survey of WV birthing facilities that included questions on breastfeeding polices and support. The WV Breastfeeding Alliance was instrumental in updating nurse managers regarding infant feeding and practice guidelines during the COVID-19 pandemic.

**Safe Sleep**

**Mail "Safe to Sleep" materials to all families with a birth record.**

The OMCFH continued to mail "Safe to Sleep" materials to all families with a birth record. This mailing contains current information about risk factors such as co-sleeping/bed-sharing, early prenatal care, maternal smoking during pregnancy, infant exposure to secondhand smoke, and a safe sleeping environment. The OMCFH continued to also provide current, relevant educational materials statewide to health care providers as well as parents, grandparents, and other caregivers of WV's infants in an effort to decrease the State's infant mortality rate.

**Offer evidence-based provider training.**

Infant Safe Sleep Awareness Month was held during the month of September and was launched with a gubernatorial proclamation. In partnership with First Candle, CDC, Cribs for Kids, Charlies Kids Foundation, and NIH, OBSS partners participated in the #SafeSleepSnap social media campaign. OBSS Facebook posts reached 3,154 people with 455 post engagements. An updated OBSS Infant Safe Sleep Month Awareness electronic toolkit was provided to partners, in addition to a toolkit for the #SafeSleepSnap campaign. Partners also hosted community baby showers and displayed and distributed materials throughout the month.

The *Say YES* webcast training task team convened to work on a new on demand web-based training module. 167 home visitors were required to complete the Safe Sleep online training either as a new home visitor or renewal of their annual competency.

**Utilize evidence-based curriculum to educate families on safe sleep environments.**

At least 80% of home visitors have completed the required annual competencies required for safe sleep education. The training has been transitioned to an online platform, including the annual competencies. Home visiting programs utilized an evidence-based curriculum with the appropriate handouts on safe sleep for every family enrolled. A new training tacking form was developed to ensure all home visitors complete all required trainings and appropriate renewal certifications.

Completed five Dad Baby Showers with five different home visiting programs with 64 dads participating. When home visiting programs transitioned to virtual visits, one of the Dad's baby showers transitioned to a closed Facebook event. Over 25 dads participated in the event. This number was higher then expected at the face to face

event. WVHVP is working with local sites to transition the Dad's Baby Showers to virtual for the rest of the sites that planned to hold events before the end of 2020.

**Work with Hospitals to develop safe sleep practices.**

All birthing hospitals participated in the "Say YES to Safe Sleep for Babies" initiative in 2019, and all births occurring in WV birthing hospitals took place in facilities providing some level of safe sleep information and education consistent with AAP recommendations. The web-based online training is available through "Say YES" website and safe sleep educators and nursing staff were encouraged to review the training materials provided through the online module.

During the 2019 calendar year twenty-two birthing hospitals reporting data provided for a total of 68 professional or community presentations were the safe sleep information and AAP recommendations for safe sleep were made available. An estimated 5,574 people were reached in communities served by the reporting hospitals through these professional and community presentations or events through 2019.

**Substance Use Disorder**

**Work with healthcare providers to develop recommendations for identifying Neonatal abstinence syndrome (NAS).**

WVHVP is working with the Bureau for Children and Families on the Family First Title IV funding and processes to utilize Parents as Teachers as one of the evidenced-based practices for families with an open CPS case. Four collaborative trainings have been completed between WVHVP and CPS staff on home visiting in six counties. The Family First State Plan has been submitted and a Family First Home Visiting work group is working through the next steps of the process for enrolling families through a coordinated referral system with Bureau for Children and Families.

WVHVP is partnering with West Virginia University on the Rural IMPACT grant for pregnant women and infants impacted by substance exposure. Three demonstration sites, Wheeling Hospital, Burlington United Family Methodist Services and Wheeling CASA project will partner with home visiting for any families enrolled in IMPACT. In order to be eligible for IMPACT additional support services, families must be enrolled in a MIECHV funded home visiting program within three months of the referrals. In addition, a comprehensive training program is being developed for home visiting for working with families impacted by substance use and a comprehensive resource directory available for families, providers and home visiting programs. WV is the only State to have received the rural impact grant.

WVHVP Program manager serves on the Steering Committee for the piloted Family Treatment Court sites in West Virginia. Boone, Randolph and Ohio counites are the first three counties to house Family Treatment Court with an additional 3 counties to be added by the end of 2020. Home visiting services are offered to families participating as part of step four of the program on community supports and parenting education.

The "Eat, Sleep, Console" scheduled for Princeton Community Hospital as a pilot for the state, postponed due to pandemic. Yale university is under contract to provide technical assistance and guidance to Princeton Community Hospital moving forward with the implementation of the innovative approach.

Provided in-hospital Bereavement Sensitivity Education including bereavement Sensitivity Education for families whose infants were removed from custody. The WV Bereavement Team met biannually to review polices and discuss education and training efforts needed in State. A Bereavement Workshop was scheduled but had to be cancelled due to the pandemic. An online Bereavement round-up is being finalized.

A STABLE course was held at Wheeling Hospital in September 2019 with nurses from both Wheeling and Reynolds hospital in attendance. All participants received the training books. Additional STABLE courses trainings had to be canceled due to the COVID-19 pandemic. Plans to transition to a virtual platform is ongoing.

Thirty-three unique training topics were completed either in person or online to providers through the Perinatal Partnership related to substance use before, during and after pregnancy and those related to NAS. The targeted audience ranged from medical providers, nursing staff, social workers and home visitors. This was in addition to the Newborn Day conference and the annual WV Perinatal Summit.

**Offer evidence-based provider training to facilitate appropriate diagnosis of NAS.**

The WVHVP partnered with West Virginia University Centers for Excellence and Development (WVUCED) on the RURAL Impact grant received to help reduce health disparities among children identified with NAS, their mothers who have, or still, use substances and their families. A clearinghouse of developmentally appropriate and accessible materials, tools and other resources will be web-based and publicly available for all families. This will have a communication arm embedded within it allowing individuals to provide feedback, rate materials, and use materials regularly. Online courses are in various stages of implementation for providers, families and home visiting programs. Six community of practices have been completed on stigma, motivational interviewing, self-care, parent-child interaction and the role of the Peer Recovery Coach and home visiting to support the family. The WVHVP has worked with WVUCED to promote existing programs and services in the Northern Panhandle area of the State. Services will be provided through home visiting programs with the additional assistance from local providers, telehealth structures for expert consultation and programming from the WVUCED.WV is the only State to receive the five year Rural IMPACT grant and the WVHVP Program Manager is a member of the Leadership Team for the grant.

In addition, through the RURAL Impact grant, service delivery will be increased for women/infant for three demonstration sites. The three demonstration sites have been selected and are working to increase services. The evaluation will measure provider and paraprofessional capacity at the local and regional level.

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**Maintain a comprehensive surveillance system for monitoring NAS to inform program and policy development essential to reducing the number of NAS infants.**

The Birth Score staff continued to provide education for nurses and billing coders on correct documentation of intrauterine substance exposure and NAS.

**Assess hospital policies and procedures for diagnosing and reporting NAS.**
The Birth Score Program continued quality improvement processes for data accuracy.

**Provide targeted education to improve the integrity and consistency of NAS data that is used to drive policy decisions.**

The Birth Score Program provided hospital specific data and technical assistance to improve the quality of the data collection. This allowed birthing facilities to review reported rates and consider future planning and evaluation needs.

**Establish and automatic referral process to the Children with Special Health Care Needs (CSHCN) Program using the NAS Surveillance System.**

The CSHCN Program received data from the birth score office for January 2019 – July 2019. The birth score is calculated by APGAR (5 minute), birth weight, gestational age, maternal age, maternal education, nicotine, intrauterine substance exposure, prenatal care, congenital anomalies, and previous pregnancies. This data including 1,612 records with high birth scores, with 602 (37%) reporting intrauterine substance exposure. That data was matched by first name, last name, and date of birth. Only 93 (6%) were matched as having been referred to the CSHCN Program. Of those 63 reported intrauterine substance exposures, meaning only 10% of all reported children with a high birth score and intrauterine drug exposure were referred to the CSHCN Program. This indicates improvements should be made to the referral system for children with intrauterine substance exposure. Unfortunately, without a legislative change, the OMCFH is unable to utilize the birth score data to provide outreach to children with a high birth score and their families. These referrals are currently primarily received from the Medicaid MCOs and foster care.

**CSHCN will provide case management to infants diagnosed with NAS.**

The CSHCN Program formalized procedures for care coordination. To date, 373 children who are undocumented or suspected missed diagnoses of NAS have been referred and 142 of those referrals have been closed due to request or no contact. The CSHCN Program will continue to develop procedures to ensure best practices are instituted and these children are referred for appropriate evaluation and comprehensive care coordination.

**Increase the number of Prenatal Risk Screening Instruments (PRSI) completed and submitted to the OMCFH.**

The PRSI is continuing the process to be converted to a web-based tool. The system has been developed and is in the testing phase before training is rolled out in 2021. Currently, only approximately 60% of PRSIs are received on pregnant women. The goal is to increase this percentage over the next couple of years. RFTS Regional Lead Agencies will be responsible for contacting and training the physician practices in their Region on how to complete and submit the PRSI.

**Establish referral processes between MRS and the OMCFH home visitation programs.**

PRSI referrals are a priority referral source with RFTS and home visiting programs. For Medicaid eligible women the PRSI referral is provided to RFTS and insurance eligible women are referred to a MIECHV funded home visiting program to ensure appropriate use of funding dollars. Pregnant women are contacted within 48 hours of a PRSI referral and provided information about home visiting. Once enrolled in home visiting, substance use, maternal mental health, intimate partner violence and general environment assessment is completed. Appropriate education, referrals and follow-up are provided based upon the woman's responses. RFTS started universal SBIRT screening

with all women in mid-2019 and other home visiting programs will begin late 2020. In addition, home visiting programs transitioned to the PHQ-9 mental health screener to assess the mental health of the primary caregiver.

**Maternal Mental Health**

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The WVHVP coordinated with Post-Partum Support International (PSI) to provide four regional trainings on post-partum support and bereavement. Over 100 home visitors participated in the online training and the training will be provided annually for all home visitors. The State representative for PSI in on the HV Leadership Team and provides technical assistance to a home visitor if an enrolled family experiences a perinatal loss.

The three virtual learning sessions were completed and the HV CoIIN toolkit has been implemented successfully. Screening rates have increased and exceeded the 85% screening rates and referral linkages. WVHVP had 57 parents or grandparents that participated in the Maternal Depression CoIIN. WVHVP has been able to develop parent leaders at the local implementing agency level, and at the regional level. The parent feedback provided has been invaluable for the continuous quality improvement, the MIECHV needs assessment, and building community relationships.

The Maternal Depression CoIIN has helped foster community networking and partnerships regarding the mental health of home visitation clients. Home Visitors gained comfortability with discussing mental health, using the Mothers and Babies curriculum. Maternal Depression Screening rates have risen statewide. In the past year, WV nearly doubled capacity for parent leadership, with increased engagement from in-person, virtual, and teleconferencing opportunities.

WV has been able to collaborate with 6 other states, sharing our tried and true methods and strategies for engaging parent leaders, including sturdy foundational training in CQI 101 where the importance of combining CQI and parent participation contributes to the buy-in. Participating in the COIINs have increased WV LIAs understanding of how their testing of small changes with their families contributes to the bigger success of home visiting as a whole.

## Increase Breastfeeding

### Use evidence-based curriculums to promote breastfeeding, especially during home visits.

WVHVP will leverage the skills of home visitors and the use of evidence-based curriculum to provide breastfeeding support, increase access to lactation services and create sustainable community breastfeeding support. Breastfeeding education will be provided to all new home visitors within three months of hire. In addition, WVHVP will work with the WV Breastfeeding Alliance to develop trainings for more advanced home visitors to enhance their breastfeeding knowledge. A goal of 15 home visitors trained to be lactation consultants.

Local home visiting programs will utilize their community relationships to increase the number of community partners that have breastfeeding friendly designation areas for women to breastfeed. WVHVP will work with community partners to follow the Ten Steps to Successful Breastfeeding as defined by the World Health Organization and Baby Friendly USA. In addition, local home visiting programs will develop Breastfeeding Peer to Peer Support groups through private Facebook pages for women in their communities to encourage and empower moms to breastfeed.

### Collaborate with WIC to assure that women receive evidence-based breastfeeding education.

The OMCFH and the Perinatal Partnership will coordinate with Office of Nutrition Services/WIC and Payors to improve breast pump, lactation services and donor milk coverage.

Will increase Prenatal Breastfeeding Education and Promotion by offering webinar for prenatal providers and toolkit of ACOG materials and encourage referrals to the WV WIC program for additional education and support.

### Offer evidence-based provider training

The Perinatal Partnership will coordinate with the WV Breastfeeding Alliance to update their website and social media pages to increase membership and participation in statewide lactation efforts and will provide essential updates, resources for training and best practices online.

### Provide support to hospitals working to become baby friendly

Encourage hospitals to reach *Baby-Friendly* status with current educational information and presentations.

Facilitate recognition of hospitals that achieve *Baby-Friendly* designation at the Perinatal Summit and in news media sources.

Provide in-hospital (or online) training for providers and nurses as well as home educators.

- Proper tracking and reporting of breastfeeding intention and exclusivity at discharge by reporting information to *Birthscore/Project Watch* system.
- Assist with clinical portion of *Baby Friendly* required education hours.
- Assist with implementation of the *10 Steps to Successful Breastfeeding* and how to improve mPINC scores.
- Publish Model Policy for Breastfeeding online.
- Improve rates of breastfeeding in the substance use disorder population.

### Offer certified lactation training to WV providers to increase breastfeeding support after hospital

**discharge.**

In partnership with the Perinatal Partnership, the OMCFH will facilitate a bi-annual WV Breastfeeding Conference bringing together providers, nursing staff and lactation support providers along with key stakeholders (would also serve as annual WV Breastfeeding Alliance membership meeting).

A directory of trained lactation support providers to improve breastfeeding education and support for pregnant and nursing mothers in the state will be developed and maintained. Continuing education opportunities for lactation support providers complete with Lactation Continuing Education Recognition Points (LCERPs) will be offered.

A breastfeeding expert will be provided to speak at the Perinatal Summit.

Utilize the "Perinatal All Topics Workgroup" (workgroup of the WV Perinatal Partnership, Medicaid Managed Care Organizations and DHHR leadership) to offer support for breastfeeding among their clients.

**Decrease infant mortality with an emphasis on Sudden Unexplained Infant Death (SUID)**

The OMCFH will utilize recommendations from the Infant and Maternal Mortality Review Panel to prevent future deaths when possible.

Continue a strong collaboration with the safe sleep project, *Our Babies: Safe and Sound* to develop strong public awareness messages targeting parents and providers.

**Mail Back to Sleep materials to all families with a birth record.**

Within a month of delivery all women who deliver a live birth will receive back to sleep and safe sleep information in the mail. This mailing is generated from the Vital Statistics birth file.

**Offer evidence-based provider training.**

Vigorously market *Count the Kicks* as an outreach/educational strategy regarding the importance of tracking baby movements during the third trimester of pregnancy.

Facilitate stabilization of preterm or ill infants prior to transport to tertiary facility through STABLE (Sugar, Temperature, Airway, Blood pressure, Lab work, and Emotional support) infant stabilization program.

The Perinatal Partnership will provide safe sleep education to providers and encourage discussion with their clients.

**Utilize evidence-based curriculums to educate families on safe sleep environments.**

New home visitors will be required to complete the Say YES to Safe Sleep training modules before they begin adding families to their caseloads. Annual safe sleep competency trainings will be required for all home visitors. In addition, WVHVP will work with Our Baby Safe and Sound partners to develop more advanced level professional development regarding safe sleep for families impacted by substance use to ensure temporary caregivers are aware of safe sleep environments. Home visiting programs will utilize the Say Yes to Safe Sleep toolkit to continue and expand education with families enrolled and community partners. To better support nontraditional families enrolled, targeted messaging for grandparents, foster families and temporary caregivers will be updated to ensure

cultural competency and sensitivity to the family. This will include reviewing and possible revisions to the Say YES to Safe Sleep Parent Brochure, Say Yes to Safe Sleep Grandparent brochure and Say YES to Safe Sleep Pledge Cards already being used.

Local home visiting programs will utilize their community relationships to increase the number of community partners that have Safe Sleep messaging displayed in their agencies. Community resources will be accessible for display upon completing the Say YES Educator Training Module developed by Our Baby Safe and Sound. This will include a description of initial, reinforcement and community education strategies to reach expectant parents and parents/caregivers of infants. Family Resource Networks, diaper pantries and food pantries will be targeted to include safe sleep messaging in materials provided to families.

**Work with hospitals to develop safe sleep policies.**

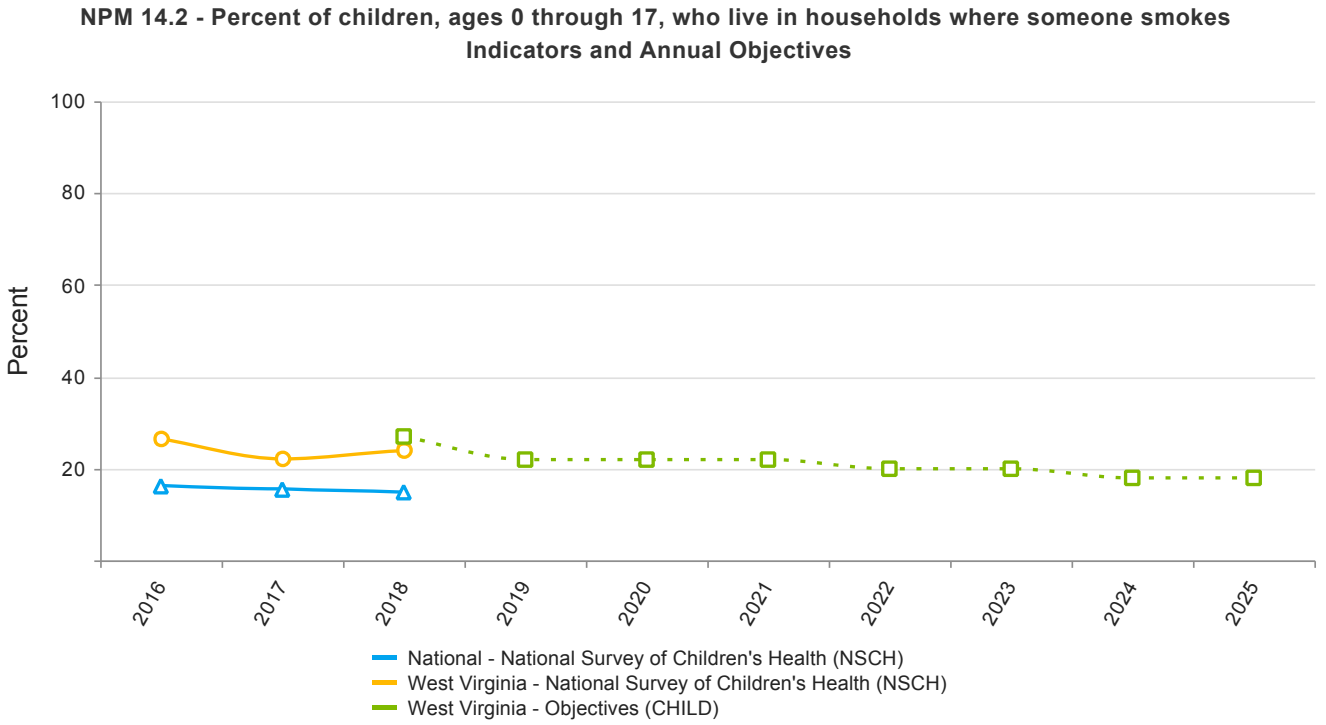
To ensure program fidelity and adherence to the latest American Academy of Pediatrics recommendations on Infant Safe Sleep, the Perinatal Partnership will sponsor the annual competency training for partners of the *Say YES To Safe Sleep For Babies*, including birthing hospitals, home visitation staff, and other community partners.

## Child Health

### Linked National Outcome Measures

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations | SID-2017 | 66.8 | NPM 14.2 |
| NOM 3 - Maternal mortality rate per 100,000 live births | NVSS-2014_2018 | 15.6 | NPM 14.2 |
| NOM 4 - Percent of low birth weight deliveries (<2,500 grams) | NVSS-2018 | 9.4 % | NPM 14.2 |
| NOM 5 - Percent of preterm births (<37 weeks) | NVSS-2018 | 11.8 % | NPM 14.2 |
| NOM 6 - Percent of early term births (37, 38 weeks) | NVSS-2018 | 29.7 % | NPM 14.2 |
| NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths | NVSS-2017 | 6.6 | NPM 14.2 |
| NOM 9.1 - Infant mortality rate per 1,000 live births | NVSS-2017 | 7.0 | NPM 14.2 |
| NOM 9.2 - Neonatal mortality rate per 1,000 live births | NVSS-2017 | 4.0 | NPM 14.2 |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births | NVSS-2017 | 2.9 | NPM 14.2 |
| NOM 9.4 - Preterm-related mortality rate per 100,000 live births | NVSS-2017 | 155.3 | NPM 14.2 |
| NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births | NVSS-2017 | 176.7 | NPM 14.2 |
| NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year | NSCH-2017_2018 | 12.9 % | NPM 13.2 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2017_2018 | 90.1 % | NPM 8.1<br>NPM 13.2<br>NPM 14.2 |
| NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) | NSCH-2017_2018 | 20.9 % | NPM 8.1 |
| NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) | WIC-2016 | 16.6 % | NPM 8.1 |
| NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) | YRBSS-2017 | 19.5 % | NPM 8.1 |

## National Performance Measures




### NPM 14.2 - Child Health

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 27 | 22 |
| Annual Indicator | | 26.5 | 22.2 | 24.1 |
| Numerator | | 97,972 | 82,198 | 88,702 |
| Denominator | | 370,309 | 370,710 | 368,117 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 22.0 | 22.0 | 20.0 | 20.0 | 18.0 | 18.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 14.2.1 - Percent of children in households where someone smokes.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2017 | 2018 | 2019 |
| Annual Objective | | | 25 |
| Annual Indicator | | | 30.4 |
| Numerator | | | 415,200 |
| Denominator | | | 1,365,123 |
| Data Source | | | NSCH |
| Data Source Year | | | 2018 |
| Provisional or Final ? | | | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 28.0 | 26.0 | 24.0 | 22.0 | 20.0 | 18.0 |

**State Performance Measures**

**SPM 3 - Increase the awareness of controlled substance use among children ages 5-17.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | PDMP/VIPP |
| Data Source Year | 2019 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 375.0 | 400.0 | 425.0 | 450.0 | 500.0 |

**SPM 4 - Percent of children, ages two to four, who are obese as defined as body mass index (BMI) at or above the 95th percentile on the CDC growth charts for age and sex.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 16.6 |
| Numerator | |
| Denominator | |
| Data Source | WIC |
| Data Source Year | 2016 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 15.0 | 14.4 | 13.0 | 12.0 | 11.0 |

**State Action Plan Table**

State Action Plan Table (West Virginia) - Child Health - Entry 1

### Priority Need

Decrease smoking specifically among pregnant women and decrease smoke exposure among children in the household.

### NPM

NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes

### Objectives

The Office of Maternal, Child and Family Health will work with partners to reduce the percentage of children in households where someone smokes from 22.2% in 2017 to 18% by 2025.

The Office of Maternal, Child and Family Health will work with partners to reduce the percentage of your who currently use electronic vapor products (including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens and mods on at least 1 day during the 30 days before the survey).

The Office of Maternal, Child and Family Health will work with partners to reduce the percentage of youths who currently smoke cigarettes (on at least 1 day during the 30 days before the survey).

### Strategies

i. Offer evidence-based cessation curriculums to pregnant women, recently delivered women, mothers and other household members via home visiting services.

ii. Provide evidence based adolescent curriculum prevention programs in schools and tobacco/e-cigarette use prevention training for teachers.

iii. Disseminate prevention information, resources and materials to schools and the communities throughout the state including brochures, posters, social media posts, website posts, YouTube, etc.

| ESMs | Status |
|---|---|
| ESM 14.2.1 - Percent of children in households where someone smokes. | Active |

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

## State Action Plan Table (West Virginia) - Child Health - Entry 2

### Priority Need

Address substance use in pregnancy and in youth/teens.

### SPM

SPM 3 - Increase the awareness of controlled substance use among children ages 5-17.

### Objectives

The VIPP Program and the Division of Infant, Child and Adolescent Health will work with partners to increase awareness of controlled substance use among children ages 5-11.

### Strategies

i. Partner with medical providers to align with best practices in prescribing controlled substances to ensure optimum outcomes.

## State Action Plan Table (West Virginia) - Child Health - Entry 3

### Priority Need

Decrease obesity among children.

### SPM

SPM 4 - Percent of children, ages two to four, who are obese as defined as body mass index (BMI) at or above the 95th percentile on the CDC growth charts for age and sex.

### Objectives

The Division of Child and Adolescent Health will work with WIC and other partners to decrease obesity among children ages 2-4.

Strategies

i. Implement the Key 2 a Healthy Start quality improvement initiative using the Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) in 50 child care centers each year.

ii. Develop a Recognition Reward Program for Child Care Centers in nutrition and physical activity meeting 60% of Best Practices for nutrition and/or physical activity for sustainability of improved best practices.

iii. Develop intensive training module for the best practices for breast feeding and infant feeding for STARS credit for all child care center in WV.

iv. Develop social marketing campaign for infant/breast feeding for child care centers and pediatric providers and disseminate with all partners.

v. Develop a Recognition Reward Program for Infant/Breast Feeding Friendly Child Care Centers and announce at Great Beginnings annual infant-toddler conference.

vi. Each year, train at least 10 provider practices in an Obesity Prevention and Early Recognition training utilizing the American Academy of Pediatrics “5210 Pediatric Obesity Clinical Decision Support Chart.”

vii. Each year, enroll at least five provider practices to participate in the 5210 Prescription (Rx) Initiative including “dispensing” produce, physical activity and drinking water “Rx” with goal setting and tracking.

viii. With recent upgrades to WIC food package: Increase WIC participation rates-partner providers with local WIC office/staff; direct enrollment at birthing hospital before discharge if WIC eligible and follow up at 2 week EPSDT.

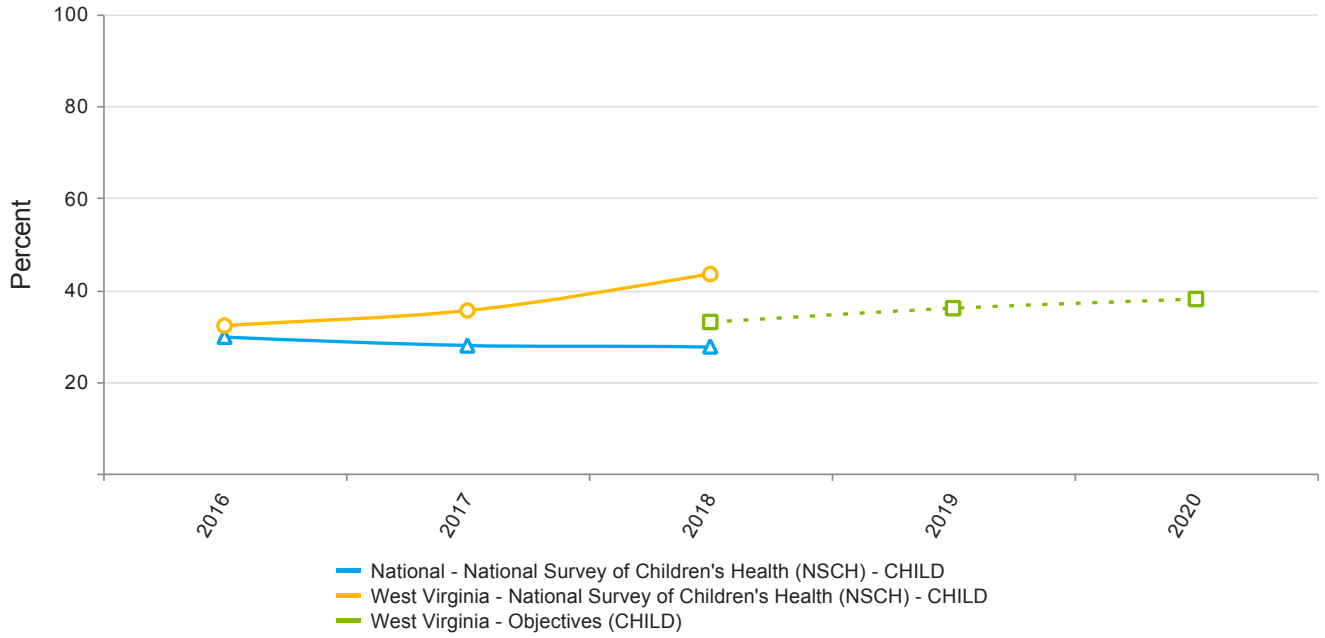
ix. Increase CACFP participation and retention rates so that full utilization of federal CACFP funds are brought into WV: re-launch Leap of Taste standards with statewide training initiatives for OCN, QRIS quality specialist, Health Educators, Nurse health care consultants and other Resource and Referral training staff; include cook/kitchen staff “scratch” cooking training.

x. Incentivize Farm to ECE (same was done with farm to school but did not include child care centers in ECE).

xi. Improve ECE licensing standards for obesity prevention- According to “Achieving a State of Healthy Weight,” many of the 47 Caring for Our Children obesity prevention standards are either partially met or missing, and a few are contradictory. Licensing regulations will not be reviewed again until 2023.

**2016-2020: National Performance Measures**

**2016-2020: NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**
**Indicators and Annual Objectives**




| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CHILD** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 33 | 36 |
| Annual Indicator | | 32.1 | 35.5 | 43.3 |
| Numerator | | 39,168 | 40,194 | 46,844 |
| Denominator | | 122,113 | 113,155 | 108,304 |
| Data Source | | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

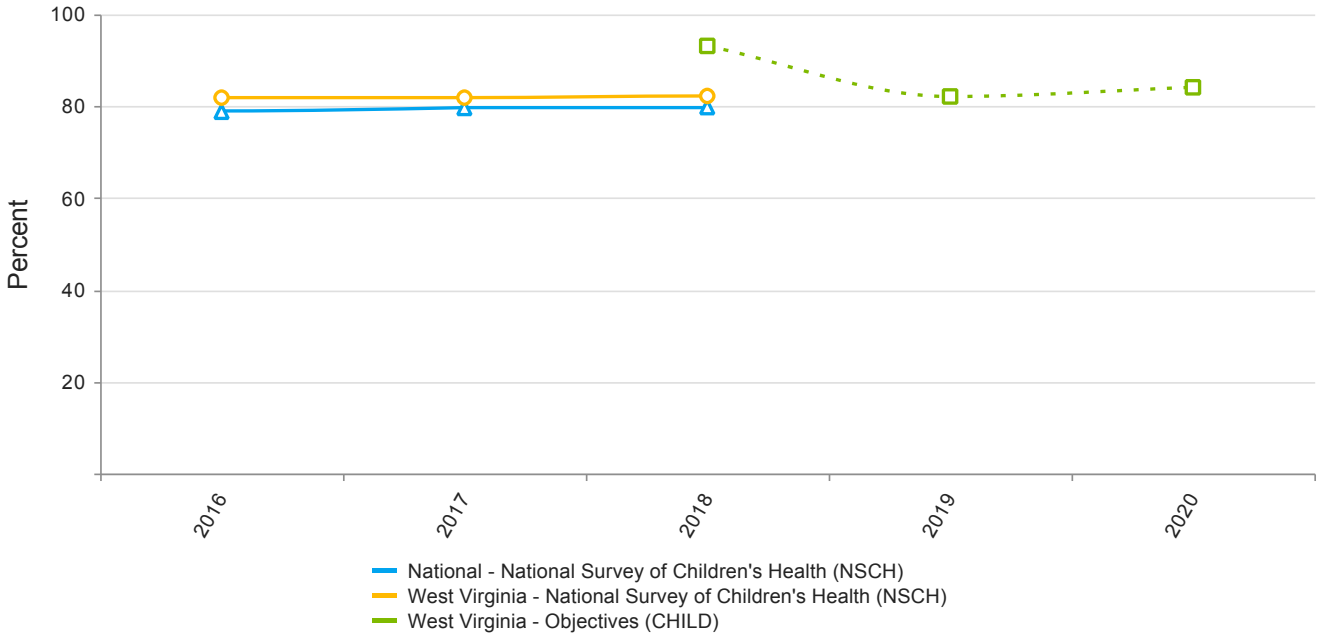
**2016-2020: ESM 8.1.1 - Number of schools surveyed that are engaged in shared use activities.**

| **Measure Status:** | | | **Active** |
|---|---|---|---|
| **State Provided Data** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 150 |
| Annual Indicator | | | 10 |
| Numerator | | | |
| Denominator | | | |
| Data Source | | | AHCS |
| Data Source Year | | | 2019 |
| Provisional or Final ? | | | Provisional |

**2016-2020: ESM 8.1.2 - Percent of children participating in the WV Coordinated Approach to Child Health (CATCH) Program**

| **Measure Status:** | | | **Active** |
|---|---|---|---|
| **State Provided Data** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 95 |
| Annual Indicator | | | 95 |
| Numerator | | | |
| Denominator | | | |
| Data Source | | | HealthCheck |
| Data Source Year | | | 2019 |
| Provisional or Final ? | | | Provisional |

**2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**
**Indicators and Annual Objectives**




**2016-2020: NPM 13.2 - Child Health**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 91 | 82 |
| Annual Indicator | | 81.8 | 81.7 | 82.2 |
| Numerator | | 283,638 | 286,309 | 285,988 |
| Denominator | | 346,833 | 350,407 | 347,833 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: ESM 13.2.1 - Percentage of pediatric care providers completing Smiles for Life Course 6: Caries Risk Assessment, Fluoride Varnish & Counseling**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 0 | 5 | 10 |
| Annual Indicator | 0 | 0 | 10 | 10 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Oral Health Program | Oral Health Program | Oral Health Program | Oral Health Program |
| Data Source Year | 2016 | 2016 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**2016-2020: State Performance Measures**

**2016-2020: SPM 2 - Percent of children ages 0 through 17 who are adequately insured**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 78.2 | 75.5 | 68 |
| Annual Indicator | 57 | 75.5 | 68.9 | 68.1 |
| Numerator | 204,781 | 271,234 | 245,477 | 252,731 |
| Denominator | 359,047 | 359,047 | 356,411 | 371,200 |
| Data Source | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2016 | 2016 | 2017 | 2017-2018 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**Increase the number of after-school and community based physical activity and health promotion activities.**

During the fall of 2016, the Adolescent Health Coordinators (AHCs) began meeting with school personnel to discuss and promote shared use activities. Those interactions are documented on a tracking tool developed by the AHI Director. To date, the AHCs have met with 181 schools. While most schools have an open, accessible playground and/or other amenity (such as a walking track or football field), many barriers were identified and included lack of funding, lack of necessary equipment, lack of available space or facilities, and lack of staff or volunteers to supervise. Staff also expressed other barriers such as being in a rural location and vandalism. If facilities are left open, the staff needs to check playgrounds for drug paraphernalia (such as used needles), broken bottles, etc. before they can be used by the school children. The AHCs worked to address some of these concerns and increase opportunities for physical activity and health promotion in schools and communities. The AHCs engage and interact with communities by initiating or participating in local committees such as the Valley Health Systems Health and Wellness Team, Healthy Berkley and Active Southern WV. These groups have worked to develop activities like weekly walking clubs in Ansted, Valley, and Collins Middle Schools, a "healthy" community dinner provided by cooking students at Huntington High and facilitated fitness events at Summersville Lake, Town Park in Fayette County and "Healthy Berkeley" in Berkeley, WV. The AHCs also partnered with local restaurants and community centers to provide dinner while educating youth on restaurant etiquette and making healthier menu choices. Over 200 youth attended these dinners across the state. Many other school and community events were planned for the Spring of 2020, however they were canceled due to COVID19.

Evidence-based programs such as GoNoodle were implemented in elementary afterschool programs until schools were closed in March 2020 due to COVID19. GoNoodle helps teachers and parents get kids moving with short interactive activities and helps kids achieve more by keeping them engaged and motivated throughout the day. South Preston Elementary began utilizing MyPlate food guide as part of their after-school farmers market program. More information about MyPlate can be found at https://www.choosemyplate.gov.

The OMCFH's HealthCheck Program continued the Coordinated Approach to Child Health (CATCH) program. The initial program began in partnership with three summer camps to offer organized, supervised physical activity for a minimum of 60 minutes per day. Activities include volleyball, basketball, softball, "ultimate frisbee" and dance, with leadership comprised from staff volunteers. Program included under this objective include, Mountaineer Boys State, American Baptist Youth Camps and the day activity program at the Marshall County Fair. Because of the COVID pandemic, all of these programs were cancelled for the 2020 summer season.

**Assist the WVDE in the facilitation of evidence-based professional development opportunities for schools and administrators.**

The AHCs provided trainings and workshops to encourage increased physical activity, healthier eating, and the implementation of WVDE Policy 2510 activities. Trainings included MyPlate, Sports Medicine and Prevention, Minds-in-Motion, GoNoodle, Walking Classroom, and PA (physical activity) in the Classroom plus many general health and wellness informational sessions and workshops. In total, the AHCs provided 20 trainings, workshops, wellness events, and health fairs to 397 teachers, administrators and community leaders and distributed over 3,600 brochures, posters, and other educational materials across WV.

**Work with school personnel to provide technical assistance to increase physical activity throughout the day as outlined in Policy 2510.**

The AHI Director is an active member of the WVDE Health and Wellness Leadership Committee. This committee serves as an advisory board for various grants and initiatives for student wellness such as Project AWARE, Stop the

Violence, School Based HIV/STD Prevention, Reclaim WV, Let's Move WV, etc. As part of this partnership, the WVDE provides funding to the 8 regional AHCs to administer Youth Risk Behavior Surveillance (YRBS) Surveys and assist with the promotion and distribution of the resulting data to schools across the state. The AHCs capitalize on the relationships formed with schools during the 2019 YRBS process. Before schools were shut down due to COVID19, the AHCs were able to connect with school administrators and staff in 78 schools to discuss needs, as well as provide resources and offer training.

**Continue oral health surveillance of children ages one through six through the Basic Screening Survey (BSS) to inform program and policy development.**

COVID permitting, the Oral Health Program will continue its surveillance system for children. The 2019/2020 state oral health surveillance focused on the Universal Pre-K population. This was the second time this BSS was conducted. Although the State Oral Health Surveillance Plan does not currently include a BSS for the adolescent population, the OHP plans to include eighth-grade BSS. The OHP is also in transition to completing state surveillance as an internal activity and will be building this capacity over the next year.

**Promote and educate pediatric care providers on importance of establishing a dental home for children ages 0-6, with an emphasis on age 1 dental visits.**

In order to increase the number of children with preventive visits, the Program has encouraged its colleagues and partners to intervene with children at multiple points. The OHP continues to work with the state AAP chapter, WV Association of School Nurses, the WV Primary Care Association and internal partners (HealthCheck and CYSCHN) to educate non-dental providers on the importance of oral disease prevention in the medical setting and referral to a dental home at six months or emergence of the first tooth.

**Promote and educate pediatric care providers on fluoride varnish application for children ages 0-21 years.**

Educate non-dental pediatric healthcare providers on the updates to fluoride varnish services, including hands-on training and promotion of the Smiles for Life Curriculum Course 6: Caries Risk Assessment, Fluoride Varnish and Counseling. The OHP has used information and resources from involvement in the 2018 National MCH Workforce Development Center Cohort to inform training and education of non-dental providers on fluoride varnish application in the medical setting. The OHP has provided webinars and in-person trainings to non-dental providers.

**Promote and educate dental care providers on service delivery of age 1 dental visits.**

The OHP continues to work with the state's only dental school, West Virginia University, as well as the schools of dental hygiene to promote the importance of establishing a dental home for children at or before the age of 1. Ongoing work with state dental workforce has supported this activity through training of WVU dental students on current pediatric best practice and continuous progress on the establishment of a pediatric residency program.

**Support implementation of West Virginia Board of Education (WVBE) Policy 2423 requiring a dental examination for students at school entry and grades 2, 7 and 12.**

Maintain the Oral Health Services Module in collaboration with the West Virginia Department of Education and the West Virginia Statewide Immunization Information System. This module is utilized by dental and school health professionals to document dental examinations for school children at school entry, 2nd, 7th and 12th grades in alignment with West Virginia Board of Education Policy 2423: Health Promotion and Disease Prevention.

**Offer evidence-based cessation curriculums to pregnant women, recently delivered women, mothers and other household members via home visiting services.**

WVHVP worked with home visiting programs on the continued use of multiple evidence-based smoking cessation

strategies. Families enrolled received referrals to Tobacco, Baby and Me, the Tobacco Quitline, SCRIPT and the www.Smokefree.gov website for text messaging. Efforts were successful to streamline the referral process for the Tobacco Quitline and a slow increase of successful referrals was indicated. WVHVP contacted George Washington University on updated SCRIPT materials and working with National representatives on utilization of SCRIPT with validity to the strategy in virtual platforms. Smoking cessation educational materials were updated to include vaping and the more current ACOG and AAP recommendations.

**Offer evidence-based cessation curriculums to pregnant women, recently delivered women, mothers and other household members via home visiting services.**

WVHVP worked with home visiting programs on the continued use of multiple evidence-based smoking cessation strategies. Each model (RFTS, PAT, HFA and EHS) utilized the approved evidence-based curriculum and parent handouts on smoking cessation strategies. Families enrolled received referrals to Tobacco, Baby and Me, the Tobacco Quitline, SCRIPT and the www.Smokefree.gov website for text messaging. WVHVP's intent was to offer women options for reducing/quitting smoking based upon what would be most successful for her in regards to face-to face, social media, texting and more in-depth counseling. Efforts were successful to streamline the referral process for the Tobacco Quitline and a slow increase of successful referrals was indicated. A revised Tobacco Quitline form and ability to use a local pharmacist for counseling has increased access for some women. As home visits transitioned to virtual, WVHVP contacted George Washington University on updated SCRIPT materials to ensure with validity to the strategy in virtual platforms. Smoking cessation educational materials were updated to include vaping and the more current ACOG and AAP recommendations. Increased training on motivational interviewing was provided to home visitors and the use of Ask, Advise, Assess, Assist and Arrange (the 5 A's) as home visiting programs started universal substance use screening for all women enrolled and completed at least twice a year.

**Medical Home/Insurance**

**Work with insurance providers to promote the coverage of medical necessary services.**

We continue to leverage our role as health care coordinators to create connections between communities and agencies and programs providing medically necessary services, specifically medical foods. The contracted CSHCN registered dietitian provides education to healthcare and insurance providers and families regarding the need, appropriate uses, and alternatives to medical foods elevating CSHCN Nutrition Services and has helped expand our partnerships and leverage our resources.

The CSHCN Health Care Coordinators continue to educate regarding the definition of medical necessity for medical foods beyond complete enteral nutrition through feeding tube and covered by the EPSDT benefit to include children who receive all of their nutrition through formula/medical foods regardless of feeding route. Additionally, recommending a referral to the WV CSHCN registered dietitian who has the expertise to address the complex needs of CSHCN is a comprehensive care coordination service offered through the WV CSHCN Program. Education in this endeavor is the path to promote statewide policies for improved early identification of CSHCN to ensure that these children are referred to appropriate types and sources of comprehensive care coordination that include services providing evaluation and education of medical nutrition foods.

**Provide easily accessible, medical necessary nutrition services as a payer of last resort.**

The CSHCN Program funded the coverage of medically necessary medical foods for 270 children in calendar year 2019 and continues to facilitate the coverage of these products through the child's MCO and EPSDT benefits. The

program has had some, but inconsistent, success in expanding coverage beyond the currently complete enteral nutrition standard by the MCOs.

Plans to include an occupational therapist in feeding and swallowing therapy clinics have been explored, however nothing has been finalized to date.

**Formalize data sharing agreements with third party payers to allow for continued monitoring of unmet needs and adequacy of insurance.**

The CSHCN Program continues to collaborate with the MCO's using data sharing agreements to improve identification of CSHCN and MCO members requiring medically necessary nutrition to ensure comprehensive care coordination is provided. Additionally, the CSHCN Director of Nursing meets monthly with MCO partners to ensure appropriate identification of CSHCN and an understanding of the Standards for Systems of Care for Children with Special Health Care Needs is endorsed when completing a plan of care to be shared with the Medical Home. One major undertaking this year was to work with MCO partners in identifying a shared care coordination platform. The CSHCN Program has started work again on a previously stalled initiative to create a platform for use by the medical home providing efficient and comprehensive care coordination.

**Offer evidence-based cessation curriculums to pregnant women, recently delivered women, mothers and other household members via home visiting services.**

Home visitation programs will utilize evidence-based curriculums that align with each of the home visiting models (RFTS, Parents as Teachers, Healthy Families America, and Early Head Start Option) to 3500 women and household members annually. Each model will utilize the approved handouts and activities addressing maternal mental health, prenatal care, referrals for community resources and supports, breastfeeding, safe sleep, and substance use. Targeted populations will be low income, pregnant women under 21 years of age, smokers, grand families, families with open Child Protective Services (CPS), family treatment court participants and women with substance use disorder. However, home visiting services will be available to any woman requesting home visiting. Each home visitor will be required to complete model specific curriculum training before adding women to their caseload.

To build training capacity for home visitors using evidence-based cessation curriculums to pregnant women, in-state model curriculum trainers will be established. Having in-state certified trainers in each model will reduce out-of-state training expenses, increase ability to have more trainings as needed and improved technical assistance for new home visitors within the State. Utilizing the curriculum and in-state trainers will maximize the support for pregnant women and in turn improve prenatal outcomes.

**Provide evidence-based adolescent curriculum prevention programs in schools and tobacco/e-cigarette use prevention training for teachers.**

Recognizing that a primary prevention approach is an effective way to avoid PTE and second-hand tobacco exposure for children, the AHI will implement evidence-based prevention and cessation strategies in schools and communities across the state. The 2018 WV School Health Profiles survey indicates that nearly all schools have a policy that prohibits the use of tobacco and vapor related products and most schools require students to take at least one tobacco prevention class. However, only 40% of the schools reported providing tobacco-use prevention information to the families of their students and only 30% of teachers reported receiving cessation training in the last 2 years. Nearly 60% of teachers stated they would like to receive additional training in tobacco use prevention. The AHI will address these gaps by providing evidence-based curriculum programs in schools and professional development training for teachers.

**Disseminate prevention information, resources and materials to schools and the communities throughout the state including brochures, posters, social media posts, web site posts, YouTube, videos, etc.**

The social learning theory is also important in school- and community-based primary prevention. The AHI will utilize this strategy by disseminating prevention information, resources and materials throughout the state in schools, community centers, School-Based Health Centers and other youth-serving organizations. The AHI will also implement a multi-media intervention utilizing web pages, social media and developing and/or distributing materials such as posters, social media posts, YouTube videos, etc. These items will contain brief messages that address educational goals such as a positive view of not smoking or vaping, a negative view of smoking or vaping, relevant health and statistical information, skills for refusing nicotine products and the perception that most people their age do not smoke or use vapor products.

**Substance use in youth/teens**

**Partner with medical providers to align with best practices in prescribing controlled substances to ensure optimum outcomes**.

In a cursory review of the 2018 NSCH, the prevalence of Attention Deficit Disorder (ADD) and Attention Deficit/Hyperactivity Disorder (ADHD) in WV is 15.8% for children age 3-17 (NCHS, Child and Family Health Measures, Indicator 2.7). However, in some WV counties with the highest rates of substance use disorder and resulting overdose fatality, prescribing data indicates that as many as 1 in 4 children in the same age range are currently prescribed a stimulant. Scholarly literature has shown a correlation between stimulant use in childhood and an increased potential for development of a substance use disorder in adulthood, especially in cases where stimulants are prescribed without an applicable corresponding mental health diagnosis. As WV leads the nation in opioid overdose fatality, this is a vitally important issue to the current and future health and viability of our state and its maternal and child health population.

In coordination with the WV Board of Pharmacy (BoP), the Division of Infant, Child and Adolescent Health (ICAH) and its Violence and Injury Prevention Program (VIPP) will use data from the National Survey of Children's Health (NSCH) and the WV Controlled Substance Monitoring Program (CSMP) to inform surveillance and corresponding outreach and education activities to increase the awareness of controlled substance use among children ages 5-11. Consideration will be given to providing current best practice information to pediatric care providers about the potential future implications of stimulant use in children, as well as internal work with our Title XIX agency to review and potentially improve medical review and prior authorization considerations for this vulnerable pediatric population. The ICAH and the VIPP will also solicit input and support for data and its dissemination from key stakeholders in child health, including the: Governor's Early Childhood Advisory Council (ECAC), Governor's Advisory on Substance Use, OMCFH Pediatric Medial Advisory Board, State Department of Education, and Bureau for Behavioral Health (State Substance Abuse Authority).

**Obesity among children**

**Implement the Key 2 a Healthy Start quality improvement initiative using the Nutrition and Physical Activity Self-Assessment for Child Care (NAPSACC) in 50 childcare centers each year.**

The Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) tool is the evidence-based tool being used to assessment programs' policies and practices regarding nutrition and physical activity. This tool will be introduced and become part of the SOP of 50 Child Care centers each year.

**Develop a Recognition Reward Program for Child Care Centers in nutrition and physical activity meeting 60% of Best Practices for nutrition and/or physical activity for sustainability of improved best practices.**

A recognition program will be developed to showcase the best of the best when it comes to Child Care Centers related to proper nutrition and physical activity. These facilities will be recognized on an annual basis and reevaluated annually to keep their distinction.

**Develop intensive training module for the best practices for breast feeding and infant feeding for STARS credit for all childcare centers in WV.**

A series of on-line trainings will be developed to offer Child Care Centers the opportunity to learn best practices when it comes to Breast Feeding and Infant Feeding. These on-line trainings will provide STAR Credit (Continuing Education Credit) for each 60-minute class taken.

**Develop social marketing campaign for Infant/Breast Feeding Friendly Child Care Centers and announce at Great Beginnings annual infant-toddler conference.**

A marketing campaign will be developed, printed, and distributed to all childcare partners. A printed piece, along with digital pieces, will be available to Child Care Centers, Physician Offices, as well as local WIC clinic focused on the best practice related to infant feeding.

**Develop a Recognition Reward Program for Infant/Breast Feeding Friendly Child Care Centers and announce at Great Beginnings annual infant-toddler conference.**

In partnership with the Great Beginnings Conference Committee, an annual award will be developed and given each year at the Great Beginning Conference. This award will recognize a Childcare Center that has gone above and beyond on education and marketing around proper nutrition of infants. This annual conference provides practical and theoretical information for all those working with infants and toddlers.

**Each year, train at least 10 provider practices in an Obesity Prevention and Early Recognition training utilizing the American Academy of Pediatrics "5210 Pediatric Obesity Clinical Decision Support Chart."**

In partnership with the WV HealthCheck program (WV's EPSDT Program), using HealthCheck program educators, train medical providers to use and recognize the "5210 Pediatric Obesity Clinical Decision Support Chart". This training will be done face-to-face with the selected provider practices throughout West Virginia. In addition, Program Educators will offer this anticipatory guidance beyond the 10 chosen providers, to any provider making a request for this information.

**Each year enroll at least five provider practices to participate in the 5210 Prescription (Rx) Initiative including "dispensing" produce, physical activity and drinking water "Rx" with goal setting and tracking.**

This objective will go beyond the knowledge of the 5210 initiative by converting policy into practice in offering prescription pads to medical provider offices to offer a "Prescription of Fresh Fruits, Vegetables, and Water". Some providers may even offer gift cards or certificates for such products at farmers markets and select grocery stores.

**With recent upgrades to WIC food package: Increase WIC participation rates-partner providers with local WIC office/staff; direct enrollment at birthing hospitals before discharge if WIC eligible and follow up at 2-week EPSDT.**

Leveraging the partnerships with the WVWIC and WV HealthCheck Programs, facilitate a direct enrollment process for the child with the WIC Program (if qualified) before leaving the hospital after birth. Followed up by the medical provider with the parent at the 2-week EPSDT well-child exam. Provider training for this program will be administered by the WV HealthCheck Program Educator.

**Increase CACFP participation and retention rates to that full utilization of federal CACFP funds are brought into WV: re-launch Leap of Taste standards with statewide training initiatives for OCN, QRIS quality specialist, health educators, nurse health care consultants and other resource and referral staff; including cook/kitchen staff "scratch" cooking training.**

The Federal program of Child and Adult Care Food Program (CACFP), offers nutritious meals and snacks to children and adults enrolled in local Child Care Centers, Day Care Centers, and Adult Day Care Centers. WV is not receiving the full Federal match due to low, or no, participation in some Counties. This objective will help to enhance participation by relaunching the Leap of Taste initiative that was created under the ACA for proper prevention through a proper diet. This program offered locally grown fresh fruits and vegetables, along with training for school cooks in scratch cooking.

**Incentivize Farm to ECE (same was done with farm to school but did not include childcare centers in ECE).**

This objective would provide incentives to Child Care Centers to utilize farm markets with locally grown fresh fruits and vegetables as part of their daily menu. Working through partners, like the local school boards and the state farmer's market association, local farmers are identified and certified by the WV Dept of Agriculture to offer the locally grown products at a competitive cost.

**Improve ECE licensing standards for obesity prevention – According to "Achieving a State of Healthy Weight," many of the 47 Caring for Our Children obesity prevention standards are either partially met or missing, and a few are contradictory. Licensing regulations will not be reviewed again until 2023.**

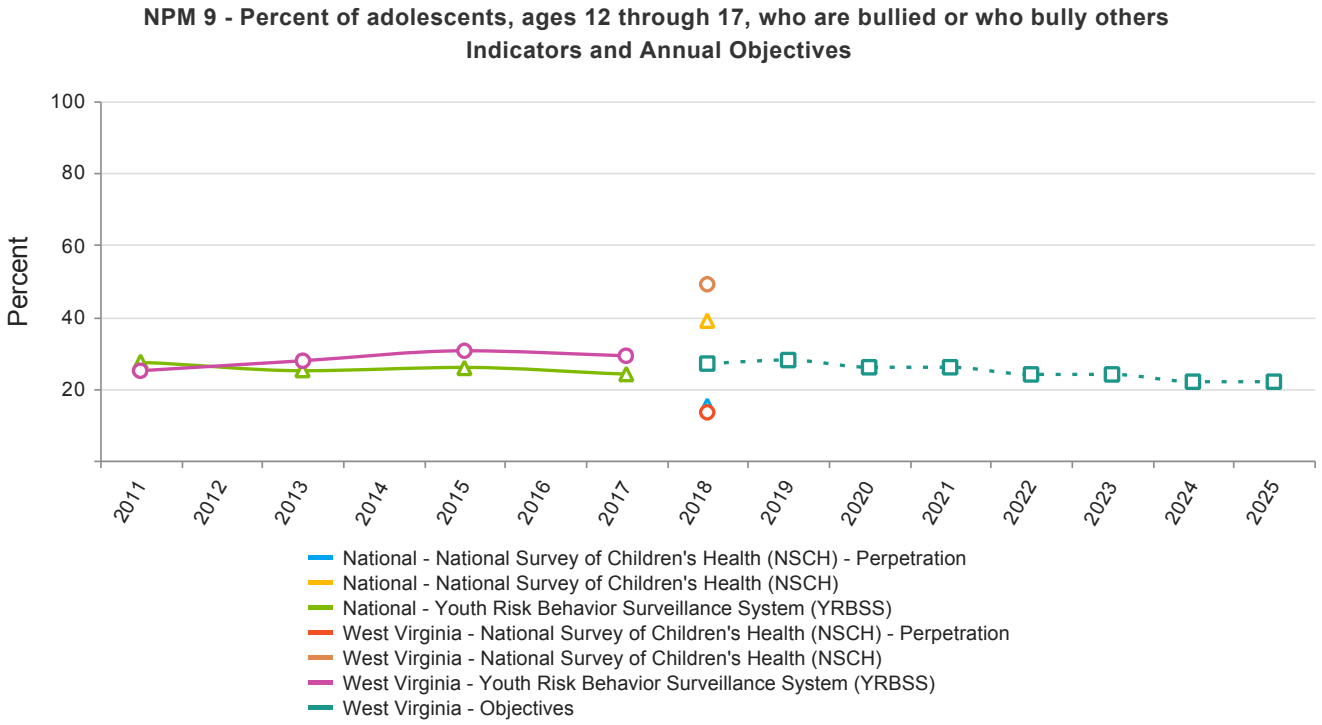
Licensing standards for Early Child Care and Education (ECE) looks at the overall well-being of both children and teachers in the public setting. We would propose to enhance these standards to incorporate many, if not all, of the strategies outlined in this overall proposal. The standards should incorporate the elements of proper nutrition and moderate physical activity for all children, and those who instruct or council them.

**Adolescent Health**

**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year | NSCH-2017_2018 | 12.9 % | NPM 13.2 |
| NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000 | NVSS-2018 | 38.7 | NPM 9 |
| NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000 | NVSS-2016_2018 | 12.6 | NPM 9 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2017_2018 | 90.1 % | NPM 8.2<br>NPM 13.2 |
| NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) | NSCH-2017_2018 | 20.9 % | NPM 8.2 |
| NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) | WIC-2016 | 16.6 % | NPM 8.2 |
| NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) | YRBSS-2017 | 19.5 % | NPM 8.2 |

**National Performance Measures**




| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: Youth Risk Behavior Surveillance System (YRBSS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 26 | 25 | 27 | 28 |
| Annual Indicator | 30.5 | 30.5 | 29.1 | 29.1 |
| Numerator | 23,959 | 23,959 | 22,608 | 22,608 |
| Denominator | 78,632 | 78,632 | 77,715 | 77,715 |
| Data Source | YRBSS | YRBSS | YRBSS | YRBSS |
| Data Source Year | 2015 | 2015 | 2017 | 2017 |

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - Perpetration** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 28 |
| Annual Indicator | | | 13.6 |
| Numerator | | | 16,987 |
| Denominator | | | 124,901 |
| Data Source | | | NSCHP |
| Data Source Year | | | 2018 |

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 28 |
| Annual Indicator | | | 49.1 |
| Numerator | | | 61,001 |
| Denominator | | | 124,257 |
| Data Source | | | NSCHV |
| Data Source Year | | | 2018 |

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 26.0 | 26.0 | 24.0 | 24.0 | 22.0 | 22.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 9.1 - Number of positive youth development (PYD) focused trainings provided to youth, parents, professionals and community members**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 87 | 95 | 112 |
| Annual Indicator | 87 | 92 | 110 | 144 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | AHCS | AHCS | AHCS | AHCS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 100.0 | 110.0 | 115.0 | 120.0 | 125.0 | 130.0 |

**ESM 9.2 - Number of schools and/or youth serving organizations in target communities that have implemented a comprehensive bullying program**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 13 | 17 | 32 |
| Annual Indicator | 13 | 16 | 30 | 38 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | AHCS | AHCS | AHCS | AHCS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 38.0 | 39.0 | 39.0 | 39.0 | 40.0 | 40.0 |

**ESM 9.3 - Number of messages disseminated via social media**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 85 | 100 | 135 |
| Annual Indicator | 85 | 98 | 130 | 122 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | AHCS | AHCS | AHCS | AHCS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 125.0 | 140.0 | 150.0 | 155.0 | 160.0 | 165.0 |

**ESM 9.4 - Number of trainings provided to youth, parents, professionals and community members**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 105 | 114 | 100 |
| Annual Indicator | 105 | 112 | 97 | 102 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | AHCS | AHCS | AHCS | AHCS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 110.0 | 112.0 | 115.0 | 118.0 | 120.0 | 122.0 |

**State Performance Measures**

**SPM 1 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 41.6 | 20 | 20 |
| Annual Indicator | 16.3 | 17 | 16.8 | 19.9 |
| Numerator | 3,240 | 3,380 | 22,582 | 25,058 |
| Denominator | 19,936 | 19,936 | 134,548 | 125,615 |
| Data Source | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2016 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 22.0 | 22.0 | 24.0 | 26.0 | 28.0 | 30.0 |

**SPM 3 - Increase the awareness of controlled substance use among children ages 5-17.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | PDMP/VIPP |
| Data Source Year | 2019 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 375.0 | 400.0 | 425.0 | 450.0 | 500.0 |

**State Action Plan Table**

State Action Plan Table (West Virginia) - Adolescent Health - Entry 1

### Priority Need

Decrease injuries among youth and teens specifically related to teen suicide.

### NPM

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

### Objectives

Reduce the percentage of adolescents, ages 12-17, who report being bullied from 29.1% in 2017 to 22% by 2025.

Decrease the percentage of high school students who seriously considered attempting suicide in the past year from 20.9% in 2019 to 15% by 2025.

Decrease the percentage of high school students who make a plan about how they would attempt suicide in the past year from 13.9% in 2019 to 10% by 2025.

Decrease the percentage of high school students who attempted suicide in the past year from 11.2% in 2019 to 8% by 2025.

Decrease the percentage of high school students whose suicide attempt resulted in an injury, poisoning or overdose that had to be treated by a doctor or nurse in the past year from 3.7% in 2019 to 2% by 2025.

### Strategies

i. Regional Adolescent Health Coordinators will utilize Search Institute's 40 Developmental Assets framework to increase protective factors and encourage adult youth connections in schools and communities to build and maintain positive relationships between young people and caring adults, including school personnel and care givers.

ii. Adolescent Health Initiative and the WV Violence and Injury Prevention Program will utilize the WV Youth Risk Behavior Survey and the Child Fatality Review to monitor progress on bullying and suicide measures.

iii. Community-based Adolescent Health Coordinators will identify and coordinate the implementation of research-based models for prevention of bullying and harassment in schools and other youth serving organizations.

iv. The VIPP will disseminate relevant data on the topic of non-fatal suicide trends for 12-17 year old in the state.

| ESMs | Status |
| --- | --- |
| ESM 9.1 - Number of positive youth development (PYD) focused trainings provided to youth, parents, professionals and community members | Active |
| ESM 9.2 - Number of schools and/or youth serving organizations in target communities that have implemented a comprehensive bullying program | Active |
| ESM 9.3 - Number of messages disseminated via social media | Active |
| ESM 9.4 - Number of trainings provided to youth, parents, professionals and community members | Active |

| NOMs |
| --- |
| NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000 |
| NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000 |

## State Action Plan Table (West Virginia) - Adolescent Health - Entry 2

### Priority Need

Increase in adolescents with and without special health care needs who receive services necessary to make transitions to adult health care.

### SPM

SPM 1 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

### Objectives

The Division of Infant, Child, and Adolescent Health will increase the percentage of adolescents (12-17) with and without special health care needs who received services necessary to make transitions to adult health care from 20.2% (CSHCN) and 20.0% (non-CSHCN) to 40% by 2025 for both populations.

### Strategies

i. Provide academic detailing to pediatric primary care physicians on the importance of adopting a transition policy including Got Transition's resources: the Six Core Elements of Health Care Transition sample tools and measurements.

ii. Complete transition readiness assessment for all enrolled CSHCN starting at age 14.

State Action Plan Table (West Virginia) - Adolescent Health - Entry 3

## Priority Need

Address substance use in pregnancy and in youth/teens.

## SPM

SPM 3 - Increase the awareness of controlled substance use among children ages 5-17.

## Objectives

The VIPP Program and the Division of Infant, Child and Adolescent Health will work with partners to increase awareness of controlled substance use among children ages 12-17.

## Strategies

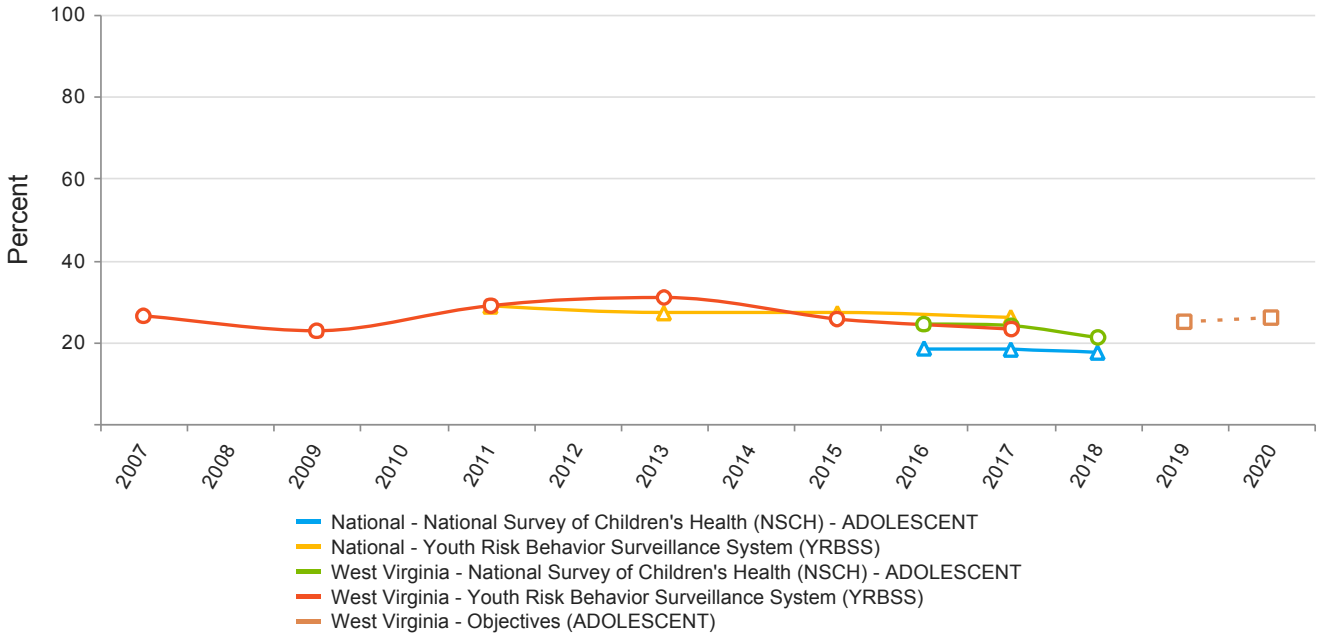
i. Partner with medical providers to align with best practices in prescribing controlled substances to ensure optimum outcomes.

ii. Provide educational information and resources to youth, parents, schools and the community about the harmful affects of drug abuse and misuse, safe storage and disposal of prescription medications and prescription monitoring in the home.

**2016-2020: National Performance Measures**

**2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**

**Indicators and Annual Objectives**




| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: Youth Risk Behavior Surveillance System (YRBSS)** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 25 |
| Annual Indicator | 25.8 | 23.4 | 23.4 |
| Numerator | 19,962 | 17,726 | 17,726 |
| Denominator | 77,480 | 75,763 | 75,763 |
| Data Source | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT |
| Data Source Year | 2015 | 2017 | 2017 |

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 25 |
| Annual Indicator | 24.3 | 24.1 | 21.2 |
| Numerator | 29,361 | 30,565 | 27,302 |
| Denominator | 120,948 | 126,776 | 128,983 |
| Data Source | NSCH-ADOLESCENT | NSCH-ADOLESCENT | NSCH-ADOLESCENT |
| Data Source Year | 2016 | 2016_2017 | 2017_2018 |

**2016-2020: Evidence-Based or –Informed Strategy Measures**

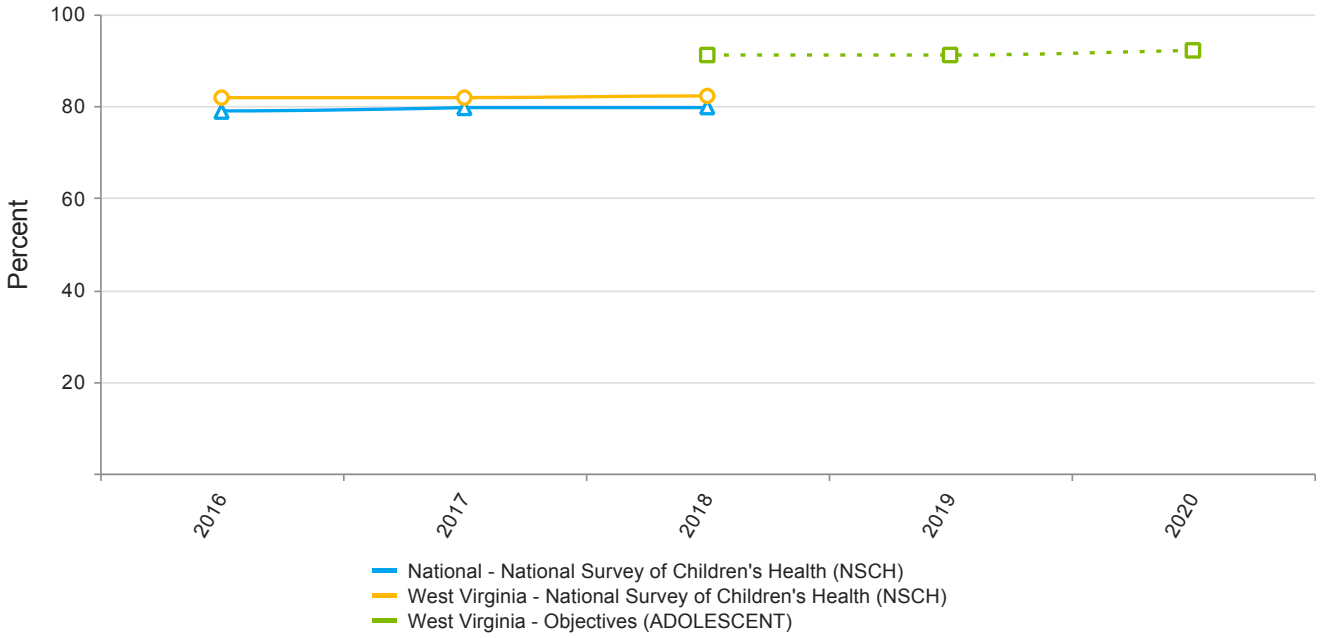
**2016-2020: ESM 8.2.1 - Number of schools surveyed that are engaged in shared use activities**

| Measure Status: | | | Active | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 139 | 145 | 180 |
| Annual Indicator | 139 | 148 | 173 | 171 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | AHCS | AHCS | AHCS | AHCS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**2016-2020: ESM 8.2.2 - Percent of children participating in the WV Coordinated Approach to Child Health (CATCH) Program**

| Measure Status: | | Active | |
|---|---|---|---|
| **State Provided Data** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | 40 | 93 | 94 |
| Annual Indicator | 93 | 94 | 94 |
| Numerator | | | |
| Denominator | | | |
| Data Source | HealthCheck | HealthCheck | HealthCheck |
| Data Source Year | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional |

**2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**
**Indicators and Annual Objectives**




**2016-2020: NPM 13.2 - Adolescent Health**

| **Federally Available Data** | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 91 | 91 |
| Annual Indicator | | 81.8 | 81.7 | 82.2 |
| Numerator | | 283,638 | 286,309 | 285,988 |
| Denominator | | 346,833 | 350,407 | 347,833 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: ESM 13.2.1 - Percentage of pediatric care providers completing Smiles for Life Course 6: Caries Risk Assessment, Fluoride Varnish & Counseling**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 0 | 5 | 10 |
| Annual Indicator | 0 | 0 | 10 | 10 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Oral Health Program | Oral Health Program | Oral Health Program | Oral Health Program |
| Data Source Year | 2016 | 2016 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**2016-2020: State Performance Measures**

**2016-2020: SPM 2 - Percent of children ages 0 through 17 who are adequately insured**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 78.2 | 75.5 | 68 |
| Annual Indicator | 57 | 75.5 | 68.9 | 68.1 |
| Numerator | 204,781 | 271,234 | 245,477 | 252,731 |
| Denominator | 359,047 | 359,047 | 356,411 | 371,200 |
| Data Source | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2016 | 2016 | 2017 | 2017-2018 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**2016-2020: SPM 4 - Percentage of adolescents ages 12-17 with a well visit in the past year**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 85 | 87 | 87 |
| Annual Indicator | 84.9 | 84.9 | 86.3 | 62.8 |
| Numerator | 95,934 | 95,934 | 116,200 | 78,233 |
| Denominator | 113,040 | 113,040 | 134,585 | 124,579 |
| Data Source | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2016 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

## Bullying

Bullying is unwanted aggressive behavior, either physical or verbal, among children where there is an actual or perceived imbalance of power. True bullying involves aggression that is repeated or has the potential to be repeated. Bullying has been linked to many negative outcomes including criminal violence, mental health impacts, substance abuse, and suicide. Victims often suffer from anxiety and depression (including suicide ideation), physical ailments, and decreased academic achievement. Perpetrators often engage in violent and abusive behavior as adults, abuse drugs or alcohol, and engage in other risky behaviors. Bystanders, or those who witness acts of bullying, are also more likely to have mental health problems, suffer from depression and anxiety, and engage in substance abuse. There are three types of bulling:

**Verbal bullying** is saying or writing mean things. Verbal bullying includes:

- Teasing
- Name-calling
- Inappropriate sexual comments
- Taunting
- Threatening to cause harm

**Social bullying**, sometimes referred to as relational bullying, involves hurting someone's reputation or relationships. Social bullying includes:

- Leaving someone out on purpose
- Telling other children not to be friends with someone
- Spreading rumors about someone
- Embarrassing someone in public

**Physical bullying** involves hurting a person's body or possessions. Physical bullying includes:

- Hitting/kicking/pinching
- Spitting
- Tripping/pushing
- Taking or breaking someone's things
- Making mean or rude hand gestures

Evidence-based youth violence prevention strategies have become more evident as available research has grown. Rather than just focusing solely on reducing problem behaviors, using broad and overlapping strategies that develop strengths within individuals, families, and society can reverse the culture of bullying within a community. The implementation of a combination of these strategies is likely to result in stronger and more sustainable improvements in health and safety than the implementation of a single strategy.

The Adolescent Health Initiative (AHI) is a health promotion project designed to address the State Title V agency priorities for WV's adolescent population. Under the direction of the AHI Director, eight community-based Adolescent Health Coordinators (AHCs) facilitate collaborative efforts that increase the assets that young West Virginians need to grow into healthy and responsible adults, and functions to improve the collective health of WV's adolescents, thus enabling them to reach their fullest potential.

**Regional Adolescent Health Coordinators will utilize Search Institute's 40 Developmental Assets framework to increase protective factors and encourage adult youth connections in schools and communities to build and maintain positive relationships between young people and caring adults, including school personnel and care givers.**

In early 2020, the AHI partnered with West Virginia University-Parkersburg to conduct surveys in schools throughout Region 5 to access impact of the AHI's asset-based positive youth development programming. Results show that youth attending AHI's programming are more likely to feel their parents give them support when they need it (84% vs. 72%), more likely to get along

with their parents (81% vs. 67%), more likely to feel they get a lot of encouragement at school (65% vs. 28%) and feel like a lot of people in their neighborhood care about them (61% vs. 39%).

To encourage these youth-adult connections, the AHI provided 144 trainings focused on positive youth development. Trainings included COVID19 focused virtual events, *Connections Matter* and other asset-based programs. Over 6,338 youth, parents, professionals, and community members attended the trainings.

Training highlights include (but aren't limited to):

- *COVID19 Virtual Facebook* event with Jenny Anderson from *Advocates for Youth*
- *Join the Asset Movement* (JAM)
- *Grief and Reaction Attachment*
- *40 Developmental Assets*
- *Resilience and Adverse Child Experience's Training*
- *Triple "P" Parenting*
- *Connections Matter*
- *Raising Awareness During COVID-19: Child Abuse Is Your Business* (Webinar)
- *When the Child Trusts You* (Webinar)
- *A Framework for Understanding Development Assets for Online At-Risk Youth* (Webinar)
- *CONNECT WV: Working Together to Keep Kids Safe and Well* (6-week series) (Webinar)
- *The Actual Effect of Screen-Time on the Developing Brains of Children*
- *Darkness to Light: Stewards of Children*
- *I Think I'm Stressed* session at the Triadelphia Middle School Health and Wellness Conference to students
- *Talking to Your Children and Substance Abuse*
- *Framework for Understanding Poverty* in-service workshop for teachers and administrators

**Adolescent Health Initiative and the WV Violence and Injury Prevention Program will utilize the WV Youth Risk Behavior Survey and the Child Fatality Review to monitor progress on bullying and suicide measures.**

The West Virginia Department of Education (WVDE) began utilizing the YRBS to collect data in 1993 and has been conducted every two years since. In 2019, the WVDE provided funding to the AHI to conduct YRBS Surveys in 116 schools across the state. The results were released in early 2020. The 2019 high school risk behavior shows a decrease in most adolescent risk behaviors since 1993, including the percentage of students who have seriously considered suicide (27% down to 21%); however, this data point did show a small increase from 19% in 2017. Students who made a plan in the past year to attempt suicide continued to decline in 2019 from 1993 (20% down to 14%). However, the high school risk behavior trend summary report shows that other measures remained basically the same or increased from 1993 (unless otherwise indicated) to 2019:

- Did not go to school because they felt unsafe (4% vs 10.5%)
- Being threatened or injured with a weapon on school property (8% vs. 7.5%)
- Feeling sad or hopeless every day for 2 weeks or more (30% in 1999 vs. 36.4%)

The middle school risk behavior trend summary report shows that several related measures remain the same or slightly increased:

- Ever carried a weapon (41% in 2001 vs. 40.4% in 2019)
- Were ever bullied on school property (47% in 2009 vs. 45.7% in 2019)
- Were ever electronically bullied on school property (25% in 2011 vs. 27.8% in 2019)

- Ever seriously thought about killing themselves (21% in 2001 vs. 24.7% in 2017)

The WVDE's YRBS surveys and trend summary reports and other publications can be found at https://wvde.us/reclaimwv/resources/.

The surveys conducted by AHI and WVU-Parkersburg with students in Region 5 showed students who participated in AHI's programs were less likely to think they are "no good at all" (26% vs. 52%), less likely to feel depressed (32% vs. 46%), more likely to say they like themselves as a whole (78% vs. 55%) and less likely to have attempted suicide (9% vs. 21%).

Lastly, to help identify students at higher risk for suicide, bullying or other negative outcomes, the AHI began conducting needs assessments and Child PTSD Symptom Screeners (CPSS) in classrooms as part of their Title V Sexual Risk Avoidance curriculum programming. Between October 1, 2018 and September 30, 2019, 580 needs assessments and 553 trauma screeners were administered resulting in 26 referrals for necessary services. That is double the number of referrals identified last year.

**Adolescent Health Initiative will provide Green Dot and Youth Mental Health First Aid (YMHFA) trainings across the state and will work with school and community partners to facilitate program implementation.**

In FY 2017, the AHI's regional AHCs began by providing over 500 *Green Dot* posters and materials to schools across the state and began meeting with school personnel and administrators to introduce the idea of a bystander intervention approach and discuss program implementation, as the program is very time intensive and requires a lot of commitment by school personnel and the community. Program implementation began with 6 schools in FY2018 and has expanded to 30 schools utilizing Green Dot and other comprehensive bully prevention curriculum programs in FY2020.

In the Fall of 2017, the AHI partnered with the DHHR's Bureau for Behavioral Health and Health Facilities to certify all of the regional AHCs as *Mental Health First Aid* trainers. *Mental Health First Aid* is an 8-hour course that teaches you how to identify, understand, and respond to signs of mental illnesses and substance use disorders. The AHI conducted 20 trainings in FY2020, in addition to the 24 trainings conducted in FY2018 and 2019. The AHI partnered with Concord University to prepare a course syllabus and offer graduate course credits in 2019, in addition to the Continuing Education Credits (CEUs) for training participants offered previously. Over 70 participants completed the course through Concord University and received 3 graduated course hours. Over 350 people attended the YMHFA trainings in FY2020.

**Community-based Adolescent Health Coordinators will identify and coordinate the implementation of research-based models for prevention of bullying and harassment in schools and other youth serving organizations.**

Recognizing that "one size does not fit all" in terms of evidenced based interventions, the AHI worked with schools and youth groups to identify programs that fit best with their needs, schedules and staff. They provided training, technical assistance and helped facilitate implementation for several programs in addition Green Dot and YMHFA. These programs include (but not limited to):

- Too Good For Drugs and Violence- A curriculum consisting of 14 core lessons and 12 additional lessons that can be integrated into the teaching of other school subjects. The program aims to promote pro-social skills, positive character traits, and violence- and drug-free norms among high school students. It includes a staff development component and optional family and community components.[1]
- Second Step- A program rooted in social-emotional learning that helps transform schools into supportive, successful learning environments uniquely equipped to encourage children to thrive. More than just a classroom curriculum, Second Step's holistic approach helps create a more empathetic society by providing education

professionals, families, and the larger community with tools to enable them to take an active role in the social-emotional growth and safety of today's children[2]

- Cyber Civics-The most comprehensive digital literacy curriculum available. It features 50-minute curriculum lessons on digital citizenship, information literacy and media literacy. It is adaptable for in-class or remote learning and is currently taught in schools in 44 states.[3]

In 2016, the AHI's surveyed over 6,000 adolescents and their parents on the topic of bullying. The survey data indicated adolescents felt "social" was the most prevalent type of bullying, versus physical or verbal bullying. In response to this data, the AHI and the VIPP partnered to provide *Media Literacy* and *Digital Footprint* trainings across the state. Additionally, the AHCs began promoting the three-year, online module program *Cyber Civics Curriculum for Middle School Students.* To date, 12 schools are implementing the program with nearly 2,400 students. After the COVID19 "stay at home" order was issued, the AHI facilitated 2 statewide webinars on online safety protocols for teachers, parents and students.

The AHI also examined survey data collected by WVU-Parkersburg to assess the AHI's asset programming's impact on bullying and violence prevention. Participants in AHI's program were less likely to have taken part in a fight (5% vs. 15%), more likely to be perceived as caring about others' feelings (92% vs. 78%) and more likely to be perceived as respectful of others' values and beliefs (92% vs. 79%). AHI's participants were more likely to be considered good at making and keeping friends (87% vs. 72%) and less likely to be afraid of being hurt at school (18% vs. 27%).

To assist with compliance of WV House Bill 2535, commonly referred to as "Jamie's Law" requiring public middle and high school administrators to disseminate and provide opportunities for all middle and high schools to discuss suicide prevention awareness information, the AHI provided 4 *Darkness to Light: Stewards of Children* trainings. This evidence-based training utilizes bystander intervention sexual abuse prevention strategies. Additionally, *Sexual Orientation and Gender Identity* workshops were held for teachers and students in Kanawha and Cabell Counties.

The AHI also partnered with Westbrook Health Services and Adolescent Suicide Prevention and Early Intervention program (ASPEN) to provide suicide prevention trainings to staff and students at multiple sites across the state. During the state shutdown due to COVID19, the AHI partnered with Valley Health Systems to provide educational board games, card games and activities that were focused on topics such as bullying, healthy relationships and stress and anger management for families in homeless shelters in Valley Health's service areas.

Lastly, the AHI provided 102 trainings and workshops; posted 122 messages, links and resources on social media; and disseminated 5,966 brochures, posters and other information literature in bullying prevention, bystander interventions and healthy relationships.

**Adolescent Well Visits**

**Facilitate Pediatric Medical Advisory Board meetings assuring the involvement of HealthCheck Program, Department of Education, CHIP, Medicaid and local health care providers.**

The OMCFH continued to facilitate semi-annual meetings of the Pediatric Medical Advisory Board and monitor involvement of various perspectives to address adolescent healthcare in WV. The fall meeting of the board was held in Charleston in early November, while the spring meeting was cancelled due to the pandemic. Communication with all board members continued throughout the pandemic, with periodic visits to several of the member's medical practices.

**Work with Department of Education to implement Policy 2423 requiring well visits for entry to grades**

**seven and twelve.**

In coordination with the HealthCheck Program Specialists, community-based AHCs met with 24 providers to encourage teen centered care, providing materials and trainings to providers in the Valley Health, Cabin Creek and New River Health Systems, including School-Based Health Centers, across the state. The AHCs worked with schools and providers to provide 14 events and 68 trainings aimed at increasing participation rates for adolescent well visits, including the promotion of WV Board of Education Policy 2423. This *Health Promotion and Disease Prevention* policy requires all students must be up to date on mandatory immunizations and requires all students entering Pre-K, Kindergarten, 2nd, 7th, and 12th grades to show proof of a HealthCheck and dental examination within 45 days of entry. Nearly 6,000 people total (not unduplicated) attended these trainings and events and over 4,000 resource materials (newsletters, brochures, posters, social media posts, etc.) were distributed throughout the year.

**Work to incorporate comprehensive well childcare into sports physicals.**

The AHI and HealthCheck provided education and information students athletes, parents, schools and providers to promote utilizing well-child exams versus a sports physical. The AHI worked with WVDE staff to encourage the WV Secondary School Activities Commission (WVSSAC) to make well child exams a requirement for participation in school sports. Thus far, the WVSSAC is willing discuss a formal recommendation but that discussion has yet to occur due to the COVID19 pandemic.

**Audit and educate providers regarding teen friendly criteria.**

Data collected across the state in 2016 indicated adolescents stated that they felt very awkward going to pediatricians and felt medical facilities were not designed to meet their needs. Many also expressed confidentiality concerns. To address this concern, a joint effort between the HealthCheck Program and the AHI created a program to recognize and promote physicians that have a desire to treat and care for older adolescent and teens. The underlying goal of this project is to boost the frequency at which teens visit their “medical home” to receive well-child services. This program teams older children with a desire for better heath to a physician in their area that has taken the pledge to treat teen patients with specialized care. Through the adoption of a Patient Bill of Rights, the physician will respect the privacy of the teen patient and seriously regard their thoughts, concerns, and questions. In addition, the physician understands that teen patients have special needs and circumstances that should be addressed through such adjustments as providing Wi-Fi in the waiting area, walk-in appointment times, teen-positive reading materials, and a commitment to honor their needs as young adults. This program has prepared materials that are designed to promote the physician for their commitment to the program. These materials include a promotions flyer that is placed in the high schools in the local service area, posters for provider waiting areas, a certificate recognizing the physician’s commitment, as well as the physician’s commitment to the rights of the teen patient. This program was launched in January of 2018 and currently has 15 physicians at locations who have received the “teen friendly” designation.

**Transition**

**Title V Agency will develop with partners and stakeholders a Transition Improvement Charter.**

In 2017-18, an estimated 23.8 percent of children, equaling almost 90,000, were children and youth with special health care needs (CYSHCN). Of these children, 45.2 percent received comprehensive, ongoing and coordinated care within a medical home. Of adolescents, 12 to 17 years of age, 20.2 percent reported receiving the services they

needed to make transitions to adult health care (2017-18 National Survey of Children's Health). To increase the number of children with special health care needs receiving services necessary to make transitions to adult health care a Transition Improvement Team was developed. The team met in October of 2019 as a subcommittee of the WV CSHCN Medical Advisory Board. Examples of a Healthcare Transition Plan, the Got Transition Registry, qualitative -"Current Assessment of Health Care Transition Activities" and quantitative-"Health Care Transition Process Measurement Tool were reviewed and approved for use in the WV CSHCN Transition Services procedures. The advancement of a value-based reimbursement model was discussed and it was determined more effort is needed to implement strategies to support physicians in providing transition services, especially those with special health care needs, to ensure these children have access to qualified providers, who are able to receive appropriate reimbursement for the complexity of providing and coordinating their care.

**Develop a transition policy.**

The Transition Improvement Team met in October of 2019 as a subcommittee of the WV CSHCN Medical Advisory Board and developed and approved two sample transition policies to be facilitated by the CSHCN Health Care Coordinator with the pediatric provider. Additionally, an example of the quantitative-"Health Care Transition Process Measurement Tool" from Got Transition was reviewed and approved for use by the CSHCN Health Care Coordinators to facilitate with the pediatric provider to determine what or all of the implementation steps have been completed. For example, developing and publicly displaying a written transition and care policy/guide has a possible score of five; that is, if this step is completed with the appropriate documentation. The sample transition policies and the measurement tool are components of an education curriculum/packet for pediatric providers.

**Share transition policy among pediatric primary care physicians.**

The tools required to introduce the Six Core Elements to pediatric providers and Project DOCC programs and to collect baseline data for said services are developed and approved by the WV CSHCN Medical Advisory Board. However, in preparation for implementation, the public health response to COVID-19 required physical and social distancing and required rapid adaptation of service delivery approaches in close partnership with public health and pediatric providers. It was also noted that CSHCN staff responsible for planning and providing transition services were also personally affected by the direct and indirect effects of the COVID-19 outbreak and efforts to slow transmission (such as physical and social distancing measures, temporary school closures, and travel advisories and restrictions). New ways of organizing services while maintaining capacity is ongoing.

**Complete transition readiness assessment for all enrolled CSHCN starting at age 14.**

CSHCN Health Care Coordinators can request from the CSHCN CTS System or the CSHCN Program Epidemiologist a report indicating the required parameters to identify children of transition age per program procedure. This grant year 545 children were eligible to receive transition services. However, the public health response to COVID-19 required physical and social distancing and required rapid adaptation of service delivery approaches in close partnership with public health and pediatric providers. It was also noted that CSHCN staff responsible for planning and providing transition services were also personally affected by the direct and indirect effects of the COVID-19 outbreak and efforts to slow transmission (such as physical and social distancing measures, temporary school closures, and travel advisories and restrictions). New ways of organizing services while maintaining capacity is ongoing.

**Obesity**

**Increase the number of after-school and community based physical activity and health promotion activities.**

During the fall of 2016, the Adolescent Health Coordinators (AHCs) began meeting with school personnel to discuss and promote shared use activities. Those interactions are documented on a tracking tool developed by the AHI Director. To date, the AHCs have met with 181 schools. While most schools have an open, accessible playground and/or other amenity (such as a walking track or football field), many barriers were identified and included lack of funding, lack of necessary equipment, lack of available space or facilities, and lack of staff or volunteers to supervise. Staff also expressed other barriers such as being in a rural location and vandalism. If facilities are left open, the staff needs to check playgrounds for drug paraphernalia (such as used needles), broken bottles, etc. before they can be used by the school children. The AHCs worked to address some of these concerns and increase opportunities for physical activity and health promotion in schools and communities. The AHCs engage and interact with communities by initiating or participating in local committees such as the Valley Health Systems Health and Wellness Team, Healthy Berkley and Active Southern WV. These groups have worked to develop activities like weekly walking clubs in Ansted, Valley, and Collins Middle Schools, a "healthy" community dinner provided by cooking students at Huntington High and facilitated fitness events at Summersville Lake, Town Park in Fayette County and "Healthy Berkeley" in Berkeley, WV. The AHCs also partnered with local restaurants and community centers to provide dinner while educating youth on restaurant etiquette and making healthier menu choices. Over 200 youth attended these dinners across the state. Many other school and community events were planned for the Spring of 2020, however they were canceled due to COVID19.

Evidence-based programs such as GoNoodle were implemented in elementary afterschool programs until schools were closed in March 2020 due to COVID19. GoNoodle helps teachers and parents get kids moving with short interactive activities and helps kids achieve more by keeping them engaged and motivated throughout the day. South Preston Elementary began utilizing MyPlate food guide as part of their after-school farmers market program. More information about MyPlate can be found at https://www.choosemyplate.gov.

The OMCFH's HealthCheck Program continued the Coordinated Approach to Child Health (CATCH) program. The initial program began in partnership with three summer camps to offer organized, supervised physical activity for a minimum of 60 minutes per day. Activities include volleyball, basketball, softball, "ultimate frisbee" and dance, with leadership comprised from staff volunteers. Program included under this objective include, Mountaineer Boys State, American Baptist Youth Camps and the day activity program at the Marshall County Fair. Because of the COVID pandemic, all of these programs were cancelled for the 2020 summer season.

**Assist the WVDE in the facilitation of evidence-based professional development opportunities for schools and administrators.**

The AHCs provided trainings and workshops to encourage increased physical activity, healthier eating, and the implementation of WVDE Policy 2510 activities. Trainings included MyPlate, Sports Medicine and Prevention, Minds-in-Motion, GoNoodle, Walking Classroom, and PA (physical activity) in the Classroom plus many general health and wellness informational sessions and workshops. In total, the AHCs provided 20 trainings, workshops, wellness events, and health fairs to 397 teachers, administrators and community leaders and distributed over 3,600 brochures, posters, and other educational materials across WV.

**Work with school personnel to provide technical assistance to increase physical activity throughout the day as outlined in Policy 2510.**

The AHI Director is an active member of the WVDE Health and Wellness Leadership Committee. This committee

serves as an advisory board for various grants and initiatives for student wellness such as Project AWARE, Stop the Violence, School Based HIV/STD Prevention, Reclaim WV, Lets Move WV, etc. As part of this partnership, the WVDE provides funding to the 8 regional AHCs to administer Youth Risk Behavior Surveillance (YRBS) Surveys and assist with the promotion and distribution of the resulting data to schools across the state. The AHCs capitalize on the relationships formed with schools during the 2019 YRBS process. Before schools were shut down due to COVID19, the AHCs were able to connect with school administrators and staff in 78 schools to discuss needs, as well as provide resources and offer training.

**Oral Health**

**Continue oral health surveillance of adolescents through the Basic Screening Survey (BSS) to inform program and policy development.**

The Oral Health Program reconvened its surveillance system for children. Although the State Oral Health Surveillance Plan does not currently include a BSS for the adolescent population, the OHP will plans to include eighth-grade BSS. Due to Covid, the 2020/2021 BSS may be delayed. If so, the 2021/2022 BSS will be conducted for two targeted populations. The OHP is also in transition to completing state surveillance as an internal activity and will be building this capacity over the next year.

**Promote and educate pediatric care providers on importance of establishing a dental home for adolescents.**

In order to increase the number of children with preventive visits, the Program encouraged its colleagues and partners to intervene with children at multiple points. The OHP has continued to work with the state AAP chapter, WV Association of School Nurses, the WV Primary Care Association and internal partners (HealthCheck and CYSCHN) to educate non-dental providers on the importance of oral disease prevention in the medical setting and referral to a dental home. The OHP has presented information regarding the importance of establishing a dental home to non-dental providers at meetings and conferences.

**Support implementation of West Virginia Board of Education (WVBE) Policy 2423 requiring a dental examination for students at school entry and grades 2, 7 and 12.**

Maintained the Oral Health Services Module in collaboration with the West Virginia Department of Education and the West Virginia Statewide Immunization Information System. This module is utilized by dental and school health professionals to document dental examinations for school children at school entry, 2nd, 7th and 12th grades in alignment with West Virginia Board of Education Policy 2423: Health Promotion and Disease Prevention.

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[1] https://toogoodprograms.org/
[2] https://www.secondstep.org/
[3] http://www.cybercivics.com/

**Injuries among youth and teens, specifically teen suicide.**

**Regional Adolescent Health Coordinators will utilize Search Institute's 40 Developmental Assets framework to increase protective factors and encourage adult youth connections in schools and communities to build and maintain positive relationships between young people and caring adults, including school personnel and caregivers.**

The AHI Director and community-based AHCs have a longstanding association with the WVDE and have facilitated many training sessions for school administrators, teachers, school nurses, and other school personnel on positive youth development (PYD) models, including Risk and Protective factors and the Search Institute's 40 Developmental Assets®. Moreover, school personnel serve on the AHI's eight regional "asset teams." This existing affiliation will support the efforts of local education agencies in carrying out WV Board of Education *Policy 4373 – Expected Behavior in Safe and Supportive School*s, which sets forth unacceptable behaviors that undermine a school's efforts to create a positive school climate/culture. *Policy 4373* classifies bullying as a Level 3 offense. The regional AHCs will utilize existing formal and informal partnerships to implement research-based, effective models for the prevention of bullying and harassment in schools and communities.

In early 2020, the AHI partnered with West Virginia University-Parkersburg to conduct surveys in schools throughout Region 5 to access impact of the AHI's PYD programming. Students who had participated in AHI's programming had consistently higher numbers of protective factors and a marked reduction in risk behaviors. Based on these results, the regional AHCs will continue to utilize Search Institute's 40 Developmental Assets® framework and their *Sparks* curriculum to incorporate positive youth development to increase protective factors and encourage adult-youth connections in schools and communities.

**Adolescent Health Initiative and the WV VIPP will utilize the WV YRBS and the Child Fatality Review to monitor progress on bullying and suicide measures.**

In 2019, the WV Department of Education (WVDE) provided funding to the AHI to conduct YRBS surveys across the state. The AHI, working with the WVDE and other partners, began disseminating the results throughout the state in early 2020. The AHI plans to again partner with WVDE to conduct new surveys in 2021. The OMCFH realizes the importance of sharing available data in a usable format so other stakeholders can identify and implement programming in addition to what the Office is able to support and conduct. Successful prevention activities require monitoring available so the Office may make appropriate adaptations when necessary.

Also, in 2019, the AHI began conducting youth needs assessments and Child PTSD Symptom Screeners in teen pregnancy prevention curriculum classes. To date, over 2,000 screeners and assessments have been conducted. The AHI will continue to collect data from these assessments throughout 2021 to identify youth needs, make necessary referrals for services and steer program efforts.

**Community based Adolescent Health Coordinators will identify and coordinate the implementation of research-based models for prevention of bullying and harassment in schools and other youth serving organizations.**

The AHI and the VIPP partnered to provide a statewide training on the *Green Dot* bystander program in 2015. The *Green Dot* strategy is a comprehensive bystander intervention that capitalizes on the power of peer and cultural influence across all levels of the socio-ecological model. Since that time, the AHI has worked with community and school partners to implement *Green Dot* but recognizes the *Green Dot* model is not the best fit for all schools. In the coming year the AHI will work with schools to expand evidence-based programming by identifying, providing the necessary training and implementing bystander and prevention interventions best suited for each school's needs.

In the Fall of 2017, the AHI partnered with the DHHR's Bureau for Behavioral Health and Health Facilities to certify all the regional AHCs as *Mental Health First Aid* instructors. The AHCs began trainings in FY2018 and expanded to offer graduate course credits through Concord University in FY2019. In addition to YMHFA, the AHCs offer trainings in Adverse Child Experiences (ACE) and Trauma Informed Schools evidence-based models. In FY2020, challenges with COVID19 not only changed the traditional training model but also prompted the retirement of 3 of the 8 regional AHCs. In the coming year, the AHI will seek the necessary training for new staff and will work with existing staff to develop virtual training programs.

Several years ago, the AHI partnered with the VIPP and the WV Foundation for Rape Information and Services (FRIS) to develop *WV's Sexual Violence Prevention Training and Resource Toolkit: A Guide for Working with School-Aged Children*, a comprehensive, 220-page set of evidence-based resources and strategies for preventing violence in school-aged children (Kindergarten through 12th grade). The AHI and FRIS have provided several toolkit trainings across the state since 2015 and will continue to do so in the coming year. In 2019, the WVDE began working with the *Prevention Collaborative* (a statewide coalition of violence prevention partners, including FRIS, VIPP and AHI) to develop a body safety toolkit for schools. In the coming year, the *Prevention Collaborative* will work to develop online training on utilizing the new toolkit. The toolkit can be found at: https://wvde.us/leadership-system-support/body-safety-and-sexual-abuse-prevention-toolkit/body-safety-education-toolkit/

**The VIPP will disseminate relevant data on the topic of non-fatal suicide trends for 12-17 year olds in the state.**

The Division of Infant, Child and Adolescent Health (ICAH) and its Violence and Injury Prevention Program (VIPP) are the current recipient of a CDC-funded cooperative agreement to develop surveillance and data dissemination for nonfatal suicide related outcomes, including intentional opioid overdose. WV is currently ranked 8th in the nation in suicide, and one of the leading causes of child fatality in our state is intentional injury/suicide, especially among adolescents.

Leveraging the work of the CDC Emergency Department Surveillance of Nonfatal Suicide Related Outcomes Cooperative Agreement (ED-SNSRO), the ICAH and its VIPP will disseminate ongoing data findings related to nonfatal adolescent suicide trends and counts to key state stakeholders in the area of adolescent health, including the: OMCFH Adolescent Health Initiative, OMCFH Adolescent Pregnancy Prevention Initiative, State Department of Education, Prevent Suicide WV (state suicide prevention coalition), WV Foundation for Rape Information and Services (state sexual assault coalition), and the Bureau for Behavioral Health (state substance abuse authority).

**Transition**

**Provide academic detailing to pediatric primary care physicians on the importance of adopting a transition policy including Got Transition's resources: Six Core Elements of Health Care Transition sample tools and measurements.**

The WV CSHCN Transition Improvement Charter was developed to increase the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care. The WV CSHCN Healthcare Transition Services is a systems-based service provided by the WV CSHCN Program. The purpose of WV Healthcare Transition Services is to ensure that children with special health care needs receive coordinated, comprehensive care within a medical home, as well as the needed services and supports to make transitions to adult life. Although the Charter was developed in 2018, opportunities exist to implement quality improvement and service redesign in ways that could fundamentally improve healthcare coordination services for WV children. To ensure these efforts are successful, there is a need to build and sustain the ability of pediatric primary care practices to engage in academic detailing on the importance of adopting a transition policy including Got Transition's resources: the Six Core Elements of Health Care Transition sample tools and measurements.

The CSHCN Healthcare Transition Improvement Team developed a Healthcare Transition Policy endorsed by the WV CSHCN MAB for use with the CSHCN Healthcare Transition Services as part of the medical provider practicum for the medical home. The CSHCN care coordinators utilize the development of the transition policy as a tool to elicit input from children and families and to educate all practice staff about the approach to transition, the policy, the Six Core Elements of Health Care Transition 3.0 and the distinct roles of the children, family, and pediatric and adult health care team in the transition process. The policy includes a transition time frame, an explanation of the practice's transition approach, and details the legal changes that take place in privacy and consent at age 18. Once the policy is complete at the practice level it is shared with children and families beginning at age 12 and publicly

posted. The policy also serves as a structure for practice evaluation.

The CSHCN Program will collaborate with the HealthCheck and the AAP to survey WV physicians to determine if a transition policy is utilized or if a best practice has been identified for the primary care practice. When education opportunities are identified the CSHCN Program will enlist WV HealthCheck who maintain a strong network of partnerships and collaborations among all healthcare systems to start a health care transition process. HealthCheck will disseminate materials to pediatricians across the state which will include the contact information for the regional CSHCN Care Coordinator who will introduce WV CSHCN Transition Services. The services include an introduction of an organized clinical process for pediatric practices to facilitate healthcare transition preparation, transfer of care, and integration into adult-centered care, as well as support and facilitation of a medical provider practicum with clinical tools intended to help educate the medical home and initiate transition services. Services materials disseminated by the WV HealthCheck Program will include the Got Transition Six Core Elements implementation guide and Got Transition Transitioning Youth to an Adult Health Care Clinician packet.

**Complete transitions readiness assessment for all enrolled CSHCN starting at age 14.**

Additionally, WV CSHCN Transition Services include the assessment of a child's readiness to transition to an adult approach to care using the got transition, Transition Readiness Assessment for Youth, a standardized transition/self-care assessment tool to engage children and families in setting health priorities, addressing self-care needs to prepare them for an adult approach to care at age 18, and navigating the adult health care system, including health insurance. CSHCN Program care coordinators use the results to develop with children, their families and the medical home, the CSHCN Program Plan of Care, Transition Plan. Using a monthly report identifying children that are 11 years 6 months of age, the CSHCN Program care coordinator contacts children in their caseload for enrollment in West Virginia CSHCN Healthcare Transition Services. The CSHCN Program care coordinator provides the Got Transition Readiness Assessment for Youth and the Transition Readiness Assessment for Parents/Caregivers for completion. The results are discussed at the transition appointment and a Transition Plan is developed. When receiving support from the West Virginia CSHCN Healthcare Transition Services team the child's medical home will be assessed for participation in the medical provider practicum. The CSHCN Program care coordinators will conduct regular transition readiness assessments and will be notified of children who are 11 years and 6 months old. The CSHCN Epidemiologist will identify enrolled CSHCN who have received a transition readiness assessment between the age of 11 years and 6 months and 12 years and 3 months or within 3 months after enrollment to the program if enrolled after the age of 12. CSHCN Program care coordinators will also be notified of children who have not received a transition readiness assessment within these parameters.

**Substance use in youth/teens.**

**Partner with medical providers to align with best practices in prescribing controlled substances to ensure optimum outcomes.**

In a cursory review of the 2018 NSCH, the prevalence of Attention Deficit Disorder (ADD) and Attention Deficit/Hyperactivity Disorder (ADHD) in WV is 15.8% for children age 3-17 (NCHS, Child and Family Health Measures, Indicator 2.7). However, in some WV counties with the highest rates of substance use disorder and resulting overdose fatality, prescribing data indicates that as many as 1 in 4 children in the same age range are currently prescribed a stimulant. Scholarly literature has shown a correlation between stimulant use in childhood and an increased potential for development of a substance use disorder in adulthood, especially in cases where stimulants are prescribed without an applicable corresponding mental health diagnosis. As WV leads the nation in opioid overdose fatality, this is a vitally important issue to the current and future health and viability of our state and its maternal and child health population.

In coordination with the WV Board of Pharmacy (BoP), the Division of Infant, Child and Adolescent Health (ICAH)

and its Violence and Injury Prevention Program (VIPP) will use data from the National Survey of Children's Health (NSCH) and the WV PDMP, also known as the Controlled Substance Monitoring Program (CSMP), to inform surveillance and corresponding outreach and education activities to increase the awareness of controlled substance use among adolescents ages 12-17. Consideration will be given to providing current best practice information to pediatric care providers about the potential future implications of stimulant use in adolescents, as well as internal work with our Title XIX agency to review and potentially improve medical review and prior authorization considerations for this vulnerable pediatric population. The ICAH and the VIPP will also solicit input and support for data and its dissemination from key stakeholders in adolescent health, including the: Governor's Early Childhood Advisory Council (ECAC), Governor's Advisory on Substance Use, OMCFH Pediatric Medial Advisory Board, OMCFH Adolescent Health Initiative, OMCFH Adolescent Pregnancy Prevention Initiative, State Department of Education, and Bureau for Behavioral Health (State Substance Abuse Authority).

**Provide educational information and resources to youth, parents, schools and the community about the harmful affects of drug abuse and misuse, safe storage and disposal of prescription medications and prescription monitoring in the home.**

In 2017, West Virginia began collecting data on adolescent prescription misuse on the Youth Risk Behavior Surveillance (YRBS) survey. When compared to the 2017 YRBS, the survey in 2019 shows a very small, but statistically insignificant decrease in prescription misuse among high school students (12.5% down to 11.7%). However, the data shows prescription misuse nearly doubled for middle school students from 2017 to 2019 (3.6% to 6.7%). While this is not enough data to be considered a trend, it is concerning. According to the Substance Abuse and Mental Health Administration (SAMHSA), prescription misuse is the fastest growing drug problem in the United States that is "profoundly affecting the lives of young people." (www.samhsa.gov/homelessness-programs-resources/hpr-resources/teen-prescription-drug-misuse-abuse) Nationally, prescription and over-the-counter drugs are the most commonly misused substances by Americans age 14 and older, after marijuana, alcohol, and tobacco cigarettes. (https://teens.drugabuse.gov/drug-facts/prescription-drugs#topic-5)

A common misperception is that prescription drugs are safer or less harmful than other kinds of drugs. However, there are short- and long-term health consequences that are particularly harmful to a developing adolescent brain and body. The prefrontal cortex (impulse control) and outer mantel (understanding rules/laws) of our brains continue to develop until we reach our early- to mid-twenties. Our brains are becoming hardwired during adolescence; negative behaviors developing into neuropathways (like addiction) can become lifelong problems.

Educating adolescents and their parents about the risks of drug misuse and abuse is a major component to combating the problem. Research shows 1 in 4 teenagers believe that prescription drugs can be used as a study aid and nearly one-third of parents believe that attention-deficit/hyperactivity disorder (ADHD) medication can improve a child's academic or testing performance, even if that child does not have ADHD. The Adolescent Health Initiative (AHI) will educate parents, children, schools and the community on the impact of prescription drugs not only on the developing brain but also adolescent behavior. As with any mind-altering drug, prescription drug misuse can affect judgment and inhibition, putting adolescents at greater risk for sexually transmitted infections, using illicit drugs and engaging in other risky behaviors.

Research also shows that two-thirds of teens who report abusing prescription medication get it from friends, family and acquaintances, including their home medicine cabinets. Providing education on proper storage and disposal is important to prevent misuse, not only in the home but in the community. (https://drugfree.org/prescription-over-the-counter-medicine/)

Prescription monitoring is also an important factor in preventing abuse. There has been increased legislation and public pressure requiring doctors and pharmacies to better monitor how (and how often) they prescribe drugs. While provider education is key to preventing over prescribing, prescription drugs must also be monitored in homes and the community. The AHI will educate parents, grandparents, school personnel and the community on how to safeguard their medications, monitor their use and prevent theft and/or misuse.

**Children with Special Health Care Needs**

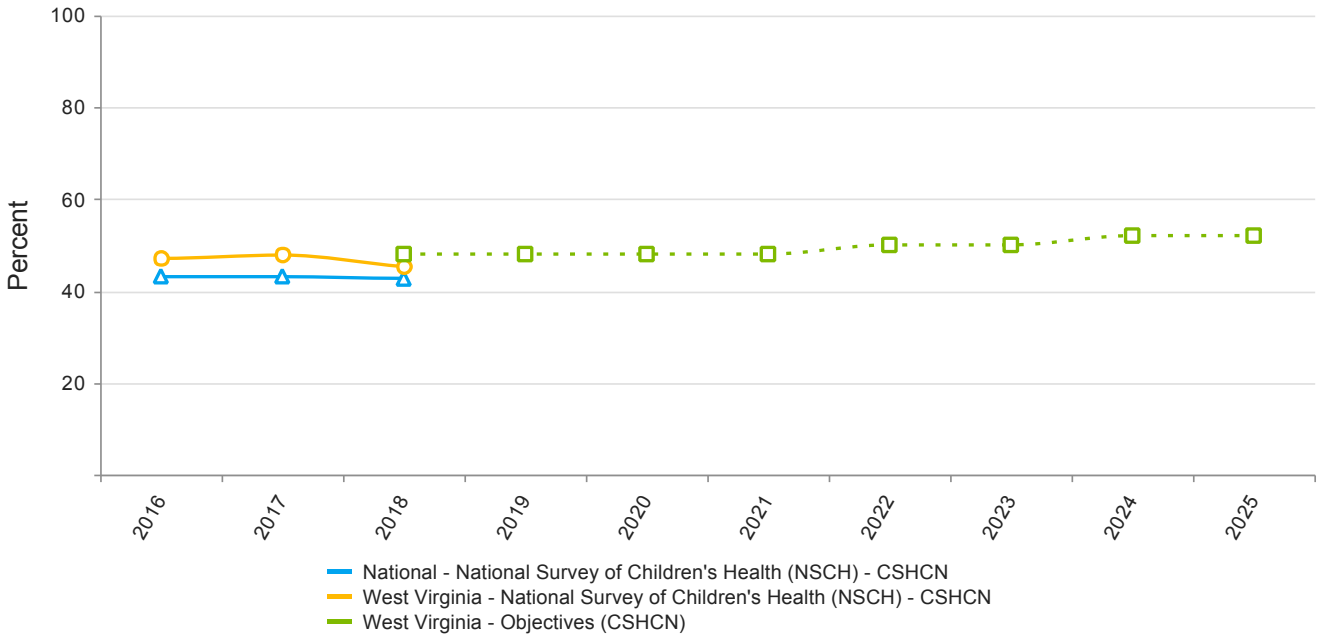
**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system | NSCH-2017_2018 | 18.7 % | NPM 11 |
| NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling | NSCH-2017_2018 | 49.3 % | NPM 11 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2017_2018 | 90.1 % | NPM 11 |
| NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year | NSCH-2017_2018 | 2.6 % | NPM 11 |

## National Performance Measures

**NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

**Indicators and Annual Objectives**




**NPM 11 - Children with Special Health Care Needs**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 48 | 48 |
| Annual Indicator | | 47.0 | 47.9 | 45.2 |
| Numerator | | 42,772 | 43,240 | 40,169 |
| Denominator | | 91,107 | 90,358 | 88,838 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 48.0 | 48.0 | 50.0 | 50.0 | 52.0 | 52.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 11.1 - Number of stakeholders who receive education and resources regarding the National Resource Center For Patient/Family-Centered Medical Home in the last calendar year.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | CSHCN |
| Data Source Year | 2019 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 3.0 | 7.0 | 7.0 | 7.0 | 7.0 |

**ESM 11.2 - Percent of well-child exams received by Medicaid members age 0-21 with a documented social determinants of health screening (as identified by claims data) in the last calendar year.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 30 |
| Numerator | 34,200 |
| Denominator | 114,000 |
| Data Source | Medicaid |
| Data Source Year | 2019 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 35.0 | 40.0 | 45.0 | 50.0 | 55.0 |

**ESM 11.3 - Number of children who receive Title V funded medially necessary medical foods.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 270 |
| Numerator | |
| Denominator | |
| Data Source | CSHCN |
| Data Source Year | 2019 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 290.0 | 310.0 | 330.0 | 350.0 | 370.0 |

**State Performance Measures**

**SPM 1 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 41.6 | 20 | 20 |
| Annual Indicator | 16.3 | 17 | 16.8 | 19.9 |
| Numerator | 3,240 | 3,380 | 22,582 | 25,058 |
| Denominator | 19,936 | 19,936 | 134,548 | 125,615 |
| Data Source | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2016 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 22.0 | 22.0 | 24.0 | 26.0 | 28.0 | 30.0 |

**State Action Plan Table**

State Action Plan Table (West Virginia) - Children with Special Health Care Needs - Entry 1

### Priority Need

Increase medical home for children with and without special health care needs.

### NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

### Objectives

The Division of Infant, Child and Family Health will work with partners to increase the percentage of children with and without special health care needs that have a medical home from 45.2% (CSHCN) and 49.3% (non CSHCN) in 2018 to 52% by 2025.

### Strategies

i. Educate stakeholders (CED, PPIE, HealthCheck, WV AAP) about the importance of PCMHs for families with CSHCN.

ii. Educate pediatric primary care providers to complete a social determinants of health screening at all well-child exams.

iii. Provide easily accessible, medically necessary nutrition services as a payer of last resort to improve access to care for CYSHCN.

| ESMs | Status |
|---|---|
| ESM 11.1 - Number of stakeholders who receive education and resources regarding the National Resource Center For Patient/Family-Centered Medical Home in the last calendar year. | Active |
| ESM 11.2 - Percent of well-child exams received by Medicaid members age 0-21 with a documented social determinants of health screening (as identified by claims data) in the last calendar year. | Active |
| ESM 11.3 - Number of children who receive Title V funded medially necessary medical foods. | Active |

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

## State Action Plan Table (West Virginia) - Children with Special Health Care Needs - Entry 2

### Priority Need

Increase in adolescents with and without special health care needs who receive services necessary to make transitions to adult health care.

### SPM

SPM 1 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

### Objectives

The Division of Infant, Child and Adolescent Health will increase the percentage of adolescents with and without special health care needs who received services necessary to make transitions to adult health care from 17% in 2016 to 30% by 2025.

### Strategies

i. Provide academic detailing to pediatric primary care physicians on the importance of adopting a transition policy including Got Transition's resources: the Six Core Elements of Health Care Transition sample tools and measurements.

ii. Complete transition readiness assessment for all enrolled CSHCN starting at age 14.

iii. Educate transition aged foster children on their entitlement to retain Medicaid coverage until age 26.

**2016-2020: National Performance Measures**

**Provide financial support to the Parent Partners in Education (PPIE) at the Marshall University School of Medicine and West Virginia University Centers for Excellence in Disabilities to administer the Project Delivery of Chronic Care (DOCC) curriculum to resident students and to expand this project to the West Virginia University School of Medicine.**

The CSHCN Program met with Project DOCC principal investigators during grant and statement of work development to discuss strategies to assess the long-term impact of Project DOCC training and curriculums. It was determined that a follow-up email survey would sufficiently gauge the incorporation of Project DOCC principals into the provider's practice, focusing on compliance with medical home best practice standards from the National Standards for Systems of Care for CYSHCN. Surveys are included in the 2020-2021 grant deliverables.

**Partner with WV HealthCheck to develop provider training regarding the National Standards for Systems of Care for CYSHCN for WV HealthCheck/EPSDT Providers.**

The National Standards for Systems of Care for CYSHCN provider training was developed and scheduling for the WV AAP winter meeting was discussed with stakeholders. Unfortunately, the WV AAP winter meeting was cancelled due to the public health response to COVID-19. Revision of OMCFH policies and procedures regarding inter-office program orientation continues.

**Develop a database to facilitate activity tracking among CSHCN Program care coordination teams and to support performance measure tracking and quality assurance/improvement efforts.**

Monitoring, improvement, and training will be ongoing to ensure the CSHCN Program's database is functional and comprehensive to meet the needs of the care coordinators to manage their caseloads. Numerous reports have been developed and incorporated into CTS to assist CSHCN Program staff in managing their caseloads. Efforts to develop performance measures and quality assurance monitoring activities in CTS are put on hold pending development of the program's new procedure.

The CSHCN Program epidemiologist has developed a report to provide program enrollment data to Medicaid from the new data system. This report has been provided to MIS and Medicaid's system administrator, DXC, to incorporate into their upload sequence and replace the existing report. This will allow the CSHCN Program to discontinue use of their antiquated and redundant mainframe application that previous acted as the program's sole data system.

**Title V agency will develop with partners and stakeholders a strategic plan for achieving medical homes for CSHCN.**

Employees of the OMCFH, Bureaus within the WV DHHR, CSHCN families and a pediatrician convened in an innovative Action Learning Collaborative (ALC) designed for state Title V / Children and Youth with Special Health Care Needs (CYSHCN) programs. The group participated in webinars developed by National Resource Center for Patient/Family-Centered Medical Home (NRC-PFCMH) and conducted literature reviews of best practices related to screening and identifying SDOH. Baseline SDoH screening data was obtained from a participating pediatric primary care office for four months and was reviewed by the group and submitted to the AAP for reporting. The group developed SDoH screener design principals and reviewed existing screening tools for compliance from

and with best practices. From this research, the group selected four priority SDoH domains from the six SDoH domains identified by the KFF: 1) food insecurity, 2) housing instability, 3) support systems and 4) economic stability. Over four working sessions, the group came to consensus on a recommended set of standardized SDOH screening questions and compiled a list of validated questions from the various existing tools under each identified domain.

The group began work on a physician agreement and researched value-based reimbursement models to support physicians in providing SDoH screening and follow-up services. The group continues to work on implementation of a SDoH Screening process as part of a strategic plan for achieving medical homes for CSHCN.

**Promote and provide care coordination services pursuant to the National Standards for Systems of Care for Children and Youth with Special Health Care Needs.**

The CSHCN Program will also support the completion of the 2019 parent/caregiver survey. A data sharing agreement will be finalized to ensure the implementation of the survey.

The CSHCN Director of Nursing continues to meet monthly with representatives from the Medicaid Managed Care Organizations in compliance with the Memorandum of Understanding developed to establish roles and responsibilities of the MCO and programs providing services for the purposes of addressing the interface in the delivery of services to children who are served by both to ensure coordination of services. Additionally, the CSHCN Program continues to participate with the AETNA/Mountain Health Promise Family Workgroup in development of the Family Connect a web-based portal created by Aetna where individuals and members of their care team can access medical information. The CSHCN Program provided samples of the CSHCN Plan of Care to the Workgroup for consideration and approval to share via Family Connect in support of the National Standards.

The CSHCN Program continues to provide funding to The WVU Center for Excellence in Disabilities (CED) through grant agreement and the Center serves as WV's Family to Family Health Information Center (F2FHIC). The Center continues to maintain five Parent Network Specialists (PNS) statewide whom are parents of a child with a disability or chronic medical condition, are certified in all seven courses of the Strengthening Families Protective Factors Framework and trained as Circle of Parents facilitators. Services provided by the PNS are recommended in the CSHCN Plan of Care and address the social and emotional competence of the child, information & resources on the various Triple P Stepping Stones parenting education opportunities, encourage participation in support group/parent networking services, extend information about local community events that are inclusive and promote health and fitness, and provide individualized assistance in building advocacy skills within community settings such as school and afterschool care. The Parent/Family Survey data share agreement is still in development and strategies other than a traditional on-line survey have been discussed and will be reviewed.

The CSHCN Program continues to promote the CSHCN Shared Plan of Care among all service providers as per the National Standards for Systems of Care for Children and Youth with Special Health Care Needs. Through a project management contract with Berry Dunn, CSHCN Program procedures continue to be developed to ensure internal and external clarity of care coordination responsibilities and ensure consistent implementation to target populations. The procedural manual when complete will be shared with those providing services to the CSHCN population in the form of a provider guide.

**In accordance with best practice standards, develop a shared plan of care for use by CSHCN Program care coordination teams, Medicaid Managed Care Organizations and the pediatric medical community.**

The CSHCN Program Administration team continues to build infrastructure and is developing a comprehensive quality assurance plan through a project management contract with Berry Dunn that includes the assessment of plans of care utilized in provider's offices to ascertain the extent to which minimum best practice standards are being met. The WV CSHCN Medical Home Improvement Team researched and reviewed value-based payment options for medical home services for those practices that would be identified as medical home ready. Research continues regarding the implementation of value-based reimbursement models to support physicians providing services within a patient-centered medical home model of care.

The CSHCN Program revised the WV CSHCN Screener to reflect changes to the National Survey of Children's Health and the Screener will be submitted AMCHP's Innovation Station as a best practice example for the next submission period.

Through a project management contract with Berry Dunn the CSHCN Program is researching and preparing for the procurement of a new care management solution that is web-based and capable of sharing plans of care among CSHCN, their families and the medical home. Additionally, through collaboration with WVU CED, the Family Center for CSHCN (http://wvcshcn.org/frontpage/) was developed and is ready for launch. The Family Center is a web-based resource center for families of CSHCN to meet via lunch-n-learns, blog and chat rooms, as well as explore resources.

**Children with Special Health Care Needs - Application Year**

**Medical Home**

**Educate stakeholders (CED, PPIE, HealthCheck, WV AAP) about the importance of PCMHs for families with CSHCN.**

To date, efforts by the West Virginia CSHCN Program have focused on providing care coordination and improving medical home for a relatively small and targeted population of CYSHCN. However, these efforts proved unsuccessful to increase the percent of children in the state who identify as having a medical home. Moving forward, the WV CSHCN Program intends to broaden its efforts to increase the number of pediatric providers who deliver care in a patient-centered medical home (PCMH). By targeting providers offices, the CSHCN Program can increase the number of children receiving comprehensive, coordinated, patient-centered care in a medical home. The CSHCN Program will take three-pronged approach to achieve this goal by educating stakeholders to advocate for a PCMH, educating the medical community on the importance of completing a social determinants of health screening at all well-child exams, and administering quality assurance and improvement initiatives.

As of 2018, there were only 20 HRSA recognized PCMH practices in West Virginia (https://bphc.hrsa.gov/uds/datacenter.aspx?year=2018&state=WV). There are an estimated 128 pediatric primary care practices in the state. To address this gap, the CSHCN Program will utilize materials from HRSA, the AAP, and the National Resource Center for Patient/Family-Centered Medical Home to develop educational materials outlining the importance of the PCMH for all children, specifically CYSHCN. These educational materials will include the benefits of the PCMH model, HRSA's PCMH recognition process, and incentives for obtaining HRSA's PCMH recognition. The CSHCN will seek opportunities to share these educational materials with other stakeholders and partner agencies who can in turn share them directly with providers. These stakeholders will include the West Virginia University Center for Excellence in Disabilities, Parent Partners in Education at Marshall University, the West Virginia HealthCheck program, the West Virginia chapter of the AAP, the West Virginia Primary Care Association, along with any others that are identified. The expectation is that these stakeholders will share this information with pediatric primary care providers in their networks. In addition to these educational opportunities, the CSHCN Program will survey pediatric primary care providers on their knowledge of HRSA's PCMH recognition. This survey will also include a basic assessment of the primary tenants of the PCMH to identify practices who may be in compliance without seeking the recognition.

**Educate pediatric primary care providers to complete a social determinants of health screening at all well-child exams.**

Screening for and addressing social determinants of health (SDOH) at both the patient and population level within the practice are central to the PCHM recognition process. Anecdotally, the CSHCN Program has noticed inconsistencies in methods for screening for SDOH. To address these inconsistencies, the CSHCN Program will identify and/or develop a comprehensive screening tool to assess SDOH. This screening tool will incorporate suggested action items to address any identified negative SDOH. The CSHCN Program will create training and educational materials regarding SDOH screening and best practices to share with stakeholders. In addition to these trainings, the CSHCN Program will mail training materials and the screening tool to pediatric primary care provider and will partner with HealthCheck to follow-up with academic detailing to these offices.

**Provide easily accessible, medically necessary nutrition services as a payer of last resort to improve access to care for CYSHCN.**

The CSHCN Program will continue to coordinate with the Medicaid MCOs and Medicaid's EPSDT benefit to ensure children receive medically necessary medical foods. The CSHCN Program will also continue to utilize Title V funding to provide medically necessary medical foods as a payor of last resort. Historically, medical foods are thought of as supplemental, and therefore optional. The CSHCN Program has successfully advocated for a shift in this paradigm and has obtained coverage for medically necessary medical foods by the MCOs and through the child's Medicaid EPSDT benefit. Initially, this coverage was limited to children who receive complete enteral nutrition through a feeding tube. However, the CSHCN Program has been successful in onboarding two of the four MCOs to broaden their medical necessity standard beyond complete enteral nutrition through a feeding tube. The CSHCN Program will work to educate insurance providers on the medical necessity of medical foods for this population using the National Standards of Care for CYSHCN definition of medical necessity: "the prevention, diagnosis, and treatment of an

enrollee's disease, condition, and/or disorder that results in health impairments and disability; the ability for an individual to achieve age-appropriate growth and development; the ability for an enrollee to attain, maintain, and retain functional capacity…"( http://cyshcnstandards.amchp.org/app-national-standards/#/)

**Transition**

**Provide academic detailing to pediatric primary care physicians on the importance of adopting a transition policy including Got Transition's resources: the Six Core Elements of Health Care Transition sample tools and measurements.**

The WV CSHCN Transition Improvement Charter was developed to increase the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care. The WV CSHCN Healthcare Transition Services is a systems-based service provided by the WV CSHCN Program. The purpose of WV Healthcare Transition Services is to ensure that children with special health care needs receive coordinated, comprehensive care within a medical home, as well as the needed services and supports to make transitions to adult life. Although the Charter was developed in 2018, opportunities exist to implement quality improvement and service redesign in ways that could fundamentally improve healthcare coordination services for WV children. To ensure these efforts are successful, there is a need to build and sustain the ability of pediatric primary care practices to engage in academic detailing on the importance of adopting a transition policy including Got Transition's resources: the Six Core Elements of Health Care Transition sample tools and measurements.

The CSHCN Healthcare Transition Improvement Team developed a Healthcare Transition Policy endorsed by the WV CSHCN MAB for use with the CSHCN Healthcare Transition Services as part of the medical provider practicum for the medical home. The CSHCN care coordinators utilize the development of the transition policy as a tool to elicit input from children and families and to educate all practice staff about the approach to transition, the policy, the Six Core Elements of Health Care Transition 3.0 and the distinct roles of the children, family, and pediatric and adult health care team in the transition process. The policy includes a transition time frame, an explanation of the practice's transition approach, and details the legal changes that take place in privacy and consent at age 18. Once the policy is complete at the practice level it is shared with children and families beginning at age 12 and publicly posted. The policy also serves as a structure for practice evaluation.

The CSHCN Program will collaborate with the HealthCheck and the AAP to survey WV physicians to determine if a transition policy is utilized or if a best practice has been identified for the primary care practice. When education opportunities are identified the CSHCN Program will enlist WV HealthCheck who maintain a strong network of partnerships and collaborations among all healthcare systems to start a health care transition process. HealthCheck will disseminate materials to pediatricians across the state which will include the contact information for the regional CSHCN Care Coordinator who will introduce WV CSHCN Transition Services. The services include an introduction of an organized clinical process for pediatric practices to facilitate healthcare transition preparation, transfer of care, and integration into adult-centered care, as well as support and facilitation of a medical provider practicum with clinical tools intended to help educate the medical home and initiate transition services. Services materials disseminated by the WV HealthCheck Program will include the Got Transition Six Core Elements implementation guide and Got Transition Transitioning Youth to an Adult Health Care Clinician packet.

**Complete transition readiness assessment for all enrolled CSHCN starting at age 14.**

Additionally, WV CSHCN Transition Services include the assessment of a child's readiness to transition to an adult approach to care using the got transition, Transition Readiness Assessment for Youth, a standardized transition/self-care assessment tool to engage children and families in setting health priorities, addressing self-care needs to prepare them for an adult approach to care at age 18, and navigating the adult health care system, including health insurance. CSHCN Program care coordinators use the results to develop with children, their families and the medical home, the CSHCN Program Plan of Care, Transition Plan. Using a monthly report identifying children that are 11 years 6 months of age, the CSHCN Program care coordinator contacts children in their caseload for enrollment in West Virginia CSHCN Healthcare Transition Services. The CSHCN Program care coordinator provides the Got Transition Readiness Assessment for Youth and the Transition Readiness Assessment for Parents/Caregivers for completion. The results are discussed at the transition appointment and a Transition Plan is developed. When receiving support from the West Virginia CSHCN Healthcare Transition Services team the child's medical home will be assessed for participation in the medical provider practicum. The CSHCN Program care coordinators will conduct regular transition readiness assessments and will be notified of children who are 11 years

and 6 months old. The CSHCN Epidemiologist will identify enrolled CSHCN who have received a transition readiness assessment between the age of 11 years and 6 months and 12 years and 3 months or within 3 months after enrollment to the program if enrolled after the age of 12. CSHCN Program care coordinators will also be notified of children who have not received a transition readiness assessment within these parameters.

**Educate transition aged foster children on their entitlement to retain Medicaid coverage until age 26.**

Through implementation of CSHCN Transition Services, a Transition Readiness Assessment or Self-Care Assessment is completed by those children eligible for services. The assessments address medical benefit comprehension. As needed, the WV Former Foster Children program is reviewed when required. Those eligible for this benefit must be under 26 years of age; were in foster care under the responsibility of the State of West Virginia and receiving Medicaid on the date of attaining 18 years of age, or the date they aged out of foster care, up to age 21; and not, eligible for another categorically mandatory coverage group (SSI, Deemed SSI, Parents/Caretaker Relatives, Pregnant Women, Children Under 19). There is no income or asset test to receive services. Additionally, children transitioning out of foster care ages 18-20 are referred to the WVU CED PNS for referral to the Mentoring with Oversight for Developing Independence with Foster Youth Program (MODIFY).

### Cross-Cutting/Systems Building

### Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

### Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

### III.F. Public Input

The Office formally makes its Application and Annual report available for review by the public on its website. Through this process, the Office receives requests for additional information from partner organizations, but input from the public is more limited through these venues.

To enhance input and feedback for its operations, the Office both coordinates and participates on numerous advisory boards throughout the year. Stakeholder input is continuously sought for program planning and quality improvement.

Input from stakeholder meetings is used to inform the development of the Application and Annual Report. Input was gathered from the following stakeholders within the five population domains:

| Domain | Stakeholders |
|---|---|
| Women and Maternal Health | Perinatal Partnership<br>Infant and Maternal Mortality Review Panel<br>Maternal Risk Screening Advisory<br>Perinatal and Women's Health Medical Advisory Committee |
| Perinatal and Infant Health | Perinatal Partnership<br>Newborn Metabolic Screening Advisory<br>Core Team for Substance Exposed Infants<br>Infant and Maternal Mortality Review Panel<br>Maternal Risk Screening Advisory |
| Child Health | Pediatric Medical Advisory Board<br>Child Fatality Review Board<br>Bureau for Children and Families<br>Family Resource Networks<br>WV Department of Education<br>WV Kids and Families Coalition<br>Governor's Early Childhood Planning Task Force |
| Children with Special Health Care Needs | WVU Center for Excellence in Disabilities<br>CSHCN Medical Advisory Board<br>Family Voices<br>Family to Family Health Information Center<br>Developmental Disability Council<br>WV Early Intervention Interagency Coordinating Council<br>Statewide Transition Committee<br>Early Childhood Advisory Council<br>West Virginia Advocates<br>West Virginia Parent Training and Information<br>Emergency Medical Services for Children<br>Parent Partners in Education<br>Commission for the Deaf and Hard of Hearing |
| Adolescent Health | Pediatric Medical Advisory Board<br>WV Suicide Prevention Council<br>West Virginia Violence and Injury Prevention Network<br>Key Players for Sexual Violence Prevention<br>Leadership to Prevent Teen Pregnancy Task Force<br>County level Substance Abuse Task Force<br>Governor's Substance Abuse Coalitions |

Over the past year, formal discussions were conducted with select stakeholder groups to ensure diverse input into the Application and Annual Report. These sessions were conducted with the Perinatal Partnership (covering the

women/maternal health and perinatal/infant health domains), the Pediatric Medical Advisory Board (covering the child health and adolescent health domains), West Virginia University Centers for Excellence in Disabilities (covering the cshcn domain), and the Children with Special Health Care Needs Medical Advisory Board.

In addition, the Office of Maternal, Child and Family Health Family Advisory group conducted meetings in West Hamlin, Clarksburg, Martinsburg, Beckley and Benwood. These gatherings invited, via e-mail and US Mail, program participants from the respective regions to gather and discuss the positives, as well as the short coming of the various OMCFH program. An overview of any new initiatives was presented, while WVU CED moderated the discussion period of the meeting to detail any issue or concern that were voiced. The plan going forward is to continue to have Family Advisory group meetings 6 times per year, each time in a different region of the state.

### III.G. Technical Assistance

The OMCFH may seek assistance in working with local, state and federal partners to address health inequity to improve the health of all minority populations, including socio-economic disparities, racial and ethnic minorities, people with disabilities, sexual and gender minorities, and because of the state's geography, rural populations. This assistance is especially needed to determine how best to communicate the demographic makeup of the state, nearly 94% white non-Hispanic, in relation to describing the inequity, or lack thereof, among the populations mentioned. It is difficult to explain how the small numbers, such as black maternal deaths, when reported even as a multi-yearly rate seems extremely higher than white maternal deaths. For example, from 2007 to 2017 there was only one black pregnancy related maternal death. Guidance on how to best communicate this language to the general public would be most helpful.

## IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - 2021 MCH Block Grant.pdf

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - 2020-2021-OMCFH ADVISORIES.pdf

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - WV Org Charts 2020.pdf

## VII. Appendix

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## Form 2
## MCH Budget/Expenditure Details

**State: West Virginia**

| | FY 21 Application Budgeted | |
|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 6,176,181 | |
| A. Preventive and Primary Care for Children | $ 2,166,784 | (35%) |
| B. Children with Special Health Care Needs | $ 1,852,961 | (30%) |
| C. Title V Administrative Costs | $ 460,678 | (7.5%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 4,480,423 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 13,272,503 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 0 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 21,193,138 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 34,465,641 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 4,362,527 | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 40,641,822 | |
| 9. OTHER FEDERAL FUNDS<br>Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2. | | |
| 10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9) | $ 29,431,884 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 70,073,706 | |

| OTHER FEDERAL FUNDS | FY 21 Application Budgeted |
|---|---|
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) | $ 100,000 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program | $ 291,198 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS) | $ 135,510 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program | $ 330,349 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs) | $ 458,227 |
| Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning | $ 2,021,000 |
| US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA) | $ 2,333,044 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants | $ 5,885,415 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention | $ 235,000 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 262,411 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant | $ 120,000 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF) | $ 1,717,445 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP) | $ 1,875,468 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program | $ 600,000 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control | $ 7,479,323 |

| OTHER FEDERAL FUNDS | FY 21 Application Budgeted |
|---|---|
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program | $ 370,000 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health | $ 400,000 |
| Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs | $ 4,817,494 |

| | FY 19 Annual Report Budgeted | | FY 19 Annual Report Expended | |
|---|---|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 6,056,026 | | $ 6,055,641 | |
| A. Preventive and Primary Care for Children | $ 2,329,844 | (38.5%) | $ 2,257,243 | (37.2%) |
| B. Children with Special Health Care Needs | $ 2,215,121 | (36.6%) | $ 1,844,179 | (30.4%) |
| C. Title V Administrative Costs | $ 528,103 | (8.7%) | $ 529,803 | (8.8%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 5,073,068 | | $ 4,631,225 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 13,264,963 | | $ 12,629,175 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 0 | | $ 0 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 19,282,861 | | $ 19,526,885 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 32,547,824 | | $ 32,156,060 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 4,362,527 | | | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 38,603,850 | | $ 38,211,701 | |
| 9. OTHER FEDERAL FUNDS<br>Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2. | | | | |
| 10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9) | $ 27,916,986 | | $ 22,293,910 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 66,568,241 | | $ 60,505,611 | |

| OTHER FEDERAL FUNDS | FY 19 Annual Report Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 265,709 | $ 202,049 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF) | $ 2,231,162 | $ 877,624 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enhanced State Opioid Overdose Surveillance | $ 455,472 | $ 70,209 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP) | $ 2,132,302 | $ 1,312,750 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS) | $ 135,510 | $ 89,273 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose: Prevention for States Program | $ 2,217,897 | $ 1,257,183 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant | $ 101,431 | $ 111,414 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program | $ 27,702 | $ 195,558 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs) | $ 196,480 | $ 164,549 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program | $ 310,600 | $ 257,128 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program | $ 898,913 | $ 534,576 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Zika Surveillance Systems Grant Program | $ 173,783 | $ 256,650 |

| OTHER FEDERAL FUNDS | FY 19 Annual Report Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Early and Periodic Screening, Diagnosis & Treatment (EPSDT) | $ 1,275,000 | $ 910,892 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Children's Oral Care Access Program | $ 275,033 | $ 107,669 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants | $ 6,231,476 | $ 7,491,821 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health | $ 500,000 | $ 658,138 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention | $ 89,125 | $ 95,962 |
| Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning | $ 3,092,000 | $ 2,336,279 |
| Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH | $ 722,800 | $ 405,241 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program | $ 394,324 | $ 405,897 |
| Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs | $ 3,828,201 | $ 2,151,050 |
| US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA) | $ 2,262,066 | $ 2,192,356 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) | $ 100,000 | $ 96,635 |
| Department of Justice > Office of Violence Against Women > ARREST | | $ 113,007 |

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Federal Allocation, B. Children with Special Health Care Needs:** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |

**Field Note:**
Birth to Three received a settlement of more than expected, so a decrease in the required funds were needed in Birth to Three.

**Data Alerts: None**

## Form 3a
## Budget and Expenditure Details by Types of Individuals Served

**State: West Virginia**

### I. TYPES OF INDIVIDUALS SERVED

| IA. Federal MCH Block Grant | FY 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 192,965 | $ 195,474 |
| 2. Infants < 1 year | $ 404,500 | $ 299,885 |
| 3. Children 1 through 21 Years | $ 2,166,784 | $ 2,257,243 |
| 4. CSHCN | $ 1,852,961 | $ 1,844,179 |
| 5. All Others | $ 1,098,293 | $ 929,057 |
| Federal Total of Individuals Served | $ 5,715,503 | $ 5,525,838 |

| IB. Non-Federal MCH Block Grant | FY 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 948,212 | $ 583,697 |
| 2. Infants < 1 year | $ 492,699 | $ 138,382 |
| 3. Children 1 through 21 Years | $ 839,801 | $ 900,424 |
| 4. CSHCN | $ 10,000,449 | $ 10,244,778 |
| 5. All Others | $ 383,321 | $ 591,581 |
| Non-Federal Total of Individuals Served | $ 12,664,482 | $ 12,458,862 |
| Federal State MCH Block Grant Partnership Total | $ 18,379,985 | $ 17,984,700 |

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

None

**Data Alerts: None**

## Form 3b
## Budget and Expenditure Details by Types of Services

**State: West Virginia**

### II. TYPES OF SERVICES

| IIA. Federal MCH Block Grant | FY 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 1,555,926 | $ 1,512,404 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 192,965 | $ 195,474 |
| B. Preventive and Primary Care Services for Children | $ 0 | $ 0 |
| C. Services for CSHCN | $ 1,362,961 | $ 1,316,930 |
| 2. Enabling Services | $ 490,000 | $ 527,249 |
| 3. Public Health Services and Systems | $ 4,130,255 | $ 4,015,988 |
| 4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service | | |
| Pharmacy | | $ 4,331 |
| Physician/Office Services | | $ 264,181 |
| Hospital Charges (Includes Inpatient and Outpatient Services) | | $ 0 |
| Dental Care (Does Not Include Orthodontic Services) | | $ 0 |
| Durable Medical Equipment and Supplies | | $ 0 |
| Laboratory Services | | $ 0 |
| Other | | |
| Personnel/travel/subrecipients | | $ 1,243,892 |
| Direct Services Line 4 Expended Total | | $ 1,512,404 |
| **Federal Total** | $ 6,176,181 | $ 6,055,641 |

| IIB. Non-Federal MCH Block Grant | FY 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 1,417,272 | $ 721,057 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 948,212 | $ 583,697 |
| B. Preventive and Primary Care Services for Children | $ 0 | $ 0 |
| C. Services for CSHCN | $ 469,060 | $ 137,360 |
| 2. Enabling Services | $ 27,972,934 | $ 27,841,888 |
| 3. Public Health Services and Systems | $ 5,075,435 | $ 3,589,452 |
| 4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service | | |
| Pharmacy | | $ 2,563 |
| Physician/Office Services | | $ 71,059 |
| Hospital Charges (Includes Inpatient and Outpatient Services) | | $ 236,640 |
| Dental Care (Does Not Include Orthodontic Services) | | $ 0 |
| Durable Medical Equipment and Supplies | | $ 0 |
| Laboratory Services | | $ 0 |
| Other | | |
| subrecipients, case and client services | | $ 410,795 |
| Direct Services Line 4 Expended Total | | $ 721,057 |
| **Non-Federal Total** | $ 34,465,641 | $ 32,152,397 |

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

None

## Form 4
## Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

**State: West Virginia**

**Total Births by Occurrence: 19,006** **Data Source Year: 2019**

**1. Core RUSP Conditions**

| Program Name | (A) Aggregate Total Number Receiving at Least One Screen | (B) Aggregate Total Number Presumptive Positive Screens | (C) Aggregate Total Number Confirmed Cases | (D) Aggregate Total Number Referred for Treatment |
|---|---|---|---|---|
| Core RUSP Conditions | 18,212 (95.8%) | 158 | 19 | 19 (100.0%) |

| Program Name(s) | | | | |
|---|---|---|---|---|
| 3-Hydroxy-3-Methyglutaric Aciduria | 3-Methylcrotonyl-Coa Carboxylase Deficiency | Argininosuccinic Aciduria | Biotinidase Deficiency | Carnitine Uptake Defect/Carnitine Transport Defect |
| Citrullinemia, Type I | Classic Galactosemia | Classic Phenylketonuria | Congenital Adrenal Hyperplasia | Cystic Fibrosis |
| Glutaric Acidemia Type I | Holocarboxylase Synthase Deficiency | Homocystinuria | Isovaleric Acidemia | Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency |
| Maple Syrup Urine Disease | Medium-Chain Acyl-Coa Dehydrogenase Deficiency | Methylmalonic Acidemia (Cobalamin Disorders) | Methylmalonic Acidemia (Methylmalonyl-Coa Mutase) | Primary Congenital Hypothyroidism |
| Propionic Acidemia | S, ßeta-Thalassemia | S,C Disease | S,S Disease (Sickle Cell Anemia) | Severe Combined Immunodeficiences |
| ß-Ketothiolase Deficiency | Trifunctional Protein Deficiency | Tyrosinemia, Type I | Very Long-Chain Acyl-Coa Dehydrogenase Deficiency | X-Linked Adrenoleukodystrophy |

### 2. Other Newborn Screening Tests

| Program Name | (A) Number Receiving at Least One Screen | (B) Number Presumptive Positive Screens | (C) Number Confirmed Cases | (D) Number Referred for Treatment |
|---|---|---|---|---|
| CCHD Critical Congenital Heart Disease | 17,130 (90.1%) | 29 | 0 | 0 (0%) |
| Newborn Hearing Screening | 18,509 (97.4%) | 619 | 10 | 10 (100.0%) |

### 3. Screening Programs for Older Children & Women

None

### 4. Long-Term Follow-Up

Long-term follow-up is provided through West Virginia University Pediatrics/Genetics for those with genetic conditions and by the Office of Maternal, Child and Family Health for those needing metabolic formulas/supplements for PKU, Tyrosinemia and Organic Acidemia disorders.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Total Births by Occurrence** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total Births by Occurrence Notes** |
| | **Field Note:** 2019 preliminary Vital Statistics | |
| 2. | **Field Name:** | **Data Source Year** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Data Source Year Notes** |
| | **Field Note:** 2019 State Lab newborn screening results | |
| 3. | **Field Name:** | **Core RUSP Conditions - Confirmed Cases** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:** only includes 2019 resident infants with confirmed conditions,does not include variants, carriers or traits | |
| 4. | **Field Name:** | **CCHD Critical Congenital Heart Disease - Receiving At Least One Screen** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** 2019 Birth Score data - occurrence births | |
| 5. | **Field Name:** | **CCHD Critical Congenital Heart Disease - Positive Screen** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** does not include those not screened (1396) or picked up prenatally | |
| 6. | **Field Name:** | **CCHD Critical Congenital Heart Disease - Confirmed Cases** |
| | **Fiscal Year:** | **2019** |

| | | |
|---|---|---|
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** none of the 29 presumptive positive screens were confirmed positive | |
| 7. | **Field Name:** | **CCHD Critical Congenital Heart Disease - Referred For Treatment** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** none needing referral for treatment | |
| 8. | **Field Name:** | **Newborn Hearing Screening - Receiving At Least One Screen** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** 2019 Birth Score data - occurrence births | |
| 9. | **Field Name:** | **Newborn Hearing Screening - Positive Screen** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** 2019 NHS data. Not passed but does not include not screened (408). | |
| 10. | **Field Name:** | **Newborn Hearing Screening - Confirmed Cases** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** Documented hearing loss | |
| 11. | **Field Name:** | **Newborn Hearing Screening - Referred For Treatment** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** 10 referred to EI includes 4 enrolled in EI | |

**Data Alerts: None**

## Form 5
## Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

**State: West Virginia**

**Annual Report Year 2019**

### Form 5a – Count of Individuals Served by Title V
### (Direct & Enabling Services Only)

| | | Primary Source of Coverage | | | | |
|---|---|---|---|---|---|---|
| Types Of Individuals Served | (A) Title V Total Served | (B) Title XIX % | (C) Title XXI % | (D) Private / Other % | (E) None % | (F) Unknown % |
| 1. Pregnant Women | 15,403 | 48.0 | 0.0 | 50.0 | 2.0 | 0.0 |
| 2. Infants < 1 Year of Age | 16,361 | 48.0 | 0.0 | 50.0 | 2.0 | 0.0 |
| 3. Children 1 through 21 Years of Age | 241,706 | 43.0 | 0.0 | 53.0 | 4.0 | 0.0 |
| 3a. Children with Special Health Care Needs | 49,966 | 58.0 | 0.0 | 36.0 | 6.0 | 0.0 |
| 4. Others | 48,746 | 21.0 | 0.0 | 71.0 | 8.0 | 0.0 |
| Total | 322,216 | | | | | |

### Form 5b – Total Percentage of Populations Served by Title V
### (Direct, Enabling, and Public Health Services and Systems)

| Populations Served by Title V | Reference Data | Used Reference Data? | Denominator | Total % Served | Form 5b Count (Calculated) | Form 5a Count |
|---|---|---|---|---|---|---|
| 1. Pregnant Women | 18,248 | Yes | 18,248 | 94 | 17,153 | 15,403 |
| 2. Infants < 1 Year of Age | 19,038 | Yes | 19,038 | 98 | 18,657 | 16,361 |
| 3. Children 1 through 21 Years of Age | 434,939 | Yes | 434,939 | 70 | 304,457 | 241,706 |
| 3a. Children with Special Health Care Needs | 106,778 | Yes | 106,778 | 57 | 60,863 | 49,966 |
| 4. Others | 1,353,022 | Yes | 1,353,022 | 24 | 324,725 | 48,746 |

**Form Notes for Form 5:**

None

**Field Level Notes for Form 5a:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women Total Served** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:** includes MCH Maternity Services, Maternal Risk Screening and all positive pregnancy tests referred to RFTS from Medicaid | |
| 2. | **Field Name:** | **Infants Less Than One YearTotal Served** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:** includes infants with abnormal/unacceptable newborn screens, infants who failed/not screened newborn hearing, CSHCN infants, Birth Score referrals and EPSDT/HealthCheck infant visits | |
| 3. | **Field Name:** | **Children 1 through 21 Years of Age** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:** includes EPSDT/HealthCheck, childhood lead poisoning elevated levels, Adolescent Health Initiative participants, oral health clients and family planning clients | |
| 4. | **Field Name:** | **Children with Special Health Care Needs** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:** includes CSHCN, BTT and children with disabilities | |
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:** includes family planning for males (any age) and females over the age of 21, BCCSP and WISEWOMAN clients | |

**Field Level Notes for Form 5b:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:** includes MCH Maternity Services, Maternal Risk Screening, all positive pregnancy tests referred to RFTS from Medicaid, all Home Visitation programs and WIC | |
| 2. | **Field Name:** | **InfantsLess Than One Year** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:** includes newborn screening (metabolic, hearing CCHD), CSHCN infants, Birth Score referrals, EPSDT/HealthCheck, WIC, immunizations and education outreach | |
| 3. | **Field Name:** | **Children 1 Through 21 Years of Age** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:** includes all Home Visitation programs, EPSDT/HealthCheck, childhood lead poisoning, Adolescent Health Initiative, oral health, family planning, WIC and students enrolled in state school systems | |
| 4. | **Field Name:** | **Children With Special Health Care Needs** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:** includes CSHCN, BTT, children with disabilities and children enrolled in special education with the state school systems | |
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:** includes family planning for males (any age) and females over the age of 21, BCCSP and WISEWOMAN clients, WIC, all Home Visitation programs and education outreach | |

**Data Alerts: None**

## Form 6
## Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

**State: West Virginia**

**Annual Report Year 2019**

### I. Unduplicated Count by Race/Ethnicity

| | (A) Total | (B) Non-Hispanic White | (C) Non-Hispanic Black or African American | (D) Hispanic | (E) Non-Hispanic American Indian or Native Alaskan | (F) Non-Hispanic Asian | (G) Non-Hispanic Native Hawaiian or Other Pacific Islander | (H) Non-Hispanic Multiple Race | (I) Other & Unknown |
|---|---|---|---|---|---|---|---|---|---|
| 1. Total Deliveries in State | 19,401 | 17,647 | 646 | 360 | 21 | 112 | 77 | 429 | 109 |
| Title V Served | 18,432 | 16,765 | 614 | 342 | 20 | 106 | 73 | 408 | 104 |
| Eligible for Title XIX | 12,612 | 11,471 | 420 | 234 | 14 | 73 | 50 | 279 | 71 |
| 2. Total Infants in State | 19,245 | 17,018 | 761 | 387 | 42 | 176 | 8 | 853 | 0 |
| Title V Served | 18,282 | 16,167 | 723 | 368 | 40 | 167 | 7 | 810 | 0 |
| Eligible for Title XIX | 12,509 | 11,062 | 495 | 252 | 27 | 114 | 5 | 554 | 0 |

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **1. Total Deliveries in State** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total** |
| | **Field Note:**<br>2018 preliminary vital statistics data - occurrence births - total 19,041 births - Hispanic counts not deducted from each race count (360 Hispanic could be of any race) | |
| 2. | **Field Name:** | **1. Title V Served** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total** |
| | **Field Note:**<br>calculated at 95% | |
| 3. | **Field Name:** | **1. Eligible for Title XIX** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total** |
| | **Field Note:**<br>calculated at 65% | |
| 4. | **Field Name:** | **2. Total Infants in State** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total** |
| | **Field Note:**<br>2018 preliminary vital statistics data - resident infants | |
| 5. | **Field Name:** | **2. Title V Served** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total** |
| | **Field Note:**<br>calculated at 95% | |
| 6. | **Field Name:** | **2. Eligible for Title XIX** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total** |
| | **Field Note:**<br>calculated at 65% | |

## Form 7
## State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

**State: West Virginia**

| A. State MCH Toll-Free Telephone Lines | 2021 Application Year | 2019 Annual Report Year |
|---|---|---|
| 1. State MCH Toll-Free "Hotline" Telephone Number | (800) 642-8522 | (800) 642-8522 |
| 2. State MCH Toll-Free "Hotline" Name | WV OMCFH | WV OMCFH |
| 3. Name of Contact Person for State MCH "Hotline" | Kristian Ball | Kristian Ball |
| 4. Contact Person's Telephone Number | (304) 558-5388 | (304) 558-5388 |
| 5. Number of Calls Received on the State MCH "Hotline" | | 13,922 |

| B. Other Appropriate Methods | 2021 Application Year | 2019 Annual Report Year |
|---|---|---|
| 1. Other Toll-Free "Hotline" Names | | |
| 2. Number of Calls on Other Toll-Free "Hotlines" | | |
| 3. State Title V Program Website Address | http://www.wvdhhr.org.mcfh/ | http://www.wvdhhr.org/mcfh/ |
| 4. Number of Hits to the State Title V Program Website | | 89,301 |
| 5. State Title V Social Media Websites | | |
| 6. Number of Hits to the State Title V Program Social Media Websites | | |

**Form Notes for Form 7:**

None

## Form 8
## State MCH and CSHCN Directors Contact Information

**State: West Virginia**

| 1. Title V Maternal and Child Health (MCH) Director | |
|---|---|
| Name | James Jeffries |
| Title | OMCFH Director |
| Address 1 | 350 Capitol St |
| Address 2 | Room 427 |
| City/State/Zip | Charleston / WI / 25301 |
| Telephone | (304) 558-5388 |
| Extension | |
| Email | James.E.Jeffries@wv.gov |

| 2. Title V Children with Special Health Care Needs (CSHCN) Director | |
|---|---|
| Name | Teresa |
| Title | Marks |
| Address 1 | 350 Capitol St |
| Address 2 | Room 427 |
| City/State/Zip | Charleston / WV / 25301 |
| Telephone | (304) 558-5388 |
| Extension | |
| Email | Teresa.D.Marks@wv.gov |

| 3. State Family or Youth Leader (Optional) | |
|---|---|
| Name | |
| Title | |
| Address 1 | |
| Address 2 | |
| City/State/Zip | |
| Telephone | |
| Extension | |
| Email | |

**Form Notes for Form 8:**

None

## Form 9
## State Priorities – Needs Assessment Year

**State: West Virginia**

**Application Year 2021**

| No. | Priority Need | Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period) |
|---|---|---|
| 1. | Decrease smoking specifically among pregnant women and decrease smoke exposure among children in the household. | Revised |
| 2. | Decrease infant mortality with an emphasis on Sudden Unexplained Infant Death (SUID). | Continued |
| 3. | Decrease preterm and low birthweight infants. | Continued |
| 4. | Decrease injuries among youth and teens specifically related to teen suicide. | Continued |
| 5. | Increase breastfeeding, both initiation and continuation. | Continued |
| 6. | Address substance use in pregnancy and in youth/teens. | New |
| 7. | Increase medical home for children with and without special health care needs. | Continued |
| 8. | Decrease obesity among children. | Revised |
| 9. | Increase dental care specifically during pregnancy. | New |
| 10. | Increase in adolescents with and without special health care needs who receive services necessary to make transitions to adult health care. | New |

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

## Form 10
## National Outcome Measures (NOMs)

**State: West Virginia**

**Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.**

None

**NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 78.8 % | 0.3 % | 14,217 | 18,043 |
| 2017 | 77.5 % | 0.3 % | 14,290 | 18,441 |
| 2016 | 79.2 % | 0.3 % | 14,989 | 18,927 |
| 2015 | 78.2 % | 0.3 % | 15,192 | 19,421 |
| 2014 | 76.9 % | 0.3 % | 15,247 | 19,816 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 1 - Notes:**

None

**Data Alerts: None**

**NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 66.8 | 6.1 | 122 | 18,261 |
| 2016 | 81.8 | 6.7 | 151 | 18,465 |
| 2015 | 73.0 | 7.2 | 105 | 14,376 |
| 2014 | 83.2 | 6.6 | 162 | 19,477 |
| 2013 | 71.6 | 6.0 | 143 | 19,971 |
| 2012 | 69.8 | 5.9 | 139 | 19,906 |
| 2011 | 61.3 | 5.7 | 118 | 19,262 |
| 2010 | 80.8 | 6.4 | 159 | 19,667 |
| 2009 | 61.3 | 5.4 | 128 | 20,881 |
| 2008 | 55.8 | 5.2 | 117 | 20,985 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 2 - Notes:**

None

**Data Alerts: None**

**NOM 3 - Maternal mortality rate per 100,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014_2018 | 15.6 | 4.0 | 15 | 96,108 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 3 - Notes:**

None

**Data Alerts: None**

**NOM 4 - Percent of low birth weight deliveries (<2,500 grams)**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 9.4 % | 0.2 % | 1,708 | 18,244 |
| 2017 | 9.5 % | 0.2 % | 1,781 | 18,671 |
| 2016 | 9.6 % | 0.2 % | 1,835 | 19,064 |
| 2015 | 9.6 % | 0.2 % | 1,891 | 19,792 |
| 2014 | 9.1 % | 0.2 % | 1,852 | 20,284 |
| 2013 | 9.4 % | 0.2 % | 1,955 | 20,796 |
| 2012 | 9.2 % | 0.2 % | 1,917 | 20,814 |
| 2011 | 9.6 % | 0.2 % | 1,985 | 20,704 |
| 2010 | 9.2 % | 0.2 % | 1,880 | 20,457 |
| 2009 | 9.2 % | 0.2 % | 1,952 | 21,244 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 4 - Notes:**

None

**Data Alerts: None**

**NOM 5 - Percent of preterm births (<37 weeks)**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 11.8 % | 0.2 % | 2,158 | 18,240 |
| 2017 | 12.0 % | 0.2 % | 2,237 | 18,661 |
| 2016 | 11.8 % | 0.2 % | 2,259 | 19,071 |
| 2015 | 11.3 % | 0.2 % | 2,227 | 19,792 |
| 2014 | 10.8 % | 0.2 % | 2,198 | 20,294 |
| 2013 | 10.5 % | 0.2 % | 2,190 | 20,803 |
| 2012 | 10.7 % | 0.2 % | 2,229 | 20,812 |
| 2011 | 11.2 % | 0.2 % | 2,327 | 20,701 |
| 2010 | 10.6 % | 0.2 % | 2,167 | 20,446 |
| 2009 | 10.8 % | 0.2 % | 2,302 | 21,248 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 5 - Notes:**

None

**Data Alerts: None**

**NOM 6 - Percent of early term births (37, 38 weeks)**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 29.7 % | 0.3 % | 5,415 | 18,240 |
| 2017 | 28.0 % | 0.3 % | 5,218 | 18,661 |
| 2016 | 28.4 % | 0.3 % | 5,423 | 19,071 |
| 2015 | 27.0 % | 0.3 % | 5,337 | 19,792 |
| 2014 | 26.2 % | 0.3 % | 5,314 | 20,294 |
| 2013 | 26.8 % | 0.3 % | 5,568 | 20,803 |
| 2012 | 27.0 % | 0.3 % | 5,609 | 20,812 |
| 2011 | 26.9 % | 0.3 % | 5,575 | 20,701 |
| 2010 | 27.4 % | 0.3 % | 5,597 | 20,446 |
| 2009 | 29.4 % | 0.3 % | 6,254 | 21,248 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 6 - Notes:**

None

**Data Alerts: None**

**NOM 7 - Percent of non-medically indicated early elective deliveries**

**Data Source: CMS Hospital Compare**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018/Q2-2019/Q1 | 2.0 % | | | |
| 2018/Q1-2018/Q4 | 1.0 % | | | |
| 2017/Q4-2018/Q3 | 1.0 % | | | |
| 2017/Q3-2018/Q2 | 1.0 % | | | |
| 2017/Q2-2018/Q1 | 1.0 % | | | |
| 2017/Q1-2017/Q4 | 2.0 % | | | |
| 2016/Q4-2017/Q3 | 2.0 % | | | |
| 2016/Q3-2017/Q2 | 2.0 % | | | |
| 2016/Q2-2017/Q1 | 3.0 % | | | |
| 2016/Q1-2016/Q4 | 4.0 % | | | |
| 2015/Q4-2016/Q3 | 5.0 % | | | |
| 2015/Q3-2016/Q2 | 6.0 % | | | |
| 2015/Q2-2016/Q1 | 6.0 % | | | |
| 2015/Q1-2015/Q4 | 6.0 % | | | |
| 2014/Q4-2015/Q3 | 6.0 % | | | |
| 2014/Q3-2015/Q2 | 7.0 % | | | |
| 2014/Q2-2015/Q1 | 8.0 % | | | |
| 2014/Q1-2014/Q4 | 8.0 % | | | |
| 2013/Q4-2014/Q3 | 9.0 % | | | |
| 2013/Q3-2014/Q2 | 9.0 % | | | |
| 2013/Q2-2014/Q1 | 10.0 % | | | |

**Legends:**

**NOM 7 - Notes:**

None

**Data Alerts: None**

**NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 6.6 | 0.6 | 123 | 18,749 |
| 2016 | 6.2 | 0.6 | 119 | 19,140 |
| 2015 | 6.4 | 0.6 | 128 | 19,862 |
| 2014 | 6.1 | 0.6 | 125 | 20,355 |
| 2013 | 5.4 | 0.5 | 112 | 20,876 |
| 2012 | 5.9 | 0.5 | 123 | 20,883 |
| 2011 | 6.3 | 0.6 | 131 | 20,783 |
| 2010 | 5.1 | 0.5 | 105 | 20,524 |
| 2009 | 7.1 | 0.6 | 151 | 21,333 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 8 - Notes:**

None

**Data Alerts: None**

**NOM 9.1 - Infant mortality rate per 1,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 7.0 | 0.6 | 130 | 18,675 |
| 2016 | 7.2 | 0.6 | 138 | 19,079 |
| 2015 | 7.1 | 0.6 | 141 | 19,805 |
| 2014 | 6.9 | 0.6 | 141 | 20,301 |
| 2013 | 7.6 | 0.6 | 159 | 20,825 |
| 2012 | 7.2 | 0.6 | 149 | 20,827 |
| 2011 | 6.6 | 0.6 | 136 | 20,717 |
| 2010 | 7.3 | 0.6 | 150 | 20,470 |
| 2009 | 7.7 | 0.6 | 163 | 21,268 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.1 - Notes:**

None

**Data Alerts: None**

**NOM 9.2 - Neonatal mortality rate per 1,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 4.0 | 0.5 | 75 | 18,675 |
| 2016 | 4.4 | 0.5 | 84 | 19,079 |
| 2015 | 4.3 | 0.5 | 86 | 19,805 |
| 2014 | 4.5 | 0.5 | 92 | 20,301 |
| 2013 | 4.5 | 0.5 | 94 | 20,825 |
| 2012 | 4.5 | 0.5 | 94 | 20,827 |
| 2011 | 4.0 | 0.4 | 83 | 20,717 |
| 2010 | 3.9 | 0.4 | 80 | 20,470 |
| 2009 | 5.1 | 0.5 | 108 | 21,268 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.2 - Notes:**

None

**Data Alerts: None**

**NOM 9.3 - Post neonatal mortality rate per 1,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 2.9 | 0.4 | 55 | 18,675 |
| 2016 | 2.8 | 0.4 | 54 | 19,079 |
| 2015 | 2.8 | 0.4 | 55 | 19,805 |
| 2014 | 2.4 | 0.4 | 49 | 20,301 |
| 2013 | 3.1 | 0.4 | 65 | 20,825 |
| 2012 | 2.6 | 0.4 | 55 | 20,827 |
| 2011 | 2.6 | 0.4 | 53 | 20,717 |
| 2010 | 3.4 | 0.4 | 70 | 20,470 |
| 2009 | 2.6 | 0.4 | 55 | 21,268 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.3 - Notes:**

None

**Data Alerts: None**

**NOM 9.4 - Preterm-related mortality rate per 100,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 155.3 | 28.9 | 29 | 18,675 |
| 2016 | 220.1 | 34.0 | 42 | 19,079 |
| 2015 | 222.2 | 33.5 | 44 | 19,805 |
| 2014 | 236.4 | 34.2 | 48 | 20,301 |
| 2013 | 153.7 | 27.2 | 32 | 20,825 |
| 2012 | 240.1 | 34.0 | 50 | 20,827 |
| 2011 | 188.3 | 30.2 | 39 | 20,717 |
| 2010 | 161.2 | 28.1 | 33 | 20,470 |
| 2009 | 239.8 | 33.6 | 51 | 21,268 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.4 - Notes:**

None

**Data Alerts: None**

**NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 176.7 | 30.8 | 33 | 18,675 |
| 2016 | 162.5 | 29.2 | 31 | 19,079 |
| 2015 | 116.1 | 24.2 | 23 | 19,805 |
| 2014 | 142.9 | 26.6 | 29 | 20,301 |
| 2013 | 187.3 | 30.0 | 39 | 20,825 |
| 2012 | 120.0 | 24.0 | 25 | 20,827 |
| 2011 | 144.8 | 26.5 | 30 | 20,717 |
| 2010 | 195.4 | 30.9 | 40 | 20,470 |
| 2009 | 211.6 | 31.6 | 45 | 21,268 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.5 - Notes:**

None

**Data Alerts: None**

**NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2015 | 2.7 % | 0.6 % | 455 | 17,163 |
| 2014 | 2.5 % | 0.6 % | 434 | 17,452 |
| 2013 | 1.8 % | 0.4 % | 324 | 17,998 |
| 2011 | 1.4 % | 0.4 % | 250 | 18,023 |
| 2010 | 3.7 % | 0.6 % | 660 | 17,717 |
| 2009 | 3.3 % | 0.6 % | 616 | 18,473 |
| 2008 | 3.0 % | 0.5 % | 548 | 18,462 |
| 2007 | 3.7 % | 0.7 % | 691 | 18,712 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM 10 - Notes:**

None

**Data Alerts: None**

**NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 53.5 | 1.8 | 937 | 17,507 |
| 2016 | 46.2 | 1.6 | 828 | 17,913 |
| 2015 | 38.1 | 1.7 | 550 | 14,443 |
| 2014 | 34.9 | 1.4 | 687 | 19,705 |
| 2013 | 29.9 | 1.3 | 579 | 19,394 |
| 2012 | 19.9 | 1.0 | 386 | 19,445 |
| 2011 | 16.1 | 0.9 | 295 | 18,334 |
| 2010 | 14.0 | 0.9 | 265 | 18,941 |
| 2009 | 11.1 | 0.8 | 225 | 20,226 |
| 2008 | 9.4 | 0.7 | 189 | 20,117 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 11 - Notes:**

None

**Data Alerts: None**

**NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)**

**Federally available Data (FAD) for this measure is not available/reportable.**

**NOM 12 - Notes:**

None

**Data Alerts: None**

**NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)**

**Federally available Data (FAD) for this measure is not available/reportable.**

**NOM 13 - Notes:**

None

**Data Alerts: None**

**NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2018 | 12.9 % | 1.5 % | 44,812 | 348,124 |
| 2016_2017 | 10.3 % | 1.4 % | 36,108 | 351,825 |
| 2016 | 8.0 % | 1.4 % | 27,832 | 348,720 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 14 - Notes:**

None

**Data Alerts: None**

**NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 17.4 | 3.1 | 31 | 178,429 |
| 2017 | 22.0 | 3.5 | 40 | 181,551 |
| 2016 | 28.2 | 3.9 | 52 | 184,634 |
| 2015 | 14.5 | 2.8 | 27 | 186,682 |
| 2014 | 27.3 | 3.8 | 51 | 187,009 |
| 2013 | 27.7 | 3.8 | 52 | 187,604 |
| 2012 | 29.1 | 3.9 | 55 | 188,771 |
| 2011 | 18.1 | 3.1 | 34 | 188,184 |
| 2010 | 26.9 | 3.8 | 51 | 189,855 |
| 2009 | 21.6 | 3.4 | 41 | 189,712 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 15 - Notes:**

None

**Data Alerts: None**

**NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 38.7 | 4.3 | 82 | 211,615 |
| 2017 | 33.8 | 4.0 | 72 | 212,829 |
| 2016 | 36.3 | 4.1 | 78 | 214,739 |
| 2015 | 41.5 | 4.4 | 90 | 216,751 |
| 2014 | 43.5 | 4.5 | 95 | 218,519 |
| 2013 | 39.9 | 4.3 | 88 | 220,349 |
| 2012 | 35.1 | 4.0 | 78 | 221,930 |
| 2011 | 40.7 | 4.3 | 92 | 225,821 |
| 2010 | 38.4 | 4.1 | 88 | 229,137 |
| 2009 | 45.2 | 4.4 | 104 | 230,133 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.1 - Notes:**

None

**Data Alerts: None**

**NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016_2018 | 18.8 | 2.4 | 61 | 324,758 |
| 2015_2017 | 17.7 | 2.3 | 58 | 328,219 |
| 2014_2016 | 15.4 | 2.2 | 51 | 331,243 |
| 2013_2015 | 17.4 | 2.3 | 58 | 334,114 |
| 2012_2014 | 17.8 | 2.3 | 60 | 336,590 |
| 2011_2013 | 20.1 | 2.4 | 69 | 342,539 |
| 2010_2012 | 19.4 | 2.4 | 68 | 350,361 |
| 2009_2011 | 23.2 | 2.5 | 83 | 358,457 |
| 2008_2010 | 25.1 | 2.6 | 91 | 362,805 |
| 2007_2009 | 29.9 | 2.9 | 109 | 364,038 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.2 - Notes:**

None

**Data Alerts: None**

**NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016_2018 | 12.6 | 2.0 | 41 | 324,758 |
| 2015_2017 | 9.4 | 1.7 | 31 | 328,219 |
| 2014_2016 | 11.2 | 1.8 | 37 | 331,243 |
| 2013_2015 | 10.5 | 1.8 | 35 | 334,114 |
| 2012_2014 | 11.0 | 1.8 | 37 | 336,590 |
| 2011_2013 | 9.6 | 1.7 | 33 | 342,539 |
| 2010_2012 | 9.4 | 1.6 | 33 | 350,361 |
| 2009_2011 | 8.6 | 1.6 | 31 | 358,457 |
| 2008_2010 | 7.7 | 1.5 | 28 | 362,805 |
| 2007_2009 | 7.7 | 1.5 | 28 | 364,038 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2018 | 23.8 % | 1.7 % | 88,838 | 373,324 |
| 2016_2017 | 24.0 % | 1.6 % | 90,358 | 376,860 |
| 2016 | 24.1 % | 1.9 % | 91,107 | 378,166 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.1 - Notes:**

None

**Data Alerts: None**

**NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2018 | 18.7 % | 3.3 % | 16,575 | 88,838 |
| 2016_2017 | 20.9 % | 3.1 % | 18,899 | 90,358 |
| 2016 | 19.2 % | 3.3 % | 17,525 | 91,107 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.2 - Notes:**

None

**Data Alerts: None**

**NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2018 | 3.0 % | 0.8 % | 9,179 | 308,731 |
| 2016_2017 | 3.0 % | 0.7 % | 9,459 | 313,022 |
| 2016 | 2.7 % | 0.7 % | 8,295 | 311,129 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2018 | 13.4 % | 1.6 % | 40,849 | 304,304 |
| 2016_2017 | 11.4 % | 1.3 % | 35,685 | 312,223 |
| 2016 | 11.7 % | 1.7 % | 36,434 | 310,910 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2018 | 49.3 % | 5.5 % | 26,093 | 52,960 |
| 2016_2017 | 45.5 % | 5.2 % | 21,988 | 48,298 |
| 2016 | 46.4 % | 6.1 % | 22,232 | 47,901 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts: None**

**NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2018 | 90.1 % | 1.2 % | 335,740 | 372,739 |
| 2016_2017 | 90.7 % | 1.1 % | 339,372 | 374,024 |
| 2016 | 90.7 % | 1.4 % | 338,118 | 372,957 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 19 - Notes:**

None

**Data Alerts: None**

**NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)**

**Data Source: WIC**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016 | 16.6 % | 0.3 % | 2,360 | 14,222 |
| 2014 | 16.4 % | 0.3 % | 2,450 | 14,902 |
| 2012 | 14.1 % | 0.3 % | 2,223 | 15,729 |
| 2010 | 14.4 % | 0.3 % | 2,541 | 17,669 |
| 2008 | 14.3 % | 0.3 % | 2,425 | 16,941 |

**Legends:**

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**Data Source: Youth Risk Behavior Surveillance System (YRBSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 19.5 % | 1.5 % | 14,439 | 73,912 |
| 2015 | 17.9 % | 1.5 % | 13,610 | 76,035 |
| 2013 | 15.5 % | 1.0 % | 10,893 | 70,405 |
| 2011 | 14.8 % | 1.2 % | 11,236 | 76,083 |
| 2009 | 14.2 % | 1.2 % | 11,308 | 79,485 |
| 2007 | 14.6 % | 1.1 % | 11,161 | 76,441 |
| 2005 | 14.5 % | 1.1 % | 11,321 | 78,193 |

**Legends:**

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2018 | 20.9 % | 2.4 % | 33,942 | 162,466 |
| 2016_2017 | 20.3 % | 2.3 % | 32,698 | 161,223 |
| 2016 | 19.9 % | 2.8 % | 30,835 | 154,830 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 20 - Notes:**

None

**Data Alerts: None**

**NOM 21 - Percent of children, ages 0 through 17, without health insurance**

**Data Source: American Community Survey (ACS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 2.6 % | 0.6 % | 9,577 | 363,568 |
| 2017 | 2.5 % | 0.4 % | 9,467 | 372,814 |
| 2016 | 1.4 % | 0.3 % | 5,406 | 376,524 |
| 2015 | 2.6 % | 0.4 % | 9,708 | 379,162 |
| 2014 | 3.1 % | 0.6 % | 11,843 | 383,010 |
| 2013 | 4.0 % | 0.5 % | 15,453 | 382,540 |
| 2012 | 3.9 % | 0.6 % | 15,018 | 385,073 |
| 2011 | 4.9 % | 0.6 % | 19,048 | 385,974 |
| 2010 | 4.6 % | 0.6 % | 17,941 | 386,304 |
| 2009 | 5.4 % | 0.6 % | 20,739 | 384,595 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 21 - Notes:**

None

**Data Alerts: None**

**NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)**

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 72.4 % | 3.0 % | 20,606 | 28,462 |
| 2017 | 74.7 % | 3.0 % | 21,874 | 29,299 |
| 2016 | 64.7 % | 3.6 % | 19,143 | 29,593 |
| 2015 | 64.9 % | 4.0 % | 19,419 | 29,917 |
| 2014 | 63.4 % | 3.9 % | 18,732 | 29,554 |
| 2013 | 65.5 % | 4.0 % | 18,653 | 28,465 |
| 2012 | 60.8 % | 4.0 % | 17,516 | 28,814 |
| 2011 | 60.9 % | 3.1 % | 17,703 | 29,061 |
| 2010 | 47.7 % | 3.3 % | 14,342 | 30,053 |
| 2009 | 30.5 % | 3.8 % | 8,932 | 29,333 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

**NOM 22.1 - Notes:**

None

**Data Alerts: None**

**NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza**

**Data Source: National Immunization Survey (NIS) - Flu**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018_2019 | 55.2 % | 1.5 % | 192,210 | 348,018 |
| 2017_2018 | 53.0 % | 1.7 % | 186,635 | 352,298 |
| 2016_2017 | 54.8 % | 2.0 % | 195,063 | 356,085 |
| 2015_2016 | 56.7 % | 2.5 % | 202,548 | 357,480 |
| 2014_2015 | 60.5 % | 2.3 % | 219,307 | 362,371 |
| 2013_2014 | 53.9 % | 2.0 % | 193,950 | 359,845 |
| 2012_2013 | 54.9 % | 2.3 % | 199,546 | 363,414 |
| 2011_2012 | 49.3 % | 2.9 % | 180,771 | 367,014 |
| 2010_2011 | 49.0 % | 3.8 % | 177,796 | 362,849 |
| 2009_2010 | 44.9 % | 4.6 % | 175,494 | 390,856 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.2 - Notes:**

None

**Data Alerts: None**

**NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine**

**Data Source: National Immunization Survey (NIS) - Teen**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 61.3 % | 3.0 % | 64,645 | 105,501 |
| 2017 | 60.9 % | 3.2 % | 65,118 | 106,872 |
| 2016 | 54.2 % | 3.4 % | 58,114 | 107,233 |
| 2015 | 53.5 % | 3.1 % | 57,188 | 106,944 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.3 - Notes:**

None

**Data Alerts: None**

**NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine**

**Data Source: National Immunization Survey (NIS) - Teen**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 87.9 % | 2.2 % | 92,753 | 105,501 |
| 2017 | 87.5 % | 2.1 % | 93,477 | 106,872 |
| 2016 | 89.7 % | 1.9 % | 96,187 | 107,233 |
| 2015 | 85.8 % | 2.1 % | 91,801 | 106,944 |
| 2014 | 77.9 % | 3.0 % | 84,112 | 107,983 |
| 2013 | 76.7 % | 2.8 % | 83,829 | 109,300 |
| 2012 | 68.2 % | 3.6 % | 75,287 | 110,442 |
| 2011 | 60.1 % | 3.1 % | 66,951 | 111,468 |
| 2010 | 49.9 % | 3.1 % | 55,342 | 110,946 |
| 2009 | 40.5 % | 3.5 % | 45,302 | 111,994 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.4 - Notes:**

None

**Data Alerts: None**

**NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine**

**Data Source: National Immunization Survey (NIS) - Teen**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 88.7 % | 2.1 % | 93,595 | 105,501 |
| 2017 | 87.9 % | 2.1 % | 93,931 | 106,872 |
| 2016 | 89.0 % | 2.0 % | 95,413 | 107,233 |
| 2015 | 86.0 % | 2.2 % | 91,926 | 106,944 |
| 2014 | 78.9 % | 2.9 % | 85,210 | 107,983 |
| 2013 | 77.3 % | 2.8 % | 84,458 | 109,300 |
| 2012 | 64.1 % | 3.8 % | 70,787 | 110,442 |
| 2011 | 54.9 % | 3.1 % | 61,174 | 111,468 |
| 2010 | 45.7 % | 3.1 % | 50,708 | 110,946 |
| 2009 | 39.0 % | 3.5 % | 43,630 | 111,994 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts: None**

**NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 25.4 | 0.7 | 1,317 | 51,808 |
| 2017 | 27.1 | 0.7 | 1,416 | 52,305 |
| 2016 | 29.3 | 0.7 | 1,555 | 53,087 |
| 2015 | 32.0 | 0.8 | 1,719 | 53,648 |
| 2014 | 36.6 | 0.8 | 1,972 | 53,878 |
| 2013 | 40.2 | 0.9 | 2,178 | 54,217 |
| 2012 | 44.0 | 0.9 | 2,407 | 54,648 |
| 2011 | 44.0 | 0.9 | 2,461 | 55,942 |
| 2010 | 45.2 | 0.9 | 2,608 | 57,753 |
| 2009 | 48.2 | 0.9 | 2,845 | 58,992 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 23 - Notes:**

None

**Data Alerts: None**

**NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 19.4 % | 1.8 % | 3,024 | 15,586 |
| 2017 | 12.4 % | 1.5 % | 1,932 | 15,525 |
| 2016 | 16.5 % | 1.6 % | 2,722 | 16,506 |
| 2015 | 15.4 % | 1.4 % | 2,631 | 17,068 |
| 2014 | 13.8 % | 1.3 % | 2,401 | 17,430 |
| 2013 | 16.9 % | 1.3 % | 3,038 | 17,994 |
| 2012 | 18.6 % | 1.5 % | 3,347 | 18,041 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM 24 - Notes:**

None

**Data Alerts: None**

**NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2018 | 2.6 % | 0.7 % | 9,643 | 371,534 |
| 2016_2017 | 2.7 % | 0.6 % | 10,172 | 372,994 |
| 2016 | 3.3 % | 1.0 % | 12,403 | 373,480 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 25 - Notes:**

None

**Data Alerts: None**

## Form 10
## National Performance Measures (NPMs)

**State: West Virginia**

**NPM 2 - Percent of cesarean deliveries among low-risk first births**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Vital Statistics System (NVSS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 25 | 24 | 26 | 25 |
| Annual Indicator | 27.2 | 27.0 | 27.6 | 27.3 |
| Numerator | 1,766 | 1,652 | 1,654 | 1,598 |
| Denominator | 6,498 | 6,116 | 5,989 | 5,845 |
| Data Source | NVSS | NVSS | NVSS | NVSS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 25.0 | 24.0 | 24.0 | 23.0 | 23.0 | 22.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 4A - Percent of infants who are ever breastfed**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 63 | 65 | 67 | 69 |
| Annual Indicator | 64.6 | 65.4 | 68.6 | 68.2 |
| Numerator | 12,784 | 12,994 | 12,974 | 12,736 |
| Denominator | 19,786 | 19,882 | 18,907 | 18,666 |
| Data Source | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 70.0 | 70.0 | 72.0 | 72.0 | 74.0 | 74.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 4B - Percent of infants breastfed exclusively through 6 months**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 12 | 15 | 20 | 22 |
| Annual Indicator | 14.1 | 19.0 | 20.2 | 15.2 |
| Numerator | 2,748 | 3,708 | 3,610 | 2,790 |
| Denominator | 19,557 | 19,555 | 17,857 | 18,401 |
| Data Source | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 18.0 | 20.0 | 22.0 | 22.0 | 24.0 | 24.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 5A - Percent of infants placed to sleep on their backs**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 77 | 80 | 84 | 87 |
| Annual Indicator | 79.5 | 83.7 | 86.6 | 82.0 |
| Numerator | 13,573 | 14,091 | 13,445 | 12,495 |
| Denominator | 17,071 | 16,839 | 15,534 | 15,245 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2014 | 2015 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 84.0 | 86.0 | 86.0 | 88.0 | 88.0 | 90.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface**

| Federally Available Data | | |
|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | |
| | **2018** | **2019** |
| Annual Objective | | 40 |
| Annual Indicator | 37.7 | 36.1 |
| Numerator | 5,742 | 5,401 |
| Denominator | 15,239 | 14,977 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 40.0 | 40.0 | 42.0 | 42.0 | 44.0 | 44.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding**

| Federally Available Data | | |
|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | |
| | **2018** | **2019** |
| Annual Objective | | 40 |
| Annual Indicator | 39.8 | 43.1 |
| Numerator | 6,129 | 6,470 |
| Denominator | 15,392 | 15,017 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 44.0 | 46.0 | 46.0 | 48.0 | 48.0 | 50.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: Youth Risk Behavior Surveillance System (YRBSS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 26 | 25 | 27 | 28 |
| Annual Indicator | 30.5 | 30.5 | 29.1 | 29.1 |
| Numerator | 23,959 | 23,959 | 22,608 | 22,608 |
| Denominator | 78,632 | 78,632 | 77,715 | 77,715 |
| Data Source | YRBSS | YRBSS | YRBSS | YRBSS |
| Data Source Year | 2015 | 2015 | 2017 | 2017 |

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - Perpetration** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 28 |
| Annual Indicator | | | 13.6 |
| Numerator | | | 16,987 |
| Denominator | | | 124,901 |
| Data Source | | | NSCHP |
| Data Source Year | | | 2018 |

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 28 |
| Annual Indicator | | | 49.1 |
| Numerator | | | 61,001 |
| Denominator | | | 124,257 |
| Data Source | | | NSCHV |
| Data Source Year | | | 2018 |

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 26.0 | 26.0 | 24.0 | 24.0 | 22.0 | 22.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 48 | 48 |
| Annual Indicator | | 47.0 | 47.9 | 45.2 |
| Numerator | | 42,772 | 43,240 | 40,169 |
| Denominator | | 91,107 | 90,358 | 88,838 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 48.0 | 48.0 | 50.0 | 50.0 | 52.0 | 52.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 32 | 38 | 40 | 36 |
| Annual Indicator | 37.9 | 39.3 | 35.6 | 36.0 |
| Numerator | 6,464 | 6,554 | 5,622 | 5,633 |
| Denominator | 17,066 | 16,685 | 15,797 | 15,656 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2014 | 2015 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 38.0 | 40.0 | 42.0 | 44.0 | 46.0 | 48.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 14.1 - Percent of women who smoke during pregnancy**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Vital Statistics System (NVSS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 27 | 25 | 24 | 23 |
| Annual Indicator | 25.2 | 25.1 | 24.7 | 23.9 |
| Numerator | 4,902 | 4,591 | 4,590 | 4,337 |
| Denominator | 19,469 | 18,305 | 18,551 | 18,138 |
| Data Source | NVSS | NVSS | NVSS | NVSS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 22.0 | 22.0 | 20.0 | 20.0 | 18.0 | 18.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes - Child Health**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 27 | 22 |
| Annual Indicator | | 26.5 | 22.2 | 24.1 |
| Numerator | | 97,972 | 82,198 | 88,702 |
| Denominator | | 370,309 | 370,710 | 368,117 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 22.0 | 22.0 | 20.0 | 20.0 | 18.0 | 18.0 |

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

**State: West Virginia**

**2016-2020: NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CHILD** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 33 | 36 |
| Annual Indicator | | 32.1 | 35.5 | 43.3 |
| Numerator | | 39,168 | 40,194 | 46,844 |
| Denominator | | 122,113 | 113,155 | 108,304 |
| Data Source | | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: Youth Risk Behavior Surveillance System (YRBSS)** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 25 |
| Annual Indicator | 25.8 | 23.4 | 23.4 |
| Numerator | 19,962 | 17,726 | 17,726 |
| Denominator | 77,480 | 75,763 | 75,763 |
| Data Source | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT |
| Data Source Year | 2015 | 2017 | 2017 |
| **Federally Available Data** | | | |
| **Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 25 |
| Annual Indicator | 24.3 | 24.1 | 21.2 |
| Numerator | 29,361 | 30,565 | 27,302 |
| Denominator | 120,948 | 126,776 | 128,983 |
| Data Source | NSCH-ADOLESCENT | NSCH-ADOLESCENT | NSCH-ADOLESCENT |
| Data Source Year | 2016 | 2016_2017 | 2017_2018 |

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 91 | 82 |
| Annual Indicator | | 81.8 | 81.7 | 82.2 |
| Numerator | | 283,638 | 286,309 | 285,988 |
| Denominator | | 346,833 | 350,407 | 347,833 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

**Field Level Notes for Form 10 NPMs:**

None

**NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health**

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## State Performance Measures (SPMs)

**State: West Virginia**

**SPM 1 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 41.6 | 20 | 20 |
| Annual Indicator | 16.3 | 17 | 16.8 | 19.9 |
| Numerator | 3,240 | 3,380 | 22,582 | 25,058 |
| Denominator | 19,936 | 19,936 | 134,548 | 125,615 |
| Data Source | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2016 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 22.0 | 22.0 | 24.0 | 26.0 | 28.0 | 30.0 |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Indicator 4.15 of NSCH 2016 | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>based on Indicator 4.15 of NSCH 2016 | |
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2017 NSCH<br>CSHCN 13.1 and non CSHCN 20.8<br>previous years only reported on CSHCN | |
| 4. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2018 NSCH<br>CSHCN 20.2 and non CSHCN 19.6<br>previous years only reported on CSHCN | |

**SPM 2 - Increase identification of pregnant women using substances during pregnancy.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 61 |
| Numerator | |
| Denominator | |
| Data Source | WV PRSI |
| Data Source Year | 2018 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 65.0 | 70.0 | 75.0 | 80.0 | 85.0 |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
2018 PRSI data - completed forms received

**SPM 3 - Increase the awareness of controlled substance use among children ages 5-17.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | PDMP/VIPP |
| Data Source Year | 2019 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 375.0 | 400.0 | 425.0 | 450.0 | 500.0 |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
will begin academic detailing in 2021

**SPM 4 - Percent of children, ages two to four, who are obese as defined as body mass index (BMI) at or above the 95th percentile on the CDC growth charts for age and sex.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 16.6 |
| Numerator | |
| Denominator | |
| Data Source | WIC |
| Data Source Year | 2016 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 15.0 | 14.4 | 13.0 | 12.0 | 11.0 |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** WIC PC data | |

## Form 10
## State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

**2016-2020: SPM 2 - Percent of children ages 0 through 17 who are adequately insured**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 78.2 | 75.5 | 68 |
| Annual Indicator | 57 | 75.5 | 68.9 | 68.1 |
| Numerator | 204,781 | 271,234 | 245,477 | 252,731 |
| Denominator | 359,047 | 359,047 | 356,411 | 371,200 |
| Data Source | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2016 | 2016 | 2017 | 2017-2018 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Indicator 3.4 | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Based upon Indicator 3.4 | |
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2017 NSCH<br>continuously and adequately insured | |
| 4. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2017-2018 NSCH Indicator 3.4a: Adequate and continuous insurance coverage | |

**2016-2020: SPM 3 - Rate of infants born with neonatal abstinence syndrome.**

| Measure Status: | | | Active | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 54 | 50 | 45 |
| Annual Indicator | 55.6 | 51.2 | 49.6 | 55.5 |
| Numerator | 182 | 962 | 901 | 1,028 |
| Denominator | 3,272 | 18,797 | 18,174 | 18,526 |
| Data Source | Birth Score Program | Birth Score Program | Birth Score Program | Birth Score Program |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** The data source changed from last reporting - the Birth Score Program began collecting NAS data in October of 2016. | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** Birth Score Program data | |
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** Birth Score Program data | |
| 4. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** Birth Score Program data | |

**2016-2020: SPM 4 - Percentage of adolescents ages 12-17 with a well visit in the past year**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 85 | 87 | 87 |
| Annual Indicator | 84.9 | 84.9 | 86.3 | 62.8 |
| Numerator | 95,934 | 95,934 | 116,200 | 78,233 |
| Denominator | 113,040 | 113,040 | 134,585 | 124,579 |
| Data Source | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2016 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>NSCH 2016 | |
| 2. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2017 NSCH<br>preventive medical visit in the past year | |
| 3. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2018 NSCH<br>preventive medical visit in the past year | |

## Form 10
## Evidence-Based or –Informed Strategy Measure (ESM)

**State: West Virginia**

**ESM 2.1 - Number of first time pregnant women who have participated in the Lamaze International Evidence Based Labor Support Workshop.**

| Measure Status: | Active |
|---|---|
| **State Provided Data** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 100 |
| Numerator | |
| Denominator | |
| Data Source | Perinatal Partnership |
| Data Source Year | 2021 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 100.0 | 200.0 | 250.0 | 300.0 | 350.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
data collection will begin with CY 2021

**ESM 4.1 - Number of birthing facilities designated Baby-Friendly under the EMPower initiative**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 1 | 5 | 5 |
| Annual Indicator | 0 | 2 | 4 | 5 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Baby Friendly USA | Baby Friendly USA | Baby Friendly USA | Baby Friendly USA |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 6.0 | 6.0 | 8.0 | 8.0 | 10.0 | 10.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 4.2 - Percent of infants who are breastfeeding at time of discharge from a birthing facility**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 65 | 67 | 65 |
| Annual Indicator | 65.2 | 64.5 | 64.9 | 64.9 |
| Numerator | 11,859 | 11,514 | 11,465 | 11,465 |
| Denominator | 18,179 | 17,865 | 17,662 | 17,662 |
| Data Source | Vital Statistics | Vital Statistics | Vital Statistics | Vital Statistics |
| Data Source Year | 2016 | 2017 | 2018 | 2018 |
| Provisional or Final ? | Final | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 66.0 | 68.0 | 70.0 | 72.0 | 74.0 | 74.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** WV resident births only - denominator does not include unknown breastfeeding at discharge | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** WV resident births only - denominator does not include unknown breastfeeding at discharge | |
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** WV resident births only - denominator does not include unknown breastfeeding at discharge | |
| 4. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** WV resident births only - denominator does not include unknown breastfeeding at discharge | |

**ESM 4.3 - Percent of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 5 | 9 | 13 |
| Annual Indicator | 8.7 | 8.8 | 11.1 | 11.7 |
| Numerator | 2 | 18 | 74 | 160 |
| Denominator | 23 | 204 | 668 | 1,367 |
| Data Source | WV Home Visitation Program (HFA, PAT, EHS) | WV Home Visitation Program | WV Home Visitation Program (HFA, EHS, PAT, MIHOW, | WV Home Visitation Program (HFA, EHS, PAT, RFTS) |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 12.0 | 14.0 | 16.0 | 18.0 | 20.0 | 22.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Data collection began October 1, 2016 when questions were implemented. The denominator includes only those infants who reached 6 months of age by the end of 2016. The numerator includes those infants from the denominator whose caregivers indicated that through 6 months of age the infant had been exclusively breastfed. Home Visitation Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based Option. MIHOW and RFTS were not included as they are not evidence based programs.

| | | |
|---|---|---|
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
The above indicator reflects data collected from 1/1/2017-9/30/2017. The Home Visitation programs did not have access to a data system after September 30, 2017; therefore, data for 2017 was limited to 9 months. The denominator includes only those infants who reached 6 months of age by September 30, 2017. The numerator includes those infants from the denominator whose caregivers indicated that through 6 months of age the infant had been exclusively breastfed. Home Visitation Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based Option and Right From the Start. MIHOW data was not included as it is not an evidence based program.

| | | |
|---|---|---|
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
The above indicator reflects data collected from 1/1/2018-12/31/2018. The Home Visitation programs transitioned to a new data system in July 2018 after being without a data system for over 10 months. The data reported above should be interpreted with caution due to a large number of missing data for participants in the home visitation programs. The denominator includes only those infants who reached 6 months of age by December 31, 2018. The numerator includes those infants from the denominator whose caregivers indicated that through 6 months of age the infant had been exclusively breastfed. Home Visitation Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based Option, MIHOW and Right From the Start.

| | | |
|---|---|---|
| 4. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Indicator reflects data collected from 1/1/2019-12/31/2019. The denominator includes only those infants who reached 6 months of age by December 31, 2019. The numerator includes those infants from the denominator whose caregivers indicated that through 6 months of age the infant had been exclusively breastfed. Home Visitation Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based Option, and Right From the Start.

**ESM 5.1 - Percent of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 90 | 95 | 100 |
| Annual Indicator | 92 | 100 | 100 | 100 |
| Numerator | 23 | 25 | 25 | 25 |
| Denominator | 25 | 25 | 25 | 25 |
| Data Source | Our Babies Safe and Sound | Our Babies Safe and Sound | Our Babies Safe and Sound | Our Babies Safe and Sound |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>23 of 25 in state birthing hospitals trained - 15 nationally certified as Safe Sleep Hospitals | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>25 of 25 in state birthing hospitals trained plus Garret Memorial in MD because of proximity to WV | |
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>25 of 25 in state birthing hospitals trained plus Garret Memorial in MD because of proximity to WV | |
| 4. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>25 of 25 in state birthing hospitals trained plus Garret Memorial in MD because of proximity to WV | |

**ESM 5.2 - Percent of families enrolled in a home visitation program who received safe sleep education from a trained home visitation provider on the first visit after child's birth**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 72 | 86 | 86 |
| Annual Indicator | 71.1 | 83.9 | 61.9 | 75 |
| Numerator | 27 | 177 | 599 | 804 |
| Denominator | 38 | 211 | 968 | 1,072 |
| Data Source | WV Home Visitation Program (HFA, PAT, EHS, MIHOW)) | WV Home Visitation Program | WV Home Visitation Program (HFA, EHS, PAT, MIHOW, | WV Home Visitation Program (HFA, EHS, PAT, RFTS) |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 80.0 | 82.0 | 84.0 | 86.0 | 88.0 | 90.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Data collection began October 1, 2016 when questions were implemented. The denominator includes families with a child less than 1 year of age during the reporting period (CY 2016) who received their first home visit on or after October 1, 2016. The numerator includes those families from the denominator who received Safe Sleep education on the 1st visit after the child's birth. Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based option, Maternal Infant Health Outreach Worker. RFTS was not included due to timing of data collection.

| | | |
|---|---|---|
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
The above indicator reflects data collected from 1/1/2017-9/30/2017. The Home Visitation programs did not have access to a data system after September 30, 2017; therefore, data for 2017 was limited to 9 months. The denominator includes families with a child less than 1 year of age during the reporting period (CY 2017) who received their first postpartum home visit on or after 1/1/2017. The numerator includes those families from the denominator who received Safe Sleep education on the 1st visit after the child's birth. Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based Option, Maternal Infant Health Outreach Worker. RFTS was not included due to timing of data collection.

| | | |
|---|---|---|
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Field Level Notes: The above indicator reflects data collected from 1/1/2018-12/31/2018. The Home Visitation programs transitioned to a new data system in July 2018 after being without a data system for over 10 months. The data reported above should be interpreted with caution due to a large number of missing data for participants in the home visitation programs. The denominator includes families with a child less than 1 year of age during the reporting period (CY 2018) who received their first postpartum home visit on or after 1/1/2018. The numerator includes those families from the denominator who received Safe Sleep education on the 1st visit after the child's birth. Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based Option, Maternal Infant Health Outreach Worker and Right From the Start

| | | |
|---|---|---|
| 4. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Indicator reflects data collected from 1/1/2019-12/31/2019. The denominator includes families with a child less than 1 year of age during the reporting period (CY 2019) who received their first postpartum home visit on or after 1/1/2019. The numerator includes those families from the denominator who received Safe Sleep education on the 1st visit after the child's birth. Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based Option, and Right From the Start.

**ESM 5.3 - Percent of infants enrolled in a home visitation program that are always placed to sleep on their backs, without bed-sharing or soft bedding**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 75 | 78 | 80 |
| Annual Indicator | 77.1 | 76.8 | 55 | 74.8 |
| Numerator | 199 | 730 | 820 | 1,554 |
| Denominator | 258 | 951 | 1,492 | 2,077 |
| Data Source | WV Home Visitation Program (HFA, PAT, EHS, MIHOW)) | WV Home Visitation Program | WV Home Visitation Program (HFA, EHS, PAT, MIHOW, | WV Home Visitation Program (HFA, EHS, PAT, RFTS) |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 80.0 | 82.0 | 84.0 | 86.0 | 88.0 | 90.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Data collection began October 1, 2016 when questions were implemented. The denominator includes infants enrolled in a home visitation program who were aged less than 1 year during the reporting period. Any infant less than age 1 was included in the count, regardless of enrollment date in CY 2016. The numerator includes those infants from the denominator whose caregivers indicated that the infant was always placed to sleep on their backs, without bed-sharing, and free of soft bedding. Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home based option, Maternal Infant Health Outreach Worker. RFTS was not included due to inconsistent data collection for the Safe Sleep indicators.

| | | |
|---|---|---|
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
The above indicator reflects data collected from 1/1/2017-9/30/2017. The Home Visitation programs did not have access to a data system after September 30, 2017; therefore, data for 2017 was limited to 9 months. The denominator includes infants enrolled in a home visitation program who were aged less than 1 year during the reporting period. The numerator includes those infants from the denominator whose caregivers indicated that the infant was always placed to sleep on their backs, without bed-sharing, and free of soft-bedding. Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based Option, Maternal Infant Health Outreach Worker and Right From the Start.

| | | |
|---|---|---|
| 3. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Indicator reflects data collected from 1/1/2019-12/31/2019. The denominator includes infants enrolled in a home visitation program who were aged less than 1 year during the reporting period. The numerator includes those infants from the denominator whose caregivers indicated that the infant was always placed to sleep on their backs, without bed-sharing, and free of soft-bedding. Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based Option, and Right From the Start.

**ESM 9.1 - Number of positive youth development (PYD) focused trainings provided to youth, parents, professionals and community members**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 87 | 95 | 112 |
| Annual Indicator | 87 | 92 | 110 | 144 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | AHCS | AHCS | AHCS | AHCS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 100.0 | 110.0 | 115.0 | 120.0 | 125.0 | 130.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 9.2 - Number of schools and/or youth serving organizations in target communities that have implemented a comprehensive bullying program**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 13 | 17 | 32 |
| Annual Indicator | 13 | 16 | 30 | 38 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | AHCS | AHCS | AHCS | AHCS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 38.0 | 39.0 | 39.0 | 39.0 | 40.0 | 40.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 9.3 - Number of messages disseminated via social media**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 85 | 100 | 135 |
| Annual Indicator | 85 | 98 | 130 | 122 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | AHCS | AHCS | AHCS | AHCS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 125.0 | 140.0 | 150.0 | 155.0 | 160.0 | 165.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 9.4 - Number of trainings provided to youth, parents, professionals and community members**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 105 | 114 | 100 |
| Annual Indicator | 105 | 112 | 97 | 102 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | AHCS | AHCS | AHCS | AHCS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 110.0 | 112.0 | 115.0 | 118.0 | 120.0 | 122.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 11.1 - Number of stakeholders who receive education and resources regarding the National Resource Center For Patient/Family-Centered Medical Home in the last calendar year.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | CSHCN |
| Data Source Year | 2019 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 3.0 | 7.0 | 7.0 | 7.0 | 7.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2022** |
| | **Column Name:** | **Annual Objective** |

**Field Note:**
will work to identify more stakeholders or modify ESM once target of 7 is reached

**ESM 11.2 - Percent of well-child exams received by Medicaid members age 0-21 with a documented social determinants of health screening (as identified by claims data) in the last calendar year.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 30 |
| Numerator | 34,200 |
| Denominator | 114,000 |
| Data Source | Medicaid |
| Data Source Year | 2019 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 35.0 | 40.0 | 45.0 | 50.0 | 55.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
based upon DOJ data request indicating 113,781 members with a well child exam in calendar year 2019

**ESM 11.3 - Number of children who receive Title V funded medially necessary medical foods.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 270 |
| Numerator | |
| Denominator | |
| Data Source | CSHCN |
| Data Source Year | 2019 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 290.0 | 310.0 | 330.0 | 350.0 | 370.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 13.1.1 - Establish a curriculum for WVU School of Dentistry on dental care for pregnant women.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Oral Health Program |
| Data Source Year | 2019 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 60.0 | 60.0 | 60.0 | 60.0 | 60.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
will begin collecting for 2021-2022 school year

**ESM 14.1.1 - Number of health care workers who have had Help2Quit maternity care provider training**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | |
|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 |
| Annual Objective | | 150 | 350 | 350 |
| Annual Indicator | 148 | 334 | 44 | 217 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Perinatal Partnership | Perinatal Partnership | Perinatal Partnership | Perinatal Partnership |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Provisional | Provisional | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 300.0 | 300.0 | 320.0 | 320.0 | 340.0 | 340.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
there was delay in contact agreement which limited the number of trainings provided in the time period allowed after signing of the contract but is expected to resume previous trainings as provided in the past

**ESM 14.1.2 - Percent of women enrolled in HV who reported using any tobacco products at enrollment and were referred to tobacco cessation within 3 months of enrollment.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2017 | 2018 | 2019 |
| Annual Objective | | | 60 |
| Annual Indicator | | | 41.5 |
| Numerator | | | 85 |
| Denominator | | | 205 |
| Data Source | | | WV Home Visitation Program (HFA, EHS, PAT, RFTS) |
| Data Source Year | | | 2019 |
| Provisional or Final ? | | | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 50.0 | 55.0 | 60.0 | 65.0 | 70.0 | 75.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Indicator reflects data collected from 1/1/2019-12/31/2019. The denominator includes women who were enrolled in a home visitation program and indicated use of tobacco products at that time. The numerator includes those women from the denominator who received a referral for tobacco cessation services within 3 months of enrollment. Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based option. Right From the Start was not included due to a change in the referral reporting during the calendar year.

**ESM 14.2.1 - Percent of children in households where someone smokes.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2017 | 2018 | 2019 |
| Annual Objective | | | 25 |
| Annual Indicator | | | 30.4 |
| Numerator | | | 415,200 |
| Denominator | | | 1,365,123 |
| Data Source | | | NSCH |
| Data Source Year | | | 2018 |
| Provisional or Final ? | | | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 28.0 | 26.0 | 24.0 | 22.0 | 20.0 | 18.0 |

**Field Level Notes for Form 10 ESMs:**

None

## Form 10
## Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

**2016-2020: ESM 2.1 - Number of maternity care providers who have participated in the Lamaze International Evidence Based Labor Support Workshop**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 22 | 30 | 45 |
| Annual Indicator | 0 | 50 | 44 | 48 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Perinatal Partnership | Perinatal Partnership | Perinatal Partnership | Perinatal Partnership |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: ESM 8.1.1 - Number of schools surveyed that are engaged in shared use activities.**

| **Measure Status:** | | | **Active** |
|---|---|---|---|
| **State Provided Data** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 150 |
| Annual Indicator | | | 10 |
| Numerator | | | |
| Denominator | | | |
| Data Source | | | AHCS |
| Data Source Year | | | 2019 |
| Provisional or Final ? | | | Provisional |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: ESM 8.1.2 - Percent of children participating in the WV Coordinated Approach to Child Health (CATCH) Program**

| Measure Status: | | | Active |
|---|---|---|---|
| **State Provided Data** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | | | 95 |
| Annual Indicator | | | 95 |
| Numerator | | | |
| Denominator | | | |
| Data Source | | | HealthCheck |
| Data Source Year | | | 2019 |
| Provisional or Final ? | | | Provisional |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: ESM 8.2.1 - Number of schools surveyed that are engaged in shared use activities**

| Measure Status: | | | Active | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 139 | 145 | 180 |
| Annual Indicator | 139 | 148 | 173 | 171 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | AHCS | AHCS | AHCS | AHCS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: ESM 8.2.2 - Percent of children participating in the WV Coordinated Approach to Child Health (CATCH) Program**

| Measure Status: | | Active | |
|---|---|---|---|
| **State Provided Data** | | | |
| | **2017** | **2018** | **2019** |
| Annual Objective | 40 | 93 | 94 |
| Annual Indicator | 93 | 94 | 94 |
| Numerator | | | |
| Denominator | | | |
| Data Source | HealthCheck | HealthCheck | HealthCheck |
| Data Source Year | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: ESM 11.1 - Number of resident medical students who completed the Project DOCC training through the Parent Partners in Education grant**

| Measure Status: | | | Active | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 83 | 100 | 25 |
| Annual Indicator | 83 | 15 | 20 | 15 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | CSHCN | CSHCN | CSHCN | CSHCN |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Additionally 72 medical students were trained by PPIE in a 1.5 hour grand rounds presentation by parents of CSHCN. This grand rounds presentation is related to the Project DOCC curriculum, but not explicatively part of it.

**2016-2020: ESM 11.2 - Number of CSHCN served by the WV CSHCN Program**

| Measure Status: | | | Active | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 1,715 | 1,912 | 2,103 |
| Annual Indicator | 1,559 | 1,739 | 1,830 | 3,050 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | WV CSHCN | WV CSHCN | WV CSHCN | WV CSHCN |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Provisional | Provisional | Provisional |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: ESM 13.1.1 - Number of prenatal care providers educated on national consensus statement**

| **Measure Status:** | | | **Active** | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 100 | 120 |
| Annual Indicator | 0 | 100 | 90 | 100 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Oral Health | Oral Health Program | Oral Health Program | Oral Health Program |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: ESM 13.1.2 - Number of dental care providers educated on national consensus statement**

| Measure Status: | | | Active | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 25 | 30 |
| Annual Indicator | 0 | 20 | 25 | 25 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Oral Health Program | Oral Health Program | Oral Health Program | Oral Health Program |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: ESM 13.2.1 - Percentage of pediatric care providers completing Smiles for Life Course 6: Caries Risk Assessment, Fluoride Varnish & Counseling**

| Measure Status: | | | Active | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 0 | 5 | 10 |
| Annual Indicator | 0 | 0 | 10 | 10 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Oral Health Program | Oral Health Program | Oral Health Program | Oral Health Program |
| Data Source Year | 2016 | 2016 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Provisional | Provisional | Provisional |

**Field Level Notes for Form 10 ESMs:**

None

## Form 10
## State Performance Measure (SPM) Detail Sheets

**State: West Virginia**

**SPM 1 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care**
**Population Domain(s) – Adolescent Health, Children with Special Health Care Needs**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the percent of adolescents with and without special health care needs who have received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. |
| **Definition:** | **Numerator:** Number of adolescents with and without special health care needs, ages 12 through 17, whose families report that they received the services necessary to transition to adult health care<br>**Denominator:** Number of adolescents, ages 12 through 17<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Healthy People 2020 Objective:** | Related to Disability and Health (DH) Objective 5: Increase the proportion of youth with special health care needs whose health care provider has discussed transition planning from pediatric to adult health care. (Baseline: 41.2%, Target: 45.3%) |
| **Data Sources and Data Issues:** | The revised National Survey of Children's Health (NSCH) beginning in 2017. States can use data from the 2009-2010 NS-CSHCN as a baseline. |
| **Significance:** | The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions. |

**SPM 2 - Increase identification of pregnant women using substances during pregnancy.**
**Population Domain(s) – Women/Maternal Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase identification of pregnant women using substances during pregnancy utilizing the PRSI form and increase the number of women referred for treatment. |
| **Definition:** | **Numerator:** Number of pregnant women reporting substance use on the PRSI form.<br>**Denominator:** Number of pregnant women identified through the PRSI form.<br>**Unit Type:** Count<br>**Unit Number:** 100,000 |
| **Healthy People 2020 Objective:** | MICH-11.4 Increase abstinence from illicit drugs among pregnant women. |
| **Data Sources and Data Issues:** | The PRSI form will be utilized as the data collection system. The leading barrier of the PRSI form is the number of providers not complying with state mandate for completing the form. With the transition from paper to a web based system it is hoped this barrier will decrease. |
| **Significance:** | The Prenatal Risk Screening Instrument (PRSI) is intended to promote early and accurate identification of prenatal risk factors. Prenatal Risk Screening Instrument is to be completed by the physician/clinician at the first prenatal visit. If the patient answers “Yes” to any pregnancy or medical risk factor, a Maternal Fetal Medicine consultation should be considered. Data gathered through the PRSI will be used to develop procedures, policy, and obtain funding to address prenatal risk. The goal is to improve birth outcomes for mother and infant. Completion and submission of this form is required by State Law. |

**SPM 3 - Increase the awareness of controlled substance use among children ages 5-17.**
**Population Domain(s) – Child Health, Adolescent Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the provider, family and general public awareness of controlled substance use among children ages 5-17. |
| **Definition:** | **Numerator:** Number of controlled substance prescribing providers who received academic detailing regarding substance use.<br>**Denominator:** Number of controlled substance prescribing providers in the state.<br>**Unit Type:** Count<br>**Unit Number:** 10,000 |
| **Healthy People 2020 Objective:** | HP 2020 SA-19 Reduce the past year non-medical use of prescription drugs, although does not address the specific age groups it does include those aged 12 years and over. |
| **Data Sources and Data Issues:** | PDMP for number of prescribing providers and VIPP Program for number of prescribing providers receiving academic detailing. |
| **Significance:** | Studies have shown that non-medical use of controlled substances, e.g. stimulants, during childhood results in an increased risk of SUD in adulthood. |

**SPM 4 - Percent of children, ages two to four, who are obese as defined as body mass index (BMI) at or above the 95th percentile on the CDC growth charts for age and sex.**
**Population Domain(s) – Child Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Decrease obesity rates in children, ages two to four, from 16.6% (WIC data 2016) to 14.4% by 2022. |
| **Definition:** | **Numerator:** Number of children ages two to four participating in WIC who are obese as defined as BMI at or above the 95th percentile on the CDC growth charts for age and sex.<br>**Denominator:** Total number of children ages two to four participating in WIC.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Healthy People 2020 Objective:** | Related to Nutrition and Weight Status (NWS) 10.4. Reduce the proportion of children and adolescents aged 2 to 19 years who are considered obese. (Baseline: 16.1% in 2005-2008, Target: 14.5%).<br>Related to NWS 11. (Developmental) Prevent inappropriate weight gain in youth and adults. |
| **Data Sources and Data Issues:** | Data are from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Participant and Program Characteristics (WIC PC). WIC PC is a biennial census in even years for participating children two to four year in age. Data are analyzed by CDC's Obesity Prevention and Control Branch. Data issues include recent decline in participation rates in WV even though poverty rates are stable and/or increasing. |
| **Significance:** | West Virginia, unfortunately, has led the nation in adult obesity and chronic disease rates including diabetes, hypertension and cardiovascular disease. WV adolescents are following the same trend of continually increasing overweight and obesity rates leading to early morbidity and an economic strain on health insurance costs. Nationally, obesity prevalence in children aged two to four years participating in WIC decreased from 15.9% in 2010 to 13.9% in 2016 and during 2010–2014, decreased in 34 of the 56 WIC states/territories. WV was only one of three states that had increasing obesity rates (from 14.4% in 2010 to 16.4% in 2014). WV must start earlier to address primary prevention efforts in young children. Research has shown that obesity prevention efforts from elementary school to adulthood have been inadequate, and mostly unsuccessful, to slow the obesity epidemic. However, obesity prevention initiatives in Early Care and Education (ECE) settings show promising results; not only for successfully decreasing obesity rates over a short time period (2010-2014), but also across all ethnic groups (The State of Obesity: Better Policies for a Healthier America 2018, Trust for America's Health, Robert Wood Johnson Foundation, 2018). Other successful initiatives have actually widened the disparity gap. Equitable access to early education addresses the deleterious effects of poverty on children's development. According to the Centers for Disease Control and Prevention (CDC), it is easier to influence children's food and activity choices when they are young. The ECE setting can directly influence what children eat and drink and how active they are, which builds a foundation for healthy habits. For this reason, early education is included in the CDC Health Impact in 5 Years (HI-5) because it reaches entire populations of people at once and requires less individual effort. |

## Form 10
## State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

**2016-2020: SPM 2 - Percent of children ages 0 through 17 who are adequately insured**
**Population Domain(s) – Child Health, Adolescent Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the number of children who are adequately insured |
| **Definition:** | **Numerator:** Number of children, ages 0 through 17, who were reported to be adequately insured, based on 3 criteria: whether their children's insurance covers needed services and providers, and reasonably covers costs.<br>**Denominator:** Number of children, ages 0 through 17<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Healthy People 2020 Objective:** | Related to Access to Health Services (AHS) Objective 1: Increase the proportion of persons with health insurance.<br>Related to Access to Health Services (AHS) Objective 6: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines. |
| **Data Sources and Data Issues:** | National Survey of Children's Health (NSCH) |
| **Significance:** | Almost one-quarter of American children with continuous insurance coverage are not adequately insured. Inadequately insured children are more likely to have delayed or forgone care, lack a medical home, be less likely to receive needed referrals and care coordination, and receive family-centered care. The American Academy of Pediatrics highlighted the importance of this issue with a policy statement. The major problems cited were cost-sharing requirements that are too high, benefit limitations, and inadequate coverage of needed services. |

**2016-2020: SPM 3 - Rate of infants born with neonatal abstinence syndrome.**
**Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To reduce the rate of infants born with neonatal abstinence syndrome. |
| **Definition:** | **Numerator:** Number of infants born with neonatal abstinence syndrome.<br>**Denominator:** Number of deliveries.<br>**Unit Type:** Rate<br>**Unit Number:** 1,000 |
| **Healthy People 2020 Objective:** | Related to Maternal, Infant, and Child Health Objective 11.4. Increase abstinence from illicit drugs among pregnant women. |
| **Data Sources and Data Issues:** | WV Birth Score Program |
| **Significance:** | In West Virginia, the rate of infants born with NAS per 1,000 deliveries has increased from 16.5 in 2008 to 45.4 in 2013. |

**2016-2020: SPM 4 - Percentage of adolescents ages 12-17 with a well visit in the past year**
**Population Domain(s) – Adolescent Health**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of adolescents ages 12-17 receiving preventive medical care such as a physical exam or well-child checkup during the last 12 months</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of adolescents, ages 12 through 17 with a preventive well visit in the past year.</td></tr>
<tr><td>Denominator:</td><td>Number of adolescents, ages 12 through 17</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>AH-1 Increase the proportion of adolescents who have had a wellness checkup in the past 12 months.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The revised National Survey of Children's Health (NSCH) beginning in 2017. States can use data from the 2009-2010 NS-CSHCN as a baseline.</td></tr>
<tr><td>Significance:</td><td>Adolescence is also a time when many chronic physical, mental health and substance use conditions first emerge. Early identification of these conditions and behaviors leads to earlier referral and subsequent treatment. Furthermore, addressing risky behaviors early and promoting positive health behaviors through periodic well care visits can help adolescents identify and respond to stresses, and make good choices in managing their health.</td></tr>
</table>

## Form 10
## State Outcome Measure (SOM) Detail Sheets

**State: West Virginia**

No State Outcome Measures were created by the State.

## Form 10
## Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

**State: West Virginia**

**ESM 2.1 - Number of first time pregnant women who have participated in the Lamaze International Evidence Based Labor Support Workshop.**
**NPM 2 – Percent of cesarean deliveries among low-risk first births**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of first time pregnant women, fathers, families and support persons who have participated in the Lamaze International Evidence Based Labor Support Workshop. |
| **Definition:** | **Numerator:** Number of first time pregnant women who participated in the Lamaze International Evidence Based Labor Support Workshop.<br>**Denominator:** Number of first time pregnant women.<br>**Unit Type:** Count<br>**Unit Number:** 100,000 |
| **Data Sources and Data Issues:** | Vital Statistics and Perinatal Partnership |
| **Significance:** | Research shows that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of one-on-one support. A Cochrane meta-analysis states the association with a statistically significant reduction in the rate of cesarean deliveries. |

**ESM 4.1 - Number of birthing facilities designated Baby-Friendly under the EMPower initiative**
**NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the number of birthing facilities designated Baby-Friendly under the EMPower initiative from 5 in 2020 to 10 by 2025. |
| **Definition:** | **Numerator:** Number of birthing facilities designated as Baby-Friendly by Baby Friendly USA.<br>**Denominator:** Number of birthing facilities.<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Vital Statistics and Baby Friendly USA |
| **Significance:** | Birthing facility utilization the Ten Steps to Successful Breastfeeding will encourage breastfeeding and increase the percent of infants who are ever breastfed and breastfed exclusively through 6 months. |

**ESM 4.2 - Percent of infants who are breastfeeding at time of discharge from a birthing facility**
**NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the percentage of infants who are breastfeeding at time of discharge from a birthing facility to 74% by 2025. |
| **Definition:** | **Numerator:** Number of infants who are breastfeeding at time of discharge from birthing facilities<br>**Denominator:** Number of live infant discharged from a birthing facility<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Vital Statistics |
| **Significance:** | Birthing facility utilization the Ten Steps to Successful Breastfeeding will encourage breastfeeding and increase the percent of infants who are ever breastfed and breastfed exclusively through 6 months. |

**ESM 4.3 - Percent of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age**
**NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the number of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age. |
| **Definition:** | **Numerator:** Number of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age<br>**Denominator:** Number of infants enrolled in an evidence-based home visitation program who have reached six months of age<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | OMCFH home visitation programs |
| **Significance:** | Breastfeeding can reduce post neonatal mortality rate per 1,000 live births and reduce Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births |

**ESM 5.1 - Percent of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education**
**NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education from 95% in 2020 to 100% by 2024.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of birthing hospitals in the state that have been trained using the “Say YES to Safe Sleep” curriculum</td></tr>
<tr><td>Denominator:</td><td>Number of birthing hospitals in the state</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The number of birthing hospitals in the State is determined by state licensing. The number of hospitals that have been trained is collected from “Our Babies: Safe and Sound” project.</td></tr>
<tr><td>Significance:</td><td>Currently, 95% of births in WV occur in a birthing hospital that uses the “Say YES to Safe Sleep” curriculum to provide safe sleep education to new families. By increasing the number of birthing hospitals who are trained to use the curriculum, a greater percentage of the birth population will be reached with Safe Sleep education.</td></tr>
</table>

**ESM 5.2 - Percent of families enrolled in a home visitation program who received safe sleep education from a trained home visitation provider on the first visit after child's birth**
**NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Provide Safe Sleep education on the first visit after child's birth to 88% of families enrolled in a home visitation program</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of families (with a child less than 1 year) enrolled in a home visitation program who received safe sleep education on the first visit after child's birth from a trained home visitor</td></tr>
<tr><td>Denominator:</td><td>Number of families enrolled in a home visitation program with a child aged less than 1 year during the reporting period</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be collected from WV Home Visitation Programs.</td></tr>
<tr><td>Significance:</td><td>Increasing the number of families who receive Safe Sleep education will help to reach those families who did not receive the education in the hospital and will also serve to reinforce the message for those families who did receive the education prior to hospital discharge. Many families feel more comfortable having conversations and asking questions with their trusted home visitor with whom they have built a good relationship. Safe Sleep education delivered during home visits will help to overcome barriers related to safe sleep practices.</td></tr>
</table>

**ESM 5.3 - Percent of infants enrolled in a home visitation program that are always placed to sleep on their backs, without bed-sharing or soft bedding**
**NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the percentage of infants enrolled in a home visitation program that are always placed to sleep on their backs, without bed-sharing or soft bedding to 93% by 2024 |
| **Definition:** | |

| | |
|---|---|
| **Numerator:** | Number of infants (aged less than 1 year) enrolled in a home visitation program whose primary caregiver reports that they are always placed to sleep on their backs, without bed-sharing or soft bedding |
| **Denominator:** | Number of infants enrolled in a home visitation program who were aged less than 1 year during the reporting period |
| **Unit Type:** | Percentage |
| **Unit Number:** | 100 |

| | |
|---|---|
| **Data Sources and Data Issues:** | Data will be collected from WV Home Visitation Programs. |
| **Significance:** | By asking primary caregivers to report sleep practices regularly, home visitors will have additional opportunities to provide safe sleep education and reinforce the risks of unsafe sleep. |

**ESM 9.1 - Number of positive youth development (PYD) focused trainings provided to youth, parents, professionals and community members**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To foster positive and nurturing relationships between young people and caring adults within their communities. |
| **Definition:** | **Numerator:** Number of PYD trainings provided to youth, parents, professionals and community members<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**Unit Number:** 1,000 |
| **Data Sources and Data Issues:** | Data will be provided by Adolescent Health grantees |
| **Significance:** | By fostering strong youth-adult relationships, the OMCFH is supporting well-researched protective factors against bullying and many other risk behaviors. This approach is further supported by statewide data WV OMCFH collected in 2015-2016. |

**ESM 9.2 - Number of schools and/or youth serving organizations in target communities that have implemented a comprehensive bullying program**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To implement comprehensive, evidence-based bullying prevention programming in schools and communities |
| **Definition:** | **Numerator:** Number of schools and/or youth serving organizations that have implemented a comprehensive bullying program<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**Unit Number:** 1,000 |
| **Data Sources and Data Issues:** | Data provided by the Adolescent Health grantees, the Violence and Injury Prevention grantees and the WV Dept. of Education |
| **Significance:** | By encouraging the implementation of comprehensive prevention programs, the WV OMCFH is supporting a systematic approach to reducing bullying among youth in WV schools and communities |

**ESM 9.3 - Number of messages disseminated via social media**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase awareness about bullying, cyberbullying and the associated negative outcomes, while promoting positive behaviors, educating on bystander skills and supporting WVDE Policy 4373 |
| **Definition:** | **Numerator:** Number of social media messages.<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**Unit Number:** 10,000 |
| **Data Sources and Data Issues:** | Data will be provided by Adolescent Health grantees |
| **Significance:** | The utilization of social media is an evidence-based youth violence prevention strategy that will be used in combination with other strategies. By implementing a combination of strategies, the WV OMCFH is supporting stronger and more sustainable improvements in health and safety than the implementation of a single strategy |

**ESM 9.4 - Number of trainings provided to youth, parents, professionals and community members**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase awareness about bullying, cyberbullying and the associated negative outcomes, while promoting positive behaviors, educating on bystander skills and supporting WVDE Policy 4373 |
| **Definition:** | **Numerator:** Number of trainings provided to youth, parents, professionals and community members<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**Unit Number:** 1,000 |
| **Data Sources and Data Issues:** | Data will be provided by Adolescent Health grantees |
| **Significance:** | By educating youth and adults as part of a comprehensive approach to reducing youth violence and victimization, the WV OMCFH is supporting stronger and more sustainable improvements in health and safety than the implementation of a single strategy |

**ESM 11.1 - Number of stakeholders who receive education and resources regarding the National Resource Center For Patient/Family-Centered Medical Home in the last calendar year.**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | CSHCN |
| **Goal:** | To improve the medical community's knowledge and adoption of the Patient-Centered Medical Home model of primary care. |
| **Definition:** | **Numerator:** Number of stakeholders who receive education and resources regarding the National Resource Center for Patient/Family-Centered Medical Home<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**Unit Number:** 10,000 |
| **Data Sources and Data Issues:** | CSHCN Program will inform this ESM. This measure will require a consistent definition and application for "stakeholder." |
| **Significance:** | The AAP endorses the Patient-Centered Medical home as the optimal way to provide comprehensive, coordinated, and ongoing care to children. This ESM will allow the CSHCN Program to gauge stakeholder and community education on the Patient-Centered Medical Home. |

**ESM 11.2 - Percent of well-child exams received by Medicaid members age 0-21 with a documented social determinants of health screening (as identified by claims data) in the last calendar year.**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To improve the number of well-child exams received by Medicaid members age 0-21 with a documented social determinants of health screening. |
| **Definition:** | **Numerator:** Number of well-child exams received by Medicaid members age 0-21 with a documented social determinants of health screener (as identified by claims data) in the last calendar year.<br>**Denominator:** Number of well-child exams received by Medicaid members age 0-21 in the last calendar year.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | The CSHCN Program will utilize Medicaid claims data to inform this ESM. Inconsistent billing and coding may cause issues with this ESM. |
| **Significance:** | Social determinants of health are recognized as having a tremendous impact on children's physical and mental health. The CSHCN Program can address social determinants of health through care coordination within the program's client population and also provide stakeholders with community resources to help address social determinants of health for all CSHCN in the state of West Virginia. |

**ESM 11.3 - Number of children who receive Title V funded medially necessary medical foods.**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Ensure children in need of medically necessary medical foods are served. |
| **Definition:** | **Numerator:** Number of children who receive Title V funded medically necessary foods.<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**Unit Number:** 10,000 |
| **Data Sources and Data Issues:** | CSHCN Program |
| **Significance:** | Necessary to ensure coverage for medically necessary nutrition services to children. |

**ESM 13.1.1 - Establish a curriculum for WVU School of Dentistry on dental care for pregnant women.**
**NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | Pregnant Women |
| **Goal:** | Increase the number of pregnant women with preventive dental visits during pregnancy by establishing a curriculum for WVU School of Dentistry on dental care for pregnant women. |
| **Definition:** | **Numerator:** Number of students completing the dental care curriculum for pregnant women.<br>**Denominator:** Number of students in WVU School of Dentistry<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | WVU School of Dentistry |
| **Significance:** | Through ongoing work of the Oral Health Program on perinatal oral health quality improvement, it is understood that there are many challenges around dental care during pregnancy. The national consensus statement is currently the best resource to create a standard knowledge base for dental care during pregnancy. Education of prenatal care providers on this topic should increase the number of pregnant women who are referred for dental care during pregnancy and increase the number of pregnant women receiving dental services. |

**ESM 14.1.1 - Number of health care workers who have had Help2Quit maternity care provider training**
**NPM 14.1 – Percent of women who smoke during pregnancy**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | Pregnant Women |
| **Goal:** | To increase the number of health care workers who have had Help2Quit maternity care provider training |
| **Definition:** | **Numerator:** Number of health care providers who have had Help2Quit maternity care provider training<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**Unit Number:** 1,000 |
| **Data Sources and Data Issues:** | WV Perinatal Partnership |
| **Significance:** | Decreasing the percentage of women who smoked during pregnancy and the percentage of children in households where someone smokes can reduce the following: rate of severe maternal morbidity per 10,000 delivery hospitalizations, maternal mortality rate per 100,000 live births, percent of low birth weight deliveries (<2,500 grams), percent of very low birth weight deliveries (<1,500 grams), percent of moderately low birth weight deliveries (1,500-2,499 grams), percent of preterm births (<37 weeks), percent of early preterm births (<34 weeks), percent of late preterm births (34-36 weeks), percent of early term births (37, 38 weeks), perinatal mortality rate per 1,000 live births plus fetal deaths, infant mortality rate per 1,000 live births, neonatal mortality rate per 1,000 live births, post neonatal mortality rate per 1,000 live births, preterm-related mortality rate per 100,000 live births, sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births, and percent of children in excellent or very good health. |

**ESM 14.1.2 - Percent of women enrolled in HV who reported using any tobacco products at enrollment and were referred to tobacco cessation within 3 months of enrollment.**
**NPM 14.1 – Percent of women who smoke during pregnancy**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | Pregnant Women |
| **Goal:** | To increase the number of clients who are referred to smoking cessation services within the first 3 months of enrollment in a home visitation program. |
| **Definition:** | **Numerator:** Number of women enrolled in home visitation who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment.<br>**Denominator:** Number of women enrolled in home visitation who reported using tobacco or cigarettes at enrollment and were enrolled for at least 3 months.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | OMCFH Home Visitation Programs |
| **Significance:** | Decreasing the percentage of women who smoking during pregnancy and the percentage of children in households where someone smokes can reduce the following: rate of severe maternal morbidity per 10,000 delivery hospitalizations, maternal mortality rate per 100,000 live births, percent of low birth weight deliveries (<2,500 grams), percent of very low birth weight deliveries (<1,500 grams), percent of moderately low birth weight deliveries (1,500-2,499 grams), percent of preterm births (<37 weeks), percent of early preterm births (<34 weeks), percent of late preterm births (34-36 weeks), percent of early term births (37, 38 weeks), perinatal mortality rate per 1,000 live births plus fetal deaths, infant mortality rate per 1,000 live births, neonatal mortality rate per 1,000 live births, post neonatal mortality rate per 1,000 live births, preterm-related mortality rate per 100,000 live births, sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births, and percent of children in excellent or very good health. |

**ESM 14.2.1 - Percent of children in households where someone smokes.**
**NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To decrease the number of households where someone smokes. |
| **Definition:** | **Numerator:** Number of children ages 0-17 who live in households where there is household member who smokes.<br>**Denominator:** Number of children ages 0 through 17<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | NSCH |
| **Significance:** | Children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections; and SIDS |

## Form 10
## Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

**2016-2020: ESM 2.1 - Number of maternity care providers who have participated in the Lamaze International Evidence Based Labor Support Workshop**
**NPM 2 – Percent of cesarean deliveries among low-risk first births**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Provision of evidence based support during labor to improve the birth process and reduce cesarean deliveries without a medical indication |
| **Definition:** | **Numerator:** Number of labor/delivery nurses that receive evidence based labor support training<br>**Denominator:** Number of labor/delivery nurses employed in birth facilities<br>**Unit Type:** Count<br>**Unit Number:** 10,000 |
| **Data Sources and Data Issues:** | Birth facilities count of Labor and Delivery nurses employed January 1, 2017. Number of participants in the Evidence Based Labor Support Workshops conducted by the Perinatal Partnership. |
| **Significance:** | Research shows that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of one-on-one support. A Cochrane meta-analysis states the association with a statistically significant reduction in the rate of cesarean deliveries. |

**2016-2020: ESM 8.1.1 - Number of schools surveyed that are engaged in shared use activities.**
**2016-2020: NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase physical activity and improved nutrition in communities through school-based and community-based activities. |
| **Definition:** | **Numerator:** Number of schools implementing shared use.<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**Unit Number:** 1,000 |
| **Data Sources and Data Issues:** | Data will be provided by the Adolescent Health Grantees |
| **Significance:** | By increasing shared use agreements and other opportunities for physical activity and improved nutrition, the WV OMCFH is supporting a systematic improvement to obesity. |

**2016-2020: ESM 8.1.2 - Percent of children participating in the WV Coordinated Approach to Child Health (CATCH) Program**
**2016-2020: NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase physical activity rates through facilitation of the CATCH program at various summer camps and programs. |
| **Definition:** | **Numerator:** Number of children ages 6 through 12 who are physically active for a minimum of 60 minutes per day through participation in supervised and organized activities at summer camps.<br>**Denominator:** Number of children who attend the selected camps.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Staff that will facilitate the CATCH program recording numbers of participants and hours of organized supervised activity. |
| **Significance:** | Increased activity in an organized setting is shown to reduce the effect and results of obesity. This program will show evidence of hours spent to reach the goals of the program to increase physical activity time and reduce the rates of obesity. |

**2016-2020: ESM 8.2.1 - Number of schools surveyed that are engaged in shared use activities**
**2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase physical activity and improved nutrition in communities through school-based and community-based activities |
| **Definition:** | **Numerator:** Number of schools implementing shared use<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**Unit Number:** 1,000 |
| **Data Sources and Data Issues:** | Data will be provided by the Adolescent Health Grantees |
| **Significance:** | By increasing shared use agreements and other opportunities for physical activity and improved nutrition, the WV OMCFH is supporting a systematic improvement to obesity |

**2016-2020: ESM 8.2.2 - Percent of children participating in the WV Coordinated Approach to Child Health (CATCH) Program**
**2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase physical activity rates through facilitation of the CATCH program at various summer camps and programs. |
| **Definition:** | **Numerator:** Number of adolescents ages 12 through 17 who are physically active for a minimum of 60 minutes per day through participation in supervised and organized activities at summer camps.<br>**Denominator:** Number of children who attend the selected camps.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Staff that will facilitate the CATCH program recording numbers of participants and hours of organized supervised activity. |
| **Significance:** | Increased activity in an organized setting is shown to reduce the effect and results of obesity. This program will show evidence of hours spent to reach the goals of the program to increase physical activity time and reduce the rates of obesity. |

**2016-2020: ESM 11.1 - Number of resident medical students who completed the Project DOCC training through the Parent Partners in Education grant**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To improve resident medical student's knowledge of the importance of family centered care by educating them on the impact of chronic illness and disability on the families of CSHCN. |
| **Definition:** | **Numerator:** Number of resident medical students who completed the Project DOCC training through the Parent Partners in Education grant<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**Unit Number:** 1,000 |
| **Data Sources and Data Issues:** | Data will be received from the Parent Partners in Education grantee. The resident medical student must have documented completion of all Project DOCC components to be considered as completing the training. |
| **Significance:** | By educating resident medical students in the importance of family-centered care, the WV OMCHF is supporting a systematic improvement to the system of care for CSHCN and their families. |

**2016-2020: ESM 11.2 - Number of CSHCN served by the WV CSHCN Program**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To provide quality care coordination and support the medical home for CSHCN in the state of WV who meet the Program's eligibility criteria. |
| **Definition:** | **Numerator:** Number of unique CSHCN enrolled in the WV CSHCN Program in FY 2017<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**Unit Number:** 10,000 |
| **Data Sources and Data Issues:** | Data will be obtained from the CSHCN Program. |
| **Significance:** | The WV Title V agency administers the CSHCN Program to provide comprehensive care coordination and gap filling services to CSHCN in the state of WV. These services are provided pursuant to the National Standards for Systems of Care for CYSHCN. |

**2016-2020: ESM 13.1.1 - Number of prenatal care providers educated on national consensus statement**
**NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of prenatal care providers educated on national consensus statement by 20%. |
| **Definition:** | **Numerator:** Number of WV prenatal care providers educated on national consensus statement.<br>**Denominator:** Number of WV prenatal care providers.<br>**Unit Type:** Count<br>**Unit Number:** 1,000 |
| **Data Sources and Data Issues:** | Information will be collected by Oral Health Program through work of state program staff and Regional Oral Health Coordinators. There is no anticipated issue with this data collection. |
| **Significance:** | Through ongoing work of the Oral Health Program on perinatal oral health quality improvement, it is understood that there are many challenges around dental care during pregnancy. The national consensus statement is currently the best resource to create a standard knowledge base for dental care during pregnancy. Education of prenatal care providers on this topic should increase the number of pregnant women who are referred for dental care during pregnancy and increase the number of pregnant women receiving dental services. |

**2016-2020: ESM 13.1.2 - Number of dental care providers educated on national consensus statement**
**NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of dental care providers educated on national consensus statement by 20% |
| **Definition:** | **Numerator:** Number of West Virginia dental care providers educated on national consensus statement<br>**Denominator:** Number of dental care providers in West Virginia<br>**Unit Type:** Count<br>**Unit Number:** 1,000 |
| **Data Sources and Data Issues:** | Information will be collected by Oral Health Program through work of state program staff and Regional Oral Health Coordinators. There is no anticipated issue with this data collection. |
| **Significance:** | Through ongoing work of the Oral Health Program on perinatal oral health quality improvement, it is understood that there are many challenges around dental care during pregnancy. The national consensus statement is currently the best resource to create a standard knowledge base for dental care during pregnancy. Education of dental care providers on this topic should increase the number of pregnant women who are seen by dentists during pregnancy. |

**2016-2020: ESM 13.2.1 - Percentage of pediatric care providers completing Smiles for Life Course 6: Caries Risk Assessment, Fluoride Varnish & Counseling**
**2016-2020: NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of pediatric care providers who complete the Smiles for Life course required in West Virginia for reimbursement of fluoride vanish application for children ages 0-3 by 20%.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of pediatric care providers who complete Smiles for Life Course 6</td></tr>
<tr><td>Denominator:</td><td>Number of pediatric care providers in West Virginia</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Information will be collected by Oral Health Program through work of state program staff and Regional Oral Health Coordinators. There is no anticipated issue with this data collection.</td></tr>
<tr><td>Significance:</td><td>Children typically see their pediatric care provider 11 times before they first see a dentist, which positions pediatric providers in a unique position to support oral health early in a child’s life. Fluoride varnish application is a simple service to provide in the medical setting and has been shown to reduce caries risk by 25-45% in early childhood. The challenge with these services in West Virginia remains reliable reimbursement. The Oral Health Program is working on quality improvement to understand the barriers to reliable reimbursement for these services when provided for the target population. It is also the desire of the Oral Health Program to work on policy analysis and potential revision based on the Bright Futures/USPTF recommendation of these services for children ages 0-5.</td></tr>
</table>

## Form 11
## Other State Data

### State: West Virginia

The Form 11 data are available for review via the link below.

Form 11 Data