

**Maternal and Child  
Health Services Title V  
Block Grant**

**West Virginia**

**FY 2022 Application/  
FY 2020 Annual Report**

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## I. General Requirements

### I.A. Letter of Transmittal



STATE OF WEST VIRGINIA  
**DEPARTMENT OF HEALTH AND HUMAN RESOURCES**  
**Bureau for Public Health**

Bill J. Crouch  
Cabinet Secretary

Office of Maternal, Child and Family Health

Ayne Amjad, MD, MPH  
Commissioner & State Health Officer

September 1, 2021

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 2022.
2. Fiscal Year 2020 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,

A handwritten signature in blue ink, appearing to read "James Jeffries".

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](http://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 2021 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: January 31, 2024.

## **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: January 31, 2024.*

### III. Components of the Application/Annual Report

#### III.A. Executive Summary

##### III.A.1. Program Overview

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 of these same collaboratives 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 and pregnant women.

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 22% 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 48% 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 18% 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 20.9% in 2017 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 19.6% (non-CSHCN) in 2018 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 19.6% (non-CSHCN) in 2018 to 40% for both populations by 2025.

### **III.A.2. How Federal Title V Funds Complement State-Supported 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 and infant 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

The Prenatal Risk Screening Instrument (PRSI) was developed to assist with assessment of enrollment in the State's Medicaid Home Visitation Program called Right From the Start (RFTS). If the enrollee had medical complications or risks a nurse was assigned as the care coordinator and if the enrollee had social or environmental risks a social worker was assigned as the care coordinator.

In 2010, Legislation was enacted that mandated Maternal Risk Screening (W. Va. Code § 16-4E-1. et seq.). The Legislature finds that there is a need for a more comprehensive and uniform approach to any screening conducted by physicians and midwives to discover at-risk and high-risk pregnancies. This legislation gave the OMCFH the charge to convene an advisory council to provide assistance in the development of a uniform maternal risk screening tool to be utilized and submitted to the OMCFH by all health care providers offering maternity services to pregnant woman.

Initially it was a struggle for physicians to comply with the mandate as they still believed it was only to be used for Medicaid patients. The percentage of completed PRSIs has continued to increase and in 2020 approximately 75% of pregnant women had a PRSI completed and submitted.

In 2019, funds were available from the CDC ZIKA award, that allowed for the addition of questions to the PRSI about the risk for the ZIKA Virus. With the CDCs blessing, between 2020 and 2021 the funds were used to contract with Local Data Solutions to develop a web-based collection system that physicians could use and send the data electronically. This website has been developed and is awaiting physician office training.

Utilizing the eight RFTS Regional Lead Agency sub-recipient grantees who are required to visit all maternity care providers in their assigned region, training is being provided to the providers on use of the system. The system should be fully operational by Spring 2022.

The OMCFH Office Director collaborated with Medicaid on sending PRSI information to the MCOs responsible for the enrollee's medical care. This effort necessitated a legislative change to the code which did not allow for sharing of identifiers and requiring a rule change to allow information to be received by the OMCFH other than fax. In March 2020 the Code was amended and the Rules are currently under review by legal representatives.

Risk factors collected on the PRSI are sent electronically weekly to Medicaid which in turn sends it to the appropriate MCO. This gives the MCO a heads up to start care coordination for any risks identified. Physicians also use the PRSI to make referrals for additional services.





to 2020 US Census. 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 18,090 preliminary 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 2019 across several health measures, including overall health, obesity, and physical inactivity. 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 2019, the percent of obese adults reached 39.7%; WV ranked 49th 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 2019, WV was ranked 46th with 31.2% 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 15.7% in 2019. In 2019, WV ranked 50th in terms of smoking with 23.8% 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 2019 WV Pregnancy Risk Assessment Monitoring System (PRAMS) data, smoking during the last three months of pregnancy has decreased to 18.5% after increasing from 18.6% in 2017 to 24.9% in 2018.

The report did however list the following strengths for the state: low prevalence of excessive drinking, high school graduation rate and low racial gap in low birth weight. The report also highlighted a 37% decrease in teen births, a 10% increase in access to high-speed internet and a 32% decrease in the percent of adults who avoided care due to cost.

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 21 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 59 Rural Health Clinics in WV, 254 Federally Qualified Health Center (FQHC) sites providing services in the State, 10 short term hospitals outside of urban areas and 21 critical access hospitals. Six point six (6.6) percent of WV residents lack health insurance (Kaiser, 2019). According to the Economic Research Service, the average per capita income for WV residents in 2019 was \$42,315 and rural per capita income lagged at \$38,358. Estimates from 2019 indicate a poverty rate of 17.6% exists in rural WV areas compared to 16.3% in urban areas.

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, ages zero to one, increased to 158% Federal Poverty Level (FPL) and children ages 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. Medicaid eligibility for pregnant women also expanded to 158% FPL. The current eligibility levels are: ages zero to one 163% FPL, ages one to six 146% FPL, ages six to 19 138% FPL and pregnant women and their newborns 190% 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. The new guidelines eliminate the asset test previously required for non-disabled adults and the elderly. 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. The most recent survey (survey year 2019) found that 6.8% of WV children are currently uninsured, but according to the 2020 WVCHIP Report there are only 3.5% children currently uninsured.

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*)

- i. 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. Needs Assessment**

#### **FY 2022 Application/FY 2020 Annual Report Update**

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. 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, including children with special health care needs, population groups.

Based upon findings from the 2020 Needs Assessment, West Virginia chose 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

Discussed below are the impacts WV has made in the selected priority areas over the last year despite challenges of the COVID pandemic, the ongoing drug epidemic and changes in Bureau leadership.

#### **Smoking – Maternal**

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).

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 18.5% of women in 2019 smoked during the last trimester of pregnancy, this is lower than the 29.5% of women that reported smoking in the three months before pregnancy.

Maternal smoking three months before pregnancy is most common among mothers less than 34-years of age, those who receive Medicaid, and those with less than a high school degree; an alarming 48% and 38% of those mothers without a high school degree reported smoking in the 3 months before pregnancy and the last trimester of pregnancy, respectively, in 2019. 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.

#### **Smoking - Home 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 2017 and 2018 (it decreased from 8.5% in 2017 to 5.8% in 2018). In 2019, smoking was allowed in at least part of the home in less than 6% (5.8%) of homes.

#### **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. 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.

The most recent calendar year data available from the Infant and Maternal Mortality Review Panel is 2016, the Panel has met and reviewed 2/3 of the infant deaths for 2017 and hope to complete the full calendar year of 2017 by October 2021. For calendar year 2016, 139 infant deaths were reviewed by the IMMRRP. The manner of death was listed as 89 (64%) natural, 30 (22%) undetermined, one (<1%) homicide, five (4%) accidental and 14 (10%) unknown.

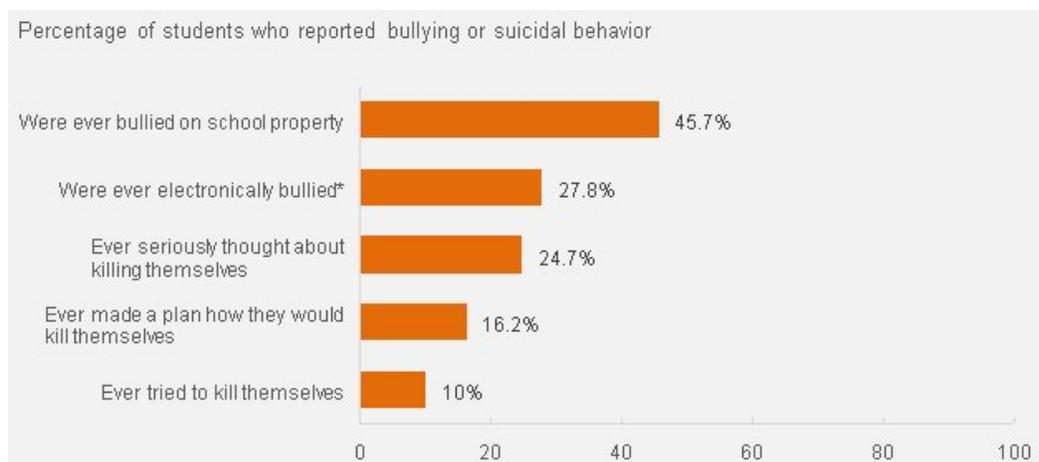
The infant mortality rate for West Virginia in 2016 was 7.28 infant deaths per 1,000 live births (calculated as 139 infant deaths divided by 19,070 resident births - 2016 Health Statistics Center data). In 2016, the CDC reported the U.S. infant mortality rate as 5.87 infant deaths per 1,000 live births.

### Premature Birth

The West Virginia Health Statistics Center reports preliminary data from 2019 showing 12.6% of births were preterm. This was an increase in overall preterm births from 2018, which was reported as 11.9%.

### Bullying and Suicidal Behaviors

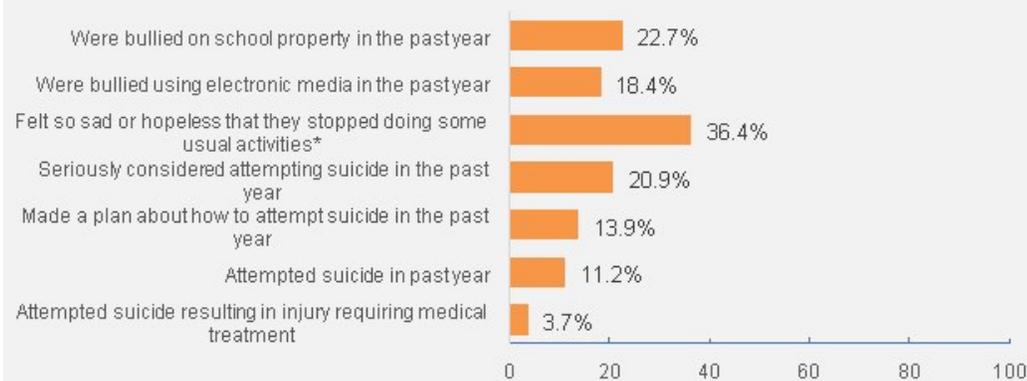
The 2019 West Virginia Youth Risk Behavior Survey revealed the following rates of bullying and suicidal behaviors reported by WV middle school students. There were slight increases/decreases (not significant) reported in all the listed areas.



### Bullying and Suicidal Behaviors

The 2019 West Virginia Youth Risk Behavior Survey revealed the following rates of bullying and suicidal behaviors reported by WV high school students. There were slight increases/decreases (not significant) were reported in all the listed areas.

Percentage of students reported bullying or suicidal behavior



### Substance use in pregnancy

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 DFMB Project is a comprehensive and integrative medical and behavioral health program for pregnant and postpartum women. The project supports healthy baby outcomes by providing prevention, early intervention, addiction treatment, and recovery support services. In 2012, the West Virginia Perinatal Partnership awarded funding to four pilot project sites. Since 2018, the Drug Free Moms and Babies Project has expanded to twelve additional facilities.

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 2020, MRS indicated 8.1% of pregnant respondents reported a problem with drugs or alcohol currently and 9.5% reported problem with drugs or alcohol in the past. In 2019, 6.9% of pregnant respondents reported a problem with drugs or alcohol currently and 9.3% reported problem with drugs or alcohol in the past. MRS also found that, of those PRSIs submitted in 2020, 2.2% reported current opioid abuse treatment and 2.4% reported previous opioid abuse treatment. In 2019, 2.8% reported current opioid abuse treatment and 2.8% reported previous opioid abuse treatment.

The Birth Score Program collects incidence of intrauterine substance exposure (IUSE) and signs of NAS in infants through the Birth Score collection tool. Every baby born in the state receives a birth score as mandated by state code. The percent of infants with IUSE has hovered just below 14% from 2017 to 2020 and the percent of infants born with signs of NAS has increased from 5.06% to 6.55% in 2020.

### Substance use in youth/teens

West Virginia continues to experience some of the highest national averages of substance use morbidity and mortality based on its population. These substance use behaviors can develop in youth and adolescence, making prevention and intervention at a young age critically important in our state.

The most recent data available (2019) from the Youth Risk Behavior Surveillance System (YRBSS) indicates that some areas of alcohol and other drug use are more likely in West Virginia than in the United States. Specifically, West Virginia high school respondents were more likely to: report that the largest number of drinks they had in a row was 10 or more (WV – 5.0% v. US – 3.1%); ever use synthetic marijuana (WV – 10.4% v. US – 7.3%); ever use methamphetamines (WV – 3.5% v. US – 2.1%); and ever injected any illegal drug (WV – 2.7% v. US – 1.6%).

Looking at WV 2019 YRBSS data comparing males and females, male respondents were more likely to: ever used cocaine (female – 3.1% v. male – 5.8%); ever used methamphetamines (female – 2.2% v. male – 4.6%); ever used ecstasy (female – 3.3% v. male – 5.8%); and ever took steroids without a doctor's prescription (female – 1.9% v. male – 5.2%).

In a preliminary analysis of data from West Virginia's Prescription Drug Monitoring Program (PDMP, aka Controlled Substance Monitoring Program/CSMP), males between the ages of 5 – 17 are regularly prescribed stimulants; in some counties in the state, the prescribing of stimulants greatly exceeds the prevalence of ADD/ADHD in the population, specifically for males. This analysis will be continued to determine the true need of stimulant prescriptions in the West Virginia resident population.

### **Breastfeeding Initiation and Duration**

The National Immunization Survey 2020 Breastfeeding Report Card (based up 2017 births) indicates WV's ever breastfed rate at 69.9%. The WV Health Statistics Center reports infants breastfeeding at time of discharge after delivery as 66.2% in 2019 and 66.8% in 2020. The report card also lists WV's total mPINC score for 2018 at 76, compared to the US National score of 79.

In 2019, WV PRAMS indicates that 71.6% of women ever breastfed and only 44.1% of women were breastfeeding at the time of the survey (4-6 months postpartum). Almost 69% of women indicated they breastfed for less than a week, compared to the 17.8% that breastfed greater than 8 weeks.

### **Medical Home and Transition**

In the 2018/2019 combined Survey of Children's Health data, only 41.8% of CSHCN in WV reported receiving coordinated, ongoing, comprehensive care within a medical home. This is down from 45.2% in 2017/2018, but within the 95% confidence interval. Sixty-nine percent of CSHCN in WV received needed care coordination. The CSHCN Program is well-positioned to improve this metric.

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		2018/2019	
	WV	U.S.	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%	25.6%	22.9%
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%	50.4%	50.5%
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%	70.2%	69.7%
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%	35.6%	35.7%
YSHCN whose doctors discussed the shift to providers who treat adults, if needed	12.6%	17.3%	18.8%	20.0%	26.2%	24.8%

## Obesity in Children

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.

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 (i.e., 16.4% up to 16.6%). The results are reported as WV had a 2.2% increase in prevalence (14.4% to 16.6%). The most recent data available (2018) for WIC participants ages 2-4 that are obese is 16.5% in West Virginia, ranking fourth nationally behind Alaska, New Hampshire, and Rhode Island.

## Oral Health and Pregnancy

PRAMS 2019 data shows that 41.9% of women received teeth cleanings prior to pregnancy and only 31.5% of women received cleanings during pregnancy. This leaves 68.5% of pregnant women that did not partake in teeth cleanings as part of their prenatal care.



## **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**

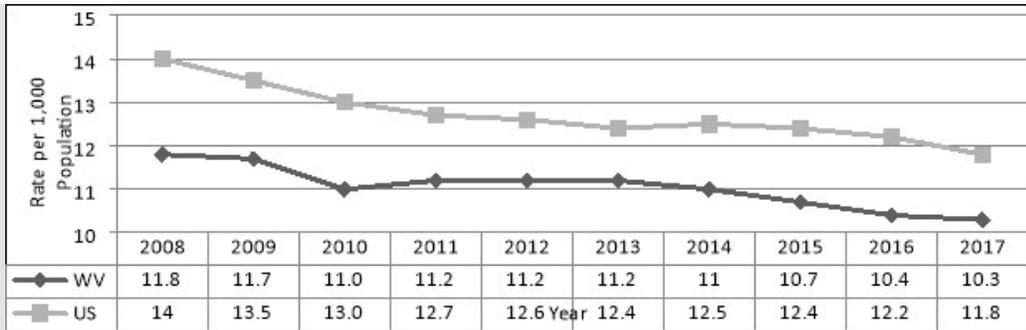
##### **Women/Maternal Health**

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

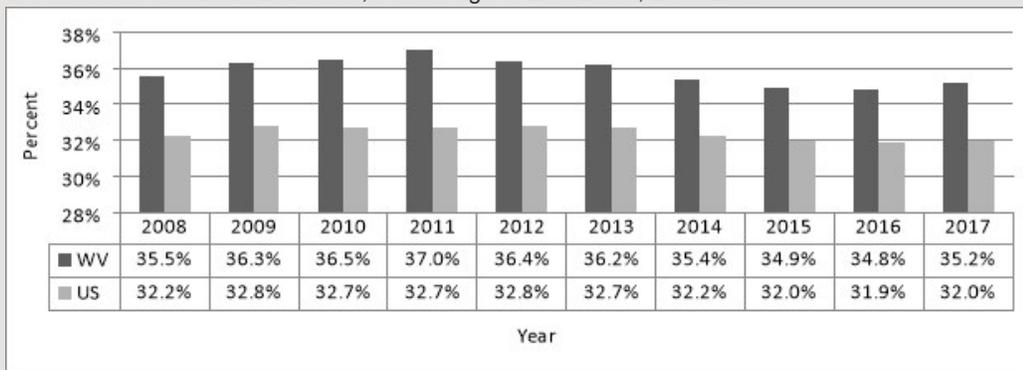


Data source (WV): West Virginia Health Statistics Center, Vital Statistics Center. (National): CDC Wonder

### Delivery Method

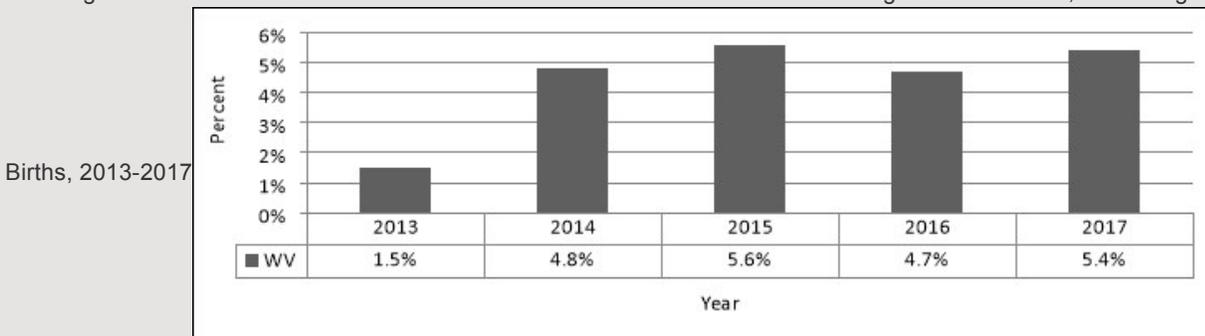
The proportion of cesarean deliveries in WV peaked in 2011 at 37.0% of all births, though that percent has decreased to around 35.0% in recent years. The proportion of cesarean sections in the U.S. has remained steady at around 35.0% since 2014. As a result of negative birth outcomes, the proportion 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.

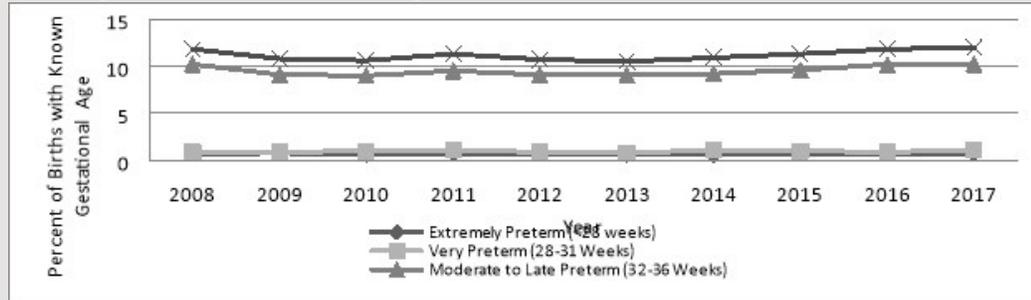
Data source: West Virginia Health Statistics Center, Vital Statistics Center

### 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

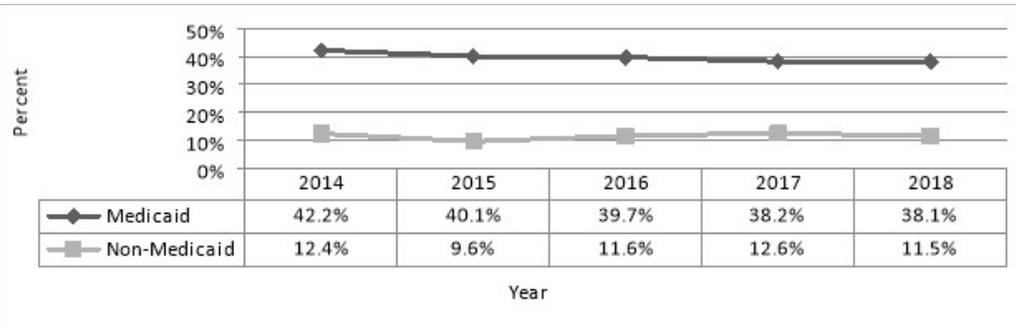
Smoking status during pregnancy	2014	2015	2016	2017	2018*
Smoked	27.9%	25.3%	25.4%	24.7%	23.7%
Did not smoke	72.1%	74.7%	74.6%	75.3%	76.3%

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



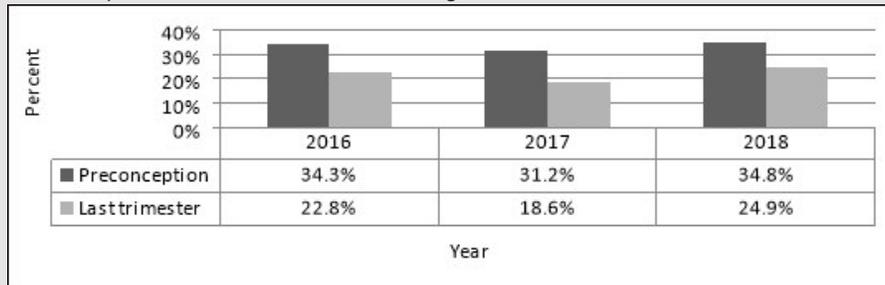
Data source: WV Health Statistics Center, Vital Statistics System

\*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.

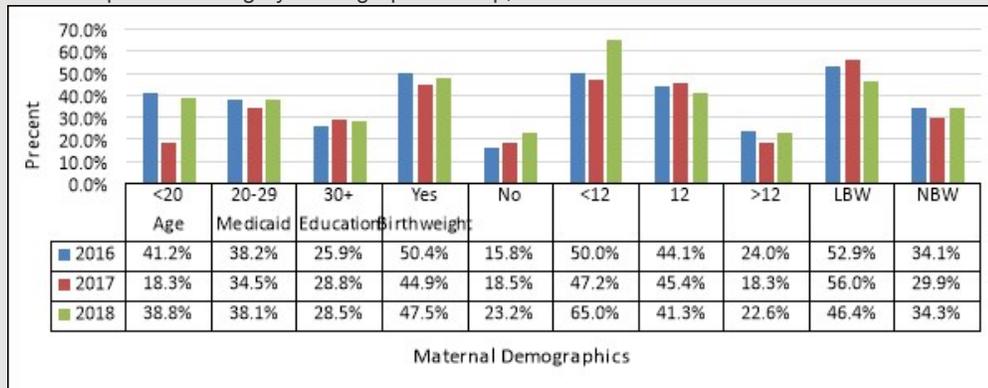
#### Preconception and Last Trimester Smoking, 2016-2018



Data source: WV PRAMS

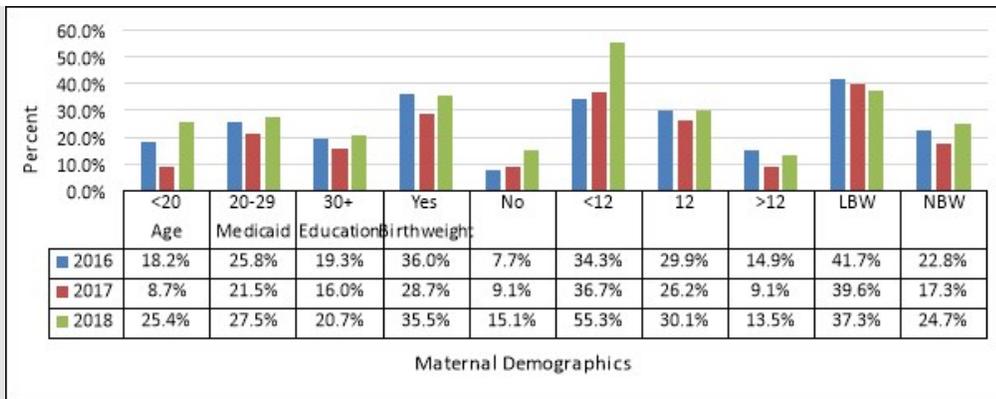
Maternal smoking three months before pregnancy is most common among mothers less than 29-years of age, those who receive Medicaid, and those with less than a high school degree; an alarming 65% and 55% of those mothers without a high school degree reported smoking in the 3 months before pregnancy and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



Data source: WV PRAMS

#### Last Trimester Smoking by Demographic Group, 2016-2018



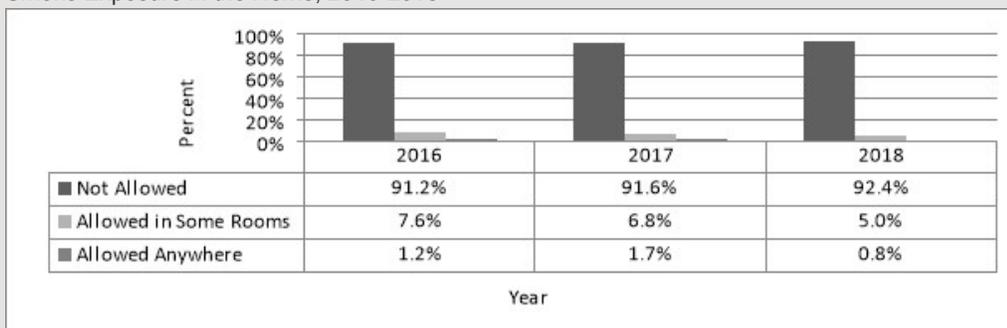
Data source: WV PRAMS

### 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



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**

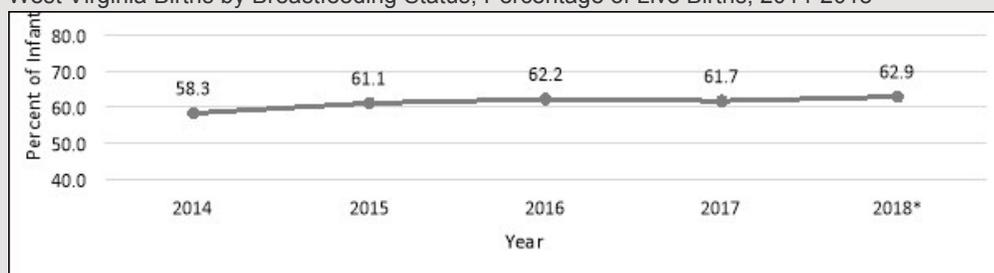
	IUSE		NAS	
	N	%	N	%
2017	2,265	14.3	802	5.1
2018	2,148	14.3	737	4.9
2019	2,052	13.4	862	5.6

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**

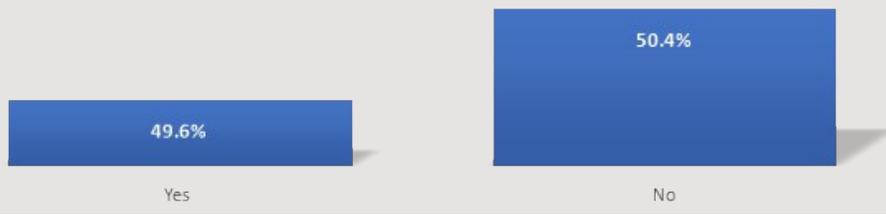
	Ever breastfed		Breastfeeding at 6 months		Breastfeeding at 12 months		Exclusive breastfeeding at 3 months		Exclusive breastfeeding at 6 months	
	WV	U.S.	WV	U.S.	WV	U.S.	WV	U.S.	WV	U.S.
2012	62.3	80.0	34.3	51.4	17.7	29.2	27.8	43.3	11.5	21.9
2013	64.6	81.1	35.8	51.8	18.3	30.7	32.6	44.4	14.1	22.3
2014	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.

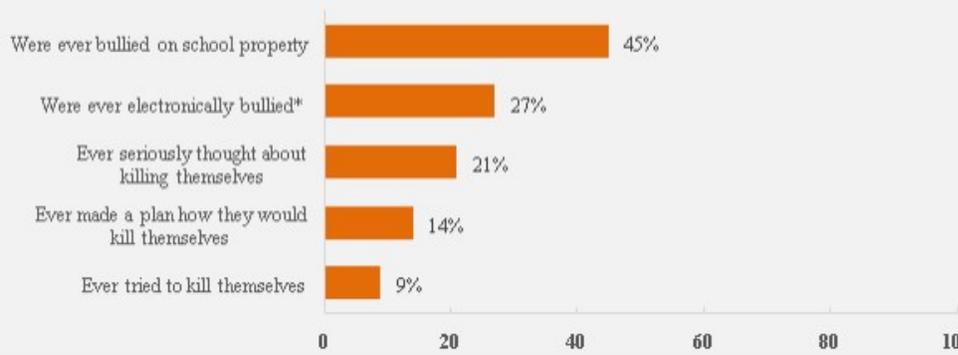
Adolescents often exhibit risky behaviors that can have immediate and prolonged detrimental health effects. Numerous adult diseases and causes of premature death can be attributed to risky behaviors in adolescence. Additionally, risky behaviors such as unprotected sex and bullying can lead to adolescents 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

Percentage of students who reported experiencing bullying or suicidal behavior in the past year



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

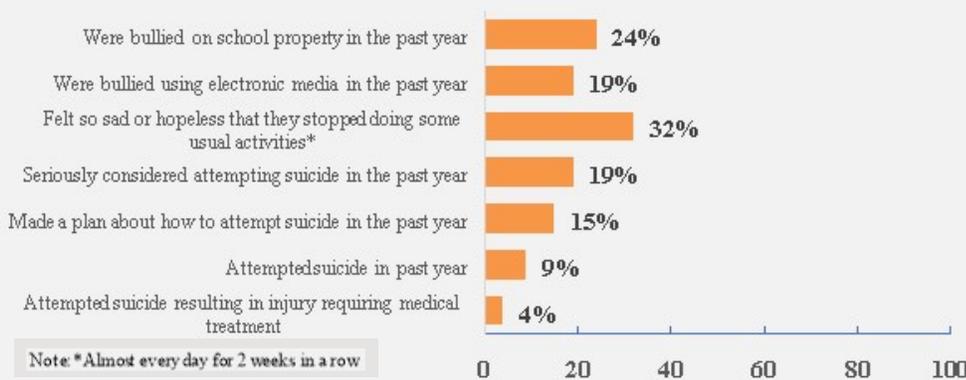
*Data source: West Virginia Department of Education Trends in the West Virginia Youth Risk Behavior Survey, 2017: Middle School 2018 Fact Sheet.*  
**High School**

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.

Percentage of students reported bullying or suicidal behavior



Note: \*Almost every day for 2 weeks in a row

### 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%
<b>Medical Home Components</b>				
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%
<b>Components of Transition</b>				
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 Initiative, 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

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$6,056,026	\$6,055,416	\$6,056,026	\$6,055,641
<b>State Funds</b>	\$13,485,615	\$10,983,296	\$13,264,963	\$12,629,175
<b>Local Funds</b>	\$0	\$0	\$0	\$0
<b>Other Funds</b>	\$0	\$0	\$0	\$0
<b>Program Funds</b>	\$20,399,917	\$19,589,153	\$19,282,861	\$19,526,885
<b>SubTotal</b>	\$39,941,558	\$36,627,865	\$38,603,850	\$38,211,701
<b>Other Federal Funds</b>	\$24,853,776	\$22,849,741	\$27,964,391	\$22,293,910
<b>Total</b>	\$64,795,334	\$59,477,606	\$66,568,241	\$60,505,611
	2020		2021	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$6,056,584	\$6,117,166	\$6,176,181	
<b>State Funds</b>	\$13,341,754	\$12,190,559	\$13,272,503	
<b>Local Funds</b>	\$0	\$0	\$0	
<b>Other Funds</b>	\$0	\$180	\$0	
<b>Program Funds</b>	\$0	\$21,615,897	\$21,193,138	
<b>SubTotal</b>	\$19,398,338	\$39,923,802	\$40,641,822	
<b>Other Federal Funds</b>	\$33,256,949	\$19,729,699	\$29,431,884	
<b>Total</b>	\$52,655,287	\$59,653,501	\$70,073,706	

	2022	
	Budgeted	Expended
<b>Federal Allocation</b>	\$6,205,535	
<b>State Funds</b>	\$13,146,376	
<b>Local Funds</b>	\$0	
<b>Other Funds</b>	\$0	
<b>Program Funds</b>	\$22,300,975	
<b>SubTotal</b>	\$41,652,886	
<b>Other Federal Funds</b>	\$29,724,428	
<b>Total</b>	\$71,377,314	

### III.D.1. Expenditures

The Office of Maternal, Child and Family Health (OMCFH) expects to allocate nearly \$72,000,000 in resources for FY 2022. These funds are comprised of State, Federal, and private resources. Title V Block Grant funds in the amount of \$6,205,535 are used to provide the foundational structure for the OMCFH. Specifically, the funds are used to ensure and facilitate access to medical homes, reduce infant mortality, ensure access to prenatal care, ensure access to preventive and childcare 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 \$13,146,376 in State funds and will generate \$22,300,975 in program income. The total state match provided is \$35,447,351. Program income consists 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 33.7% for preventive and primary care for children and 43% 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 6.8% for administrative costs, complying with the 10% limit.

The Office served over 347,546 pregnant women and children and youth ages one through 21 years of age during annual report year 2020, approximately 75% of those West Virginia populations. Nearly 16,000 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. Nearly 18,000 infants received newborn screening services and Birth Score referrals. Over 51,463 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 and low birthweight infants, breastfeeding, infant mortality, youth and teen injuries and teen suicide, medical home for children with and without special health care needs, oral health during pregnancy, smoking during pregnancy and exposure in the household, transitions to adult care for children with and without special health care needs, 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 ensuring that project work plans and grant agreements align with the needs assessment and action plans on an annual basis. Specifically, MCH Block Grant funds support a skilled MCH workforce, programs to reduce infant and maternal morbidity and mortality, reduce smoking during pregnancy, increase breastfeeding, facilitate action plans to reduce preterm births, identify and decrease substance use in pregnancy, and provide staff support to identify high-risk pregnancies and address Neonatal Abstinence Syndrome (NAS). Block grant funds also support West Virginia's Adolescent Health Initiative to address teen injuries and suicide, 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. State funds are 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 populations.

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. Moreover, the Office's Violence and Injury Prevention Program serves as the West Virginia State Health Department subunit responsible for implementing the CDC's National Center for Injury Control and Prevention (NCIPC) funded cooperative agreements, including *Overdose Data to Action* (supporting high quality, complete, and timelier data on overdoses, and use of those data to inform prevention and response), *Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes* and *Firearm Injury Surveillance Through Emergency Rooms*.

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 (specifically West Virginia University and Marshall University), 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 Covid 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.

In response to the opioid epidemic, 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. State MCH Capacity to Advance Effective Public Health Systems

#### 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, Early Intervention/Part C (Birth to Three) Director 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)

**Pamela Roush**, BA Psychology

**Education:**

Bachelor of Arts, Indiana University, Bloomington, IN, 1973

Legal Studies, WVU University, Charleston, WV, 2005-2006

**Professional:**

WV Birth to Three, Director, OMCFH/BPH (1992-Present)

TA Specialist, WV Birth to Three OMCFH/BPH (1991-1992)

**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, Perinatal Partnership Summit, Public Health Conference, KidStrong Conference, Celebrating Connections, Rural Health Conference, the State Social Worker CEU 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.

The Title V workforce makeup in WV includes: 26.5 FTE Title V funded positions, 5 new Title V staff were onboarded since September 2020 composed of 2 HHR Program Manager I, an HHR Associate, a Physician Director (MCH only covers 10% of this position), an Epidemiologist 1 and an HHR Specialist Sr., and there are currently 6 vacant Title V positions.

### 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 2021-2022, 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. MCH Data Capacity

#### III.E.2.b.iii.a. MCH Epidemiology Workforce

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).

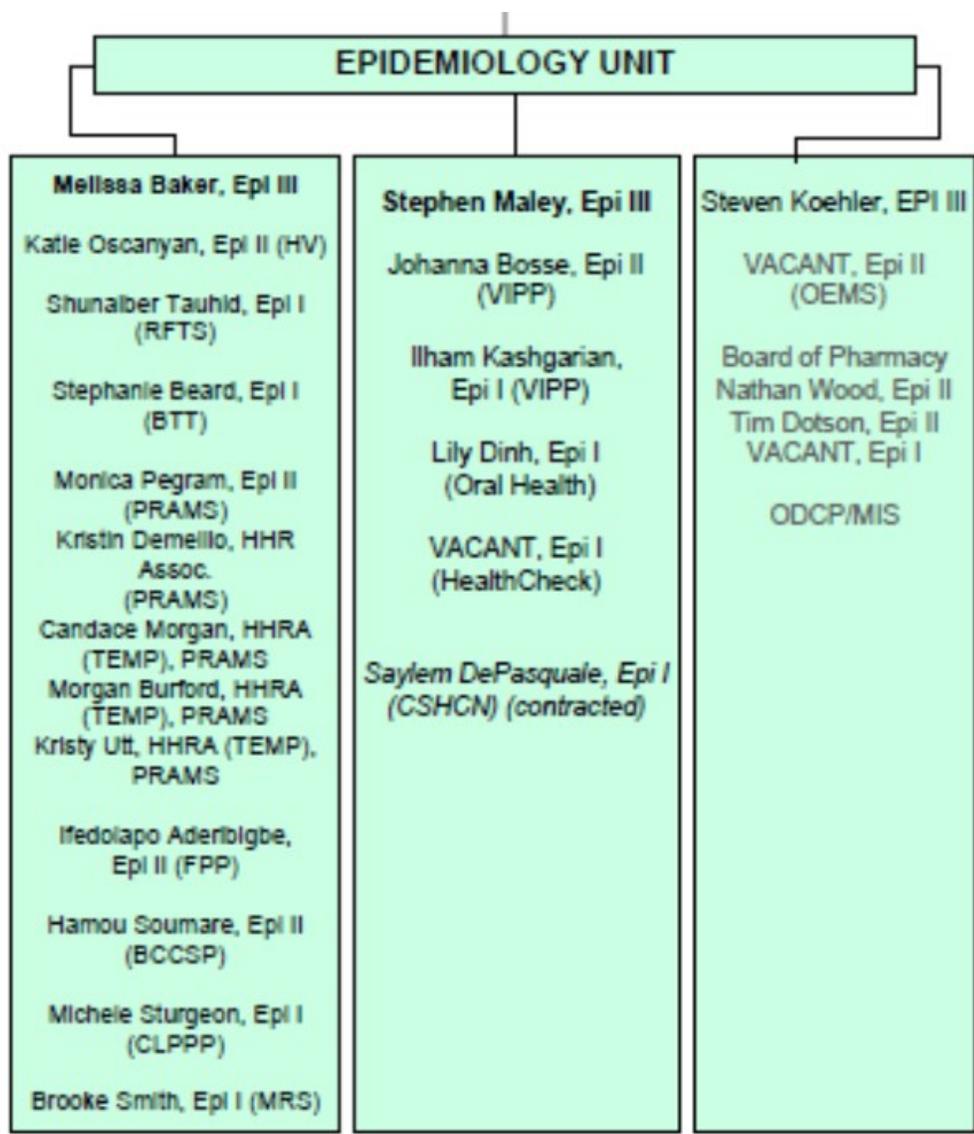
The Office provides ongoing support for staff to attend professional development opportunities both in-state and out-of-state to assure the understanding and knowledge of evidence-based practice. Opportunities include various national program specific meetings, annual conferences including Council of State and Territorial Epidemiologists (CSTE), CityMatCH, and MCH Epi. Attendance to other national, state and local training programs available to enhance the epidemiology capacity is encouraged. OMCFH pays the yearly dues for all epi staff to be members of CSTE.

In addition to utilizing federal funds to maintain adequate staffing, the Office also embeds epidemiology personnel employed by its partners. For example, personnel from West Virginia University Center for Excellence in Disabilities serves as the epidemiologist for CSHCN, the Board of Pharmacy employs three epidemiologists housed in OMCFH, and the Office of Drug Control Policy staffs an epidemiologist located in OMCFH. 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.

The majority of the epidemiology staff are funded through the program to which they staff while only a few are funded by Title V. All epidemiology staff have at a minimum master's degree. OMCFH epidemiology experience for the currently filled positions are:

- 1-3 years = 5
- 3-5 years = 7
- 5-10 years = 4
- 25 years = 1

The chart below depicts the structure of the MCH Epi Unit.



### III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

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. Historically, WV has funded a Programmer Analyst position using the SSDI award and has chosen to support surveillance systems development over the years to address data needs related to emerging MCH issues such as birth defects that may be caused by the Zika virus, maternal mortality, maternal substance use, infant mortality, newborn screening, newborn hearing screening, childhood lead poisoning, maternal risk screening, maternal smoking, etc. as state specific measures. Because the Programmer Analyst is imbedded in the Office of Maternal, Child and Family Health, the SSDI award is not a stand-alone project, but rather benefits many data related efforts for data collection and linkages. The MCH Epidemiologist is housed within the Research Division and funded by Title V and supports SSDI efforts. The MCH Epidemiologist has a significant leadership role in submission of the Title V Application and Progress Report as well as the 5-Year Needs Assessment. There are three Epidemiologist III Supervisors who supervise 14 epidemiologists to support OMCFH programs. The Office provides funding for Board of Pharmacy epidemiologists, and they are housed in the Office as well.

#### **Most Recent Accomplishments:**

##### **Birth Defects:**

WV added the CDC Birth Defects Registry database and collected data abstracted from medical records on ICD-10 codes, P00.0 - P37.9 and Q000.0 – Q99.9. WV was awarded CDC Zika Birth Defect funds, and this allowed a contractual arrangement with two part-time nurses to abstract the medical information. A Memoranda of Understanding with all birthing facilities was updated and all hospitals cooperated by either sending hard copy medical records, discs or allowed access to the hospital medical records electronically. Previously, only 8 of the 23 birthing facilities were sending in birth defect information with limited data. Currently all birthing facilities are submitting information. WV was able to successfully submit data to the CDC. To date, 2016, 2017, and 2018 information has been collected and entered in the data system. The Zika Birth Defects grant ended on August 31, 2019, but the project continued to complete the abstractions for 2016 using Title V dollars. The Zika Birth Defects award also allowed WV to contract with Local Data Solutions to develop an on-line data collection tool for use by physicians for the Perinatal Risk Screening Instrument (PRSI) designed to identify maternal risks at their first prenatal visit. The PRSI is shared with Medicaid for follow-up with women who have high risk issues. WV also submits data to CDC on birth defects quarterly. West Virginia's birth defects surveillance system, however, continues to be a passive system.

##### **COVID-19 Activities**

During the COVID-19 Pandemic, the experience of abstracting birth defects information that may have been caused by the Zika Virus, led the Office to be asked by The Office of Epidemiology and Prevention Services who have the ELC Grant to identify and abstract medical information on children with Multi-Inflammatory Syndrome in Children (MIS-C) and abstraction and follow-up on COVID-19 positive pregnant women and their infants. To date, WV has identified 18 children who meet inclusion criteria and has submitted all data to CDC. Also, to date, over 700 pregnant women have been identified who were positive for COVID-19. SSDI assisted in building a compatible data base to send data to CDC for the positive Covid-19 pregnant women.

In 2020, the SSDI Programmer Analyst assigned to the grant built an access database to capture community testing event data for COVID-19. Data collected from the sites is used to determine characteristics of the population being tested at the testing location. Data entry staff housed within OMCFH are being used to enter the data and the Childhood Lead Poisoning Prevention Program epidemiologist is assisting with analysis and data cleaning.

**Maternal and Infant Mortality:**

WV added the CDC MMRIA database to capture more extensive data on maternal deaths. WV continues to participate in training sessions offered by CDC and has entered data for years 2016-2019. The MMRIA database has gone through several revision updates. WV agreed to have CDC provide the hosting environment to eliminate server issues within the state environment. The review nurse develops a summary of each case reviewed to share with the Infant and Maternal Mortality Review Panel to determine pregnancy-related or pregnancy-associated and preventable or non-preventable. WV also added the FIMR database in 2018 and continues to capture infant mortality data. The review nurses also develop a summary of each case abstracted to share with the Advisory Panel to determine preventability and non-preventability. Recommendations are solicited from the Advisory Panel to reduce infant and maternal mortality. SSDI was involved in the addition of these two data programs.

**Childhood Lead Poisoning:**

A lead module was purchased and added to the immunization register to allow Head Start personnel and medical providers access to lead screening information. A grant from the Robert Wood Johnson Foundation was secured for this activity. Access is now available, and data is pulled from the Lead database and sent to Immunizations for upload. SSDI staff were involved in the collaboration and implementation process.

### III.E.2.b.iii.c. Other MCH Data Capacity Efforts

The West Virginia Office of Maternal, Child and Family (OMCFH) has the good fortune to employ high level epidemiologists. Two years ago, the Department of Personnel increased the starting salaries for epidemiologists which helped tremendously with hiring and retention. As entry level epidemiologists (epidemiologist I's) meet qualifications for an epidemiologist II, paperwork is submitted to allow for advancements. This also increases retention and satisfaction.

Currently, OMCFH employs three (3) Epidemiologist IIIs, two with PH. Ds and one with a master's degree and 20 years' experience. OMCFH also employs eight (8) Epidemiologist IIs and four (4) Epidemiologist Is. These Epidemiologists cover Perinatal Risk Screening Instrument (PRSI), PRAMS, Home Visitation (MIECHV), Right From the Start (Medicaid Home Visitation Program), Early Periodic, Screening, Diagnostic and Treatment (EPSDT) called HealthCheck, Violence and Injury Prevention (VIPPP), Childhood Lead Poisoning Prevention (CLPP), Newborn Hearing Screening (NHS), Breast and Cervical Cancer Screening (BCCSP), Family Planning, Oral Health, Children with Special Health Care Needs (CSHCN), Drug overdoses and deaths, Firearm Safety, birth defects, and Infant and Maternal Mortality. One Epidemiologist may cover more than one Program or be proficient in a certain data set. Because of our versatility and using different grant funding awards to cover salaries of the Epidemiologists, the OMCFH is able to capture valuable statistical information. The OMCFH has access to death records, occurrence births, birth defects using a passive system, newborn hearing screening (NBHS), newborn screening, State Unintentional Drug Overdose Reporting System (SUDORS), Syndromic Surveillance (Essence) data using ER and Med Express data, Neonatal Abstinence Syndrome data, PRAMS, Prescription drugs, Early Intervention/Part C called Birth To Three (BTT), Home Visitation data, COVID Positive Pregnant Women and their infants, children diagnosed with MIS-C, Infant and Mortality Review, Childhood Lead Poisoning, Medicaid eligibility, Breast and Cervical Cancer Screening and Foster Children.

The OMCFH also employs by contract with WVU, staff for evaluation efforts for some of our programs.

The OMCFH has in place a contract with WVU called Project Watch, formerly called the Birth Score Office that collects data for the OMCFH on the infant's risk of developmental delay or death within the first year of life, NAS, NBHS, and Critical Congenital Heart Disease. This information is completed at the birthing facility before discharge and sent to Project Watch. Project Watch also provides analysis when requested or will share data sets. Physicians are notified of high-risk infants and NAS diagnosis and referrals are automatically sent to RFTS for home visitation services and Children With Special Health Care Needs.

The OMCFH also financially supports three (3) Epidemiology positions from the Board of Pharmacy who are housed within the OMCFH. This collaboration provides the opportunity to provide prescription drug information for various Program activities and assessments.

The Health Statistics Center (Vital Statistics) provides random birth sampling for PRAMS, infant and maternal mortality data for the Infant and Maternal Mortality Review Panel, access to the death file and occurrence birth file, overdose deaths and requests for resident infant deaths and birth information on birth outcomes such as prematurity, smoking during pregnancy, gestational age, etc.

Birth Defects information is collected monthly from each birthing facility.

The OMCFH also collects data on a woman's first prenatal visit to determine risk. This collection tool is called the Prenatal Risk Screening Instrument (PRSI). Information on Medicaid patients is shared with Medicaid to distribute to the appropriate Medicaid Managed Care Organization.

The Hospital Association also provides data on hospital discharges, although won't share identifiers so WV lacks the capacity to data match. The same situation occurs for WIC.

### III.E.2.b.iv. MCH Emergency Planning and Preparedness

Currently, OMCFH is not heavily involved in the state's emergency preparedness and response planning activities. The existing emergency operations plan for the Department of Health and Human Resources is entitled the Public Health All-Hazard Plan and is reviewed annually. The needs of the MCH population, including at-risk and medically vulnerable women, infants, and children is not specifically addressed but is discussed below.

The OMCFH was accepted to participate in round two of the AMCHP sponsored "Building Emergency Preparedness and Response (EPR) Capacity for Maternal and Infant Health Action Learning Collaborative (ALC)" in August 2019. It was hoped that participation in this project would strengthen the EPR capacity for MCH populations across the state. The MCH population has been defined as more vulnerable in times of emergency simply because of the characteristics this population exhibit. In the past WV has experienced both natural and man-made disasters. The state is prone to flooding caused by storms, heavy rains and snowfall during certain times of the year. The state has also been subject in recent years to a water crisis caused by a chemical leak. The goals of the OMCHF and its partners the Center for Threat Preparedness (CTP) and the Public Health Threat Response Planning Group (PHTRPG) as participants in this collaborative was: to test the MCH preparedness checklist created in conjunction with those states who participated in round one of this project and to create an action plan detailing protocol for integrating the MCH population into the state response plan.

The team for this ALC included: Melissa Baker-OMCFH (co-lead), Scott Eubank-CTP (co-lead), Cathy Capps-Amburgey-OMCFH, Mekell Golden-OMCFH, Christi Clark-CTP, and Carolyn Elswick-CTP with support from office directors Jim Jeffries-OMCFH and Donnie Haynes-CPT.

The OMCHF in collaboration with the EPR, CTP and PHTRPG worked to develop a comprehensive emergency plan that encompasses the MCH population regardless of the source of the emergency and will be an Appendix to the larger Department of Health and Human Resources Public Health All-Hazard Plan. Those plans include all emergency phases including preparedness, response, recovery and mitigation. In the preparedness phase response plans targeting the MCH population were to be developed and training and exercises following Homeland Security Exercise and Evaluation Program (HSEEP) guiding principles were to be modified to incorporate the MCH population. The response phase was to include safety, stabilization, preservation and mass care of the MCH population. The recovery phase was to include health and social support services, housing and economic support services. The mitigation phase was to include public education, evaluation and improved infrastructure based upon assessments.

The OMCFH, along with CTP and the PHTRPG was committed to participating in the proposed monthly webinars and attending the in-person meeting. The OMCFH, CTP and PHTRPG were also committed to assembling the recommended multidisciplinary team, submitting the required interim progress report sharing the status of the state's ALC action plan, completing and presenting the state's action plan at the close of the ALC and submitting a final report on the state's activities, successes, barriers and willingness to share experiences with other states.

The ALC started off well with team members attending the in-person meeting of round two states in Chicago. Monthly calls took place after the initial meeting and WV reported out on the progress made in achieving the goals outlined. Once COVID impacted public health staff, the ability to continue with the action learning collaborative was put on hold. States, including WV, were not able to dedicate the time needed to pursue the development of emergency preparedness response to include and/or expand inclusion of the MCH population.

There was a final report out that asked if the ALC was relevant in the following areas: Integrating MCH considerations into the state EPR plan – WV responded "yes"; Developing strategies to gather epidemiologic/surveillance data on women of reproductive age and infants to guide action – WV responded "yes"; Establishing/promoting EPR communications about target populations with clinical partners, public health and governmental partners, and with the general public – WV responded "yes"; and Identifying public health programs, interventions, and policies to protect/promote health and prevent disease and injury in emergencies among maternal and infant populations – WV responded "yes".

Although the formal completion of the ALC was not achieved, participation did lead to more open communication between OMCFH and CTP. The inclusion of a comprehensive emergency plan that encompasses the MCH population regardless of the source of the emergency will be an Appendix to the larger Department of Health and Human Resources Public Health All-Hazard Plan in the future. This goal is still in the planning stages and it is hoped to be completed once staff from both agencies can again devote time to this endeavor.



### **III.E.2.b.v. Health Care Delivery System**

#### **III.E.2.b.v.a. Public and Private Partnerships**

The West Virginia Office of Maternal, Child and Family Health (OMCFH) within the Bureau for Public Health under the umbrella of the Department of Health and Human Resources operates in partnership with the federal and state governments and the state's medical community including private practicing physicians, county health departments, community health centers and hospitals. The OMCFH is no stranger to forming public and private partnerships. Many of these collaborations have led to increasing the ability to leverage funding along with service provision.

These partnerships also participate on many of the OMCFH program advisory committees and offer input to Title V priorities. For example, for over 25 years the OMCFH has forged a relationship with West Virginia University Pediatrics Genetics to provide medical services to children with special needs and children identified with disorders through newborn screening. WVU Pediatrics provides six (6) outreach clinics throughout the state to assist families with access to services. They also provide guidance and advice to the follow-up nurses and medical community on how to treat many of the disorders diagnosed. The Newborn Screening Program Advisory consists of the WVU Pediatrics personnel as well as specialists for Cystic Fibrosis, Hemoglobinopathies, and Endocrinology. There are other stakeholders involved as well such as the State Laboratory that performs the initial newborn screening testing.

The Advisory makes recommendations on new disorders that should be screened for and cut-off values for indicating whether an infant is in critical need of a confirmatory result.

The Medicaid partnership has been an important part of the OMCFH's ability to improve the health care delivery system to the most vulnerable. Medicaid supports the Managed Care Organizations (MCOs) in providing care coordination to those women identified as high risk during their first prenatal visit. The OMCFH uses the results from the Prenatal Risk Screening Instrument (PRSI) that identifies a high-risk pregnancy and shares information with Medicaid to pass along to the correct MCO. Medicaid supplies data on pregnant eligible women and foster children so that services can be offered early for medical and home visitation support. Data from Medicaid claims is used to determine services that were rendered to assess utilization. Medicaid also financially supports Right From The Start, the State's Medicaid Home Visitation Program housed in OMCFH and the EPSDT Program for children eligible for Medicaid, also housed in OMCFH.

The OMCFH's partnerships and collaborations are so extensive and intertwined, that a grid was developed and is attached identifying the partnership and programs that work together and/or data that is collected or available as a result of the collaboration. The grid is not all inclusive as there may be other partnerships that are not mentioned. Please refer to the attached grid for more detailed information.

### **III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)**

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 (the State's Medicaid Home Visitation Program) 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. Beginning July 1, 2021, Medicaid increased coverage for postpartum care for up to one year. As a result, Right From the Start also increased Home Visitation services for up to one year. Last year WV CHIP increased coverage to include pregnant women up to 300% of the FPL. As a result, OMCFH increased the MCH Maternity Services Program eligibility up to 325% of the FPL based on family size, including the unborn child. The MCH Maternity Services Program also covers pregnant teens under age 19 with no other insurance and prenatal care, associated/prenatal lab work and OB provider delivery fee for non-US citizens. WV Medicaid has a special policy provision that may provide delivery and inpatient coverage.

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. HealthCheck 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. The Bureau for Medical Services (BMS), Center for Managed Care, initiated a risk-based managed care program called Mountain Health Trust (MHT) in September 1996. Mountain Health Trust includes Medicaid and CHIP and provides managed care services to approximately 87% of the state's Medicaid and CHIP membership. Populations covered under managed care include most adults and children, pregnant women, and members receiving Supplemental Security Income (SSI). The Bureau contracts with three Managed Care Organizations (MCOs) for the provision of Medicaid medically necessary services. Services carved out of managed care include point of sale pharmacy, long-term care, Home and Community-Based waivers and non-emergency medical transportation services. Effective January 1, 2021 West Virginia Children's Health Insurance Program (WVCHIP) members are included in the MHT program. In January 2021, there were 438,987 Medicaid members enrolled in Mountain Health Trust.

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. In 2020, 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.

House Bill 2266, passed by the WV Legislature on April 10, 2021, amended and reenacted §9-5-12 of the Code of West Virginia to extend Medicaid coverage to pregnant women and their newborn infants up to 185 percent of the federal poverty level and to provide coverage up to 1-year postpartum care, effective July 1, 2021. Said postpartum care may include the provision of care coordination services (targeted case management from Medicaid's perspective) and health education to Medicaid-eligible pregnant women via the RFTS Program administered by West Virginia's Title V agency.

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

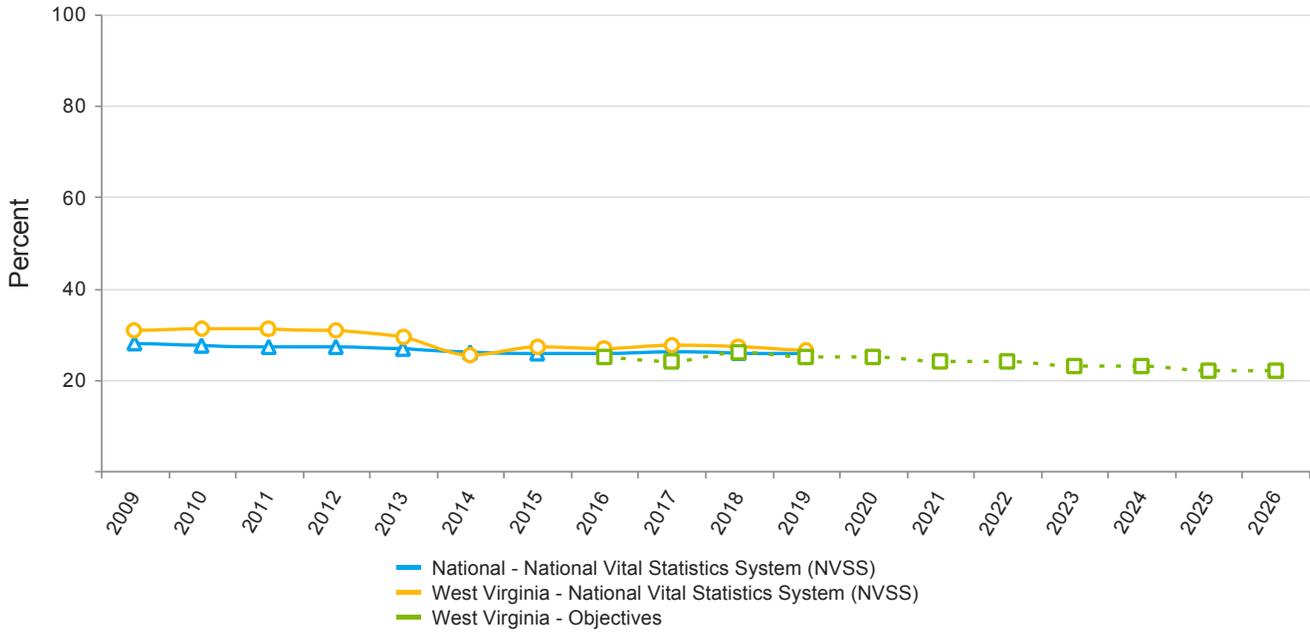
#### Women/Maternal Health

##### 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-2018	85.5	NPM 2 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	16.0	NPM 2 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	9.8 %	NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	12.6 %	NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	29.9 %	NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	7.0	NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	7.0	NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.3	NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.6	NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	153.4	NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	153.4	NPM 14.1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	15.4 %	NPM 13.1
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-2018_2019	17.6 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.7 %	NPM 13.1 NPM 14.1

National Performance Measures

NPM 2 - Percent of cesarean deliveries among low-risk first births  
Indicators and Annual Objectives



Federally Available Data

Data Source: National Vital Statistics System (NVSS)

	2016	2017	2018	2019	2020
Annual Objective	25	24	26	25	25
Annual Indicator	27.2	27.0	27.6	27.3	26.3
Numerator	1,766	1,652	1,654	1,598	1,528
Denominator	6,498	6,116	5,989	5,845	5,811
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	24.0	24.0	23.0	23.0	22.0	22.0

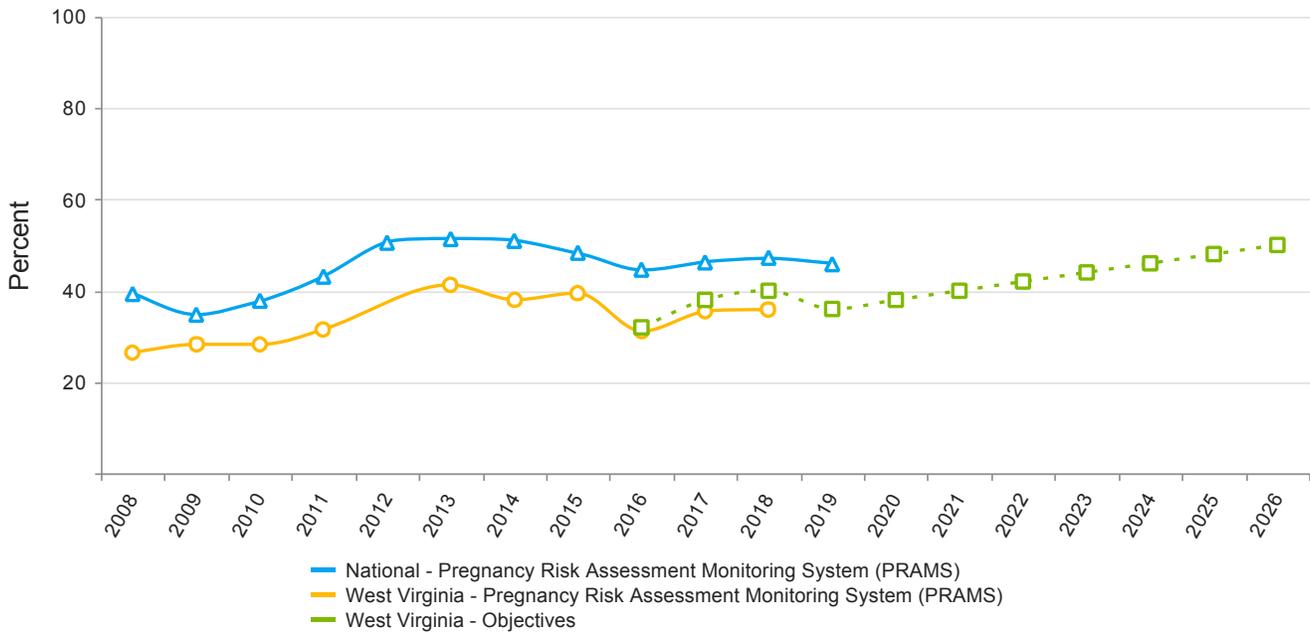
**Evidence-Based or –Informed Strategy Measures**

**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	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Perinatal Partnership	Perinatal Partnership
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	150.0	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	2020
Annual Objective	32	38	40	36	38
Annual Indicator	37.9	39.3	35.6	36.0	36.0
Numerator	6,464	6,554	5,622	5,633	5,633
Denominator	17,066	16,685	15,797	15,656	15,656
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2018	2018

**Annual Objectives**

	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	42.0	44.0	46.0	48.0	50.0

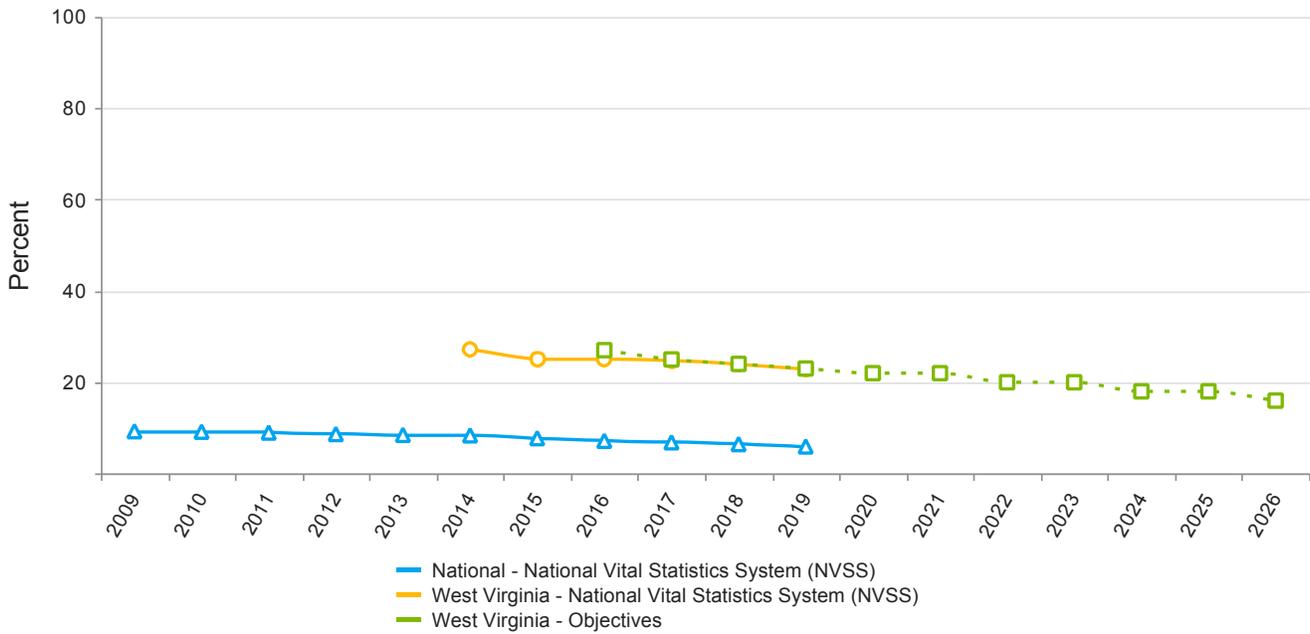
**Evidence-Based or –Informed Strategy Measures**

**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	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Oral Health Program	Oral Health Program
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	50.0	60.0	60.0	60.0	60.0

**NPM 14.1 - Percent of women who smoke during pregnancy  
Indicators and Annual Objectives**



**Federally Available Data**

**Data Source: National Vital Statistics System (NVSS)**

	2016	2017	2018	2019	2020
Annual Objective	27	25	24	23	22
Annual Indicator	25.2	25.1	24.7	23.9	23.0
Numerator	4,902	4,591	4,590	4,337	4,161
Denominator	19,469	18,305	18,551	18,138	18,106
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

**Annual Objectives**

	2021	2022	2023	2024	2025	2026
Annual Objective	22.0	20.0	20.0	18.0	18.0	16.0

**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	2020	
Annual Objective		150	350	350	300	
Annual Indicator	148	334	44	217	245	
Numerator						
Denominator						
Data Source	Perinatal Partnership					
Data Source Year	2016	2017	2018	2019	2020	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	300.0	320.0	320.0	340.0	340.0	350.0

**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	2020
Annual Objective			60	50
Annual Indicator			41.5	52.7
Numerator			85	178
Denominator			205	338
Data Source			WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	55.0	60.0	65.0	70.0	75.0	78.0

**State Performance Measures**

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

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	6.9	8.1
Numerator	776	737
Denominator	11,203	9,059
Data Source	PRSI	PRSI
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	6.0	6.0	5.0	5.0	4.0

## 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

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

## 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

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

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

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

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

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

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

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

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

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

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

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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.

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

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

## **Women/Maternal Health - Annual Report**

### **Decrease preterm and low birthweight infants**

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

Rescheduled trainings to Winter 2021 due to COVID restrictions within the hospital setting for in person training.

#### **Provide Lamaze childbirth education.**

Completed Lamaze Childbirth Education training to 8 participants from six different hospitals. 2 – Camden Clark, 2 – Greenbrier Valley, 1 each from Grant Memorial, Princeton, St. Josephs and Thomas Memorial.

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

Completed two “Spinning Babies” courses in June with 25 people attending each session.

#### **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.**

Rescheduled Grand rounds on Implicit Bias in Racial and Impoverished Families to late 2021 due to COVID training restrictions.

Provided fetal monitor instruction to St Mary’s hospital to three attendees from two hospitals with a new online format. The three attendees will advance to instructor trainers within the State.

### **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.**

The Oral Health Program is 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. The Oral Health Program will monitor claims data through the CMS 416 quarterly report.

#### **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 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.**

COVID impacted the use of CO monitors in the home for SCRIPT when home visiting programs transitioned from in person visits to virtual. Smoking cessation questions continued to be asked and the five A’s utilized with each client. Referrals were made based upon the woman’s request for referrals.

Over the next year home visiting programs as programs transition to a hybrid model of home visiting of both in person and virtual based upon the initial assessment triage process, the use of CO monitors in the home will be reinstated. Home visiting programs will develop a tiered incentive approach with women based upon the goals established for smoking cessation. The intent is to utilize multiple smoking cessation strategies and tiered incentives to increase the number of clients quitting or reducing smoking.

Due to COVID restrictions on in person training through the National Parents as Teachers Center, one potential trainer's certification was delayed. All in person trainings were cancelled. All trainings through the National Center had to be transitioned to a virtual platform. Due to the intensity and content of the training, it was several months before a virtual training became available. The new trainer finalized her last section of training certification was completed in late June 2021.

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

COVID impacted the use of CO monitors in the home for SCRIPT when home visiting programs transitioned from in person visits to virtual. Smoking cessation questions continued to be asked and the five A's utilized with each client. Referrals were made based upon the woman's request for referrals.

Over the next year home visiting programs as programs transition to a hybrid model of home visiting of both in person and virtual based upon the initial assessment triage process, the use of CO monitors in the home will be reinstated. Home visiting programs will develop a tiered incentive approach with women based upon the goals established for smoking cessation. The intent is to utilize multiple smoking cessation strategies and tiered incentives to increase the number of clients quitting or reducing smoking.

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

COVID impacted the use of CO monitors in the home for SCRIPT when home visiting programs transitioned from in person visits to virtual. Smoking cessation questions continued to be asked and the five A's utilized with each client. Referrals were made based upon the woman's request for referrals.

Over the next year home visiting programs as programs transition to a hybrid model of home visiting of both in person and virtual based upon the initial assessment triage process, the use of CO monitors in the home will be reinstated. Home visiting programs will develop a tiered incentive approach with women based upon the goals established for smoking cessation. The intent is to utilize multiple smoking cessation strategies and tiered incentives to increase the number of clients quitting or reducing smoking.

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

Provided training and intervention programs to 107 obstetrical and pediatric providers (physicians, nurse midwives, nurses and nurse practitioners) to reduce smoking before, during, and after pregnancy.

Facilitated training for obstetrical and pediatric tobacco cessation champions. Partnered with ACOG and AAP WV Chapters to develop a strategic planning report in consultation with project provider champions.

Identified, trained, and supported pediatric health care providers on best practice smoking /vaping cessation interventions to address second and third hand smoke exposure. A Pediatric Toolkit was shared. Digital files as well

as hard copies will be provided to all pediatric practices.

Promoted a consistent and unified message about cessation of smoking in pregnancy. Contacted 123 OB/GYN providers and 143 pediatric and family practice practitioners in southern WV counties regarding the Help2Quit program.

Completed "Turning the Tables on Tobacco" presentation to pediatric providers, including residents from Cabell Huntington Hospital and CAMC Women and Children's on December 4, 2020 to 66 participants. Distributed 2,071 patient education materials to Obstetrical and pediatric providers on tobacco cessation.

Collaborated with WV AAP and [Our Babies Safe and Sound](#) to get safe sleep materials to all the pediatric provider practices in the state, and the "this side up" onesie (infant t-shirt) campaign around National Safe Sleep month (October). The onesies were distributed to all the delivering hospitals along with "Clean Air Zone" information postcard for parents. Per TFFAC Quitline info is to be included as well.

"Turning the Tables on Tobacco" presentation made to pediatric providers, including residents from Cabell Huntington Hospital and CAMC Women and Children's on December 4, 2020, 66 participants 2,071 patient education materials were provided to Obstetrical and pediatric providers on tobacco cessation.

Collaboration between WV AAP and Our Babies Safe and Sound to get safe sleep materials to all the pediatric provider practices in the state, and the "this side up" onesie (infant t-shirt) campaign around National Safe Sleep month (October). The onesies will be distributed to all the delivering hospitals along with "Clean Air Zone" information postcard for parents. Per TFFAC Quitline info is to be included as well.

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

Completed scheduled virtual meetings were completed with the Tobacco Free Families Advisory Council with recorded minutes and updates from key partners on statistics and activities related to maternal smoking and 2<sup>nd</sup> hand exposure.

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

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

Finalized the web based PRSI system in early 2021 and internal OMCFH office entry of PRSI forms started. The online implementation phase with providers was moved to summer/fall 2021 to ensure all providers received the appropriate training needed within offices for PRSI accuracy. A combined virtual and in person training plan has been developed for OB providers and RFTS, including use of the web based system by a select group of OB providers.

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

Trained RCCs trained in the use of the on-line data system. Established an effective communication process between RFTS, the PRSI epidemiologist and Local Data Solutions.

##### **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.

## **Women/Maternal Health - Application Year**

### **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.

WVHVP will train 8 RFTS DCCs as doulas to work with women during their pregnancy on risk factors identified during the initial PRSI.

#### **Provide Lamaze childbirth education.**

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

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

WVHVP will increase the number of RFTS enhanced service providers that can provide childbirth education virtually to 10 providers Statewide.

WVHVP will provide childbirth education through RFTS enhanced service providers 100 women Statewide.

WVHVP will partner with three primary care centers to pilot enhanced services childbirth education at the primary care center.

WVHVP will develop a "Real WV Moms" social media campaign from women that have completed childbirth education, breastfed and utilized home visiting services to promote activities. This will personalize the messaging to moms from other moms and address real WV stigmas around pregnancy, postpartum mental and physical health concerns and importance of prenatal care.

#### **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.

Facilitate Grand Rounds on Implicit Bias in Racial and Impoverished Families in pediatric 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.**

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

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.

RFTS will utilize SCRIPT with pregnant and postpartum women requesting to quit or reduce smoking.

WVHVP will coordinate referrals with WV Quitline and develop a quarterly referral/outcomes report with the WV Quitline indicating number of women referred and accepting services through the WV Quitline.

WVHVP will provide SCRIPT and smoking cessation training to all new home visitors within 30 days of hire to ensure home visitors provide the smoking cessation strategies tool kit to women requesting to quit or reduce smoking.

Increase education to families enrolled in home visiting on second-hand smoke and provide referrals as appropriate for family members within the household to quit or reduce smoking.

**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.

Utilize evidence-based smoking cessation activities to provide a client tool kit for smoking cessation, including a tiered incentive program for women successfully meeting their goal to quit smoking.

Increase the number of home visitors trained and certified in tobacco cessation by 10 to ensure a tobacco cessation specialist is available regionally for any women enrolled in home visiting that requests a tobacco cessation specialist to assist with smoking cessation.

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

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

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.

Identify, train, and support pediatric health care providers on best practice smoking /vaping cessation interventions to address second and third hand smoke exposure.

Promote a consistent and unified message about cessation of smoking in pregnancy. Complete "Turning the Tables on Tobacco" presentations to pediatric providers, including residents from Cabell Huntington Hospital and CAMC Women and Children's. Collaborate between WV AAP and Our Babies Safe and Sound to get safe sleep materials to all the pediatric provider practices in the state, and the "this side up" onesie (infant t-shirt) campaign around National Safe Sleep month (October). The onesies will be distributed to all the delivering hospitals along with "Clean Air Zone" information postcard for parents. Per TFFAC Quitline info is to be included as well.

**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 2<sup>nd</sup> 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 RFTS case management home visiting model will utilize the 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 provide training on the new PRSI system and completion of the PRSI form to practicing obstetrical providers. The number of practicing obstetrical providers in each region will be identified. A goal of 80% 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 two 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.

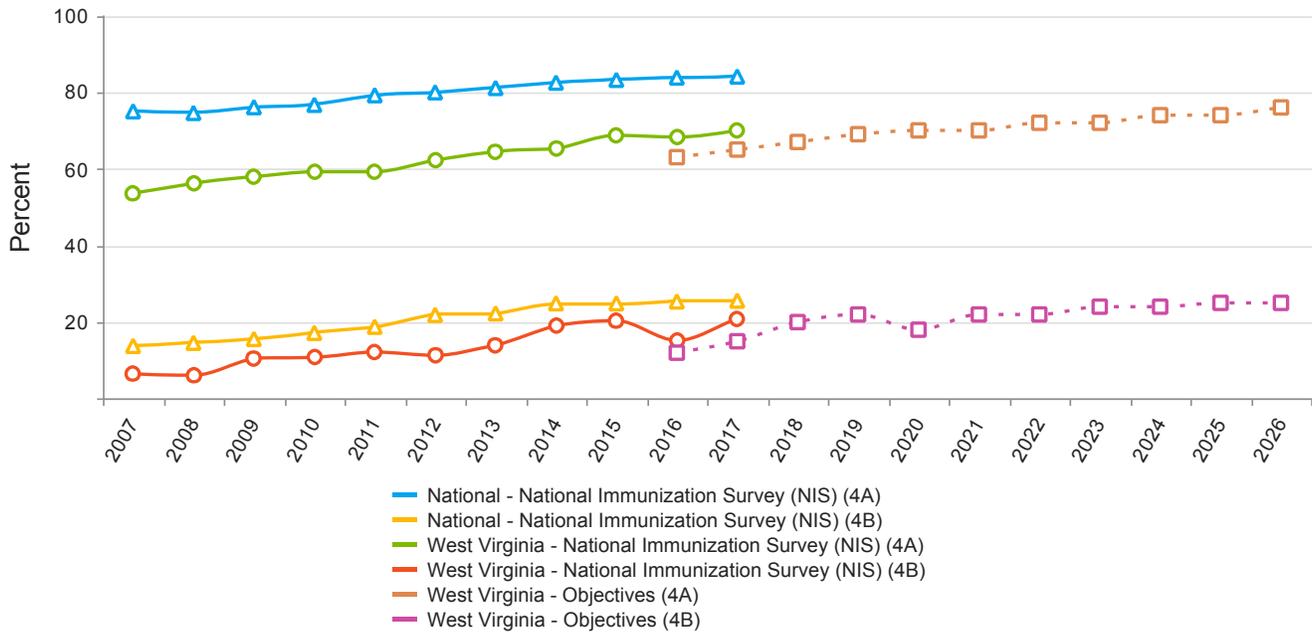
## Perinatal/Infant Health

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	7.0	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.6	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	153.4	NPM 4 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	2020
Annual Objective	63	65	67	69	70
Annual Indicator	64.6	65.4	68.6	68.2	69.9
Numerator	12,784	12,994	12,974	12,736	12,372
Denominator	19,786	19,882	18,907	18,666	17,711
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	72.0	72.0	74.0	74.0	76.0

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	2017	2018	2019	2020
Annual Objective	12	15	20	22	18
Annual Indicator	14.1	19.0	20.2	15.2	20.9
Numerator	2,748	3,708	3,610	2,790	3,678
Denominator	19,557	19,555	17,857	18,401	17,602
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22.0	22.0	24.0	24.0	25.0	25.0

**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	2020
Annual Objective		1	5	5	6
Annual Indicator	0	2	4	5	5
Numerator					
Denominator					
Data Source	Baby Friendly USA				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	8.0	8.0	10.0	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	2020
Annual Objective		65	67	65	66
Annual Indicator	65.2	64.5	64.9	66.2	66.8
Numerator	11,859	11,514	11,465	11,515	11,065
Denominator	18,179	17,865	17,662	17,405	16,574
Data Source	Vital Statistics				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

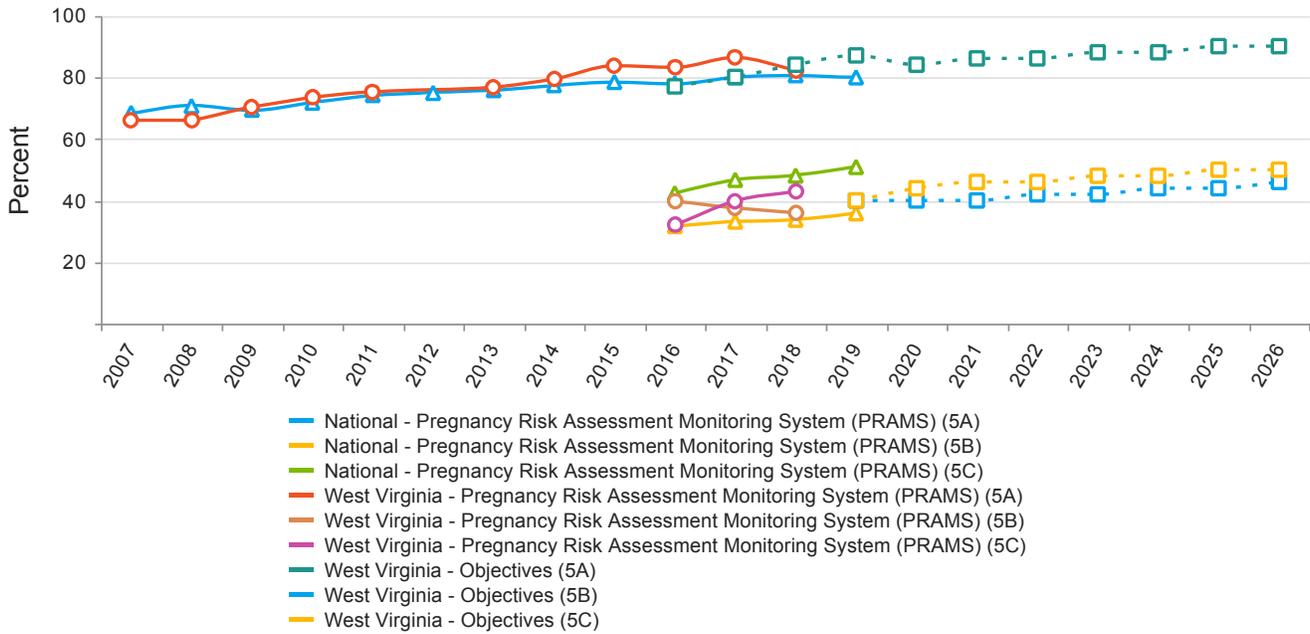
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	68.0	70.0	70.0	72.0	72.0	74.0

**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	2020
Annual Objective		5	9	13	12
Annual Indicator	8.7	8.8	11.1	11.7	11.9
Numerator	2	18	74	160	149
Denominator	23	204	668	1,367	1,256
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	14.0	16.0	18.0	20.0	22.0	23.0

**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	2020
Annual Objective	77	80	84	87	84
Annual Indicator	79.5	83.7	86.6	82.0	82.0
Numerator	13,573	14,091	13,445	12,495	12,495
Denominator	17,071	16,839	15,534	15,245	15,245
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2018	2018

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	86.0	86.0	88.0	88.0	90.0	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	2020
Annual Objective		40	40
Annual Indicator	37.7	36.1	36.1
Numerator	5,742	5,401	5,401
Denominator	15,239	14,977	14,977
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2018

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	42.0	42.0	44.0	44.0	46.0

**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	2020
Annual Objective		40	44
Annual Indicator	39.8	43.1	43.1
Numerator	6,129	6,470	6,470
Denominator	15,392	15,017	15,017
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2018

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.0	46.0	48.0	48.0	50.0	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	2020	
Annual Objective		90	95	100	100	
Annual Indicator	92	100	100	100	100	
Numerator	23	25	25	25	21	
Denominator	25	25	25	25	21	
Data Source	Our Babies Safe and Sound					
Data Source Year	2016	2017	2018	2019	2020	
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
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	2020
Annual Objective		72	86	86	80
Annual Indicator	71.1	83.9	61.9	75	77.5
Numerator	27	177	599	804	816
Denominator	38	211	968	1,072	1,053
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	82.0	84.0	86.0	88.0	90.0	92.0

**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	2020
Annual Objective		75	78	80	80
Annual Indicator	77.1	76.8	55	74.8	82.8
Numerator	199	730	820	1,554	1,689
Denominator	258	951	1,492	2,077	2,039
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	82.0	84.0	86.0	88.0	90.0	92.0

## 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 20.9% in 2017 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 - 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 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

## **Perinatal/Infant Health - Annual Report**

### **Increase Breastfeeding**

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

Utilized the Partnering for a Healthy Baby curriculum with pregnant women enrolled in RFTS. Parents as Teachers and Healthy Families America utilized the National model approved evidenced based curriculum for prenatal care. New home visitors were required to complete breastfeeding education virtually due to COVID restrictions. Eight home visitors completed the online Certified Lactation Consultant training and 11 home visitors completed a week-long series of trainings to become Breastfeeding Champions. Documentation was completed in the data collection system on breastfeeding and education provided to women enrolled in home visiting.

Provided breastfeeding education to women enrolled in a Medication Assisted Treatment program at Drug Free Moms and Babies locations. WVHVP continued to partner 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.

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

The RFTS registered dieticians served a dual role in some counties as both the WIC consultant and the RFTS enhanced services provider. Educational brochures were distributed to families enrolled in home visiting on WIC services and appropriate referrals and follow-up completed by the home visitor.

Worked with WIC on promoting ZipMilk, however, did experience challenges due to COVID and clients having appointments via the phone. Scheduled tutorial with Massachusetts Breastfeeding Coalition for operation of ZipMilk for signing up for the directory of lactation consultants available to WIC clients.

#### **Offer evidence-based provider training**

The DPWH provided funding to the WV Perinatal Partnership to conduct statewide Lamaze childbirth education workshops. The target audience was uncertified childbirth educators, nurses and others interested in providing childbirth education. Completed a new online format to provide Lamaze instructor training with eight participants from six hospitals participated.

Invited to participate in an early childhood project "Keys 4 Kids" Obesity prevention. Breastfeeding is key intervention related to promoting and supporting breastfeeding in day care settings. The WVPP participates in the intervention group for Breastfeeding Friendly Childcare. Intervention workgroup for Breastfeeding Friendly Childcare meeting bi-monthly on activities to support breastfeeding in childcare.

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

Reviewed "Implementation of Hospital Practices Supportive of Breastfeeding in the Context of COVID-19" (MMWR report) with WV Breastfeeding Alliance Steering Committee. Due to challenges of COVID, many hospitals supporting breastfeeding struggled with sometimes conflicted COVID prevention and control measures. During summer 2020, hospitals implemented a variety of practices intended to balance evidence-based maternity care with infection prevention and control. Because of the pandemic, 17.95 of hospitals reported that in-person lactation support decreased and 72.9% reported discharging mothers and babies less than 48 hours after birth.

Challenges occurred with less in-person lactation support- many hospitals furloughed or eliminated lactation positions. Little infrastructure in place to support breastfeeding families (telephone or virtual).

Promoted "Baby Friendly USA and the Virtual World: Innovative Assessments and More" webinar as an alternative to in person trainings during COVID.

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

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

Utilized 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.

Surveyed WV Tertiary hospitals for interest and formed committee. WV Donor Milk Project met in October with three hospitals represented. Discussed donor milk surplus, current donor milk usage in WV and sources of donor milk and milk banks.

Provided resources for COVID and breastfeeding information for delivering hospitals re; medication safety and lactation, pumping protocol for hospitalized mothers with COVID.

Shared Breastfeeding University by CGBI online training for healthcare facility staff with two hospitals who specifically requested the information.

Disseminated 2020 CDC Breastfeeding Report Card with information with new 2020 Healthy People Breastfeeding Objectives which have been reduced to exclusively breastfeeding at 6 months and any breastfeeding at one year.

Breastfeeding Employee Webinar; WV Summit on Race Matters CHAMPS webinar “COVID and Breastfeeding Pumps and Lactation Services Reimbursement” webinar; Community Breastfeeding Support in Public Health Emergencies; Advances in Breastfeeding Strategies for Clinical Champions; Legal Protection for Lactating Employees: DC Medicaid Reimbursement for Lactation Consultants; NACCHO Lactation Support programs in era of COVID Breastfeeding Legislation Priority.

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

Assigned case ascertainment of fifty-four (54) 2019 infant mortality cases with autopsy. Additional 2018 cases to be assigned after completion. Reviewed 133 (100%) of completed 2017 case documents. Continued to work with IMMRRP on implementation of interventions along with educational initiatives related to SUID.

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

The OMCFH mailed “Safe to Sleep” materials to all families with a birth record. This mailing contained current information about risk factors such as co-sleeping/bed-sharing, early prenatal care, maternal smoking during pregnancy, infant exposure to second hand smoke, and a safe sleeping environment. The OMCFH continued to provide current, relevant educational materials statewide to health care providers as well as parents, grandparents, and other caregivers of WV’s infants.

### **Offer evidence-based provider training.**

Vigorously marketed *Count the Kicks* as an outreach/educational strategy regarding the importance of tracking baby movements during the third trimester of pregnancy. 10,000 magnets were ordered for OB provider offices to hand out to mothers in the 3<sup>rd</sup> trimester. CTK messaging was placed on perinatal social media accounts one per month. There were 85 website visits. Additional materials were ordered for use in outreach for How to Count Kicks and Baby Saves.

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 activities had to be delayed due to COVID.

Oriented Our Babies Safe and Sound Director Kristy Stout on activities and collaboratives with multiple partners.

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

At least 85% of home visitors have completed the required annual competencies required for safe sleep education. The training transitioned to an online platform, including the annual competencies. Utilizing an online platform increased the number of people able to participate during one training and will continue to be utilized. Home visiting programs utilized an evidence-based curriculum with the appropriate handouts on safe sleep for every family enrolled.

**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 sponsored the annual competency training for partners of the Say YES to Safe Sleep, including birthing hospitals, home visitation staff, and other community partners.

## **Perinatal/Infant Health - Application Year**

### **Increase Breastfeeding**

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

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.

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.

Explore the use of a doula model for RFTS utilizing a partnership with the State's Healthy Start grantee. Provide a week-long series of Lunch and Learns for early childhood providers on breastfeeding. Each one-hour session will address a topic related to breastfeeding and will be provided during breastfeeding awareness month.

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

- The WVBA Director will facilitate the WVBA Steering Committee and conduct quarterly virtual meetings with WVBA membership.
- Develop a robust website with resources for health care providers, parents, caregivers, businesses and communities.
- Improve communication and social media to increase participation in statewide lactation efforts.
- Coordinate with Office of Nutrition Services/WIC and Payors to improve breast pump, lactation services and donor milk coverage.
- Provide health care providers with current curriculum and materials for their patients.
- Train community-based providers on supporting breastfeeding through the Outpatient Breastfeeding Champion Program of IABLE (Institute for Breastfeeding and Lactation Education).
- Provide instruction and continuing education for all levels including:
  - Certified Lactation Counselor training or Certified Breastfeeding Specialist Training
  - Assistance with pathway to International Board Certified Lactation Consultant (IBCLC) designation
  - Provider training modules, and comprehensive course for clinical breastfeeding medicine scholarships
- Maintain Lactation Support Directory through Zipmilk. Zipmilk, a website that helps mothers and providers locate breastfeeding support is based upon zip codes.

#### **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.

The DPWH provided funding to the WV Perinatal Partnership to conduct statewide Lamaze childbirth education workshops. The target audience was uncertified childbirth educators, nurses and others interested in providing childbirth education. Completed a new online format to provide Lamaze instructor training with eight participants from six hospitals participated.

Invited to participate in an early childhood project "Keys 4 Kids" Obesity prevention. Breastfeeding is key intervention related to promoting and supporting breastfeeding in day care settings. The WVPP participates in the intervention group for Breastfeeding Friendly Childcare. Intervention workgroup for Breastfeeding Friendly Childcare meeting bi-monthly on activities to support breastfeeding in childcare.

### **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 in October 2021.

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.

Assure that RN Case Reviewers have access to necessary information for complete case ascertainment:

- CPS data, law enforcement records
- Prenatal records from private OBs (if not in hospital records)
- Infant records from pediatric providers (if not in hospital records)
- Prenatal records for WV mothers who receive out-of-state care
- Infant records for WV infants with out-of-state deaths (hospitals, medical examiners)

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.**

Work with early childhood programs (home visiting, head start, childcare) to promote with all pregnant women the Count the Kicks materials, website and app. Utilize parents enrolled as social media influencers on local agency social media platforms to promote the use.

Coordinate 8 community-based baby shower events sponsored by RFTS for pregnant women focusing on the third trimester of pregnancy and preparing for birth.

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. Summer 2021 courses are planned to be offered.

Facilitate stabilization of preterm or ill infants prior to transport to a tertiary facility through STABLE infant stabilization program. Provide STABLE workbooks and nurses to outlying delivering hospitals.

**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, including birthing hospitals, home visitation staff, and other community partners.

## Child Health

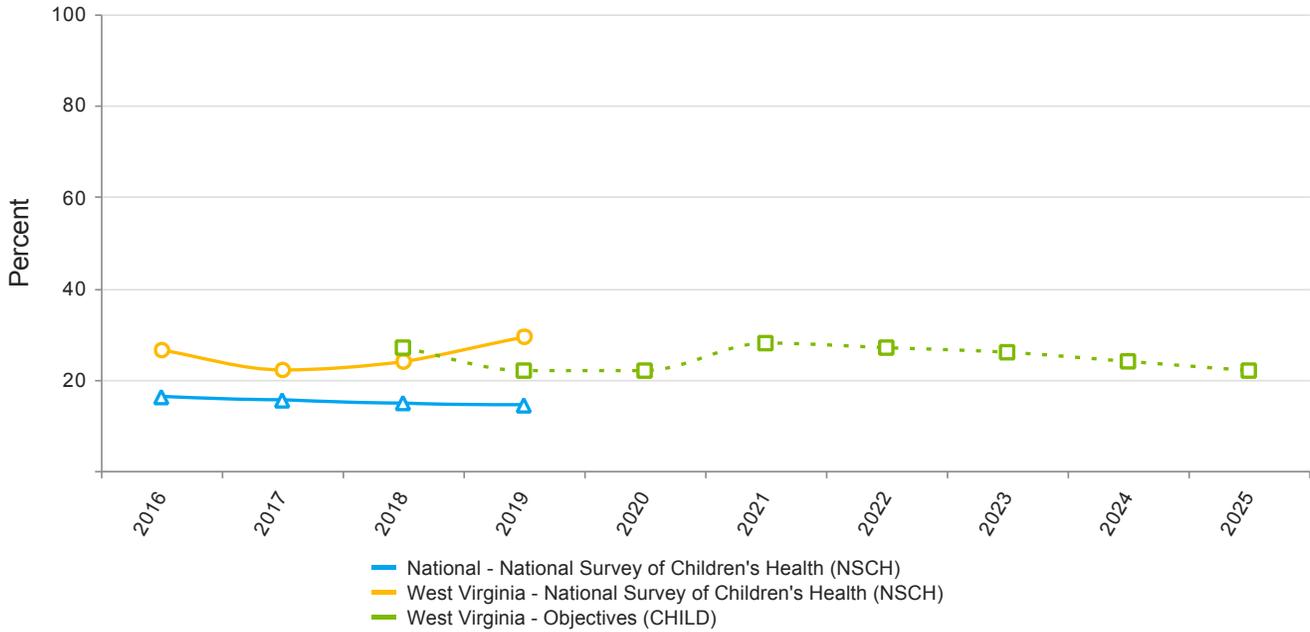
### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	85.5	NPM 14.2
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	16.0	NPM 14.2
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	9.8 %	NPM 14.2
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	12.6 %	NPM 14.2
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	29.9 %	NPM 14.2
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	7.0	NPM 14.2
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	7.0	NPM 14.2
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.3	NPM 14.2
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.6	NPM 14.2
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	153.4	NPM 14.2
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	153.4	NPM 14.2
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	15.4 %	NPM 13.2
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-2018_2019	17.6 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.7 %	NPM 8.1 NPM 13.2 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-2018_2019	19.6 %	NPM 8.1

National Outcome Measures	Data Source	Indicator	Linked NPM
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-2018	16.5 %	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-2019	22.9 %	NPM 8.1

**National Performance Measures**

**NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes  
Indicators and Annual Objectives**



**NPM 14.2 - Child Health**

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			27	22	22
Annual Indicator		26.5	22.2	24.1	29.5
Numerator		97,972	82,198	88,702	105,832
Denominator		370,309	370,710	368,117	358,760
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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						
	2021	2022	2023	2024	2025	2026
Annual Objective	28.0	27.0	26.0	24.0	22.0	22.0

**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	2020
Annual Objective			25	28
Annual Indicator			28.6	28.3
Numerator			100,750	99,750
Denominator			352,397	352,397
Data Source			NSCH	NSCH
Data Source Year			2019	2019
Provisional or Final ?			Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	27.0	25.0	25.0	23.0	23.0	21.0

**State Performance Measures**

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

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	PDMP/VIPP	PDMP/VIPP
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	200.0	250.0	300.0	350.0	400.0

**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.**

<b>Measure Status:</b>		<b>Active</b>
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator	16.6	
Numerator		
Denominator		
Data Source	WIC	
Data Source Year	2016	
Provisional or Final ?	Provisional	

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	16.0	15.8	15.5	15.0	14.4	14.0

## 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 youth 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

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

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

---

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

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

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

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

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

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

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

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

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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

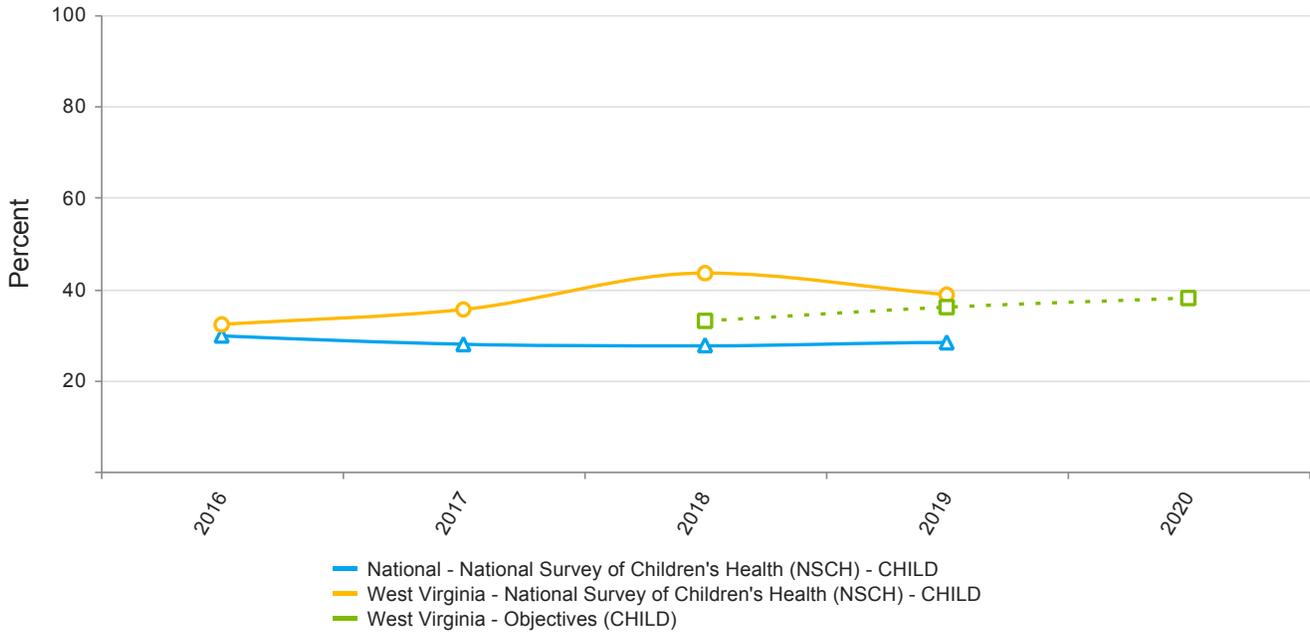
The Division of Child and Adolescent Health will work with WIC and other partners to decrease obesity among children ages 2-4.

### 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	2020
Annual Objective			33	36	38
Annual Indicator		32.1	35.5	43.3	38.6
Numerator		39,168	40,194	46,844	45,057
Denominator		122,113	113,155	108,304	116,689
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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**

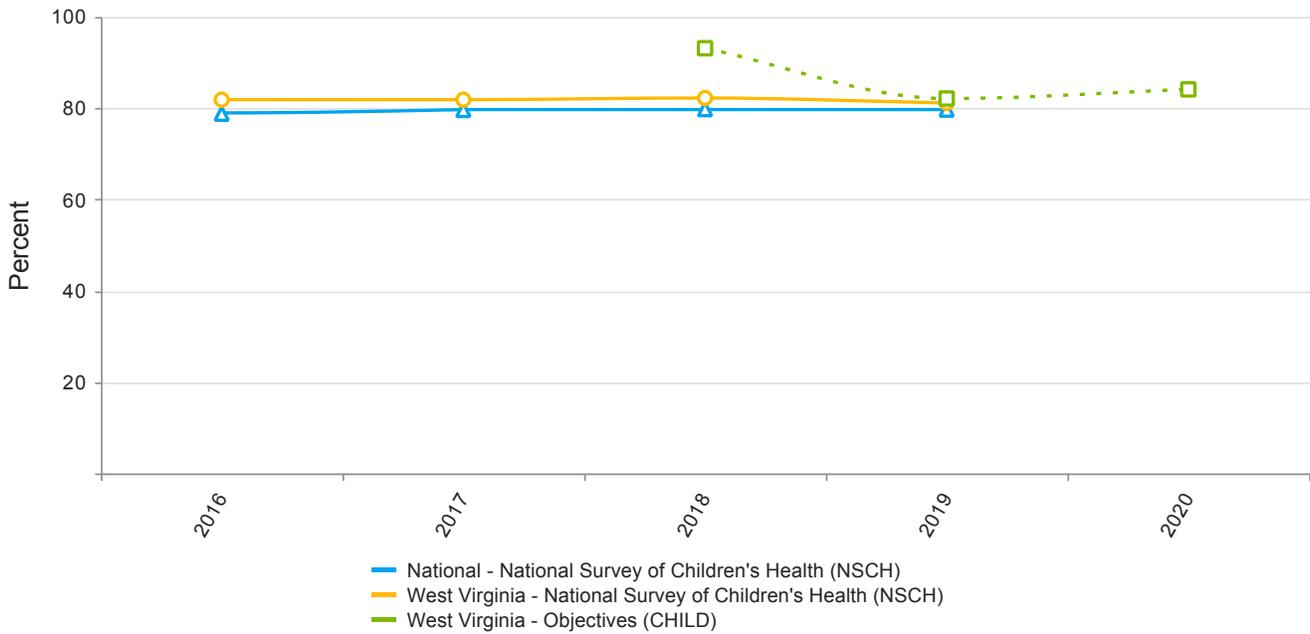
**2016-2020: ESM 8.1.1 - Number of schools surveyed that are engaged in shared use activities.**

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	2020
Annual Objective			150	155
Annual Indicator			10	10
Numerator				
Denominator				
Data Source			AHCS	AHCS
Data Source Year			2019	2020
Provisional or Final ?			Provisional	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	2020
Annual Objective			95	95
Annual Indicator			95	0
Numerator				
Denominator				
Data Source			HealthCheck	HealthCheck
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Final

**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	2020
Annual Objective			91	91	84
Annual Indicator		81.8	81.7	82.2	81.0
Numerator		283,638	286,309	285,988	277,319
Denominator		346,833	350,407	347,833	342,425
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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	2020
Annual Objective		0	5	10	15
Annual Indicator	0	0	10	10	10
Numerator					
Denominator					
Data Source	Oral Health Program				
Data Source Year	2016	2016	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

**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	2020
Annual Objective		78.2	75.5	68	70
Annual Indicator	57	75.5	68.9	68.1	70.2
Numerator	204,781	271,234	245,477	252,731	255,189
Denominator	359,047	359,047	356,411	371,200	363,517
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016	2017	2017-2018	2018-2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

## Child Health - Annual Report

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

To ensure evidenced based curriculums were implemented with fidelity, training needs addressed and parent/child activities aligned with current best practices in home visiting, WVHVP increased continuous quality improvement (CQI) capacity to better support both local implementing agencies and multiple ongoing workgroups. The scope was changed to also include assurances of CQI processes being utilized with Reflective Supervision, Maternal Mental Health, well child visits and COVID protocols. WVHVP Leadership team members attended workgroups with a focus on developing CQI projects for each group.

The State CQI team completed the following:

- CQI vision, mission and core values associated with work;
- Standard language for the Charter of Expectations;
- Allocation of time and resources needed for CQI; and
- Protocol on online CQI trainings for all LIAs.

CQI consultants coached LIAs and offered tools and resources to engage families. LIAs already gathered annual feedback. CQI consultants developed methods for better utilizing the data received and make recommendations. Regular reviews of data reports to monitor change by local teams, using lessons learned from CQI work to guide decision-making, Quarterly Site Visits, multiple forms of communication with the LIAs and the CQI Consultants ensured the State team has a strong monitoring process for CQI.

Aligned many activities with Title V priorities to ensure coordinated priorities and activities. Additional screening questions and activities were implemented to assess the outcomes of families served in each priority area. Due to changes in some family dynamics, community challenges and increased need for professional development for home visitors, more concentrated efforts were made on substance use and impact on families and communities. To better meet the needs of families served, a substance use screening was added to RFTS, along with a stronger emphasis on adverse childhood experiences (ACEs) and resiliency. Initial plans were to implement the substance use screening tool much earlier this year with all home visiting programs. However, with the changes occurring within home visiting due to COVID-19, the decision was made to implement the new substance use screening tool in October 2021. WV was also one of two state's asked to participate in the substance use screening pilot with MIECHV to assist with developing two new construct and benchmark areas with home visiting programs nationally.

Identifying resource/referral partners for grand families was a priority to better support the physical and mental health of primary caregivers over 40 years of age. This was an area to be prioritized due to the number of grand families, but also with the transition to virtual visits. For some grand families, the use of a virtual platform was very challenging. As WVHVP worked on activities related to COVID-19, utilizing virtual platforms with families challenged by limited broadband width, cell service, comfort levels for use and privacy for sensitive screenings was addressed, but remained a challenge in rural communities for many families.

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

The AHI identified the curriculum program CATCH My Breath and began training school staff across the state during 2019-2020. CATCH My Breath is a best-practices youth E-cigarette and JUUL prevention program developed by The University of Texas Health Science Center at Houston (UTHealth) School of Public Health. The program provides up-to-date information to teachers, parents, and health professionals to equip students with the knowledge and skills they need to make informed decisions about the use of E-cigarettes, including JUUL devices. CATCH My Breath utilizes a peer-led teaching approach and meets National and State Health Education Standards. The AHI partnered with the West Virginia University Extension Agents to provide programming in 40 schools, to over 6,000 students in 2019. Over 200 presentations and trainings were scheduled for 2020. Although most were cancelled due to the pandemic, the Regional Adolescent Health Coordinators (AHCs) were able to provide programming in 12 middle

schools and 2 high schools, reaching approximately 3,800 students and teachers before schools were closed in early 2020.

The pandemic created an unprecedented level of stress and anxiety for students, parents, and school staff. Because of this, school priorities shifted and the AHCs devoted much of the 2020-2021 school year providing mental health support, resources and trainings. However, the AHCs were able to provide another series of CATCH My Breath trainings in 2021.

**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.**

Schools and communities have requested the AHCs help distribute information to students and parents at health fairs, wellness conferences and open houses. Over 7,000 letters and brochures were distributed to parents and students during the 2019 school year. Due to COVID19, all school open houses, health fairs and in-person conferences in 2020 were canceled. Classes throughout the state were conducted virtually for much of the 2020-2021 school year and community events were non-existent. Despite these challenges, the AHCs were able to distribute 5,581 pieces of literature providing information on the dangers of smoking and vaping. This was accomplished by providing schools with materials to be sent home in homework packets, school enrollment packets, etc. The AHCs also mailed materials to local Family Resource Networks, school counselors, physicians' offices and clinics and local food banks; anywhere that provided services to families during the pandemic.

### **Substance use in youth/teens**

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

The OMCFH has identified substance use in children (ages 5-11) as a priority, specifically related to the prescription of and use of stimulants to address behavioral health issues in West Virginia. Modeled after the OMCFH's successful initiative with the WVU School of Pharmacy and its Safe and Effective Management of Pain Program (SEMPP) as funded by the Centers for Disease Control and Prevention since 2016, the Office has collaborated to begin to develop a similar education and training initiative addressing stimulant use and prescribing recommendations for children and youth. Currently, WV Medicaid does not require a prior authorization or a corresponding diagnosis for prescription of stimulants to its eligible members ages 0-20.

### **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.**

During this year, the WV HealthCheck priorities were shifted to provide support for the COVID-19 pandemic efforts. HealthCheck Specialists were instructed to assist in contact tracing efforts and to provide call assistance for the vaccine hotline. In addition, the HealthCheck program Director resigned in September. Both events prevented initial

planning of this project within the fiscal 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.**

Development of a reward program for childcare centers in nutrition and physical activity were not established within the fiscal year due to the overwhelming impact of COVID-19 pandemic's impact on state government, healthcare, and childcare making implementation of new initiatives extremely difficult. In addition, the vacancies within program leadership lead to many previous initiatives being placed on hold.

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

Due to COVID-19 pandemic and loss of workforce this new initiative was unable to be developed.

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

A social marketing campaign was developed in partnership with Division of Early Care and Education, West Virginia Supplemental Nutrition for Women, Infants and Children (WIC), KEYS 4 HealthyKids, and the West Virginia Breastfeeding alliance. This campaign is the West Virginia Breastfeeding Friendly Child Care Designation Initiative. The initiative provides support and education on breastfeeding to childcare centers. To obtain the designation, Child Care Centers must complete Ten Steps for Breast Feeding Friendly Child Care Centers. These steps were adapted from the Breastfeeding Hospital Initiative Ten Steps that were developed by World Health Organization (WHO) and United Nations Children's Fund (UNICEF). Unfortunately, due to COVID-19 pandemic, the Great Beginnings Conference that is normally held in person was postponed. The conference is now going to be held on September 23, 2021.

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

A recognition reward program for facilities receiving the designation has been written. Upon the completion of the 10 steps, each facility will receive a bonus stipend and a certificate of designation and recognition during the Great Beginnings Infant/Toddler Conference or Celebrating Connections Conference.

**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."**

The WV HealthCheck/EPSTD program was unable to initiate this strategy within this fiscal year. Several challenges prevented the implementation of this strategy. In September 2020, the HealthCheck Program Director resigned, and this position remained vacant until January of 2021 which had a large impact on the program implementing new initiatives. Also during this time, effort was placed on implementing items that were required by the DHHR's agreement with the Department of Justice (DOJ), this included an analysis of Mental Health Screening during EPSTD visits which was time sensitive and imperative for the DHHR to complete which delayed implementation. The COVID-19 pandemic presented the most difficult challenge. During the pandemic, most provider offices restricted visitors and/or were closed which prevented the HealthCheck Program Specialists from conducting face-to-face visits and trainings. The pandemic also impacted utilization of HealthCheck's workforce as priorities were placed on COVID-19 efforts. Specifically, EPSTD Program Specialists were utilized by the DHHR to conduct and support contact tracing efforts. Additional EPSTD staff members were utilized to conduct data entry and the vaccine hotline.

**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.**

Due to the COVID-19 pandemic, providers did not receive education on the 5210 Pediatric Clinical Decision Support Chart which relates directly to the 5210 Prescription Initiative.

**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 by the one month EPSDT visit.**

HealthCheck Program Specialists Staff distributed WIC information to WV Medicaid providers on the recent upgrades to the food packages either through drop-off outside the facility or by mail due to visitors being restricted within offices during the pandemic. Due to the resignation of the HealthCheck Program Director in September of 2020 and the resignation of the HealthCheck Epidemiologist in February 2021, procedures were not developed to capture follow-up on WIC enrollment and participation at the EPSDT periodic visit indicated. |

**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.**

This initiative was new for this plan, unfortunately, was unable to be addressed during this year. Efforts were shifted from program initiatives to responding to the COVID-19 pandemic through staff being utilized to support contact tracing efforts, COVID-19 vaccine hotline, and data entry.

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

Due to turnover within the office during this year led to this initiative not being implemented. Current and future work to be continued on this strategy to develop and work with partners within the upcoming year with guidance of the local pediatrician serving as the subject matter expert toward incentivizing Farm to early childhood education (ECE). Identification of partners for this initiative will occur and meetings to be set in order to work with partnerships with Department of Education, ECE, and Department of Agriculture and other important stakeholders.

**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.**

Due to vacancies in leadership and availability of subject matter expert, this new initiative was unable to be addressed. In the upcoming months, a meeting with Dr. Jamie Jeffrey (subject matter expert) will be established to define goals and strategies to be able to suggest and ultimately update ECE licensing standards by working with all internal and external partners to address the Caring for Our Children obesity prevention standards.

## Child Health - Application Year

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

WVHVP will implement an enhanced obesity/nutrition project with families served based upon the Supper in a Sack developed through George Washington University. The five week project focuses on preparing healthy meals, family interaction, budgeting, food prep and farm to table methods of cooking. The project partners home visiting programs with the community partners and extension offices in a common goal of reducing obesity in children, increasing physical activity and parent/child interaction.

Develop training plan working with parents screening positive for postpartum depression based upon regional collaborative meetings related to mental health and parent leadership input.

Develop a State level Health Equity plan intent to duplicate at the local implementing agency level in partnership with the WV Infant Toddler Mental Health Association (WVITMHA). The WVITMHA strives to increase awareness and build capacity of early childhood professionals to promote healthy social emotional competence in young children. The crucial role of supporting children and families has been amplified during the past year. Relationships have been sustaining during this challenging time. WVITMHA is jointly funded by MIECHV and other early childhood programs within the State.

In support of this work, the Association added a continually updated collection of resources for professionals and families during COVID-19. The collection of materials includes information on self-care, how to explain COVID-19 and social distancing to young children, behaviors that may emerge, and the impact of COVID-19 on young children. In addition, the Association developed two informational handouts for distribution within home visitation programs: *Supporting WV Home Visitors* and *Supporting Supervisors and Reflective Practice During COVID-19*. The Association has hosted a series of lunchtime webinars in October, focused on supporting children, families, staff, and ourselves during times of uncertainty.

The WVITMHA and WVHVP will focus on health equity, inclusion, and diversity. This focus is on all areas – families served, Advisory Boards, the professional development offered, the language used, and the resources that creates and/or shares. A survey will be developed and released to local programs, partners and families on health equity. The goal is to develop a plan that models authentic community partnerships; inclusive and culturally responsive internal and external communications; and an understanding of the social, environmental, and structural determinants of inequity. Based on the outcome of this survey, WVITMHA and WVHVP will begin developing policies and plans to improve within these areas.

Being mindful of health equity, the Association hosted a weeklong set of webinars in May that focused on Culturally Responsive Practice with Young Children and Their Families; How to Support Families Experiencing Food Insecurity; Rebuilding Relationships After COVID; and How Substance Exposure Impacts Development and Learning. In addition, the Association hosted a screening and discussion of the documentary “Resilience – The Biology of Stress and the Science of Hope.” This series will run again in 2022 and additional series added.

Continue work of local sites participating in the federal home visiting Collaborative Improvement & Innovation Network) (CollN) on depression and well child visits. The pandemic halted momentum on the Maternal Depression CollN work, in which regions were beginning to create expanded aim statements related to maternal depression that would have taken them down parent-led paths beyond the scripted CollN goals. Although our LIAs continued to report on the measures for this CollN project, they stopped reporting Plan, Do, Study, Act (PDSAs) related to this topic. We closed that project with 93.8% of screened women who received 1 or more evidence-based service contact showing at least a 25% reduction in depression symptoms, which exceeded the goal of 85%. In addition, 2 LIAs continued to participate in a well-child visit CollN through April of 2021. These successes happened concurrently with covid-related challenges, marked resilience, and innovations.

Although some of the work has halted, WV will continue to utilize this process to develop a plan for other childhood programs (childcare, Head Start and early intervention) to broaden the discussion on depression with families served. In addition, presentations will be shared with OB and pediatric providers on the work within early childhood to further strengthen the role of early childhood in maternal health and good pregnancy outcomes. This work will help outline recommendations on maternal mortality and several maternal mobility on the role of home visiting for the following:

- Educating families about early prenatal care, postpartum warning signs, management of chronic conditions, treatment for perinatal mood disorders, and substance use disorders
- Connecting families with community resources and programs (hotlines, local treatment programs, domestic violence support programs, Circle of Parents, parent led peer to peer support groups)

**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 and vaping prevention. School staff members are struggling to identify vaping devices as they keep changing and look like other devices, such as thumb drives. The AHCs have found many students and parents still believe vaping is safe. Some parents even encouraged vaping as a “safe” alternative to smoking. Students as young as middle school are telling AHCs they are addicted to vaping and are now fearful after learning about potential health risks. The AHI will address these gaps in required trainings and lack of education by providing evidence-based curriculum programs in schools and professional development training for teachers, both in-person and virtually.

**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. Recognizing that virtual programming will remain prevalent post-pandemic, 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. The AHI is also developing a new and improved website that will offer information and resources on many adolescent health related topics.

**Substance use in youth/teens**

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

The OMCFH will continue to collaborate with the WVU School of Pharmacy develop an education and training initiative addressing stimulant use and prescribing recommendations for children and youth. Next steps include

finalizing the expert panel (comprised of pediatric health care providers, pharmacists, social workers, and representatives from applicable state agencies, including WV Medicaid) which will assist in the development of prescribing best practices and recommend policy change for WV Medicaid and a potential drug utilization review (DUR) process. Educational information will also be developed once best practices are established; this information will be disseminated via OMCFH's strategic partnerships, including its Pediatric Medical Advisory Board and in-person through academic detailing conducted by EPSDT/HealthCheck Program Specialists.

## **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.**

Going forth into FY year 2021-2022, the new WV HealthCheck Director will establish contact with the local pediatrician, who will serve as the subject matter expert for this project, and conduct monthly meetings to develop procedures to pilot implementation of the Key 2 a Health Start quality improvement initiative in childcare centers across the state utilizing the NAPSACC.

### **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.**

In the coming year, The WV HealthCheck program will consult with subject Matter Expert in Childhood Obesity to identify partners. From the identification of these partners, initiate a workgroup. WV HealthCheck will work toward establishing revolving meetings with the workgroup including the Subject Matter Expert to discuss and establish guidelines for Best nutrition practices and/or physical activity and to establish a recognition reward program for child care centers to improve best nutrition practices to reduce childhood obesity rates.

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

In the upcoming year, partnership with the Bureau for Children and Families, Division of Early Childhood Education (ECE) as well as including other pertinent stakeholders will be built upon. Work will be geared toward establishing meetings with partners to be able to develop a curriculum to align with subject matter expert recommendations and a strategic plan for implementing the training modules with childcare centers in WV.

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

A social marketing campaign was developed in partnership with Division of Early Care and Education, West Virginia Supplemental Nutrition for Women, Infants and Children (WIC), KEYS 4 HealthyKids, and the West Virginia Breastfeeding alliance. This campaign is the West Virginia Breastfeeding Friendly Child Care Designation Initiative. The social marketing campaign is to be presented during a segment of the Great Beginnings annual infant-toddler conference on September 23, 2021.

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

Due to the COVID-19 pandemic, the Great Beginnings annual infant-toddler conference was postponed. However, efforts were made, and the conference will now be virtual and held on September 23, 2021. During a segment of the conference with social campaign and the recognition reward program will be presented to childcare attendees.

During this conference application process, designation criteria, and the recognition reward items will be announced. Upon meeting all criteria and receiving the designation, the facility will receive a bonus stipend and a certificate of designation and recognition during the conference.

Information will be collected of how many attendees attended this segment of conference as well as talking with partners over the coming year to determine how many child care facilities are participating in working toward the designation as well as how many receive the designation over the coming year.

**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.”**

Within the next fiscal year, the HealthCheck/EPSTD program will work toward accomplishing this strategy by June 30, 2022. Goals to meet this strategy in the upcoming year will be: purchase copies of “5210 Pediatric Obesity Clinical Decision Support Chart” to provide training to providers, development of an educational training for HealthCheck Program Specialists to provide consistent messaging on education of providers, and to provide training to at least 10 providers on how to use the “5210 Pediatric Obesity Clinical Decision Support Chart.”

**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.**

Within the next fiscal year, WV HealthCheck will consult with a local pediatrician who serves as a subject matter expert for this project to establish best practices for educating physicians on the 5210 Prescription (RX) Initiative which includes dispensing produce, physical activity, and drinking water. Continued Discussions with subject matter expert to discuss and develop sustainable ways for physicians to set goals and tracking will be conducted with the goal of having at least 5 participating physicians enrolled during this fiscal year.

**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 one month EPSTD visit.**

To work toward meeting this strategy, the new WV HealthCheck Director will work to establish a direct point of contact within the WVWIC program to discuss and facilitate a direct enrollment/referral process before a child leaves the hospital after birth. WV Medicaid providers will continue to be educated on upcoming changes to WVWIC food packages and eligibility changes by HealthCheck Program Specialists as WVWIC outreach materials are updated and distributed.

**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.**

WV HealthCheck will work with partners to support efforts to increase Child and Adult Care Food Program (CACFP) participation rates and support education to provider offices on statewide training initiatives as developed and reviewed by local pediatrician that is serving as the Subject Matter Expert for this initiative.

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

Work will be initiated to consult the local pediatrician serving as the subject matter expert toward incentivizing Farm to early childhood education (ECE). Identification of partners for his initiative will occur and meetings to be set in order to work with partnerships with Department of Education, ECE, and Department of Agriculture and other important stakeholders to be able to work toward this strategy.

**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.**

In the upcoming months, a meeting with Dr. Jamie Jeffrey (subject matter expert) will be established to define goals and strategies to be able to suggest and ultimately update ECE licensing standards by working with all internal and external partners to address the Caring for Our Children obesity prevention standards.

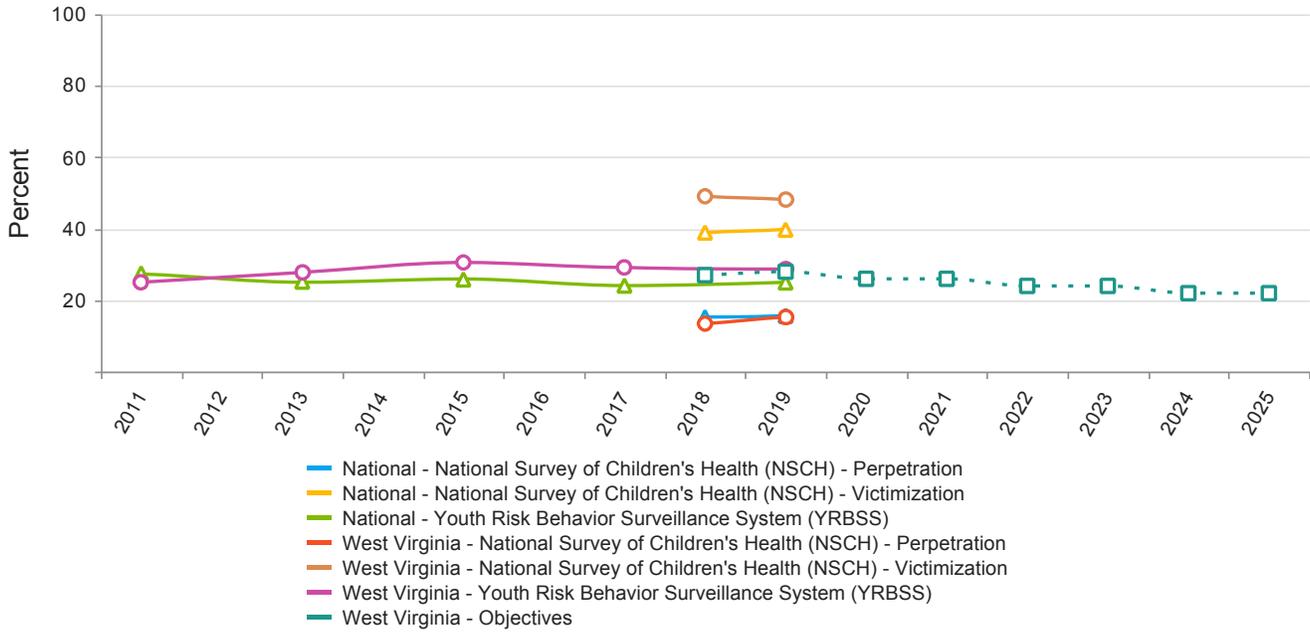
## Adolescent Health

### 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-2018_2019	15.4 %	NPM 13.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	42.5	NPM 9
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	14.0	NPM 9
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-2018_2019	17.6 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.7 %	NPM 8.2 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-2018_2019	19.6 %	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)	WIC-2018	16.5 %	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-2019	22.9 %	NPM 8.2

National Performance Measures

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



Federally Available Data

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

	2016	2017	2018	2019	2020
Annual Objective	26	25	27	28	26
Annual Indicator	30.5	30.5	29.1	29.1	28.7
Numerator	23,959	23,959	22,608	22,608	22,112
Denominator	78,632	78,632	77,715	77,715	77,035
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017	2019

**Federally Available Data**

**Data Source: National Survey of Children's Health (NSCH) - Perpetration**

	2017	2018	2019	2020
Annual Objective			28	26
Annual Indicator			13.6	15.2
Numerator			16,987	18,340
Denominator			124,901	120,396
Data Source			NSCHP	NSCHP
Data Source Year			2018	2018_2019

**i** 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) - Victimization**

	2017	2018	2019	2020
Annual Objective			28	26
Annual Indicator			49.1	48.0
Numerator			61,001	57,581
Denominator			124,257	120,074
Data Source			NSCHV	NSCHV
Data Source Year			2018	2018_2019

**i** 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**

	2021	2022	2023	2024	2025	2026
Annual Objective	26.0	24.0	24.0	22.0	22.0	20.0

**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	2020	
Annual Objective		87	95	112	100	
Annual Indicator	87	92	110	144	71	
Numerator						
Denominator						
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS	
Data Source Year	2016	2017	2018	2019	2020	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	110.0	115.0	120.0	125.0	130.0	135.0

**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	2020
Annual Objective		13	17	32	38
Annual Indicator	13	16	30	38	30
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	39.0	39.0	39.0	40.0	40.0	43.0

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

Measure Status:				Active	
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		85	100	135	125
Annual Indicator	85	98	130	122	111
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	140.0	150.0	155.0	160.0	165.0	170.0

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

Measure Status:				Active	
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		105	114	100	110
Annual Indicator	105	112	97	102	59
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	112.0	115.0	118.0	120.0	122.0	124.0

**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	2020	
Annual Objective		41.6	20	20	22	
Annual Indicator	16.3	17	16.8	19.9	25	
Numerator	3,240	3,380	22,582	25,058	30,365	
Denominator	19,936	19,936	134,548	125,615	121,321	
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH	
Data Source Year	2016	2016	2017	2018	2018-2019	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	29.0	33.0	35.0	38.0	40.0	40.0

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

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	PDMP/VIPP	PDMP/VIPP
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	200.0	250.0	300.0	350.0	400.0

## 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

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

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ESM 9.3 - Number of messages disseminated via social media Active

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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

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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

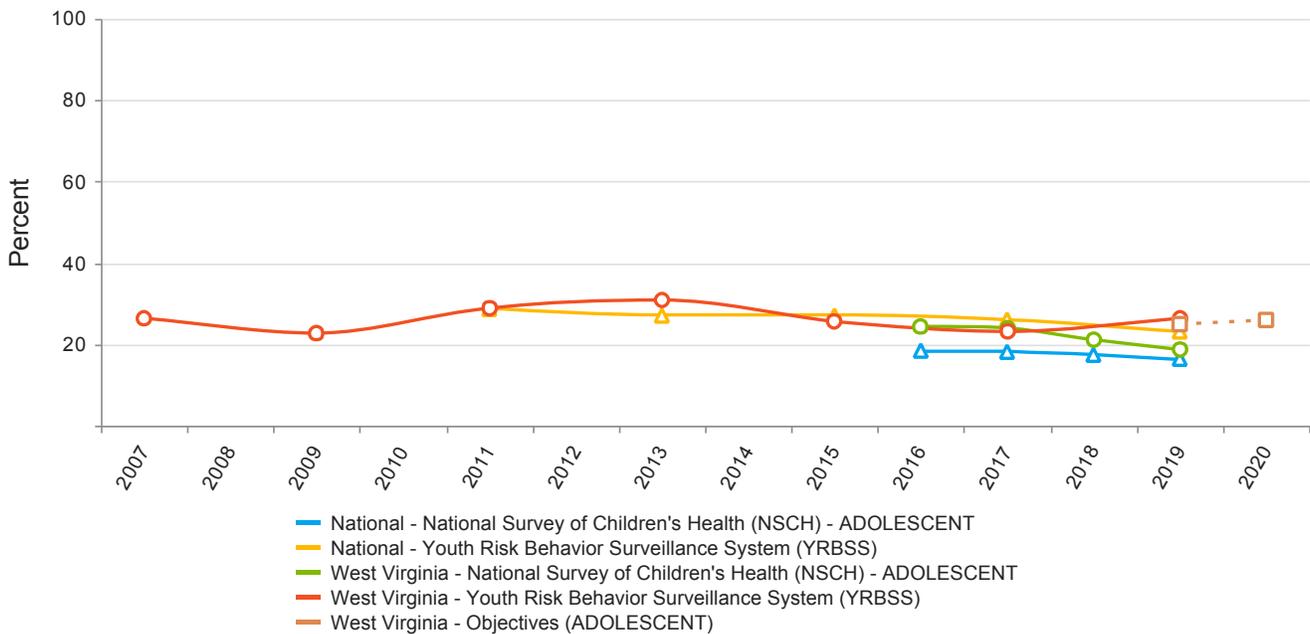
The VIPP Program and the Division of Infant, Child and Adolescent Health will work with partners to increase awareness of controlled substance use among children ages 12-17.

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



<b>Federally Available Data</b>				
<b>Data Source: Youth Risk Behavior Surveillance System (YRBSS)</b>				
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			25	26
Annual Indicator	25.8	23.4	23.4	26.3
Numerator	19,962	17,726	17,726	19,988
Denominator	77,480	75,763	75,763	75,897
Data Source	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT
Data Source Year	2015	2017	2017	2019
<b>Federally Available Data</b>				
<b>Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT</b>				
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			25	26
Annual Indicator	24.3	24.1	21.2	18.9
Numerator	29,361	30,565	27,302	22,930
Denominator	120,948	126,776	128,983	121,077
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2016	2016_2017	2017_2018	2018_2019

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

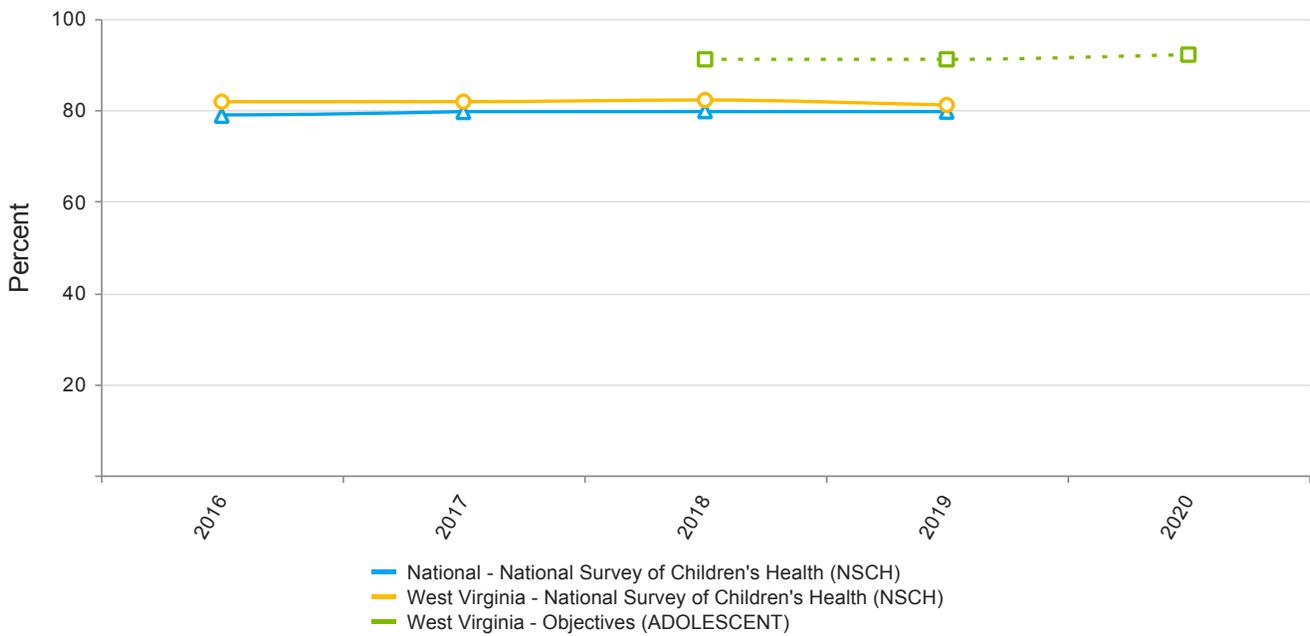
**2016-2020: ESM 8.2.1 - Number of schools surveyed that are engaged in shared use activities**

Measure Status:		Active			
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		139	145	180	185
Annual Indicator	139	148	173	171	170
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	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	2020	
Annual Objective	40	93	94	94	
Annual Indicator	93	94	94	0	
Numerator					
Denominator					
Data Source	HealthCheck	HealthCheck	HealthCheck	HealthCheck	
Data Source Year	2017	2018	2019	2020	
Provisional or Final ?	Provisional	Provisional	Provisional	Final	

**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	2020
Annual Objective			91	91	92
Annual Indicator		81.8	81.7	82.2	81.0
Numerator		283,638	286,309	285,988	277,319
Denominator		346,833	350,407	347,833	342,425
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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	2020
Annual Objective		0	5	10	15
Annual Indicator	0	0	10	10	10
Numerator					
Denominator					
Data Source	Oral Health Program				
Data Source Year	2016	2016	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

**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	2020
Annual Objective		78.2	75.5	68	70
Annual Indicator	57	75.5	68.9	68.1	70.2
Numerator	204,781	271,234	245,477	252,731	255,189
Denominator	359,047	359,047	356,411	371,200	363,517
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016	2017	2017-2018	2018-2019
Provisional or Final ?	Provisional	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	2020
Annual Objective		85	87	87	89
Annual Indicator	84.9	84.9	86.3	62.8	85.4
Numerator	95,934	95,934	116,200	78,233	99,995
Denominator	113,040	113,040	134,585	124,579	117,103
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

## Adolescent Health - Annual Report

### 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 COVID19 pandemic had immediate and enduring effects on everyone; including schools, students, parents and communities. During a pandemic, youth ecological systems are in turmoil, with disruptions in daily routines, interruptions in information and communication across settings and drastic and abrupt changes in rules and processes. Research has shown the protective effect of positive youth development (PYD) can reduce the negative influence of traumatic situations such as COVID-19 on adolescent mental health.[1] While challenging to implement with COVID19 restrictions, the need for PYD programming and activities is more prevalent than ever.

In early 2020, the AHI partnered with West Virginia University-Parkersburg to conduct surveys in schools throughout Region 5 to assess the impact of the AHI's PYD programming. Results show that youth attending AHI's programming are more likely to feel their parents give them support when they need it (61% vs 43% strongly agree), more likely to get along with their parents (49% vs. 36% strongly agree), more likely to feel they get a lot of encouragement at school (31% vs. 11% strongly agree) and feel their teachers push them to be the best they can be (44% vs. 15% strongly agree).

While COVID19 restrictions and closures presented many implementation challenges, the AHI provided 71 trainings focused on positive youth development to encourage this youth-adult connectedness. This number is about half what the AHI usually conducts, however attendance for these trainings nearly tripled previous years. Over 18,000 youth, parents, professionals, and community members attended the trainings, 7,359 of which were youth. Trainings included the multi-week COVID19 focused virtual events titled *Connections Matter*, *Finding Your Spark!*, *Everyone's an Asset Builder* and other asset-based programs. The AHI also provided presentations on healthy family relationships, positive stress management, school re-entry and other topics. The AHI also helped facilitate several PYD focused events and activities for youth across the state.

Highlights include (but aren't limited to):

- Consequences of Choices
- The Effects of COVID 19 on our Youth
- Having Mindful Conversations About Difficult Topics
- Stress Management and Positive Coping Skills
- A Guide to Welcoming Students Back to School
- West Virginia's Mountain State Promise, Changing the Course
- Positive Behavior Supports at Home: A Practical Approach
- Who will we meet in the COVID reentry?
- I CAN OVERCOME by supporting each other
- Positive Coping Skills and Stress Management
- Everyday Gratitude
- So, What's Wrong with Kids These Days? What We Can Do to Support Youth in a Complicated World
- In the Line of Fire: Children and Domestic Violence
- Regulate, Relate and Create: Balancing in a World that is Off-Balance
- Teen Boot Camp Cooking Class (5 weeks)
- Developing Star Leaders - The Power of 1 Multiplied
- Young Life Youth Group
- Healthy Grand Family Training: Navigating the School System
- Fayette 4H Adventure Club
- I CAN BE HAPPY by facing negativity
- Sherrard Middle School Youth Service Project: Making blankets for local foster care agencies

- Totika (self-esteem) Game Days

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[1] <https://www.sciencedirect.com/science/article/pii/S1054139X21000227> The Impact of Positive Youth Development Attributes on Posttraumatic Stress Disorder Symptoms Among Chinese Adolescents Under COVID-19

**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.**

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 2017 high school risk behavior shows a decrease in most adolescent risk behaviors including the percentage of students who have seriously considered suicide since (27% down to 19%); however this data point showed a small increase to 21% in 2019. 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/>.

For the 2019 YRBS data, two analyses occurred: a trend report for middle and high school students and risk behaviors and sexual identity for high school students only. Students that identified as gay, lesbian, or bisexual are at greater risk for bullying and consequences associated with it. Some of the questions where gay, lesbian, or bisexual students reported greater risk are listed in the table below. The following results compare 2017 and 2019 data. While they show some progress, they are still alarming and illustrate that youth who identify as gay, lesbian, bisexual are at greater risk for bullying and the consequences associated with bullying:

YRBS Measure	Heterosexual	Gay, Lesbian, or Bisexual	Heterosexual	Gay, Lesbian, or Bisexual
	2017		2019	
	Percentage of students who were threatened or injured with a weapon on school property (such as a gun, knife, or club, one or more times during the 12 months before the survey).	5.5%	13.3%	6%
Percentage of students who were bullied on school property (ever during the 12 months before the	21.8%	40.2%	19%	33%
Percentage of students who were electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media, ever during the 12 months before the survey).	17.6%	33.7%	14.9%	27.1%
Percentage of students who felt sad or hopeless (almost every day for $\geq 2$ weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey).	27.9%	66.2%	31.5%	63%
Percentage of students who seriously considered attempting suicide (ever during the 12 months before the survey).	14.5%	51.3%	17.2%	47.7%
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey).	11.5%	44.5%	13.6%	38%
Percentage of students who attempted suicide (one or more times during the 12 months before the	7.2%	30.4%	7.4%	23%

**Community based Adolescent Health Coordinators will identify and coordinate the implementation of research-based models for prevention of bullying and forms of violence in schools and other youth serving organizations.**

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 bullying:

**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

In FY 2017, the AHI's regional AHCs began meeting with school personnel and administrators to introduce the idea of a bystander intervention and discuss evidence-based program implementation, as this approach requires commitment by school personnel and the community. Program implementation of the *Green Dot* program began with 6 schools in FY2018 and has expanded to 30 schools utilizing *Green Dot* and other comprehensive bully prevention curriculum programs in FY2021.

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*.

Also in 2017, the AHI partnered with the DHHR's Bureau for Behavioral Health and Health Facilities to certify all of the regional AHCs as *Youth Mental Health First Aid* trainers. *Youth Mental Health First Aid* (YMHFA) is an 8-hour course that teaches you how to identify, understand, and respond to signs of mental illnesses and substance use disorders. Since that time, the AHCs have also become certified trainers in *ACEs* (Adverse Childhood Experiences), *Trauma Informed Schools* and *Handle with Care* (HWC). Research shows that trauma can undermine children's ability to learn, form relationships, and function appropriately in the classroom. HWC programs support children exposed to trauma and violence through improved communication and collaboration between law enforcement, school agencies and community agencies, and connects families, schools and communities to community services. The AHI conducted 36 YMHFA and HWC trainings in FY2021 with a total 2,948 participants.

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 two *Darkness to Light: Stewards of Children* trainings. This evidence-based training utilizes bystander intervention sexual abuse prevention strategies.

In addition to the above, the AHCs provided training, technical assistance and helped facilitate implementation for the following programs:

- *Too Good For Drugs and Violence*
- *Second Step*
- *Botvin Life Skills*
- *Signs of Suicide*
- *SafeTalk Suicide Prevention*

In total, 6,712 youth, parents, school staff and community members attended the AHI's 59 trainings and workshops. The AHI also posted 111 messages, links and resources on social media; and disseminated 10,115 brochures, life-line cards, fact sheets and other literature on bullying prevention, suicide prevention, depression and mental health, violence prevention, cyber safety and ACEs.

**The VIPP will disseminate relevant data on the topic of non-fatal suicide trends for 12-17 year olds in the state.**

Due to the global pandemic within the last reporting year, data related to non-fatal suicide has been affected as populations did not seek health care services at usual points-of-care, specifically emergency departments, in early to mid-2020. As such, data products on trends were not developed, but will be as data becomes more consistent.

Epidemiology staff integral in development of such relevant data for dissemination have also been heavily involved in supporting data around the pandemic and its response.

## **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 COVID-19 pandemic and consequent PHE created or exacerbated health inequalities among WV CSHCN and required the WV CSHCN Program to analyze current service delivery approaches and review current policies and procedures to determine new ways of organizing services. This past year, the CSHCN Program reprioritized objectives and dedicated time and effort to identifying and addressing gaps in service delivery and as a result the health care transition action plan for the current grant year was delayed due to the PHE urgent priorities.

One of the urgent priorities identified by the WV CSHCN Program was to implement technologies to connect with WV CSHCN and to begin a review of all program procedures and associated documents, giving special attention to the need of accurate and reliable information about accessing needed services and protected health information during a PHE. The WV CSHCN Program and contracted partners reviewed and revised the WV CSHCN Health Care Transition Services tools and procedures based on changes to the CMS Interoperability and Patient Access final rule and the HHS Office for Civil Rights (OCR) guidance on the HIPAA, Health Information Exchanges and disclosures of protected health information for public health purposes.

### **Complete transitions readiness assessment for all enrolled CSHCN starting at age 14.**

The CSHCN Program's health care transition efforts support the Healthy People 2030 objective AH-R01 to increase the proportion of adolescents who get support for their transition to adult health care. AH-R01 is a Healthy People 2030 research objective which represents a public health issue with a high health or economic burden or significant disparity between population groups but is not yet associated with evidence-based interventions. The WV CSHCN Program new pediatric-to-adult health care transition process using the evidence-driven strategies Got Transition© Six Core Elements of Health Care Transition. As stated previously, this past year, the WV CSHCN Program and contracted partners reviewed and revised all program procedures and associated documents due to the PHE. As a result, the WV CSHCN care coordination teams completed a Transition Screening Tool beginning at age 14 to identify areas of need. In calendar year 2020, 572 enrolled CSHCN were fourteen (14) years of age or older, and 122 (21%) children of those received a Transition Screening Tool. This percentage will increase in the coming months as WV CSHCN care coordinators shift their focus from supporting families navigate the interruptions in services within the health care and community service systems and the challenges those systems presented during the PHE.

As noted in the Family Partnership section, the WVUCED Parent Network Specialists (PNS) provide parent peer supports to families of CSHCN. The PNS provide opportunities for families to attend family/peer support meetings or receive training across the State, related to navigating systems of care. These opportunities are conducted face-to-face, remotely using video conference or blogs. This past grant year, there were ninety-three (93) opportunities for families to receive education or resources that included the transition from pediatric to adult health care.

### **Substance use in youth/teens.**

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

The OMCFH has identified substance use in children (ages 12-17) as a priority, specifically related to the prescription of and use of stimulants to address behavioral health issues in West Virginia. Modeled after the OMCFH's successful initiative with the WVU School of Pharmacy and its Safe and Effective Management of Pain Program (SEMPP) as funded by the Centers for Disease Control and Prevention since 2016, the Office has collaborated to begin to develop a similar education and training initiative addressing stimulant use and prescribing recommendations for children and youth. Currently, WV Medicaid does not require a prior authorization or a corresponding diagnosis for prescription of stimulants to its eligible members ages 0-20.

**Provide educational information and resources to youth, parents, schools and the community about the harmful effects 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 and 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.

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.

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.

To address these concerns and misconceptions, the AHI provided education and information to a total of 8,585 youth, parents, school staff and staff from other community or youth serving organizations. Trainings and presentations included (but not limited to):

- *I CAN BE CLEAN by staying drug free*
- *Breaking the Cycle of Addiction: Hope in Recovery*
- *Drug-Endangered Children Initiative*
- *Consequences of Choice*
- *Why Won't My Mommy Wake Up?*
- *Proper Disposal of Medications*
- *Dangers of Substance Use*
- *Appalachian Angels (podcast), Youth Substance Abuse Prevention*

In addition, the AHI also distributed 1,150 pieces of literature, helped coordinate *Red Ribbon Week* activities across the state and facilitated 2 *Drug Take Back* events.

## Adolescent Health - Application Year

### **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 and representatives from multiple community-based organizations 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 Schools*, which sets forth unacceptable behaviors that undermine a school's efforts to create a positive school climate/culture. The AHCs will continue to utilize existing formal and informal partnerships with schools and the community to implement research-based, effective PYD models for the prevention of bullying and other forms of violence among WV's youth.

**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, disseminated the results throughout the state in 2020 and 2021. The AHI hoped to again partner with WVDE to conduct new surveys in 2021, however the YRBS was not conducted due to COVID19. Despite this, 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. The AHI will continue to work with the WVDE to collect, promote and disseminate data as it becomes available, and offer support with the YRBS in the future.

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 2022 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 other forms of violence in schools and other youth serving organizations.**

Several years ago, the AHI and the VIPP partnered to provide a statewide training on the *Green Dot* bystander program. 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 expanded to include the implementation of several prevention programs. 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.

The AHI partnered with the DHHR's Bureau for Behavioral Health and Health Facilities to certify all the regional AHCs as *Youth Mental Health First Aid* instructors. In addition to YMHFA, the AHCs offer trainings in Adverse Child Experiences (ACEs) and *Trauma Informed Schools*, and *Handle with Care* evidence-based models. In FY2020 and 2021, 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 both in-person and virtual training programs.

**The VIPP will disseminate relevant data on the topic of non-fatal suicide trends for 12-17 year olds in the state.**

Emphasis on development and dissemination of relevant data on the topic of non-fatal suicide trends is planned for the upcoming year. Currently, the position specifically tasked with this monitoring and analysis of this data via a

cooperative agreement with the Centers for Disease Control and Prevention (CDC) is vacant (as of June 2021).

## **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.**

Implementation of the health care transition action plan will be a priority in the coming months as we transition from the initial PHE response and incorporate the PHE long-term response into our regular work. Our strategies for this state performance measure remain unchanged. Once approved, updated tools and procedures will be included in the academic detailing to pediatric primary care physicians by the WV HealthCheck Program.

**Complete transitions readiness assessment for all enrolled CSHCN starting at age 14.**

Once approved, WV CSHCN Program care coordinators and WV BCF staff will receive training on the updated tools and procedures. WV CSHCN Program care coordinators will begin implementing these tools and procedures with all transition age CSHCN. Data surveillance will monitor progress and ensure all transition age CSHCN receive age-appropriate transition services.

**Substance use in youth/teens.**

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

The OMCFH will continue to collaborate with the WVU School of Pharmacy to develop an education and training initiative addressing stimulant use and prescribing recommendations for children and youth. Next steps include finalizing the expert panel (comprised of pediatric health care providers, pharmacists, social workers, and representatives from applicable state agencies, including WV Medicaid) which will assist in the development of prescribing best practices and recommend policy change for WV Medicaid and a potential drug utilization review (DUR) process. Educational information will also be developed once best practices are established; this information will be disseminated via OMCFH's strategic partnerships, including its Pediatric Medical Advisory Board and in-person through academic detailing conducted by EPSDT/HealthCheck Program Specialists.

**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.**

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.”<sup>[1]</sup> 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.<sup>[2]</sup>

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 the outer mantle (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. 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.<sup>[3]</sup> 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.

[1]<https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/teen-prescription-drug-misuse-abuse>

[2] <https://teens.drugabuse.gov/drug-facts/prescription-drugs#topic-5>

[3] <https://drugfree.org/prescription-over-the-counter-medicine/>

## Children with Special Health Care Needs

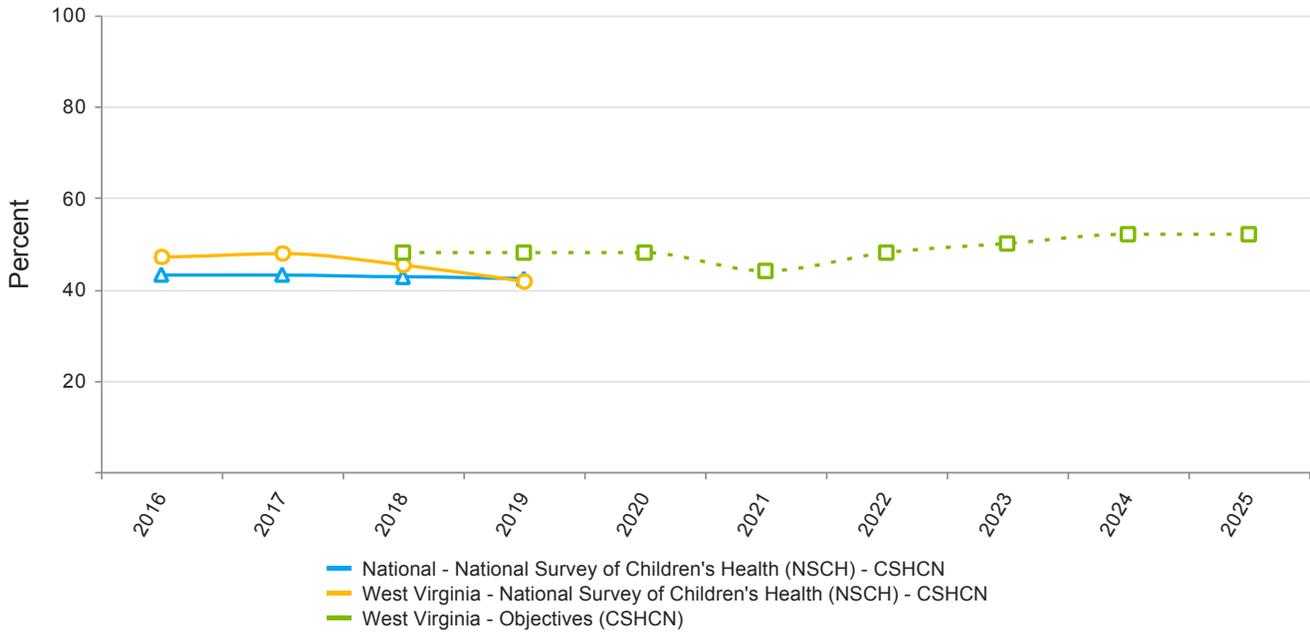
### Linked National Outcome Measures

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-2018_2019	17.6 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	54.1 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.7 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	3.1 %	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	2020
Annual Objective			48	48	48
Annual Indicator		47.0	47.9	45.2	41.8
Numerator		42,772	43,240	40,169	36,658
Denominator		91,107	90,358	88,838	87,648
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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						
	2021	2022	2023	2024	2025	2026
Annual Objective	44.0	48.0	50.0	52.0	52.0	54.0

**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	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	CSHCN	CSHCN
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	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	2020
Annual Objective		
Annual Indicator	30	30
Numerator	34,200	30,798
Denominator	114,000	102,660
Data Source	Medicaid	CMS 416
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	35.0	40.0	45.0	50.0	55.0

**ESM 11.3 - Number of children who receive Title V funded medically necessary medical foods.**

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	270	284
Numerator		
Denominator		
Data Source	CSHCN	CSHCN
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	290.0	310.0	330.0	350.0	370.0	390.0

**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	2020	
Annual Objective		41.6	20	20	22	
Annual Indicator	16.3	17	16.8	19.9	25	
Numerator	3,240	3,380	22,582	25,058	30,365	
Denominator	19,936	19,936	134,548	125,615	121,321	
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH	
Data Source Year	2016	2016	2017	2018	2018-2019	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	29.0	33.0	35.0	38.0	40.0	40.0

## 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.
- iv. Promote and provide care coordination services pursuant to the National Standards for Systems of Care for Children and Youth with Special Health Care Needs.
- v. Establish an automatic referral process to the CSHCN Program using the NAS Surveillance System.
- vi. CSHCN will provide case management to infants diagnoses with NAS.

#### 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 medically 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

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NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

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NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past 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 20.2% (CSHCN) and 19.6% (non-CSHCN) in 2016 to 40% for both populations 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.

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- ii. Complete transition readiness assessment for all enrolled CSHCN starting at age 14.

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- iii. Educate transition aged foster children on their entitlement to retain Medicaid coverage until age 26.

## Children with Special Health Care Needs - Annual Report

### Medical Home

#### **Educate stakeholders (CED, PPIE, HealthCheck, WV AAP) about the importance of PCMHs for families with CSHCN.**

These educational opportunities were delayed due to the COVID-10 public health emergency (PHE) response. However, the CSHCN Program was able to make progress on one of the foundations of the PCMH, screening for social determinants of health (SDoH). Providers seeking PCMH accreditation are required to collect data on SDoH. See below for more information.

#### **Educate pediatric primary care providers to complete a social determinants of health screening at all well-child exams.**

Under the direction of James Lewis, MD, the WV CSHCN Program and Marshall University Pediatrics participated in an Action Learning Collaborative (ALC) developed by the National Resource Center for Patient/Family-Centered Medical Home (NRC-PFCMH). The goal of the ALC is to implement innovative programs and activities to address fragmented systems of care for CSHCN. The ALC focused on partnership building, SDoH screenings and referrals, addressing psychosocial factors, and medical home access to improve systems of services for CSHCN. Specifically, the ALC seeks to ensure children have a practice-standardized social determinants of health screening completed at a health supervision visit, the family participates in a discussion about the screening that highlights family strengths and protective factors, appropriate referrals and linkage to a community resources are completed in the child's first year of life.

A chart review of 100 records for children 12 months or younger at Marshall University Pediatrics indicated there was no practice-standardized SDoH screening. Anecdotally, the individually completing the chart reviews did indicate some SDoH were addressed through the practice's electronic health record, specifically family and education, and other assessments.

The group selected the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) assessment tool as the practice standard. 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. However, Dr. Lewis felt it would be best to postpone implementation of this initiative until after the COVID-19 pandemic resolved. The group was scheduled to present at the West Virginia American Academy of Pediatrics meeting in 2020, but that meeting was cancelled.

The OMCFH continues to provide financial support to Parent Partners in Education (PPIE) at Marshall University School of Medicine to administer Project Delivery of Chronic Care to medical students. Project DOCC is designed to offer the family and CSHCN's perspective of the impact of the child's special health care needs on daily life and navigating the health care system. Medical students who participate in Project DOCC have the opportunity to have a one-on-one interview with a parent of a CSHCN who is trained to educate the medical student on the importance of the medical home, care coordination, and community supports. The parent educator provides the perspective on SDoH and their needs, difficulties, and barriers they face when navigating the system of care for their child.

#### **Provide easily accessible, medically necessary nutrition services as a payer of last resort to improve access to care for CSHCN.**

To support the medical home and ensure adequate care coordination and appropriate referrals for CSHCN, the CSHCN Program continued to coordinate with the Medicaid MCOs and Medicaid's EPSDT benefit to ensure children receive medically necessary medical foods. The CSHCN Program also continued to utilize Title V funding to provide medically necessary medical foods as a payer of last resort. During the COVID-19 PHE, the CSHCN Program collaborated with partner agency, West Virginia University (WVU) Center for Excellence in Disabilities (CED), to shift the delivery of registered dietitian services from an in-person clinical model to telehealth. The first CSHCN Program virtual nutrition clinic was held in April 2020 and the remaining 2020 nutrition clinics were conducted the same. For the Spring of 2021, all but two nutrition clinics have been delivered via telehealth. The reaction and feedback from the CSHCN Program nutrition clients and families has been very positive. Families report the virtual clinics are more convenient for them and the CSHCN. Parents state the virtual clinics allow them to stay in their own home, substantially decreasing the risk of exposure to COVID-19. Also, with the virtual platform, families do not have the mobility, equipment, and travel issues that they face when participating in a direct face-to-

face nutrition clinic. The CSHCN Program care coordination RNs have not reported the virtual clinics as favorably as the families. During the COVID-19 response, the RNs support that the nutrition children must be assessed in virtual clinics and evaluated for the continuation of nutrition services from the CSHCN Program but voice the need to see the child in person to do a thorough physical head to toe assessment. The CSHCN Registered Dietitian echoes this sentiment and expressed concerns about obtaining reliable height and weight measurements for children, especially those who are bed or wheelchair bound for whom the families may not be able to obtain accurate measurements. Considering both nutrition clinic approaches, the CSHCN Program Director of Nursing and the WV CSHCN Registered Dietitian are developing procedures for a blended model of virtual telehealth and direct clinics. The advent of telehealth as a modality for delivery of medical services will not wane and will become a permanent component of health care service delivery. Due to the rurality and topography of WV and the lack of access to health care services, telehealth can only be seen as an answer to a major health care inequity.

The CSHCN Program continues to financially support feeding and swallowing clinics at WVU CED and Marshall University. These clinics provide assessments for infants, children and adolescents who may have feeding, eating and/or swallowing issues. The feeding and swallowing team consists of occupational therapy, behavioral psychology, speech-language pathology, and social work. The team provides an interdisciplinary approach to the development of the comprehensive feeding and swallowing assessment.

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 three 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/#/>).

The CSHCN Program facilitated 822 authorizations for 284 unique children paid for through Title V funds. An additional 170 authorizations were facilitated for 94 unique children through the child's Medicaid EPSDT benefit.

### **Promote and provide care coordination services pursuant to the National Standards for Systems of Care for Children and Youth with Special Health Care Needs.**

Due to the topography and rural areas of WV, the lack of broad band services, telephone services, and connectivity issues caused operational barriers during the COVID-19 PHE for the CSHCN Program care coordinators that were working remotely. Maintaining contact with CSHCN and their families is vital. Some CSHCN Program care coordinators would drive to areas for better telephone services to call CSHCN and their families. Alternative work sites were arranged for CSHCN Program staff in other WV DHHR offices for ongoing care coordination. All care coordination activities from March 2020 through June 2021 was conducted from home or from remote work sites that strictly adhered to the quarantined policies. While the CSHCN Program staff were teleworking, there was a noted increase in the interaction and inter-dependability of the staff. As of 6/30/2021, all CSHCN staff have returned to their normal working work sites.

The CSHCN Program consulted with Berry Dunn to update the program's procedure manual and create process maps for current procedure as well as future standard the CSHCN Program is striving for. This process, combined with the COVID-19 pandemic forced the CSHCN Program to reevaluate service provisions and supports available to families. This confirmed the necessity of a web-based care coordination system to enhance communication with the medical home, include CSHCN and their families, and allow the program to seamlessly operationalize the procedure and streamline services and data collection to facilitate quality improvement and program evaluation.

Berry Dunn arranged for product demonstrations by four different vendors to allow the CSHCN Program to become familiarized with the products available in the marketplace. Through conversation with the vendors, the CSHCN Program, and review of the process maps and procedure, Berry Dunn drafted a comprehensive list of technical specifications and requirements for a web-based care coordination system.

### **Establish an automatic referral process to the CSHCN Program using the NAS Surveillance System.**

The CSHCN Program and the Medicaid Managed Care Organizations (MCO) continued to utilize the agreed operationalized NAS referral system during the past reporting year. The COVID-19 pandemic dramatically affected

the automatic referral process to the CSHCN Program resulting in decreased Neonatal Abstinence Syndrome (NAS) referrals to the CSHCN program. In 2019 the CSHCN program received 180 NAS (25 additional IUSE) referrals and for 2020, the program received 28 NAS (7 additional IUSE) referrals. So far in 2021, the CSHCN Program has already received 30 NAS referrals (6 additional IUSE). The COVID-19 PHE changed the daily workflow of the CSHCN Program which resulted in all the CSHCN Program staff working remotely. CSHCN Program services and care coordination continued during the PHE, but the decrease in the volume of referrals allowed time for review of the previous NAS referrals to the CSHCN Program. The CSHCN Program Nursing Director had long suspected a gap in the true identification of the NAS referrals, but could see additional medical and clinical records were presenting with Intrauterine Substance Exposures (IUSE). The CSHCN Program Director of Nursing and two CSHCN Program RNs audited the received NAS referrals to review for a gap in identification of the NAS birth records. The audit confirmed that fewer actual NAS diagnoses (ICD-10 code 96.1) were found in the birth records, but more of the Intrauterine Substance Exposure P04.49 diagnoses were prevalent. As a result, IUSE was made a categorical eligibility category for CSHCN Program enrollment, in addition to NAS.

This finding prompted a change in the CSHCN Program eligibility process to implement deeper research into the birth record to help differentiate between NAS and Intrauterine Substance Exposure diagnoses and to identify potentially missed NAS diagnoses. In the monthly MCO meetings of August 2020 and September 2020, the CSHCN Program Director of Nursing discussed and reviewed the CSHCN Eligibility identification change of the NAS referrals with the MCO administrators. The CSHCN Program Administration and the MCO administrators agreed that a full comprehensive medical record for all children referred with NAS diagnosis should be reviewed for Intrauterine Substance Exposure. The CSHCN Program Director of Nursing requested that the MCOs review the claims data more closely for Intrauterine Substance Exposure and that the CSHCN Eligibility Registered Nurses would review the electronic and hard copy of medical and clinical records for Intrauterine Substance Exposure. An agreed continued initiative between the CSHCN Program and the Managed Care Organizations to identifying NAS diagnoses and document a causal Intrauterine Substance Exposure has been ongoing during the Covid 19 pandemic and continues with mutual cooperation and collaboration.

#### **CSHCN will provide case management to infants diagnoses with NAS.**

The CSHCN Program continues to provide case management and care coordination for services throughout the COVID-19 PHE. Emphasis on comprehensive care coordination for enrolled CSHCN with an NAS or IUSE diagnosis is encouraged due to the vulnerability of the population and the need for medical and community services, especially during the COVID-19 pandemic. These children are categorically eligible for a higher level of service regardless of their immediate needs and health consequences. A continuing barrier for care coordinating the enrolled NAS and IUSE CSHCN is the fact that CSHCN Program participation is voluntary. Often times, these referrals are a result of the child being placed in foster care. As such, the CSHCN Program is authorized to provide services. Once the child leaves foster care, the biological or adoptive parents must give permission for the child to be enrolled into the program and for care coordination to be implemented. Without parental permission, the CSHCN's case is closed to CSHCN Program services. This could result in the child being lost to appropriate evaluation and long-term comprehensive care coordination. The cooperation of the CSHCN's parent is paramount to properly identify and monitor the neurodevelopment and neurobehavioral effects for the NAS and IUSE.

#### **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 COVID-19 pandemic and consequent PHE created or exacerbated health inequalities among WV CSHCN and required the WV CSHCN Program to analyze current service delivery approaches and review current policies and procedures to determine new ways of organizing services. This past year, the CSHCN Program reprioritized objectives and dedicated time and effort to identifying and addressing gaps in service delivery and as a result the health care transition action plan for the current grant year was delayed due to the PHE urgent priorities.

One of the urgent priorities identified by the WV CSHCN Program was to implement technologies to connect with WV CSHCN and to begin a review of all program procedures and associated documents, giving special attention to the need of accurate and reliable information about accessing needed services and protected health information during a PHE. The WV CSHCN Program and contracted partners reviewed and revised the WV CSHCN Health

Care Transition Services tools and procedures based on changes to the CMS Interoperability and Patient Access final rule and the HHS Office for Civil Rights (OCR) guidance on the HIPAA, Health Information Exchanges and disclosures of protected health information for public health purposes.

### **Complete transition readiness assessment for all enrolled CSHCN starting at age 14.**

The CSHCN Program's health care transition efforts support the Healthy People 2030 objective AH-R01 to increase the proportion of adolescents who get support for their transition to adult health care. AH-R01 is a Healthy People 2030 research objective which represents a public health issue with a high health or economic burden or significant disparity between population groups but is not yet associated with evidence-based interventions. The WV CSHCN Program new pediatric-to-adult health care transition process using the evidence-driven strategies Got Transition© Six Core Elements of Health Care Transition. As stated previously, this past year, the WV CSHCN Program and contracted partners reviewed and revised all program procedures and associated documents due to the PHE. As a result, the WV CSHCN care coordination teams completed a Transition Screening Tool beginning at age 14 to identify areas of need. In calendar year 2020, 572 enrolled CSHCN were fourteen (14) years of age or older, and 122 (21%) children of those received a Transition Screening Tool. This percentage will increase in the coming months as WV CSHCN care coordinators shift their focus from supporting families navigate the interruptions in services within the health care and community service systems and the challenges those systems presented during the PHE.

As noted in the Family Partnership section, the WVUCED Parent Network Specialists (PNS) provide parent peer supports to families of CSHCN. The PNS provide opportunities for families to attend family/peer support meetings or receive training across the State, related to navigating systems of care. These opportunities are conducted face-to-face, remotely using video conference or blogs. This past grant year, there were ninety-three (93) opportunities for families to receive education or resources that included the transition from pediatric to adult health care.

### **Educate transition aged foster children on their entitlement to retain Medicaid coverage until age 26.**

The WV CSHCN Program consulted with stakeholders to develop a health care transition procedure for children in foster care. An existing transition plan template developed by the WV Bureau for Children and Families (BCF) and the WV CSHCN Health Care Services tools were used to develop procedures and tools for transition aged foster care children. The WV CSHCN Program and contracted partners reviewed and revised the WV CSHCN Health Care Transition Services tools and procedures, using elements from the WV BCF transition plan template and based on changes to the CMS Interoperability and Patient Access final rule and the HHS Office for Civil Rights (OCR) guidance on the HIPAA, Health Information Exchanges and disclosures of protected health information for public health purposes.

During the WV CSHCN Health Care Transition Services review and revisions, transition aged foster care children receiving services from the WV CSHCN Program were notified of their entitlement to retain Medicaid coverage until age 26 by the WV CSHCN care coordinators.

## **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 2019, there were only 20 HRSA recognized PCMH practices in West Virginia (<https://data.hrsa.gov/tools/data-reporting/program-data/state/WV>). According to WV HealthCheck Program data, there are 721 pediatric provider clinics in the state as of June 11<sup>th</sup>, 2021. 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.**

Now that primary care practices are beginning to lift COVID-19 restrictions the CSHCN Program will revisit implementing this project. Members of the ALC will advocate for a practice-standard SDoH screening to be completed at each health supervision visit. To obtain support, evidential data will be introduced to state-wide stakeholders to advocate for policy to address and lessen the impact of unmet health-related social needs of WV children and their families at the next West Virginia AAP meeting. This presentation will introduce the example SDoH screener developed by the ALC. The WV HealthCheck Program will provide follow-up academic detailing and support in the providers' offices.

#### **Provide easily accessible, medically necessary nutrition services as a payer of last resort to improve access to care for CYSHCN.**

The CSHCN Program must consider that the COVID-19 pandemic is still a reality and that the CSHCN child has special physical health care needs and diagnoses that make them more vulnerable than the general pediatric population. The CSHCN Program Director of Nursing and the CSHCN Registered Dietitian will continue to develop nutrition policies that reflect our current health environment and needs of the CSHCN nutrition children and their families. Given the fact that the CSHCN Registered Dietitian has not seen some of these children in two years and has not been able to obtain reliable measurements or make a visual assessment for many of these children, the CSHCN Registered Dietitian plans to hold nutrition clinics in person starting with the next ones this fall. Appointments will be scheduled to allow for proper sanitation and social distancing. All CSHCN Program staff and the CSHCN Registered Dietitian will wear personal protective equipment per COVID-19 protocols. It will be up to the CSHCN Registered Dietitian to allow telehealth appointments on an as needed basis.

The CSHCN Program Director of Nursing and the CSHCN Registered Dietician will continue to advocate for the

child's EPSDT benefit and MCO to cover 100% life sustaining nutrition. Due to current contract language, children can be found ineligible for coverage if any food is consumed by mouth, including small tastes that provide no nutritive value. The CSHCN Program plans to propose new medical foods policy to address the ambiguous language used in current contracts. The new policy will address the current definition of enteral nutrition and when a child is unable to consume enough foods to meet nutritional requirements.

**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 work to finalize the procedure manual. Once completed, all staff will receive training on the new and updated procedures.

The CSHCN Program will develop a request for quote from the technical specifications drafted by Berry Dunn. If procurement is successful, the CSHCN Epidemiologist will work with the chosen vendor to develop the system for use and train all users.

Implementation of a web-based care coordination system will centralize all CSHCN Program forms and data, facilitating the implementation of improved quality assurance monitoring and continuous quality improvement. Currently, CSHCN Program staff are having to navigate multiple disparate systems to accomplish daily tasks. This system will also streamline processes, save staff time, and result in improved services to CSHCN and their families.

Also, for this upcoming year, work is in progress to open another CSHCN Program regional office in the Eastern Panhandle of the state which currently has a high CSHCN population. This will allow the regional teams to be realigned to better allocate caseloads and improve the quality-of-care coordination services. A regional team in the Eastern Panhandle will be more versed in the community resources available in the area.

To improve access to care for CSHCN in underserved parts of the state, the CSHCN Program is in the process of creating new multisystem clinics for the southern part of WV. The residents of the southern region of WV face many health inequities, including lack of access to care, lack of transportation, food disparities, and an overall high rate of poverty. The hope is to partner with the state universities and their residency programs for staffing of the clinics. Prior to the pandemic, the CSHCN Program was developing a plan to partner with the WV School of Osteopathic Medicine in Greenbrier County to provide medical assessments in these clinics.

The CSHCN Program continues to have excellent relationships with the MCOs. The CSHCN Program coordinates with the MCOs daily in the ongoing care coordination of CSHCN. This relationship with the MCOs helps bridge the communication between the CSHCN Program and the medical home which assists the CSHCN Program care coordinators in delivering comprehensive care coordination services.

The OMCFH will continue to partner with Walking Miracles to support outreach, education, and direct support to children and families experiencing childhood cancer. Plans for the upcoming year will focus on improving project reporting to document impact and reach to this population, as well as improving collaboration with WV Medicaid and its MCOs to ensure and monitor coordination of benefits for those eligible children and families.

**Strategy: Establish an automatic referral process to the CSHCN Program using the NAS Surveillance System.**

The CSHCN Program eligibility unit RNs and the CSHCN Program Director of Nursing will continue to collaborate and partner with the MCOs in monitoring and improving the NAS referral process to the CSHCN Program. This mutual collaboration in identifying NAS and IUSE diagnoses should result in better care coordination and case management. Early identification and intervention will result in increased services for children diagnosed with NAS or IUSE to mitigate any negative outcomes from NAS or IUSE. This is especially important in the child's early development.

In response to the CSHCN Program Director of Nursing medical record review, the CSHCN Program Epidemiologist will request birth score data to identify missed referrals. Unfortunately, at this time, the CSHCN Program will be unable to reach out to the families of any missed referrals. This will require a legislative change. While advocating for this change, the CSHCN Program will evaluate the missed referrals for any potential strategies to increase referrals.

**Strategy: CSHCN will provide case management to infants diagnoses with NAS**

The CSHCN Program Director of Nursing will continue to hold monthly meetings with the MCOs, the WV HealthCheck EPSDT Program Director, and OMCFH Medicaid MCO Coordinator. The lack of documentation in the

early birth records of IUSE will be a strong talking point for the CSHCN and MCO monthly meetings this year. We will formulate the processes needed to look further into the NAS birth records at the time of the referral. The birth medical and clinical records do not always document IUSE, but the information is often found in the claims data.

The CSHCN Program continues to meet with other state programs that provide services for NAS children in the OMCFH. The purpose of meeting with the state programs is to identify barriers that currently create silos and hinder information sharing between programs. All parties agree that early intervention is the key to delivering the services to children diagnosed with NAS.

As stated in the annual report, children diagnosed with NAS are often lost to follow-up after they leave foster care either due to return home or adoption. A work group to brainstorm ideas to encourage participation in the CSHCN Program after leaving foster care is scheduled to begin at the end of July 2021. CSHCN Program staff will receive training on how to best communicate with parents of children diagnosed with NAS or IUSE to obtain positive outcomes.

The CSHCN Program continues to partner with the BCF to ensure a comprehensive medical record is developed for all foster children, including children in foster care diagnosed with NAS or IUSE. The CSHCN Program Director is in direct contact with the BCF to partner in establishing a referral process for foster children diagnosed with NAS or IUSE. The CSHCN Program care coordinators will then participate in the BCF plan of care which will be integrated into the CSHCN Program's care plan.

An internal OMCFH work group will be established to create a process to streamline the NAS referral process to include all relevant programs and to avoid duplications. The CSHCN Program has a vested interest in all NAS referrals received by the Birth to Three Program (BTT) and Right from the Start (RFTS). These programs capture children early but cannot provide services throughout the child's full development. The CSHCN Program can provide services to age 21, so it is logical that the CSHCN Program should be involved to follow the child as they age. Conversely, the BTT and RFTS programs would benefit from the comprehensive care plan developed by the CSHCN Program.

Through bimonthly Nursing Development meetings, the CSHCN Program Director of Nursing will continue to conduct education and trainings about NAS and the availability of confirming diagnoses of suspected Intrauterine Substance Exposure through claims data. The CSHCN Program staff have access to certain protected state sponsored data systems which enables the staff to investigate birth records, medical and clinical records, ongoing medical and community needs, and claims data. The CSHCN Program Director of Nursing will implement in-service trainings on how to observe and evaluate these records for somatic signs and symptoms that could indicate undiagnosed NAS or IUSE. RNs will receive training to review records for atypically high numbers of comorbidities of global development, sensory issues, and behavioral diagnoses. The comorbidities within the medical records will result in appropriate referrals, including but not limited to neurology, developmental specialists, occupational therapy, physical therapy, and speech therapy.

## **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.**

Implementation of the health care transition action plan will be a priority in the coming months as we transition from the initial PHE response and incorporate the PHE long-term response into our regular work. Our strategies for this state performance measure remain unchanged. Once approved, updated tools and procedures will be included in the academic detailing to pediatric primary care physicians by the WV HealthCheck Program.

**Complete transition readiness assessment for all enrolled CSHCN starting at age 14.**

Once approved, WV CSHCN Program care coordinators and WV BCF staff will receive training on the updated tools and procedures. WV CSHCN Program care coordinators will begin implementing these tools and procedures with all transition age CSHCN. Data surveillance will monitor progress and ensure all transition age CSHCN receive age-appropriate transition services.

**Educate transition aged foster children on their entitlement to retain Medicaid coverage until age 26.**

Partnering with the WV HealthCheck Program and WV BCF, the WV CSHCN Program care coordinators will continue to inform transition age foster children on their entitlement to retain Medicaid coverage until age 26. Data surveillance will monitor progress and ensure all foster children are reached.

**Cross-Cutting/Systems Building**

**Cross-Cutting/Systems Building - 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 of Maternal, Child and Family Health 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 Infant and Maternal Mortality Review Panel Maternal Risk Screening Advisory Perinatal and Women's Health Medical Advisory Committee
Perinatal and Infant Health	Perinatal Partnership Newborn Metabolic Screening Advisory Newborn Hearing Screening Advisory Core Team for Substance Exposed Infants Infant and Maternal Mortality Review Panel Maternal Risk Screening Advisory
Child Health	Pediatric Medical Advisory Board Child Fatality Review Team Childhood Lead Poisoning Advisory Bureau for Children and Families Family Resource Networks WV Department of Education WV Kids and Families Coalition Governor's Early Childhood Planning Task Force
Children with Special Health Care Needs	WVU Center for Excellence in Disabilities CSHCN Medical Advisory Board Family Voices Family to Family Health Information Center Developmental Disability Council WV Early Intervention Interagency Coordinating Council Statewide Transition Committee Early Childhood Advisory Council West Virginia Advocates West Virginia Parent Training and Information Emergency Medical Services for Children WV Department of Education Parent Partners in Education Commission for the Deaf and Hard of Hearing
Adolescent Health	Pediatric Medical Advisory Board WV Department of Education WV Suicide Prevention Council West Virginia Violence and Injury Prevention Network Key Players for Sexual Violence Prevention Leadership to Prevent Teen Pregnancy Task Force County level Substance Abuse Task Force 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.

Due to the COVID-19 Pandemic, the Family Advisory group did not conduct in person meetings within community settings as was done the previous year. Advisory meetings for the various OMCFH Programs were held through Skype or ZOOM.

### **III.G. Technical Assistance**

The OMCFH may again 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.

In the past 5 years the OMCFH has experienced the ripple effects of multiple retirements. While the workforce has so far sustained the movement, the next few years will have an increased impact due to depleting the experienced workforce. Staff in State government can retire at age 55 as long as years of service combined with age add up to 80. The upcoming funding year will be extremely taxing on OMCFH as there will be several key senior leadership staff retiring. This wave of staff retirements will include those with 20 plus years of maternal and child health experience and impact all divisions within OMCFH. Technical assistance will be needed to provide quality training in maternal and child health as a younger workforce emerges over the next few years.

A third area of possible technical assistance relates to social determinants of health and how to incorporate into all programs housed in OMCFH. It has been noted in past Title V Block Grant reviews of the lack of narrative around this topic. More detailed guidance from the federal level would be of great importance to address the lack of incorporation of social determinants of health in future applications.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [BMS 2021 Interagency Agreement.pdf](#)

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [2021 OMCFH ADVISORIES.pdf](#)

Supporting Document #02 - [Public Private Partnerships.pdf](#)

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [WV2021 org chart.pdf](#)

## VII. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

State: West Virginia

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 6,205,535	
A. Preventive and Primary Care for Children	\$ 2,178,801	(35.1%)
B. Children with Special Health Care Needs	\$ 2,019,584	(32.5%)
C. Title V Administrative Costs	\$ 385,000	(6.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 4,583,385	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 13,146,376	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 22,300,975	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 35,447,351	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 4,362,527		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 41,652,886	
9. OTHER FEDERAL FUNDS 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)	\$ 29,724,428	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 71,377,314	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 160,020
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) > WISEWOMAN Program	\$ 600,000
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)	\$ 653,435
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 258,456
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,394
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) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 770,000
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)	\$ 2,369,091
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 5,889,379
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 1,684,684
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	\$ 1,544,468
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	\$ 7,332,338
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	\$ 338,862

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	\$ 4,855,999
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) > Centers for Disease Control and Prevention (CDC) > Emergency Department Surveillance	\$ 146,985
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Firearm Injury Surveillance through Emergency Rooms	\$ 224,968
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Association of University Centers on Disabilities	\$ 94,000

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 6,056,584		\$ 6,117,166	
A. Preventive and Primary Care for Children	\$ 2,039,342	(33.7%)	\$ 2,004,263	(32.7%)
B. Children with Special Health Care Needs	\$ 2,603,793	(43%)	\$ 2,166,250	(35.4%)
C. Title V Administrative Costs	\$ 410,129	(6.8%)	\$ 523,357	(8.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 5,053,264		\$ 4,693,870	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 13,341,754		\$ 12,190,559	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 180	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 21,615,897	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 13,341,754		\$ 33,806,636	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 4,362,527				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 19,398,338		\$ 39,923,802	
9. OTHER FEDERAL FUNDS 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)	\$ 25,899,611		\$ 19,729,699	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 52,655,287		\$ 59,653,501	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 265,709	\$ 218,962
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 330,349	\$ 260,702
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)	\$ 367,258	\$ 376,225
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	\$ 600,000	\$ 403,761
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	\$ 2,136,544	\$ 1,320,722
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 221,147	\$ 155,187
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 180,184
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000	\$ 92,332
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 1,900,000	\$ 1,747,276
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 6,031,476	\$ 5,382,705
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	\$ 427,940	\$ 330,203
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 2,301,492	\$ 2,595,969

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 100,000	\$ 150,000
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX - Grants to States for Medical Assistance Programs	\$ 5,153,201	\$ 3,644,974
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 2,231,162	\$ 738,153
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 1,283,333	\$ 358,601
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	\$ 200,000	\$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	\$ 2,000,000	\$ 0
Department of Health and Human Services (DHHS) > Other > Project Launch		\$ 307,162
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control Research and State and Community Based Programs		\$ 649,534
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PRESCRIPTION DRUG OVERDOSE PREVENTION FOR WEST VIRGINIA		\$ 759,074
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Surveillance, intervention, and referral to services activities for infants with microcephaly or oth		\$ 42,534
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Nonfatal Suicide Outcomes		\$ 15,439

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, B. Children with Special Health Care Needs:</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	We had a settlement payment of \$2,161,353.70 for BTT, this is due to the increase of program income, that inadvertently caused the decrease in spending in BTT
2.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs:</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Decreased in administrative costs for travel, etc.
3.	<b>Field Name:</b>	<b>5. OTHER FUNDS</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Reduction of other income for contracts
4.	<b>Field Name:</b>	<b>6. PROGRAM INCOME</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	4/10/20 we had a settlement payment of \$2,161,353.70 for BTT, this is due to the increase of program income

**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 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	\$ 142,150	\$ 109,617
2. Infants < 1 year	\$ 350,000	\$ 273,384
3. Children 1 through 21 Years	\$ 2,178,801	\$ 2,004,263
4. CSHCN	\$ 2,019,584	\$ 2,166,250
5. All Others	\$ 1,130,000	\$ 1,040,295
Federal Total of Individuals Served	\$ 5,820,535	\$ 5,593,809

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	\$ 967,447	\$ 221,417
2. Infants < 1 year	\$ 499,361	\$ 385,821
3. Children 1 through 21 Years	\$ 758,491	\$ 966,059
4. CSHCN	\$ 9,881,898	\$ 9,950,155
5. All Others	\$ 403,422	\$ 429,899
Non-Federal Total of Individuals Served	\$ 12,510,619	\$ 11,953,351
Federal State MCH Block Grant Partnership Total	\$ 18,331,154	\$ 17,547,160

**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 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	\$ 1,854,876	\$ 1,451,498
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 142,150	\$ 109,617
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 1,712,726	\$ 1,341,881
2. Enabling Services	\$ 471,858	\$ 824,368
3. Public Health Services and Systems	\$ 3,878,801	\$ 3,841,300
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		\$ 0
Physician/Office Services		\$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 348,575
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Other		
subrecipients, case and client services		\$ 1,102,923
Direct Services Line 4 Expended Total		\$ 1,451,498
<b>Federal Total</b>	<b>\$ 6,205,535</b>	<b>\$ 6,117,166</b>

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	\$ 1,286,447	\$ 415,645
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 967,447	\$ 221,417
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 319,000	\$ 194,228
2. Enabling Services	\$ 29,056,076	\$ 28,770,036
3. Public Health Services and Systems	\$ 5,104,828	\$ 10,310,822
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		\$ 0
Physician/Office Services		\$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 213,780
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Other		
subrecipients, case and client services		\$ 201,865
Direct Services Line 4 Expended Total		\$ 415,645
<b>Non-Federal Total</b>	\$ 35,447,351	\$ 39,496,503

**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: 19,008

Data Source Year: 2020

**1. Core RUSP Conditions**

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	18,536 (97.5%)	247	46	46 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methylglutaric 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)	Mucopolysaccharidosis Type 1
Primary Congenital Hypothyroidism	Propionic Acidemia	S, βeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiencies	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	β-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) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
CCHD Critical Congenital Heart Disease	18,039 (94.9%)	34	0	0 (0%)
Newborn Hearing Screening	17,989 (94.6%)	894	7	7 (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 infants with genetic conditions and by the Office of Maternal, Child and Family Health for those infants needing metabolic formula/supplements for PKU, Tyrosinemia and Organic Acidemia disorders and for those infants with hearing loss follow-up is conducted through the Newborn Hearing project contract.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

1.	<b>Field Name:</b>	<b>Total Births by Occurrence</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Total Births by Occurrence Notes</b>
	<b>Field Note:</b>	Vital Statistics 2019 preliminary data
2.	<b>Field Name:</b>	<b>Data Source Year</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Data Source Year Notes</b>
	<b>Field Note:</b>	2020 Newborn Screening lab data
3.	<b>Field Name:</b>	<b>CCHD Critical Congenital Heart Disease - Total Number Receiving At Least One Screen</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	2020 Birth Score program data
4.	<b>Field Name:</b>	<b>CCHD Critical Congenital Heart Disease - Total Number Presumptive Positive Screens</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	2020 Birth Score program data - pulse ox screening failed - 34, not screened - 1,193
5.	<b>Field Name:</b>	<b>CCHD Critical Congenital Heart Disease - Total Number Confirmed Cases</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	failed screens could not be followed up due to staff vacancies at WVU

6.	<b>Field Name:</b>	<b>CCHD Critical Congenital Heart Disease - Total Number Referred For Treatment</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	failed screens could not be followed up due to staff vacancies at WVU
7.	<b>Field Name:</b>	<b>Newborn Hearing Screening - Total Number Receiving At Least One Screen</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	2020 Birth Score program data
8.	<b>Field Name:</b>	<b>Newborn Hearing Screening - Total Number Presumptive Positive Screens</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	2020 Birth Score program data - initial hearing screening failed at least one ear - 894, not screened at least one ear - 480
9.	<b>Field Name:</b>	<b>Newborn Hearing Screening - Total Number Confirmed Cases</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	Newborn Hearing Screening data 2020
10.	<b>Field Name:</b>	<b>Newborn Hearing Screening - Total Number Referred For Treatment</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	all 7 received a referral to BTT for early intervention, 5 were enrolled and 2 were closed due to inability to contact the family

**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 2020

**Form 5a – Count of Individuals Served by Title V**  
**(Direct & Enabling Services Only)**

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	9,309	48.0	0.0	50.0	2.0	0.0
2. Infants < 1 Year of Age	12,352	48.0	0.0	50.0	2.0	0.0
3. Children 1 through 21 Years of Age	218,277	44.0	0.0	51.0	5.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	6,660	66.0	0.0	29.0	5.0	0.0
4. Others	47,497	21.0	0.0	71.0	8.0	0.0
Total	287,435					

**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	18,136	Yes	18,136	88.0	15,960	9,309
2. Infants < 1 Year of Age	19,004	Yes	19,004	97.0	18,434	12,352
3. Children 1 through 21 Years of Age	428,976	Yes	428,976	73.0	313,152	218,277
3a. Children with Special Health Care Needs 0 through 21 years of age^	107,215	Yes	107,215	48.0	51,463	6,660
4. Others	1,345,416	Yes	1,345,416	33.0	443,987	47,497

^Represents a subset of all infants and children.

**Form Notes for Form 5:**

After additional discussion and guidance during Learning Labs, the process of determining which counts to include in Form 5A and 5B has again been adjusted. More detail is now included in the note for each type of individuals served.

**Field Level Notes for Form 5a:**

1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Field Note:</b>	MCH Maternity Services - referrals from Medicaid for determination of eligibility for prenatal services provided by OMCFH - 244 Maternal Risk Screening - screening completed on first prenatal care visit of resident women for identification of possible high risk pregnancy - 9,059
2.	<b>Field Name:</b>	<b>Infants Less Than One Year Total Served</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Field Note:</b>	infants with abnormal/unacceptable newborn screens - 247 infants who failed/not screened newborn hearing - 894 infants who failed/not screened CCHD - 34 Childhood Lead Poisoning Prevention - elevated blood lead level follow-ups - 4 CSHCN infants - 137 Birth Score - 65% of all births referred for follow-up services EPSDT/HealthCheck expected infant visits - 9,392 (CMS 416 2020)
3.	<b>Field Name:</b>	<b>Children 1 through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Field Note:</b>	EPSDT/HealthCheck - CMS 416 eligibles who should receive at least 1 initial or periodic screen - 198,371 Childhood Lead Poisoning Prevention - elevated blood lead level follow-ups - 1,056 Adolescent Health Initiative participants - 11,693 Family Planning clients <21 years old - 7,157
4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs 0 through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Field Note:</b>	CSHCN clients - 3,015 BTT clients - 3,645
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Field Note:</b>	Family Planning clients >21 years of age - 25,273 BCCSP clients - 1,910 WISEWOMAN clients - 120 Adolescent Health Initiative participants >21 years of age - 20,194

**Field Level Notes for Form 5b:**

1.	<b>Field Name:</b>	<b>Pregnant Women</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Field Note:</b>	<p>MCH Maternity Services - referrals from Medicaid for determination of eligibility for prenatal services provided by OMCFH - 244</p> <p>Maternal Risk Screening - screening completed on first prenatal care visit of resident women for identification of possible high risk pregnancy - 9,059</p> <p>RFTS - positive pregnancy test referrals from Medicaid - 5,431</p> <p>Home Visitation pregnant participants - 1,226</p>
2.	<b>Field Name:</b>	<b>InfantsLess Than One Year</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Field Note:</b>	<p>infants with abnormal/unacceptable newborn screens - 247</p> <p>infants who failed/not screened newborn hearing - 894</p> <p>infants who failed/not screened CCHD - 34</p> <p>CSHCN infants - 137</p> <p>Home Visitation infants &lt; 1 year of age - 1,548</p> <p>newborn screens completed on 97% of all births</p> <p>Birth Score - completed on 96% of all births</p> <p>EPSDT/HealthCheck expected infant visits - 9,392</p> <p>education outreach (monthly SUID mailings to all births occurring 2 months prior to mailing minus any infant deaths identified prior to mailing, safe sleep education in all birthing hospitals conducted by Our Babies Safe and Sound funded by OMCFH) - completed on 94% of all births</p>
3.	<b>Field Name:</b>	<b>Children 1 Through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Field Note:</b>	<p>EPSDT/HealthCheck - CMS 416 eligibles who should receive at least 1 initial or periodic screen - 198,371</p> <p>Childhood Lead Poisoning Prevention - elevated blood lead level follow-ups - 1,056</p> <p>Adolescent Health Initiative participants - 11,693</p> <p>Family Planning clients &lt;21 years old - 7,157</p> <p>Home Visitation participants - 1,690</p> <p>students enrolled in state school system - 251,961</p>
4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs 0 through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Field Note:</b>	<p>CSHCN clients - 3,015</p> <p>BTT clients - 3,645</p> <p>children enrolled in special education with the state school system - 44,671</p>
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2020</b>

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**Field Note:**

Family Planning clients >21 years of age - 25,273

BCCSP clients - 1,910

WISEWOMAN clients - 120

Adolescent Health Initiative participants >21 years of age - 20,194

Home Visitation participants >21 years of age - 1,934

education outreach from all programs housed in OMCFH to population >21 years of age - estimated 1/3 of the population

**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 2020**

**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	19,381	17,627	649	368	18	159	31	490	39
Title V Served	18,413	16,746	617	350	17	151	29	466	37
Eligible for Title XIX	12,596	11,456	422	239	12	103	20	319	25
2. Total Infants in State	18,216	16,048	739	461	34	137	0	797	0
Title V Served	17,305	15,246	702	438	32	130	0	757	0
Eligible for Title XIX	11,840	10,431	480	300	22	89	0	518	0

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

1.	<b>Field Name:</b>	<b>1. Total Deliveries in State</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Total</b>
	<b>Field Note:</b>	2019 preliminary data from Vital Statistics - occurrence births - Hispanic counts not deducted from each race count (368 Hispanic could be of any race)
2.	<b>Field Name:</b>	<b>1. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Total</b>
	<b>Field Note:</b>	calculated at 95%
3.	<b>Field Name:</b>	<b>1. Eligible for Title XIX</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Total</b>
	<b>Field Note:</b>	calculated at 65%
4.	<b>Field Name:</b>	<b>2. Total Infants in State</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Total</b>
	<b>Field Note:</b>	2019 preliminary Vital Statistics data - resident infants <1 year of age
5.	<b>Field Name:</b>	<b>2. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Total</b>
	<b>Field Note:</b>	calculated at 95%
6.	<b>Field Name:</b>	<b>2. Eligible for Title XIX</b>
	<b>Fiscal Year:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Total</b>
	<b>Field Note:</b>	calculated at 65%

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**

**State: West Virginia**

<b>A. State MCH Toll-Free Telephone Lines</b>	<b>2022 Application Year</b>	<b>2020 Annual Report Year</b>
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"		9,565

<b>B. Other Appropriate Methods</b>	<b>2022 Application Year</b>	<b>2020 Annual Report Year</b>
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	<a href="http://www.wvdhhr.org.mch/">http://www.wvdhhr.org.mch/</a>	<a href="http://www.wvdhhr.org.mcfh/">http://www.wvdhhr.org.mcfh/</a>
4. Number of Hits to the State Title V Program Website		47,708
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 / WV / 25301
Telephone	3045585388
Extension	
Email	James.E.Jeffries@wv.gov

**2. Title V Children with Special Health Care Needs (CSHCN) Director**

Name	Teresa Marks
Title	ICAH/CSHCN Director
Address 1	350 Capitol St
Address 2	Room 427
City/State/Zip	Charleston / WV / 25301
Telephone	3045585388
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  
List of MCH Priority Needs**

**State: West Virginia**

**Application Year 2022**

<b>No.</b>	<b>Priority Need</b>	<b>Priority Need Type (New, Revised or Continued Priority Need for this five- year reporting period)</b>
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 9 State Priorities – Needs Assessment Year – Application Year 2021**

<b>No.</b>	<b>Priority Need</b>	<b>Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)</b>
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
2019	79.6 %	0.3 %	14,329	18,008
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
2018	85.5	7.0	152	17,769
2017	70.1	6.2	128	18,272
2016	86.0	6.9	159	18,479
2015	79.3	7.5	114	14,384
2014	85.3	6.7	166	19,460
2013	76.6	6.2	153	19,977
2012	71.3	6.0	142	19,917
2011	60.7	5.6	117	19,263
2010	79.8	6.4	157	19,667
2009	67.0	5.7	140	20,909
2008	61.4	5.4	129	21,020

**Legends:**

- Indicator has a numerator  $\leq 10$  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
2015_2019	16.0 ⚡	4.1 ⚡	15 ⚡	93,943 ⚡
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
2019	9.8 %	0.2 %	1,772	18,128
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
2019	12.6 %	0.3 %	2,281	18,127
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
2019	29.9 %	0.3 %	5,412	18,127
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
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
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
2018	7.0	0.6	129	18,318
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
2018	7.0	0.6	127	18,248
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
2018	4.3	0.5	79	18,248
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
2018	2.6	0.4	48	18,248
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
2018	153.4	29.0	28	18,248
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 - 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
2018	153.4	29.0	28	18,248
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 - Percent of women who drink alcohol 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 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations**

Data Source: HCUP - State Inpatient Databases (SID)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	44.7	1.7	769	17,209
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  $\leq 10$  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
2018_2019	15.4 %	1.5 %	52,752	342,685
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
2019	17.7	3.2	31	175,550
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
2019	42.5	4.5	89	209,168
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
2017_2019	19.3	2.5	62	321,335
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
2017_2019	14.0	2.1	45	321,335
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
2018_2019	24.0 %	1.6 %	87,648	365,876
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
2018_2019	17.6 %	2.9 %	15,450	87,648
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
2018_2019	2.3 %	0.6 %	6,995	304,252
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
2018_2019	14.5 %	1.6 %	43,407	299,224
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
2018_2019	54.1 %	4.6 %	32,599	60,256
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
2018_2019	90.7 %	1.1 %	331,215	365,244
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
2018	16.5 %	0.3 %	2,030	12,289
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
2019	22.9 %	1.6 %	16,654	72,645
2017	19.5 %	1.5 %	14,439	73,912
2015	17.9 %	1.5 %	13,670	76,308
2013	15.6 %	1.1 %	11,007	70,543
2011	14.6 %	1.2 %	11,113	76,035
2009	14.1 %	1.1 %	11,282	79,781
2007	14.5 %	1.1 %	11,127	76,652
2005	14.5 %	1.1 %	11,326	78,347

**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
2018_2019	19.6 %	2.1 %	31,187	159,345
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
2019	3.6 %	0.5 %	12,859	358,681
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 who have completed the combined 7-vaccine series (4:3:1:3\*:3:1:4) by age 24 months**

Data Source: National Immunization Survey (NIS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	63.9 %	3.4 %	12,000	19,000
2015	70.7 %	3.4 %	14,000	20,000
2014	58.3 %	3.7 %	12,000	21,000
2013	61.7 %	4.4 %	13,000	21,000
2012	61.9 %	4.2 %	13,000	21,000
2011	66.0 %	4.5 %	13,000	20,000

**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
2019_2020	57.7 %	1.6 %	198,388	343,826
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
2019	64.7 %	3.2 %	67,696	104,642
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
2019	89.4 %	2.2 %	93,561	104,642
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
2019	91.0 %	2.1 %	95,271	104,642
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
2019	25.2	0.7	1,287	51,164
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 unable to obtain needed health care in the past year**

Data Source: National Survey of Children's Health (NSCH)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	3.1 %	0.8 %	11,400	364,900
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	2020
Annual Objective	25	24	26	25	25
Annual Indicator	27.2	27.0	27.6	27.3	26.3
Numerator	1,766	1,652	1,654	1,598	1,528
Denominator	6,498	6,116	5,989	5,845	5,811
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	24.0	24.0	23.0	23.0	22.0	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	2020
Annual Objective	63	65	67	69	70
Annual Indicator	64.6	65.4	68.6	68.2	69.9
Numerator	12,784	12,994	12,974	12,736	12,372
Denominator	19,786	19,882	18,907	18,666	17,711
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	72.0	72.0	74.0	74.0	76.0

**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	2020
Annual Objective	12	15	20	22	18
Annual Indicator	14.1	19.0	20.2	15.2	20.9
Numerator	2,748	3,708	3,610	2,790	3,678
Denominator	19,557	19,555	17,857	18,401	17,602
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22.0	22.0	24.0	24.0	25.0	25.0

**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	2020
Annual Objective	77	80	84	87	84
Annual Indicator	79.5	83.7	86.6	82.0	82.0
Numerator	13,573	14,091	13,445	12,495	12,495
Denominator	17,071	16,839	15,534	15,245	15,245
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2018	2018

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	86.0	86.0	88.0	88.0	90.0	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	2020
Annual Objective		40	40
Annual Indicator	37.7	36.1	36.1
Numerator	5,742	5,401	5,401
Denominator	15,239	14,977	14,977
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2018

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	42.0	42.0	44.0	44.0	46.0

**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	2020
Annual Objective		40	44
Annual Indicator	39.8	43.1	43.1
Numerator	6,129	6,470	6,470
Denominator	15,392	15,017	15,017
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2018

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.0	46.0	48.0	48.0	50.0	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	2020
Annual Objective	26	25	27	28	26
Annual Indicator	30.5	30.5	29.1	29.1	28.7
Numerator	23,959	23,959	22,608	22,608	22,112
Denominator	78,632	78,632	77,715	77,715	77,035
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017	2019

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2017	2018	2019	2020
Annual Objective			28	26
Annual Indicator			13.6	15.2
Numerator			16,987	18,340
Denominator			124,901	120,396
Data Source			NSCHP	NSCHP
Data Source Year			2018	2018_2019

**i** 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) - Victimization**

	2017	2018	2019	2020
Annual Objective			28	26
Annual Indicator			49.1	48.0
Numerator			61,001	57,581
Denominator			124,257	120,074
Data Source			NSCHV	NSCHV
Data Source Year			2018	2018_2019

**i** 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**

	2021	2022	2023	2024	2025	2026
Annual Objective	26.0	24.0	24.0	22.0	22.0	20.0

**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	2020
Annual Objective			48	48	48
Annual Indicator		47.0	47.9	45.2	41.8
Numerator		42,772	43,240	40,169	36,658
Denominator		91,107	90,358	88,838	87,648
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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						
	2021	2022	2023	2024	2025	2026
Annual Objective	44.0	48.0	50.0	52.0	52.0	54.0

**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	2020
Annual Objective	32	38	40	36	38
Annual Indicator	37.9	39.3	35.6	36.0	36.0
Numerator	6,464	6,554	5,622	5,633	5,633
Denominator	17,066	16,685	15,797	15,656	15,656
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2018	2018

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	42.0	44.0	46.0	48.0	50.0

**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	2020
Annual Objective	27	25	24	23	22
Annual Indicator	25.2	25.1	24.7	23.9	23.0
Numerator	4,902	4,591	4,590	4,337	4,161
Denominator	19,469	18,305	18,551	18,138	18,106
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	22.0	20.0	20.0	18.0	18.0	16.0

**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	2020
Annual Objective			27	22	22
Annual Indicator		26.5	22.2	24.1	29.5
Numerator		97,972	82,198	88,702	105,832
Denominator		370,309	370,710	368,117	358,760
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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						
	2021	2022	2023	2024	2025	2026
Annual Objective	28.0	27.0	26.0	24.0	22.0	22.0

**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**

<b>Federally Available Data</b>					
<b>Data Source: National Survey of Children's Health (NSCH) - CHILD</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			33	36	38
Annual Indicator		32.1	35.5	43.3	38.6
Numerator		39,168	40,194	46,844	45,057
Denominator		122,113	113,155	108,304	116,689
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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**

<b>Federally Available Data</b>				
<b>Data Source: Youth Risk Behavior Surveillance System (YRBSS)</b>				
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			25	26
Annual Indicator	25.8	23.4	23.4	26.3
Numerator	19,962	17,726	17,726	19,988
Denominator	77,480	75,763	75,763	75,897
Data Source	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT	YRBSS- ADOLESCENT
Data Source Year	2015	2017	2017	2019
<b>Federally Available Data</b>				
<b>Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT</b>				
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective			25	26
Annual Indicator	24.3	24.1	21.2	18.9
Numerator	29,361	30,565	27,302	22,930
Denominator	120,948	126,776	128,983	121,077
Data Source	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year	2016	2016_2017	2017_2018	2018_2019

**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	2020
Annual Objective			91	91	84
Annual Indicator		81.8	81.7	82.2	81.0
Numerator		283,638	286,309	285,988	277,319
Denominator		346,833	350,407	347,833	342,425
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

**i** 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	2020
Annual Objective		41.6	20	20	22
Annual Indicator	16.3	17	16.8	19.9	25
Numerator	3,240	3,380	22,582	25,058	30,365
Denominator	19,936	19,936	134,548	125,615	121,321
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016	2017	2018	2018-2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	29.0	33.0	35.0	38.0	40.0	40.0

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Indicator 4.15 of NSCH 2016
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	based on Indicator 4.15 of NSCH 2016
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2017 NSCH CSHCN 13.1 and non CSHCN 20.8 previous years only reported on CSHCN
4.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2018 NSCH CSHCN 20.2 and non CSHCN 19.6 previous years only reported on CSHCN
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2018 - 2019 NSCH CSHCN 25.6 and non CSHCN 24.7

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

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	6.9	8.1
Numerator	776	737
Denominator	11,203	9,059
Data Source	PRSI	PRSI
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	6.0	6.0	5.0	5.0	4.0

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2019 PRSI data - number of women reporting substance use during pregnancy
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2020 PRSI data - number of women reporting substance use during pregnancy

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

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	PDMP/VIPP	PDMP/VIPP
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	200.0	250.0	300.0	350.0	400.0

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	will begin academic detailing in 2021
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Education and training on awareness is still being developed.

**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.**

<b>Measure Status:</b>		<b>Active</b>
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator	16.6	
Numerator		
Denominator		
Data Source	WIC	
Data Source Year	2016	
Provisional or Final ?	Provisional	

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	16.0	15.8	15.5	15.0	14.4	14.0

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	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**

<b>Measure Status:</b>		<b>Active</b>			
<b>State Provided Data</b>					
	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Annual Objective		78.2	75.5	68	70
Annual Indicator	57	75.5	68.9	68.1	70.2
Numerator	204,781	271,234	245,477	252,731	255,189
Denominator	359,047	359,047	356,411	371,200	363,517
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016	2017	2017-2018	2018-2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Indicator 3.4
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Based upon Indicator 3.4
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2017 NSCH continuously and adequately insured
4.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2017-2018 NSCH Indicator 3.4a: Adequate and continuous insurance coverage
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2018-2019 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	2020
Annual Objective		54	50	45	41
Annual Indicator	55.6	51.2	49.6	55.5	65.6
Numerator	182	962	901	1,028	956
Denominator	3,272	18,797	18,174	18,526	14,579
Data Source	Birth Score Program				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	The data source changed from last reporting - the Birth Score Program began collecting NAS data in October of 2016.
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Birth Score Program data
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Birth Score Program data
4.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Birth Score Program data
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Birth Score Program - resident data only

**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	2020
Annual Objective		85	87	87	89
Annual Indicator	84.9	84.9	86.3	62.8	85.4
Numerator	95,934	95,934	116,200	78,233	99,995
Denominator	113,040	113,040	134,585	124,579	117,103
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016	2017	2018	2019
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NSCH 2016
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2017 NSCH preventive medical visit in the past year
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2018 NSCH preventive medical visit in the past year
4.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2019 NSCH preventive medical visit in the past year

**Form 10  
Evidence-Based or –Informed Strategy Measures (ESMs)**

**State: West Virginia**

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

<b>Measure Status:</b>		<b>Active</b>
<b>State Provided Data</b>		
	<b>2019</b>	<b>2020</b>
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Perinatal Partnership	Perinatal Partnership
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Provisional

<b>Annual Objectives</b>						
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>
Annual Objective	100.0	150.0	200.0	250.0	300.0	350.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	data collection will begin with CY 2020
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	The Perinatal Collaborative scheduled in person Lamaze Instructor programs for many WV hospitals; however, each hospital had to cancel these classes during 2020 due to the COVID pandemic. The surveys to obtain the number of first time pregnant women participating in Lamaze workshops were planned to occur during these programs. The Collaborative switched to online education programs mid year. WV has thirty (30) Lamaze Certified Childbirth Educators (LCCE). WV is expanding the number of LCCEs through online training for the year 2021, including RFTS nurses and social workers.

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

Measure Status:				Active	
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		1	5	5	6
Annual Indicator	0	2	4	5	5
Numerator					
Denominator					
Data Source	Baby Friendly USA				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	6.0	8.0	8.0	10.0	10.0	10.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**  
according to Baby Friendly USA website as of 6-25-21

**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	2020
Annual Objective		65	67	65	66
Annual Indicator	65.2	64.5	64.9	66.2	66.8
Numerator	11,859	11,514	11,465	11,515	11,065
Denominator	18,179	17,865	17,662	17,405	16,574
Data Source	Vital Statistics				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	68.0	70.0	70.0	72.0	72.0	74.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	WV resident births only - denominator does not include unknown breastfeeding at discharge
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	WV resident births only - denominator does not include unknown breastfeeding at discharge
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	WV resident births only - denominator does not include unknown breastfeeding at discharge
4.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	WV resident births only - denominator does not include unknown breastfeeding at discharge
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	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	2020
Annual Objective		5	9	13	12
Annual Indicator	8.7	8.8	11.1	11.7	11.9
Numerator	2	18	74	160	149
Denominator	23	204	668	1,367	1,256
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	14.0	16.0	18.0	20.0	22.0	23.0

**Field Level Notes for Form 10 ESMs:**

- Field Name:** 2016

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**Column Name:** State Provided Data

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**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.
- Field Name:** 2017

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**Column Name:** State Provided Data

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**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.

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3. **Field Name:** 2018

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**Column Name:** State Provided Data

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**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

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**Column Name:** State Provided Data

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**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.

---

5. **Field Name:** 2020

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**Column Name:** State Provided Data

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**Field Note:**

The above indicator reflects data collected from 1/1/2020-12/31/2020. The denominator includes only those infants who reached 6 months of age by December 31, 2020. 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	2020
Annual Objective		90	95	100	100
Annual Indicator	92	100	100	100	100
Numerator	23	25	25	25	21
Denominator	25	25	25	25	21
Data Source	Our Babies Safe and Sound				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	23 of 25 in state birthing hospitals trained - 15 nationally certified as Safe Sleep Hospitals
2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	25 of 25 in state birthing hospitals trained plus Garret Memorial in MD because of proximity to WV
3.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	25 of 25 in state birthing hospitals trained plus Garret Memorial in MD because of proximity to WV
4.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	25 of 25 in state birthing hospitals trained plus Garret Memorial in MD because of proximity to WV
5.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	The number of birthing hospitals has continued to decline in the state. Although safe sleep training has been conducted in all birthing hospitals, recent discussions led to needs of additional trainings to other facility staff members - not limited to labor and delivery staff and mother and baby staff - but to offer to any staff member who may in contact with infants under the age of 1.

**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	2020
Annual Objective		72	86	86	80
Annual Indicator	71.1	83.9	61.9	75	77.5
Numerator	27	177	599	804	816
Denominator	38	211	968	1,072	1,053
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	82.0	84.0	86.0	88.0	90.0	92.0

**Field Level Notes for Form 10 ESMs:**

- Field Name:** 2016

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**Column Name:** State Provided Data

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**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.
- Field Name:** 2017

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**Column Name:** State Provided Data

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**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.

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3. **Field Name:** 2018

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**Column Name:** State Provided Data

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**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

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4. **Field Name:** 2019

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**Column Name:** State Provided Data

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**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.

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5. **Field Name:** 2020

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**Column Name:** State Provided Data

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**Field Note:**

The above indicator reflects data collected from 1/1/2020-12/31/2020. The denominator includes families with a child less than 1 year of age during the reporting period (CY 2020) who received their first postpartum home visit on or after 1/1/2020. 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	2020
Annual Objective		75	78	80	80
Annual Indicator	77.1	76.8	55	74.8	82.8
Numerator	199	730	820	1,554	1,689
Denominator	258	951	1,492	2,077	2,039
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	82.0	84.0	86.0	88.0	90.0	92.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	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.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	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.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	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.
4.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	The above indicator reflects data collected from 1/1/2020-12/31/2020. 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	2020
Annual Objective		87	95	112	100
Annual Indicator	87	92	110	144	71
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	110.0	115.0	120.0	125.0	130.0	135.0

**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	2020
Annual Objective		13	17	32	38
Annual Indicator	13	16	30	38	30
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	39.0	39.0	39.0	40.0	40.0	43.0

**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	2020
Annual Objective		85	100	135	125
Annual Indicator	85	98	130	122	111
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	140.0	150.0	155.0	160.0	165.0	170.0

**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	2020
Annual Objective		105	114	100	110
Annual Indicator	105	112	97	102	59
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	112.0	115.0	118.0	120.0	122.0	124.0

**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	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	CSHCN	CSHCN
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	3.0	7.0	7.0	7.0	7.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

The pediatrician involved in this initiative (Dr. Lewis) thought it would be best to delay implementation of this project because of COVID. It was decided it didn't make sense to try to add anything new to the practices given all that was going on with COVID.

**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	2020
Annual Objective		
Annual Indicator	30	30
Numerator	34,200	30,798
Denominator	114,000	102,660
Data Source	Medicaid	CMS 416
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	35.0	40.0	45.0	50.0	55.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	based upon DOJ data request indicating 113,781 members with a well child exam in calendar year 2019
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	no progress was made on this strategy due to COVID CMS 416 total eligible receiving at least one initial or periodic screen

**ESM 11.3 - Number of children who receive Title V funded medically necessary medical foods.**

Measure Status:		Active
State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	270	284
Numerator		
Denominator		
Data Source	CSHCN	CSHCN
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	290.0	310.0	330.0	350.0	370.0	390.0

**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	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Oral Health Program	Oral Health Program
Data Source Year	2019	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	50.0	60.0	60.0	60.0	60.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	will begin collecting for 2021-2022 school year
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	work towards establishing curriculum is ongoing

**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	2020
Annual Objective		150	350	350	300
Annual Indicator	148	334	44	217	245
Numerator					
Denominator					
Data Source	Perinatal Partnership				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	300.0	320.0	320.0	340.0	340.0	350.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**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	2020
Annual Objective			60	50
Annual Indicator			41.5	52.7
Numerator			85	178
Denominator			205	338
Data Source			WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	55.0	60.0	65.0	70.0	75.0	78.0

**Field Level Notes for Form 10 ESMs:**

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1. **Field Name:** 2019

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**Column Name:** State Provided Data

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**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.

---

2. **Field Name:** 2020

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**Column Name:** State Provided Data

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**Field Note:**

The above indicator reflects data collected from 1/1/2020-12/31/2020. 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.

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

Measure Status:			Active	
State Provided Data				
	2017	2018	2019	2020
Annual Objective			25	28
Annual Indicator			28.6	28.3
Numerator			100,750	99,750
Denominator			352,397	352,397
Data Source			NSCH	NSCH
Data Source Year			2019	2019
Provisional or Final ?			Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	27.0	25.0	25.0	23.0	23.0	21.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2019 NSCH single year survey
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	based upon 2019 NSCH single year survey

**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	2020
Annual Objective		22	30	45	50
Annual Indicator	0	50	44	48	0
Numerator					
Denominator					
Data Source	Perinatal Partnership				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Due to the Covid pandemic workshop trainings for the Evidence Based Labor Support could not be conducted. It is required to be in-seat and trainings were not permitted inside facilities. Instead, another Licensed Certified Childbirth Education (LCCE) seminar for 13 potential childbirth educators was conducted. Six become certified November 2020 and the rest will take the exam in November 2021.

**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	2020
Annual Objective			150	155
Annual Indicator			10	10
Numerator				
Denominator				
Data Source			AHCS	AHCS
Data Source Year			2019	2020
Provisional or Final ?			Provisional	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	2020
Annual Objective			95	95
Annual Indicator			95	0
Numerator				
Denominator				
Data Source			HealthCheck	HealthCheck
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Final

**Field Level Notes for Form 10 ESMs:**

---

1.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

---

**Field Note:**

all summer camps and programs that participate in CATCH were not conducted in 2020 due to the COVID-19 pandemic

**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	2020
Annual Objective		139	145	180	185
Annual Indicator	139	148	173	171	170
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	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	2020
Annual Objective	40	93	94	94
Annual Indicator	93	94	94	0
Numerator				
Denominator				
Data Source	HealthCheck	HealthCheck	HealthCheck	HealthCheck
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Final

**Field Level Notes for Form 10 ESMs:**

---

1.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

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**Field Note:**

all summer camps and programs that participate in CATCH were not conducted in 2020 due to the COVID-19 pandemic

**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	2020
Annual Objective		83	100	25	30
Annual Indicator	83	15	20	15	18
Numerator					
Denominator					
Data Source	CSHCN	CSHCN	CSHCN	CSHCN	PPIE annual report
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**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	2020
Annual Objective		1,715	1,912	2,103	2,313
Annual Indicator	1,559	1,739	1,830	3,050	3,015
Numerator					
Denominator					
Data Source	WV CSHCN				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

**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	2020
Annual Objective			100	120	140
Annual Indicator	0	100	90	100	95
Numerator					
Denominator					
Data Source	Oral Health	Oral Health Program	Oral Health Program	Oral Health Program	Oral Health Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

**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	2020
Annual Objective			25	30	35
Annual Indicator	0	20	25	25	25
Numerator					
Denominator					
Data Source	Oral Health Program				
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

**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	2020
Annual Objective		0	5	10	15
Annual Indicator	0	0	10	10	10
Numerator					
Denominator					
Data Source	Oral Health Program				
Data Source Year	2016	2016	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

**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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	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.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>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</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of adolescents, ages 12 through 17</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	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	<b>Denominator:</b>	Number of adolescents, ages 12 through 17
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	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								
<b>Denominator:</b>	Number of adolescents, ages 12 through 17								
<b>Healthy People 2030 Objective:</b>	<p>AH-R01 Increase the proportion of adolescents who get support for their transition to adult health care</p> <p>Additionally, the following would apply:</p> <p>AH-02 Increase the proportion of adolescents who speak privately with a provider at a preventive medical visit</p> <p>MICH-20 Increase the proportion of children and adolescents with special health care needs who have a system of care</p>								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase identification of pregnant women using substances during pregnancy utilizing the PRSI form and increase the number of women referred for treatment.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of pregnant women reporting substance use on the PRSI form.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of PRSI forms received.</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of pregnant women reporting substance use on the PRSI form.	<b>Denominator:</b>	Number of PRSI forms received.
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of pregnant women reporting substance use on the PRSI form.								
<b>Denominator:</b>	Number of PRSI forms received.								
<b>Healthy People 2030 Objective:</b>	Increase abstinence from illicit drugs among pregnant women - MICH-11.								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the provider, family and general public awareness of controlled substance use among children ages 5-17.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>10,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of controlled substance prescribing providers who received academic detailing regarding substance use.</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10,000	<b>Numerator:</b>	Number of controlled substance prescribing providers who received academic detailing regarding substance use.	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10,000								
<b>Numerator:</b>	Number of controlled substance prescribing providers who received academic detailing regarding substance use.								
<b>Denominator:</b>									
<b>Healthy People 2030 Objective:</b>	Increase the proportion of adolescents who think substance abuse is risky — SU-R01.								
<b>Data Sources and Data Issues:</b>	PDMP for number of prescribing providers and VIPP Program for number of prescribing providers receiving academic detailing.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Decrease obesity rates in children, ages two to four, from 16.6% (WIC data 2016) to 14.4% by 2022.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>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.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Total number of children ages two to four participating in WIC.</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	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.	<b>Denominator:</b>	Total number of children ages two to four participating in WIC.
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	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.								
<b>Denominator:</b>	Total number of children ages two to four participating in WIC.								
<b>Healthy People 2030 Objective:</b>	Reduce the proportion of children and adolescents with obesity — NWS-04								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	<p>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.</p>								

**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**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	To increase the number of children who are adequately insured									
<b>Definition:</b>	<table border="1" style="width: 100%;"> <tr> <td style="background-color: #cccccc;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #cccccc;"><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td style="background-color: #cccccc;"><b>Numerator:</b></td> <td>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.</td> </tr> <tr> <td style="background-color: #cccccc;"><b>Denominator:</b></td> <td>Number of children, ages 0 through 17</td> </tr> </table>		<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	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.	<b>Denominator:</b>	Number of children, ages 0 through 17
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Numerator:</b>	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.									
<b>Denominator:</b>	Number of children, ages 0 through 17									
<b>Healthy People 2020 Objective:</b>	<p>Related to Access to Health Services (AHS) Objective 1: Increase the proportion of persons with health insurance.</p> <p>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.</p>									
<b>Data Sources and Data Issues:</b>	National Survey of Children's Health (NSCH)									
<b>Significance:</b>	<p>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.</p>									

**2016-2020: SPM 3 - Rate of infants born with neonatal abstinence syndrome.**  
**Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To reduce the rate of infants born with neonatal abstinence syndrome.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Rate</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of infants born with neonatal abstinence syndrome.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of deliveries.</td> </tr> </table>	<b>Unit Type:</b>	Rate	<b>Unit Number:</b>	1,000	<b>Numerator:</b>	Number of infants born with neonatal abstinence syndrome.	<b>Denominator:</b>	Number of deliveries.
<b>Unit Type:</b>	Rate								
<b>Unit Number:</b>	1,000								
<b>Numerator:</b>	Number of infants born with neonatal abstinence syndrome.								
<b>Denominator:</b>	Number of deliveries.								
<b>Healthy People 2020 Objective:</b>	Related to Maternal, Infant, and Child Health Objective 11.4. Increase abstinence from illicit drugs among pregnant women.								
<b>Data Sources and Data Issues:</b>	WV Birth Score Program								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	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								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of adolescents, ages 12 through 17 with a preventive well visit in the past year.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of adolescents, ages 12 through 17</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of adolescents, ages 12 through 17 with a preventive well visit in the past year.	<b>Denominator:</b>	Number of adolescents, ages 12 through 17
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of adolescents, ages 12 through 17 with a preventive well visit in the past year.								
<b>Denominator:</b>	Number of adolescents, ages 12 through 17								
<b>Healthy People 2020 Objective:</b>	AH-1 Increase the proportion of adolescents who have had a wellness checkup in the past 12 months.								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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.								

**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**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	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.									
<b>Definition:</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 30%;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of first time pregnant women who participated in the Lamaze International Evidence Based Labor Support Workshop.</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>		<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100,000	<b>Numerator:</b>	Number of first time pregnant women who participated in the Lamaze International Evidence Based Labor Support Workshop.	<b>Denominator:</b>	
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	100,000									
<b>Numerator:</b>	Number of first time pregnant women who participated in the Lamaze International Evidence Based Labor Support Workshop.									
<b>Denominator:</b>										
<b>Data Sources and Data Issues:</b>	Vital Statistics and Perinatal Partnership									
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the number of birthing facilities designated Baby-Friendly under the EMPOWER initiative from 5 in 2020 to 10 by 2025.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of birthing facilities designated as Baby-Friendly by Baby Friendly USA.</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of birthing facilities designated as Baby-Friendly by Baby Friendly USA.	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of birthing facilities designated as Baby-Friendly by Baby Friendly USA.								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	Vital Statistics and Baby Friendly USA								
<b>Evidence-based/informed strategy:</b>	Baby Friendly hospitals is an intervention strategy in hospital care at birth focused on the implementation of practices that promote exclusive breastfeeding from the first hours of life and with the support, among other measures of positive impact on breastfeeding, of the International Code of Marketing of Breastmilk Substitutes. Currently, the initiative has been revised, updated and expanded to integrate care for newborns in neonatal units and care for women since prenatal care. National Baby Friendly data shows higher rates of breastfeeding in accredited hospitals than non-accredited hospitals.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the percentage of infants who are breastfeeding at time of discharge from a birthing facility to 74% by 2025.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of infants who are breastfeeding at time of discharge from birthing facilities</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of live infant discharged from a birthing facility</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of infants who are breastfeeding at time of discharge from birthing facilities	<b>Denominator:</b>	Number of live infant discharged from a birthing facility
	<b>Unit Type:</b>	Percentage							
	<b>Unit Number:</b>	100							
	<b>Numerator:</b>	Number of infants who are breastfeeding at time of discharge from birthing facilities							
<b>Denominator:</b>	Number of live infant discharged from a birthing facility								
<b>Data Sources and Data Issues:</b>	Vital Statistics								
<b>Evidence-based/informed strategy:</b>	Kellams AL, Gurka KK, Hornsby PP, et al. The impact of a prenatal education video on rates of breastfeeding initiation and exclusivity during the newborn hospital stay in a low-income population. J Hum Lact. 2016;32(1):152-159. Link: <a href="https://www.ncbi.nlm.nih.gov/pubmed/26289058">https://www.ncbi.nlm.nih.gov/pubmed/26289058</a>								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the percentage of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of infants enrolled in an evidence-based home visitation program who have reached six months of age</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age	<b>Denominator:</b>	Number of infants enrolled in an evidence-based home visitation program who have reached six months of age
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age								
<b>Denominator:</b>	Number of infants enrolled in an evidence-based home visitation program who have reached six months of age								
<b>Data Sources and Data Issues:</b>	OMCFH home visitation programs								
<b>Evidence-based/informed strategy:</b>	Home visits appear to be effective for increasing both breastfeeding initiation and exclusivity at 6 months. Peer counselor interventions appear to be effective and are more likely to influence initiation than exclusivity. Source: Garcia, S., Payne, E., Strobino, D., Minkovitz, C., & Gross, S. (2018). Strengthening the evidence-base for maternal and child health programs; NPM 4: Breastfeeding.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the percentage of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education from 95% in 2020 to 100% by 2024.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></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><b>Denominator:</b></td> <td>Number of birthing hospitals in the state</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of birthing hospitals in the state that have been trained using the “Say YES to Safe Sleep” curriculum	<b>Denominator:</b>	Number of birthing hospitals in the state
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of birthing hospitals in the state that have been trained using the “Say YES to Safe Sleep” curriculum								
<b>Denominator:</b>	Number of birthing hospitals in the state								
<b>Data Sources and Data Issues:</b>	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.								
<b>Evidence-based/informed strategy:</b>	Kuhlmann S, Ahlers-Schmidt CR, Lukasiwicz G, Truong TM. Interventions to improve safe sleep among hospitalized infants at eight children's hospitals. <i>Hosp Pediatr.</i> 2016;6(2):88-94. Link: <a href="https://www.ncbi.nlm.nih.gov/pubmed/26753631">https://www.ncbi.nlm.nih.gov/pubmed/26753631</a>								
<b>Significance:</b>	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.								

**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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Provide Safe Sleep education on the first visit after child's birth to 88% of families enrolled in a home visitation program								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></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><b>Denominator:</b></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> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	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	<b>Denominator:</b>	Number of families enrolled in a home visitation program with a child aged less than 1 year during the reporting period
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	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								
<b>Denominator:</b>	Number of families enrolled in a home visitation program with a child aged less than 1 year during the reporting period								
<b>Data Sources and Data Issues:</b>	Data will be collected from OMCFH Home Visitation Programs.								
<b>Evidence-based/informed strategy:</b>	Providing infant safe sleep education on the first home visit after delivery is similar to the Massachusetts Welcome Family promising approach. The framework and implementation plan for Welcome Family was partially modeled off Family Connects, an evidence-based universal nurse home visiting program available to all families with newborns residing within a defined service area. Findings from a randomized controlled trial indicate that Family Connects increased connections to community services, improved parenting behavior, decreased emergency room visits, and lowered healthcare costs. Source: <a href="https://www.mchevidence.org/tools/npm/5-safe-sleep.php">https://www.mchevidence.org/tools/npm/5-safe-sleep.php</a>								
<b>Significance:</b>	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.								

**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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	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								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>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</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of infants enrolled in a home visitation program who were aged less than 1 year during the reporting period</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	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	<b>Denominator:</b>	Number of infants enrolled in a home visitation program who were aged less than 1 year during the reporting period
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	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								
<b>Denominator:</b>	Number of infants enrolled in a home visitation program who were aged less than 1 year during the reporting period								
<b>Data Sources and Data Issues:</b>	Data will be collected from OMCFH Home Visitation Programs.								
<b>Evidence-based/informed strategy:</b>	The WV HVP approaches Safe Sleep education with trained nurses, social-workers and home visitors. The program is similar in nature to the Nurse Family Partnership model where families receive direct education from trained professionals. In this case, infant safe sleep is addressed at prenatal visits and every visit through one year postpartum. Families are provided with education on appropriate sleep surfaces and proper placement of infant for sleep. <a href="https://www.mchevidence.org/tools/npm/5-safe-sleep.php">https://www.mchevidence.org/tools/npm/5-safe-sleep.php</a>								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Foster positive and nurturing relationships between young people and caring adults within their communities.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of PYD trainings provided to youth, parents, professionals and community members</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000	<b>Numerator:</b>	Number of PYD trainings provided to youth, parents, professionals and community members	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,000								
<b>Numerator:</b>	Number of PYD trainings provided to youth, parents, professionals and community members								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	Data will be provided by Adolescent Health grantees								
<b>Evidence-based/informed strategy:</b>	<p>Positive Youth Development is an evidence-based strategy that focuses on asset-building and goal-setting as a means of risk reduction. This strength-based approach to prevention promotes protective factors in young people’s lives. Research has shown that the more assets youth have, the less likely they are to engage in violent behaviors; 53% (1-10 assets) vs. 3% (31-40 assets). Providing education to youth, parents, schools and communities encourages asset promotion at all levels of the CDC’s social-ecological model to prevention.</p> <p><a href="https://www.search-institute.org/wp-content/uploads/2018/01/DataSheet-Assets-x-Gender-2018-update.pdf">https://www.search-institute.org/wp-content/uploads/2018/01/DataSheet-Assets-x-Gender-2018-update.pdf</a></p> <p><a href="https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html">https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html</a></p>								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Implement comprehensive, evidence-based bullying prevention programming in schools and communities								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of schools and/or youth serving organizations that have implemented a comprehensive bullying program</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000	<b>Numerator:</b>	Number of schools and/or youth serving organizations that have implemented a comprehensive bullying program	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,000								
<b>Numerator:</b>	Number of schools and/or youth serving organizations that have implemented a comprehensive bullying program								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	Data provided by the Adolescent Health grantees, the Violence and Injury Prevention grantees and the WV Dept. of Education								
<b>Evidence-based/informed strategy:</b>	Research shows school-based anti-bullying programs are effective in reducing bullying perpetration and victimization. Anti-bullying programs should include intervention elements at multiple levels, including the school, class, parent, peer, and individual level. This supports the AHI's comprehensive prevention approach to include individual and school/community level support. <a href="https://link.springer.com/article/10.1007/s42380-019-0007-4">https://link.springer.com/article/10.1007/s42380-019-0007-4</a>								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase awareness about bullying, cyberbullying and the associated negative outcomes, while promoting positive behaviors, educating on bystander skills and supporting WVDE Policy 4373								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>10,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of social media messages.</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10,000	<b>Numerator:</b>	Number of social media messages.	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10,000								
<b>Numerator:</b>	Number of social media messages.								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	Data will be provided by Adolescent Health grantees								
<b>Evidence-based/informed strategy:</b>	Social media in health promotion is valuable for its potential to engage with audiences for enhanced communication and improved capacity to promote programs, products, and services. It can disseminate critical information quickly, expand reach to include broader, more diverse audiences and foster public engagement and partnerships with consumers. It can support other strategies to address behavior change and improve health outcomes. <a href="https://journals.sagepub.com/doi/10.1177/1524839911433467">https://journals.sagepub.com/doi/10.1177/1524839911433467</a>								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase awareness about bullying, cyberbullying and the associated negative outcomes, while promoting positive behaviors, educating on bystander skills and supporting WVDE Policy 4373								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of trainings provided to youth, parents, professionals and community members</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000	<b>Numerator:</b>	Number of trainings provided to youth, parents, professionals and community members	<b>Denominator:</b>	
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<b>Unit Number:</b>	1,000								
<b>Numerator:</b>	Number of trainings provided to youth, parents, professionals and community members								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	Data will be provided by Adolescent Health grantees								
<b>Evidence-based/informed strategy:</b>	<p>Preventing youth violence requires multiple, complementary strategies at all levels of the social ecology—the individual, relational, community, and societal. Evidence suggests that many factors can buffer or reduce the likelihood of youth violence and multiple protective factors can even offset the potential harmful influence of risk factors such trauma and mental health problems. Education and training are key to providing protective community environments, ensure proper intervention to lessen harmful impacts and strengthen youth resiliency.</p> <p><a href="https://www.cdc.gov/violenceprevention/pdf/yv-technicalpackage.pdf">https://www.cdc.gov/violenceprevention/pdf/yv-technicalpackage.pdf</a></p>								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Improve the medical community's knowledge and adoption of the Patient-Centered Medical Home model of primary care.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>10,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of stakeholders who receive education and resources regarding the National Resource Center for Patient/Family-Centered Medical Home</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10,000	<b>Numerator:</b>	Number of stakeholders who receive education and resources regarding the National Resource Center for Patient/Family-Centered Medical Home	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10,000								
<b>Numerator:</b>	Number of stakeholders who receive education and resources regarding the National Resource Center for Patient/Family-Centered Medical Home								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	CSHCN Program will inform this ESM. This measure will require a consistent definition and application for "stakeholder."								
<b>Evidence-based/informed strategy:</b>	Care provided in the medical home model is well-established and endorsed by the American Academy of Pediatrics as the standard of care for CSHCN . The PCMH has demonstrated greater health care quality and access to preventive services for CSHCN . Though not specific to children, Medicaid-eligible individuals with disabilities who receive care in a PCMH have fewer emergency room visits. Chu L, Sood N, Tu M, Miller K, Ray L, Sayles JN. Reduction of emergency department use in people with disabilities. Am J Manag Care. 2017 Dec 1;23(12):e409-e415. PMID: 29261247.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Improve the percentage of well-child exams received by Medicaid members age 0-21 with a documented social determinants of health screening.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>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.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of well-child exams received by Medicaid members age 0-21 in the last calendar year.</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	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.	<b>Denominator:</b>	Number of well-child exams received by Medicaid members age 0-21 in the last calendar year.
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	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.								
<b>Denominator:</b>	Number of well-child exams received by Medicaid members age 0-21 in the last calendar year.								
<b>Data Sources and Data Issues:</b>	The CSHCN Program will utilize Medicaid claims data to inform this ESM. Inconsistent billing and coding may cause issues with this ESM.								
<b>Evidence-based/informed strategy:</b>	When social determinants of health are addressed by a community health worker with families of CSHCN, the self-report levels of distress in caregivers and understanding of their child's diagnoses. Reported issues with food availability and housing were reduced. Costich MA, Peretz PJ, Davis JA, Stockwell MS, Matiz LA. Impact of a Community Health Worker Program to Support Caregivers of Children With Special Health Care Needs and Address Social Determinants of Health. Clin Pediatr (Phila). 2019 Oct;58(11-12):1315-1320. doi: 10.1177/0009922819851263. Epub 2019 May 25. PMID: 31130003.								
<b>Significance:</b>	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 medically necessary medical foods.**  
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Ensure children in need of medically necessary medical foods are served.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>10,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of children who receive Title V funded medically necessary foods.</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10,000	<b>Numerator:</b>	Number of children who receive Title V funded medically necessary foods.	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10,000								
<b>Numerator:</b>	Number of children who receive Title V funded medically necessary foods.								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	CSHCN Program								
<b>Evidence-based/informed strategy:</b>	Nearly all CSHCN in WV have health insurance (95.0%); however, only 74.9% indicate that their child’s insurance is adequate to usually or always meet their child’s needs, and 21.3% indicate that their out-of-pocket costs are only sometimes or never reasonable . We hypothesize that relieving the financial burden of medically-necessary medical foods for CSHCN will decrease family stress levels and result in better care and outcomes for CSHCN.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	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.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of students completing the dental care curriculum for pregnant women.</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of students completing the dental care curriculum for pregnant women.	<b>Denominator:</b>	
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<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of students completing the dental care curriculum for pregnant women.								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	WVU School of Dentistry								
<b>Evidence-based/informed strategy:</b>	The Oral Health Program will continue to work with the West Virginia University School of Dentistry and the WV Dental Association to educate dentists on the importance of providing dental care to pregnant women. Many dentists are uncomfortable providing care to pregnant women making this a challenging area for WV. The national consensus statement will be used to develop a curriculum for WVU School of Dentistry on dental care for pregnant women as it is the best resource to create a standard knowledge base for dental care during pregnancy.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the number of health care workers who have had Help2Quit maternity care provider training								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of health care providers who have had Help2Quit maternity care provider training</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000	<b>Numerator:</b>	Number of health care providers who have had Help2Quit maternity care provider training	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,000								
<b>Numerator:</b>	Number of health care providers who have had Help2Quit maternity care provider training								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	WV Perinatal Partnership								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the percentage of clients who are referred to smoking cessation services within the first 3 months of enrollment in a home visitation program.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>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.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of women enrolled in home visitation who reported using tobacco or cigarettes at enrollment and were enrolled for at least 3 months.</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	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.	<b>Denominator:</b>	Number of women enrolled in home visitation who reported using tobacco or cigarettes at enrollment and were enrolled for at least 3 months.
<b>Unit Type:</b>	Percentage								
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<b>Numerator:</b>	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.								
<b>Denominator:</b>	Number of women enrolled in home visitation who reported using tobacco or cigarettes at enrollment and were enrolled for at least 3 months.								
<b>Data Sources and Data Issues:</b>	OMCFH Home Visitation Programs								
<b>Evidence-based/informed strategy:</b>	The WV HVP approaches tobacco screening and cessation using nurses, social workers and home visitors, similar to the Nurse Family Partnership home visiting model. In addition, the RFTS program uses the SCRIPT model for tobacco cessation which assesses tobacco use, amount and willingness to quit or reduce, similar in nature to the Baby Me Tobacco Free best practice program. Source: <a href="https://www.mchevidence.org/tools/npm/14-smoking.php">https://www.mchevidence.org/tools/npm/14-smoking.php</a>								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Decrease the number of households where someone smokes.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of children ages 0-17 who live in households where there is household member who smokes.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of children ages 0 through 17</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of children ages 0-17 who live in households where there is household member who smokes.	<b>Denominator:</b>	Number of children ages 0 through 17
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of children ages 0-17 who live in households where there is household member who smokes.								
<b>Denominator:</b>	Number of children ages 0 through 17								
<b>Data Sources and Data Issues:</b>	NSCH								
<b>Evidence-based/informed strategy:</b>	The WV HVP approaches tobacco screening and cessation using nurses, social workers and home visitors, similar to the Nurse Family Partnership home visiting model. In addition, the RFTS program uses the SCRIPT model for tobacco cessation which assesses tobacco use, amount and willingness to quit or reduce, similar in nature to the Baby Me Tobacco Free best practice program. Source: <a href="https://www.mchevidence.org/tools/npm/14-smoking.php">https://www.mchevidence.org/tools/npm/14-smoking.php</a>								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Provision of evidence based support during labor to improve the birth process and reduce cesarean deliveries without a medical indication								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>10,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of labor/delivery nurses that receive evidence based labor support training</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10,000	<b>Numerator:</b>	Number of labor/delivery nurses that receive evidence based labor support training	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10,000								
<b>Numerator:</b>	Number of labor/delivery nurses that receive evidence based labor support training								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase physical activity and improved nutrition in communities through school-based and community-based activities.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of schools implementing shared use.</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000	<b>Numerator:</b>	Number of schools implementing shared use.	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,000								
<b>Numerator:</b>	Number of schools implementing shared use.								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	Data will be provided by the Adolescent Health Grantees								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase physical activity rates through facilitation of the CATCH program at various summer camps and programs.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>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.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of children who attend the selected camps.</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	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.	<b>Denominator:</b>	Number of children who attend the selected camps.
<b>Unit Type:</b>	Percentage								
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<b>Numerator:</b>	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.								
<b>Denominator:</b>	Number of children who attend the selected camps.								
<b>Data Sources and Data Issues:</b>	Staff that will facilitate the CATCH program recording numbers of participants and hours of organized supervised activity.								
<b>Significance:</b>	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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase physical activity and improved nutrition in communities through school-based and community-based activities								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of schools implementing shared use</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000	<b>Numerator:</b>	Number of schools implementing shared use	<b>Denominator:</b>	
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<b>Unit Number:</b>	1,000								
<b>Numerator:</b>	Number of schools implementing shared use								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	Data will be provided by the Adolescent Health Grantees								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase physical activity rates through facilitation of the CATCH program at various summer camps and programs.								
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<b>Denominator:</b>	Number of children who attend the selected camps.								
<b>Data Sources and Data Issues:</b>	Staff that will facilitate the CATCH program recording numbers of participants and hours of organized supervised activity.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	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.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of resident medical students who completed the Project DOCC training through the Parent Partners in Education grant</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000	<b>Numerator:</b>	Number of resident medical students who completed the Project DOCC training through the Parent Partners in Education grant	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,000								
<b>Numerator:</b>	Number of resident medical students who completed the Project DOCC training through the Parent Partners in Education grant								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To provide quality care coordination and support the medical home for CSHCN in the state of WV who meet the Program's eligibility criteria.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>10,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of unique CSHCN enrolled in the WV CSHCN Program in FY 2017</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10,000	<b>Numerator:</b>	Number of unique CSHCN enrolled in the WV CSHCN Program in FY 2017	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10,000								
<b>Numerator:</b>	Number of unique CSHCN enrolled in the WV CSHCN Program in FY 2017								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	Data will be obtained from the CSHCN Program.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the number of prenatal care providers educated on national consensus statement by 20%.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of WV prenatal care providers educated on national consensus statement.</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000	<b>Numerator:</b>	Number of WV prenatal care providers educated on national consensus statement.	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,000								
<b>Numerator:</b>	Number of WV prenatal care providers educated on national consensus statement.								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the number of dental care providers educated on national consensus statement by 20%								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of West Virginia dental care providers educated on national consensus statement</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000	<b>Numerator:</b>	Number of West Virginia dental care providers educated on national consensus statement	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,000								
<b>Numerator:</b>	Number of West Virginia dental care providers educated on national consensus statement								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the percentage of pediatric care providers who complete the Smiles for Life course required in West Virginia for reimbursement of fluoride varnish application for children ages 0-3 by 20%.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of pediatric care providers who complete Smiles for Life Course 6</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of pediatric care providers in West Virginia</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of pediatric care providers who complete Smiles for Life Course 6	<b>Denominator:</b>	Number of pediatric care providers in West Virginia
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of pediatric care providers who complete Smiles for Life Course 6								
<b>Denominator:</b>	Number of pediatric care providers in West Virginia								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	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.								

**Form 11**  
**Other State Data**  
**State: West Virginia**

The Form 11 data are available for review via the link below.

[Form 11 Data](#)

**Form 12  
MCH Data Access and Linkages**

**State: West Virginia**

**Annual Report Year 2020**

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	More often than monthly	3		
2) Vital Records Death	Yes	Yes	More often than monthly	3	Yes	
3) Medicaid	Yes	Yes	More often than monthly	1	Yes	
4) WIC	Yes	No	Quarterly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	3	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	More often than monthly	6	Yes	

**Form Notes for Form 12:**

None

**Field Level Notes for Form 12:**

None