Maternal and Child Health Services Title V Block Grant

West Virginia

FY 2023 Application/ FY 2021 Annual Report

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

Bill J. Crouch
Cabinet Secretary

Ayne Amjad, MD, MPH
Commissioner & State Health Officer

August 1, 2022

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 2023.
2. Fiscal Year 2021 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 James Jeffries, Director, Office of Maternal, Child and Family Health, at (304) 414-0491. Questions and/or comments regarding the business management responsibilities should be directed to Larry Easter, Director, Division of Grant Administration and Reporting, at (304) 352-6713.

Sincerely,

Tara L. Buckner
Chief Financial Officer

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

TLB/JEJ/vc

Enclosures

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

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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: January31, 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 2022 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

Decrease 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

Decrease 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

During March of 2020, WV declared a statewide Stay-at-Home Order to attempt to reduce the spread and infection rate of COVID 19. While this was a necessary step to ensure the health and safety of WV residents, the WV Birth to Three (WVBTT) early intervention program anticipated a decline in the number of infants/toddlers referred and enrolled in the program due to its nature of providing services in family homes. The program anticipated it being impossible to complete evaluations for eligibility and provide services while trying to comply with the stay-at-home order. WVBTT leaders in collaboration with leaders in the Office of Maternal, Child and Family Health quickly made the decision to allow WVBTT services to be provided remotely using phone and video conferencing. An interactive data dashboard was created to monitor referrals and enrollments weekly to measure impact to the program from COVID-19 and the stay-at-home order. Through this interactive data dashboard, WVBTT leaders and local program coordinators at the Regional Administrative Units were able to monitor close to real time their referral and enrollment numbers to make important local program decisions regarding child find and service provision. The program did initially see a sharp decline (66%) in referrals to the program during the week of the stay-at-home order. Enrollments into the program were affected gradually over time with our lowest enrollment numbers observed in May of 2020. WVBTT referral numbers started rising again after just three months from the stay-at-home order and enrollment numbers started to increase again in June 2020. While the program did observe lower than normal referral and enrollment numbers throughout the stay-at-home order, WVBTT never stopped serving families completely. Families who were currently receiving services through the program when the stay-at-home order was implemented were offered the option to continue their services remotely through phone/video conferencing. Most families accepted these virtual services. Enrolled professionals with WVBTT reported challenges in providing services to families through virtual means but overall heard that families were thankful to continue to have WVBTT services during the time. Enrolled professionals also reported that in some cases they observed greater parent involvement during virtual services as they needed to coach the parents more because of the nature of providing services through virtual means. In the spring of 2021, with the stay-at-home order being lifted, WVBTT adapted again their services to give families options for services to be provided in their home with safety precautions or continue with virtual services. Currently WVBTT is providing services in mixed methods (virtual and in the home) and for some months in 2021 and 2022, referral and enrollment numbers are reported above previous years.

III.B. Overview of the State

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

WV, the second most rural state in the nation, is the only state located entirely within the area known as Appalachia. Even so, WV is located within 500 miles of 60% of the nation's population. The state is traversed by two north/south and one east/west interstates that connect its major population centers. In addition, I-68, which ends at Morgantown, where West Virginia University (WVU) is located, provides access to Washington, D.C. and Baltimore, MD. Interstate 68 also connects with I-79S, providing access to Charleston, WV, the state capitol and I-79N providing access to Pittsburgh, PA. Winding secondary roads connect the majority of the state's population, with little to no public transportation available between many of the small, isolated towns. Therein lies the single most often cited issue with access to health care for many of the state's residents.

WV is surrounded by Pennsylvania, Maryland, Virginia, Ohio, and Kentucky and is commonly referred to as a South Atlantic state. The Appalachian Mountains extend through the eastern portion of the state, giving WV the highest elevation of any state east of the Mississippi River.

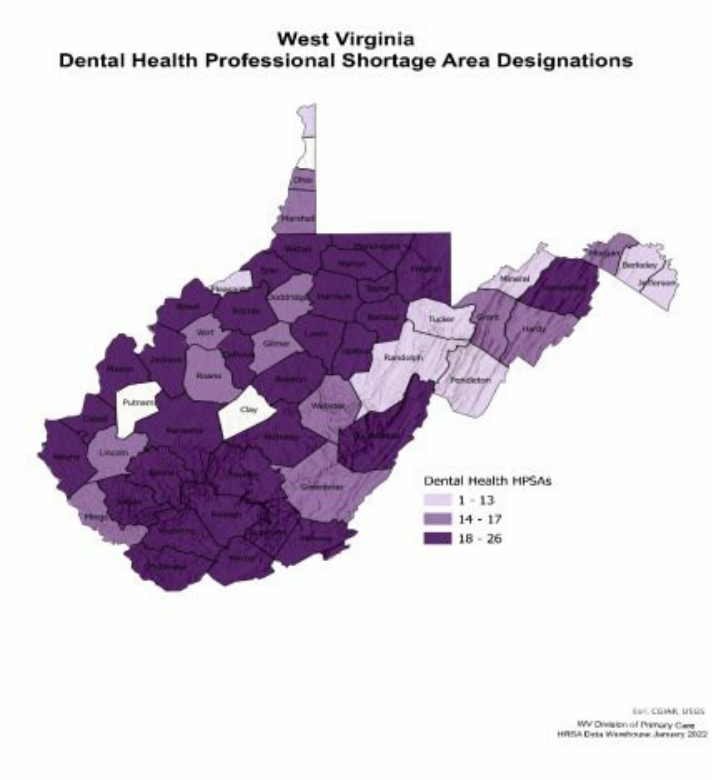
WV reached its population peak a half century ago with 2,005,552 residents counted in the 1950 US Census. The State's population has not exceeded the 2 million mark since then but has fluctuated between 1.7 and 1.9 million depending on the State's economy. Charleston, the state capitol and largest city, and Huntington are the only cities with populations nearing 50,000 people. WV is the 41st largest and the 38th most populous state in the country. Two-thirds of the State's 1.8 million people live in communities with less than 2,500 residents. The following maps show the primary care, the mental health and the dental health professional shortage areas.

West Virginia
Primary Care Health Professional Shortage Area Designations

Esri, USGS
WV Division of Primary Care
HRSA Data Warehouse, January 2022

West Virginia
Mental Health Professional Shortage Area Designations

Esri, CGIAR, USGS
WV Division of Primary Care
HRSA Data Warehouse, January 2022



Appalachia is distinguished by mountainous terrain, geographic isolation, and a history of economic underdevelopment. Although conditions in Appalachia have improved in recent years, these improvements have not benefited all communities equally. Isolated, rural areas continue to experience the most adverse social, economic, and educational deficits, resulting in significant health disparities in the incidence, prevalence, mortality, burden of chronic diseases, and their risk factors, as well as access to care. Not surprisingly, WV consistently ranks in the top three nationally in adults self-reporting their general health as either “fair” or “poor”.

WV's population is mostly homogeneous with little racial or ethnic diversity. The 2020 Census population estimates for WV reported that 93.08% of WV residents are White, 3.69% Black, 0.2% American Indian and Alaska Native, 0.8% Asian, 0.02% Native Hawaiian or Pacific Islander, 0.44% other race, and 1.77% were more than one race. The Hispanic population was reported as 1.7%.

WV has one of the oldest median ages (42.8 years) and percent of people age 60 and older in the nation according to 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 17,327 births in 2020 (preliminary data). 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 73.7% compared to 64.4% nationally. Almost 85% of individuals age 65 and older own their home.

According to America’s Health Rankings, WV ranked poorly in 2020 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 2020, the percent of obese adults reached 39.1%; 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 2020, WV was ranked 47th with 29.7% 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 2020. In 2020, WV ranked 50th in terms of smoking with 22.6% 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 2020 WV Pregnancy Risk Assessment Monitoring System (PRAMS) data, smoking during the last three months of pregnancy has decreased to 18.3% after decreasing from 24.9% in 2018 to 18.5% in 2019.

The report did however list the following strengths for the state: low prevalence of excessive drinking, low prevalence of high-risk HIV behaviors and low percentage of severe housing problems. The report also highlighted a 58% increase in Chlamydia, a 26% decrease in adults who avoided care due to cost and a 15% decrease in frequent mental distress in adults.

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, 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 later in 2022. 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 eleven 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 (ruralhealthinfo.org) there are 58 Rural Health Clinics in WV, 268 Federally Qualified Health Center (FQHC) sites providing services in the State, 10 short term hospitals outside of urban areas and 21 critical access hospitals. Five point one percent of WV residents lack health insurance (Kaiser, 2020). According to the Economic Research Service, the average per capita income for WV residents in 2020 was $44,994 and rural per capita income lagged at $40,872.

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 five 146% FPL, ages six to 18 138% FPL and pregnant women 190% FPL (Kaiser, 2022).

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 2020) found that 6.3% of WV children are currently uninsured, but according to the 2021 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 continues to apply that study and additional ACEs research findings in WV.
Beginning the fall of 2021, the Title V Director led a legislatively commissioned "ACEs Workgroup," under the supervision of the State Health Officer and Commissioner of the Bureau for Public Health, to study the impact of ACEs on the people of West Virginia. Said ACEs Workgroup consisted of 28 subject matter experts, both ex-officio and Commissioner-designated, with Workgroup efforts culminating in the development of a final report to the Governor and the Joint Committee on Government and Finance of the Legislature in the early summer of 2022 as an endeavor to facilitate further action.

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 monitor 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 delays 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, diagnostic services, and education to low-income, uninsured and underinsured women. Available in all 55 WV counties through county health departments, private practice, free clinics, federally qualified health centers (FQHC) and primary care centers – a total of 514 providers including 205 screening providers and 309 referral providers. *(WV Code §16-33)*
l. Newborn Screening Program: All infants born in WV are tested for 34 disorders and follow-up services are offered to those families with infants identified with confirmed disorders. The Program also provides for special nutritional needs as a payor of last resort. Children with confirmed abnormal results 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. Childhood 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: This Panel reviews and evaluates maternal and infant deaths to understand the diverse factors and issues that contribute to deaths and determine preventability. The panel identifies and implements interventions to address these problems based upon review findings. *(WV Code §48-2SA)*

III.C. Needs Assessment

FY 2023 Application/FY 2021 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.

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 during the perinatal period. While 18.3% of women in 2020 smoked during the last trimester of pregnancy, this is lower than the 26.2% 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 41.6% and 32.7% of those mothers without a high school degree reported smoking in the 3 months before pregnancy and the last trimester of pregnancy, respectively, in 2020. 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.

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 2018 and 2019 (it remained unchanged from 8.5%). In 2020, smoking was allowed in at least part of the home in less than 5% (4.9%) 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

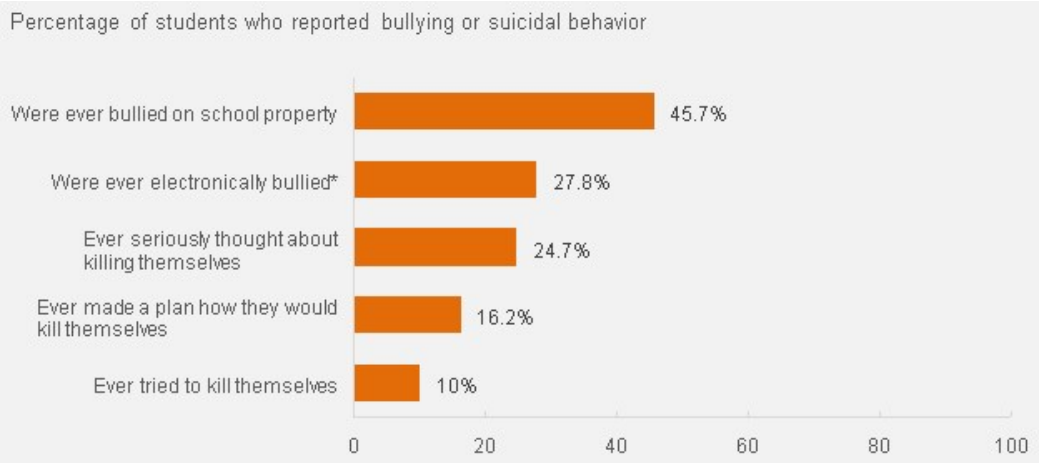
line with the leading causes of infant death in the U.S.: prematurity, birth defects, and sudden unexplained infant death.

The most recent calendar year data available from the Infant and Maternal Mortality Review Panel is 2017, the Panel has met and reviewed infant deaths for 2018 and will have the calendar year report ready for the 2023 legislative session. For calendar year 2017, 133 infant deaths were reviewed by the IMMRP. The manner of death was listed as 88 (66%) natural, 36 (27%) undetermined, three (2%) homicide and six (5%) accidental.

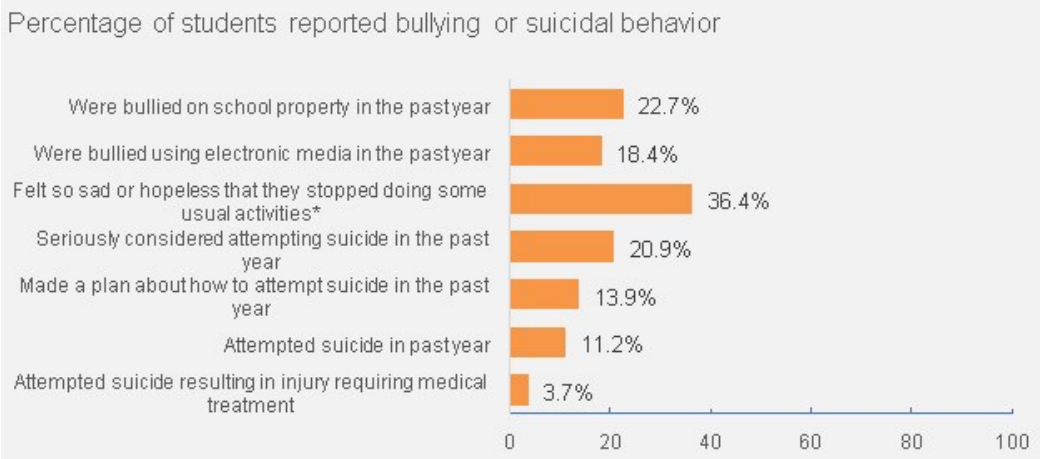
The infant mortality rate for West Virginia in 2017 was 7.12 infant deaths per 1,000 live births (calculated as 133 infant deaths divided by 18,679 resident births - 2017 Health Statistics Center data). In 2017, the CDC reported the U.S. infant mortality rate as 5.79 infant deaths per 1,000 live births.

Premature Birth
The West Virginia Health Statistics Center reports preliminary data from 2020 showing 12% of births were preterm. This was a slight decrease in overall preterm births from 2019, which was reported as 12.6%.

Bullying and Suicidal Behaviors (middle school)
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 (high school)
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.



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 2021, MRS indicated 6.6% of pregnant respondents reported a problem with drugs or alcohol currently and 8.0% reported problem with drugs or alcohol in the past. In 2020, 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. MRS also found that, of those PRSIs submitted in 2021, 1.8% reported current opioid abuse treatment and 1.3% reported previous opioid abuse treatment. In 2020, 2.2% reported current opioid abuse treatment and 2.4% 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 2021 and the percent of infants born with signs of NAS has decreased from 6.55% to 5.48% in 2021.

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), also known as the Controlled Substance Monitoring Program (CSMP), adolescent males ages 5-17 were more likely than females (12.0%, 6.2%) to have been prescribed a stimulant in 2021. According to the National Survey on Children's Health, this number is considerably higher than the national average (males-7.5%, females-3.0%). Additionally, in some counties in the state, the prescribing of stimulants greatly exceeds the prevalence of ADD/ADHD in the population, specifically for males. However, the state saw a decline in stimulant prescribing from 2020-2021 for both males and females ages 5-17 with a percent decrease of 7.0% and 4.6% respectively. This analysis will be continued to identify potentially inappropriate prescribing among prescribers to adolescents who do not have a corresponding ADD/ADHD diagnosis.

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 66.8% in 2020 and 66.7% in 2021 (provisional). The report card also lists WV's total mPINC score for 2018 at 76, compared to the US National score of 79.

In 2020, WV PRAMS indicates that 71.2% of women ever breastfed and only 43.4% of women were breastfeeding at the time of the survey (4-6 months postpartum). Almost 21.3% of women indicated they breastfed for less than a week, compared to the 36.2% that breastfed greater than 8 weeks.

Medical Home and Transition

In the 2019/2020 combined Survey of Children's Health data, only 41.9% of CSHCN in WV reported receiving coordinated, ongoing, comprehensive care within a medical home. This is slightly up from 41.8% in 2018/2019, but within the 95% confidence interval. Fifty-eight 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		2019/2020	
	WV	U.S.	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%	32.7%	22.5%
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%	58.6%	51.8%
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%	74.0%	68.2%
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%	44.5%	36.0%
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%	30.8%	25.7%

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 2021 data shows that 35.7% of women received teeth cleanings prior to pregnancy and only 28.0% of women received cleanings during pregnancy. This leave 72.0% of pregnant women that did not partake in teeth cleanings as part of their prenatal care.

Click on the links below to view the previous years' needs assessment narrative content:

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,056,026	$6,055,641	$6,056,584	$6,117,166
State Funds	$13,264,963	$12,629,175	$13,341,754	$12,190,559
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$180
Program Funds	$19,282,861	$19,526,885	$0	$21,615,897
SubTotal	$38,603,850	$38,211,701	$19,398,338	$39,923,802
Other Federal Funds	$27,964,391	$22,293,910	$33,256,949	$19,729,699
Total	$66,568,241	$60,505,611	$52,655,287	$59,653,501

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,176,181	$5,876,223	$6,205,535	
State Funds	$13,272,503	$12,148,778	$13,146,376	
Local Funds	$0	$0	$0	
Other Funds	$0	$45,804	$0	
Program Funds	$21,193,138	$21,136,166	$22,300,975	
SubTotal	$40,641,822	$39,206,971	$41,652,886	
Other Federal Funds	$29,431,884	$19,998,487	$29,724,428	
Total	$70,073,706	$59,205,458	$71,377,314	

	2023	
	Budgeted	Expended
Federal Allocation	$6,205,535	
State Funds	$14,881,084	
Local Funds	$0	
Other Funds	$0	
Program Funds	$26,718,824	
SubTotal	$47,805,443	
Other Federal Funds	$29,692,155	
Total	$77,497,598	

III.D.1. Expenditures

The OMCFH expects to allocate nearly $77,000,000 in resources for FY 2023. 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 Office. 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 $14,881,084 in State funds and will generate $26,718,824 in program income. The total state match provided is $41,599,908. 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 35.1% for preventive and primary care for children and 35.2% 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 6.3% for administrative costs, complying with the 10% limit.

The Office served over 405,000 pregnant women, infants less than one year of age, and children ages one through 21 years of age, and CSHCN clients ages 0 – 21 during annual report year 2021, slightly more than 75% of those West Virginia populations. Approximately 15,500 pregnant women received direct, enabling or public health services through OMCFH. 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 52,000 children with special health care needs received direct, enabling or public health 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, 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 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, childhood lead poisoning, 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 152 staff in professional, technical and administrative support positions and 18 temporary positions. In addition, the Office maintains three 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 75 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 current 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)

VACANT - Director; Division of Research, Evaluation and Planning,
Education:
Professional:

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)

VACANT - Director; Division of Perinatal & Women's Health
Education:
Professional:

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 identified 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: 22.6 FTE Title V funded positions, two new Title V staff were

onboarded since September 2021 composed of one HHR Office Director I and one Nurse 3 (both are temp positions), and there are currently nine vacant Title V full-time 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 trains 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.

In the 2021-2022 grant year, the OMCFH provided funds to support an extension agent for the Healthy Grandfamilies program through West Virginia State University (WVSU) Extension Service and WVSU Department of Social Work. This is a free initative that provides information and resources to any grandparent that is raising one or more grandchildren. It is designed as a series of nine discussion sessions and follow-up services. Some examples of discussion sessions include: health literacy and self care, negotiating the public school system, parenting in the 21st century, and technology and social media. Upon completion of the program, participating grandparents receive a certificate of completion and three months follow-up service with a social worker that can help locating community resources, providing confidential assistance in meeting individual needs of family, and advocacy needs. Due to COVID-19 pandemic, many in-person sessions were cancelled this year. In addition, Healthy Grandfamilies was instrumental in leading a vaccine incentive for grandparents to receive a $100 gift card upon receiving the COVID-19 vaccine.

In 2022-2023, Healthy Grandfamilies will continue to deliver services to grandparents that are serving as the primary caregivers for their grandchildren. The first Healthy Grandfamilies conference is in planning and expected to take place in August of 2023. The OMCFH is continuing to work with Healthy Grandfamilies to develop a referral process for grandparents that may benefit from the Healthy Grandfamilies program.

For 2022-2023, 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. 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 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, MCH Epi and AMCHP. 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.

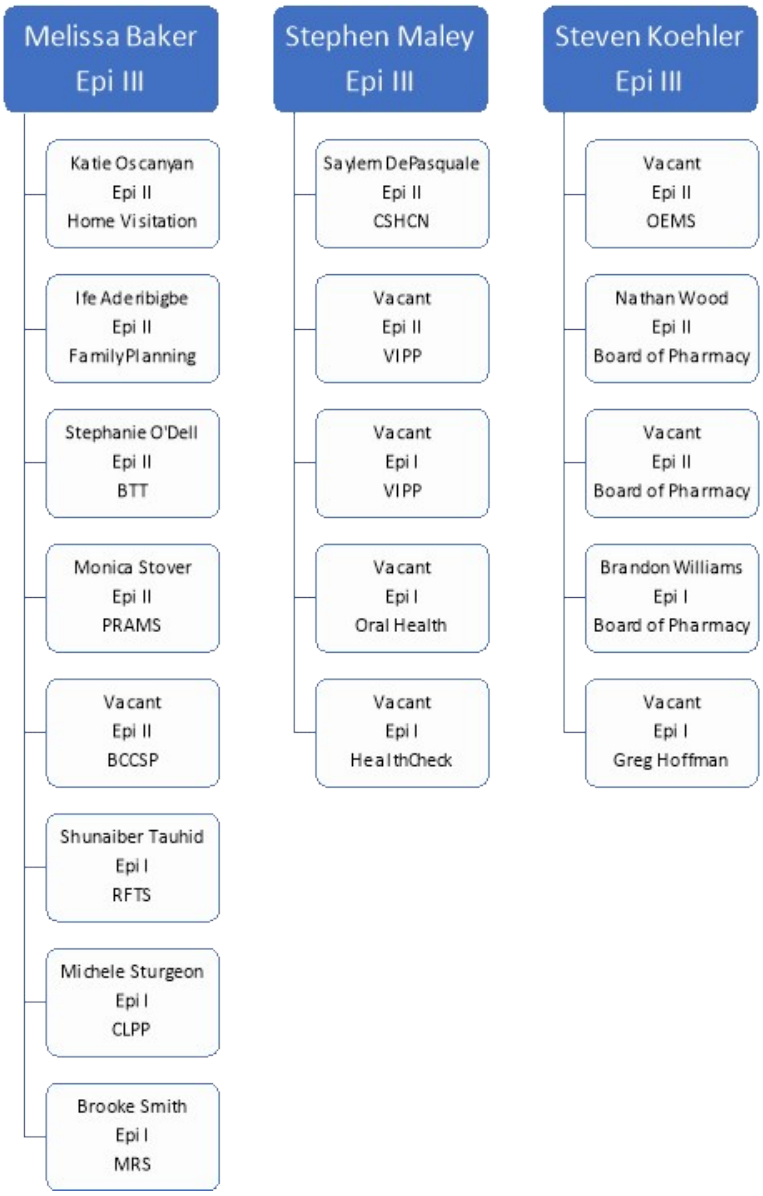
In addition to utilizing federal funds to maintain adequate staffing, the Office also embeds epidemiology personnel employed by its partners. For example, the Board of Pharmacy employs three epidemiologists housed in OMCFH, OEMS has an epidemiologist position that is supervised by OMCFH, and the Office 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. Epidemiology staff tenure in OMCFH for currently filled positions is:

- 1-5 years = 7
- 5-10 years = 1
- 10-15 years = 2
- 25+ years = 1

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

OMCFH Epidemiology 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 of the Office of Maternal, Child and Family Health (OMCFH), West Virginia's Title V agency. The Research 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 has historically been the Director of the Research Division. This ensures that SSDI grant funds are used to advance West Virginia's data capacity. Historically, WV has funded a Programmer Analysist 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, infant mortality, childhood lead poisoning, maternal risk screening, etc. Because the Programmer Analyst is imbedded in the Office of Maternal, Child and Family Health, the SSDI award benefits many data related efforts for data collection and linkages. The MCH Epidemiologist is housed within the Research Division and is funded by Title V, the position supports SSDI efforts, and also has a significant leadership role in completion and submission of the Title V Application and Progress Report as well as the 5 Year Needs Assessment. The Research Division currently houses three Epidemiologist III supervisors who oversee the MCH Epi Unit consisting of 16 epidemiologists that support OMCHF programs.

Recent Accomplishments:

Maternal Risk:

The Zika Birth Defects grant ended on August 31, 2019. The award allowed WV to contract with Local Data Solutions to develop an on-line data collection tool transitioning from the existing teleform used by physicians for submission of the Perinatal Risk Screening Instrument (PRSI). The PRSI was designed to identify maternal risks at the first prenatal visit and is a legislative mandate. The PRSI data is shared with Medicaid for follow-up with women who are at high risk for negative pregnancy outcomes.

COVID-19 Activities

The experience of abstracting birth defects information relating to the Zika Virus led OMCFH to be asked by the Office of Epidemiology and Prevention Services (OEPS), who administer the ELC Grant, to abstract medical information on children with Multi-Inflammatory Syndrome in Children (MIS-C). OEPS also asked for assistance with chart abstraction and follow-up on COVID-19 positive pregnant women and their infants. To date, WV has identified 34 children who meet inclusion criteria for MIS-C and all data has been sent to CDC by HHS Protect. Also, to date, over 1,731 pregnant women have been identified who were positive for COVID-19 (179 COVID positive pregnant women in 2022, 1,116 pregnant women in 2021 and 436 pregnant women in 2020).

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 were used to enter the data and OMCFH epidemiologists assisted with data cleaning and analysis.

Maternal and Infant Mortality:

WV transitioned to the CDC MMRIA database to capture more extensive data on maternal deaths. The MMRIA database has gone through several revision updates. WV also continues to utilize the FIMR database and continues to capture infant mortality data.

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. In 2019, the Department of Personnel increased the starting salaries for epidemiologists which helped tremendously with hiring and retention. As entry level epidemiologists (Epidemiologist I's) increase their involvement in programs and become more defined in responsibilities related to the programs they increase their need to become reclassified at the next level. If the new/additional responsibilities are approved by DOP and the staff member meets the qualifications, then paperwork is submitted to request advancement. This also increases retention and satisfaction.

Currently, OMCFH employs three Epidemiologist IIIs, seven (2 are vacant) Epidemiologist IIs and six (3 are vacant) 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 (VIPP), 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. Some epidemiologists cover more than one program and all participate in special studies or projects as they arise in OMCFH. Because of the versatility of the Epi Unit and using different grant funding to cover salaries of the epidemiologists, the OMCFH is able to capture and analyze statistical information across a wide range of public health topics impacting maternal and child health. The OMCFH has access to death records, occurrence births, birth defects using a passive system, newborn hearing screening, newborn metabolic 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 data.

The OMCFH also employs by contract staff for evaluation efforts for some of our programs, including WISEWOMAN, oral health and prescription drug overdose.

The OMCFH has in place a contract with WVU Project Watch, formerly the Birth Score Program, that collects data for the OMCFH on the infant's risk of developmental delay or death within the first year of life including IUSE, NAS, newborn hearing screening, and Critical Congenital Heart Disease. This information is compiled 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, BTT and CSHCN.

The OMCFH also financially supports three 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 monthly 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, as legislatively mandated, is collected monthly from each birthing facility. These records are sent electronically as agreed upon by the MOUs established with each 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). This collection tool has transitioned from a teleform submission to a web-based system for all providers to enter the form electronically and in real time. 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, this data however does not have identifiers so OMCFH lacks the capacity to data match with existing data sources. The same situation occurs with WIC, data is available but in a deidentified file.

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 are not specifically addressed but are 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. And most recently the COVID pandemic. 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. Currently this team has not met in the past two years and some original team members and leadership support have transitioned to other positions within the Bureau.

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 included 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. Although this goal has been moved back due to more pressing issues, specifically COVID, it is hoped to be addressed again once staff from both agencies are identified and 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. The OMCFH's partnerships and collaborations, both public and private, are extensive and intertwined. 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 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 best treat many of the disorders identified through newborn screening. The Newborn Screening Program Advisory consists of the WVU Pediatrics personnel as well as specialists for Cystic Fibrosis, Hemoglobinopathies, and Endocrinology. There are other key informants 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 included in the newborn screen panel of disorders and establishes cut-off values for indicating whether an infant is in critical need of a confirmatory result.

The partnership with Medicaid 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 coordinating MCO. Medicaid also supplies OMCFH data on pregnant eligible women and foster children to ensure 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 and the EPSDT Program for children eligible for Medicaid, both housed in OMCFH.

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. On 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. In 2020, 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. HeathCheck staff routinely contact families enrolled in fee-for-service Medicaid to facilitate the administrative components of Early and Periodic Screening, Diagnosis and Treatment (EPSDT), including scheduling of well-child exams. Likewise, nine 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 enable EPSDT. In addition to these activities, staff often attend community baby showers, health fairs 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. On January 1, 2021 West Virginia Children's Health Insurance Program (WVCHIP) members were included in the MHT program.

Through the 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. Aetna Better Health of West Virginia received the contract for this specialized managed care program. The Title V Director was involved in every aspect of this transition. Likewise, the Title V CSHCN Director and CSHCN 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 support 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% of the federal poverty level and to provide coverage up to 1 year postpartum, 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 Right from the Start Program administered by West Virginia's Title V agency.

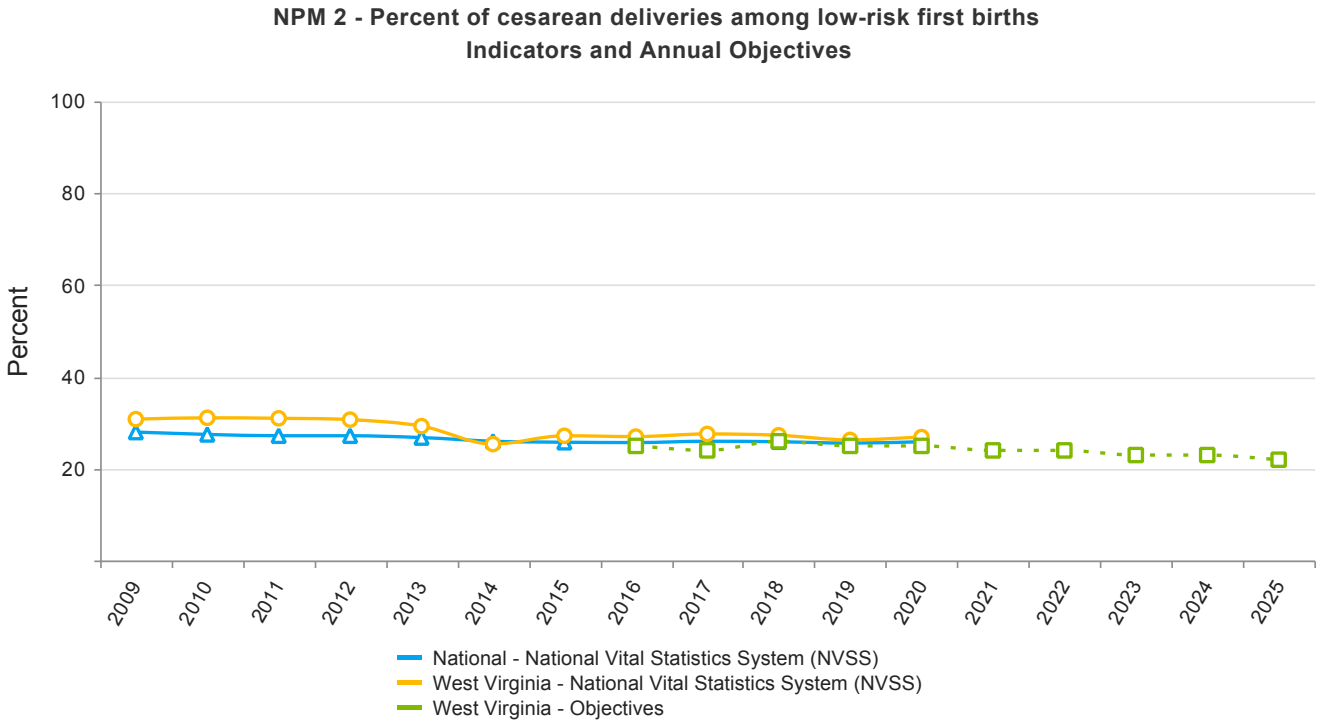
III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

West Virginia approaches the State Action Plan from a perspective of addressing each priority identified in the 5 Year Needs Assessment. Detailed strategies are then developed to address each of these priorities. Strategies are based upon the ability of each program's capacity to implement activities that will impact and address the selected priorities.

Women/Maternal Health

National Performance Measures



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	24	26	25	25	24
Annual Indicator	27.0	27.6	27.3	26.3	26.9
Numerator	1,652	1,654	1,598	1,528	1,498
Denominator	6,116	5,989	5,845	5,811	5,571
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.0	23.0	23.0	22.0

Evidence-Based or –Informed Strategy Measures

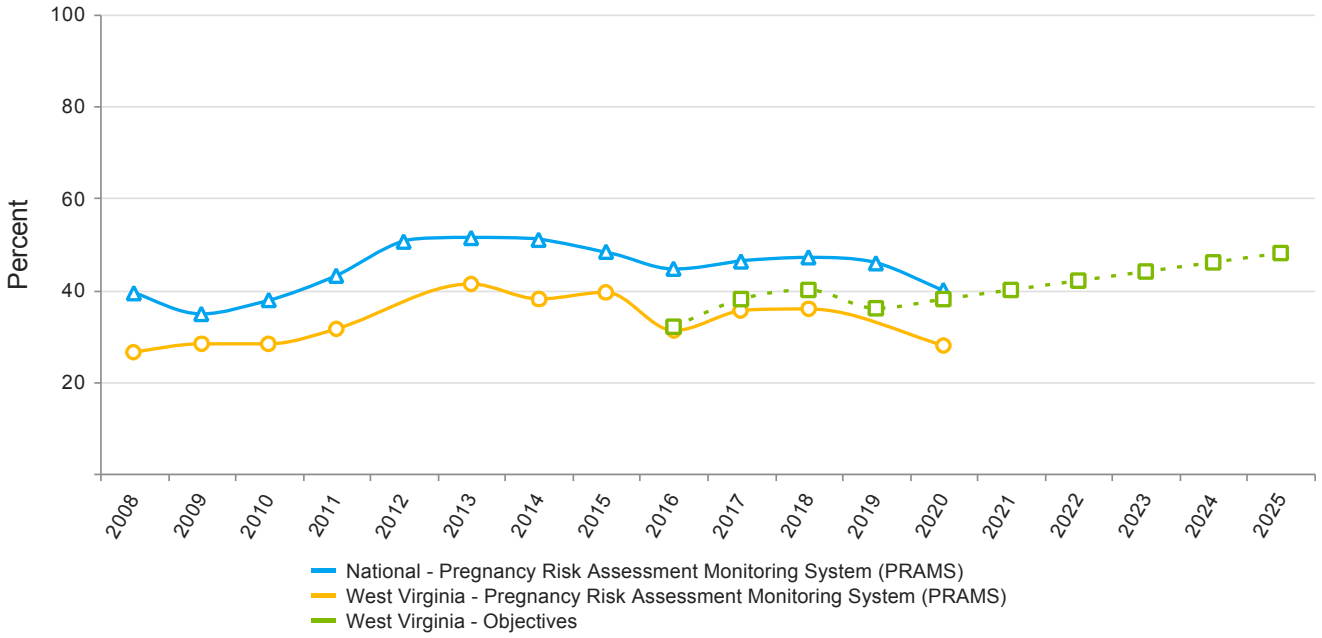
ESM 2.1 - Number of first time pregnant women who have participated in the Lamaze International Evidence Based Labor Support Workshop.

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			100
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional

ESM 2.2 - Percentage of birthing facilities that have received Evidence-based Labor Support Training through the Perinatal Partnership.

Measure Status:		Active	
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	40.0	50.0	60.0

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	38	40	36	38	40
Annual Indicator	39.3	35.6	36.0	36.0	28.0
Numerator	6,554	5,622	5,633	5,633	4,157
Denominator	16,685	15,797	15,656	15,656	14,835
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2018	2018	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	42.0	44.0	46.0	48.0

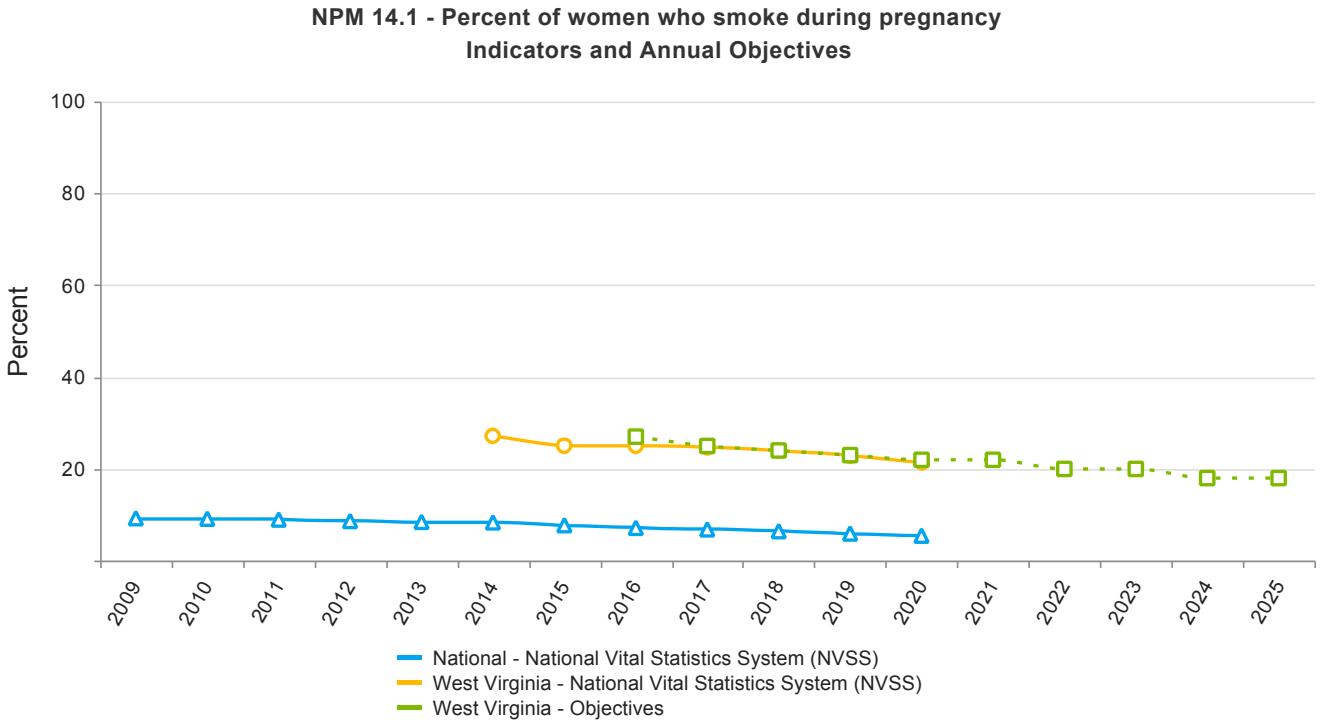
Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			50
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Oral Health Program	Oral Health Program	Oral Health Progam
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final

ESM 13.1.2 - Expectant and recently postpartum mothers who receive oral health education.

Measure Status:		Active	
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	10.0	15.0	25.0



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	25	24	23	22	22
Annual Indicator	25.1	24.7	23.9	23.0	21.4
Numerator	4,591	4,590	4,337	4,161	3,697
Denominator	18,305	18,551	18,138	18,106	17,312
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	20.0	20.0	18.0	18.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	150	350	350	300	300
Annual Indicator	334	44	217	245	137
Numerator					
Denominator					
Data Source	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	320.0	320.0	340.0	340.0

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			60	50	55
Annual Indicator			41.5	52.7	73
Numerator			85	178	197
Denominator			205	338	270
Data Source			WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	60.0	65.0	70.0	75.0

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			8
Annual Indicator	6.9	8.1	6.6
Numerator	776	737	585
Denominator	11,203	9,059	8,848
Data Source	PRSI	PRSI	PRSI
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6.0	6.0	5.0	5.0

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.	Inactive
ESM 2.2 - Percentage of birthing facilities that have received Evidence-based Labor Support Training through the Perinatal Partnership.	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.	Inactive
ESM 13.1.2 - Expectant and recently postpartum mothers who receive oral health education.	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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

Address substance use in pregnancy and in youth/teens.

SPM

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

Objectives

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

Strategies

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

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

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

Decrease preterm and low birthweight infants

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

For the second year, nursing shortages, burnout, staffing problems due to illness, and the limitations of in-seat presentations and drills have derailed some plans but Zoom meetings and webinars have been implemented with some success.

Evidence labor support was provided to 21 participants from five WV hospitals.

Provide Lamaze childbirth education.

Provided Lamaze childbirth education training through a combination of online courses with the final certification to occur in person in mid-June. Eleven people are participating in the course.

Promote childbirth education for first-time mothers statewide.

Two sessions of “Spinning Babies” is scheduled for Summer 2022.

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

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.

Three training opportunities were provided at the Perinatal Summit, Improving Access to Doula Care, Leading Causes of Maternal and Infant Mortality and Racial Disparities, and Implicit Bias in Healthcare.

A 2-day course, Intermediate Fetal Monitoring (FM), was held. Two new Fetal Monitoring instructors are being supervised in order to receive AWHONN FM teaching certification.

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 completed the third grade BSS during the 2021-2022 school year and is currently working with the West Virginia Perinatal Partnership to determine the appropriate locations to conduct BSS for the perinatal population during 2022-2023. The Oral Health Program worked 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 includes 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. To date, there have been three continuing education courses offered. These courses are offered by two board-certified pediatric dental faculty from WVU SoD via a virtual platform and are recorded for future use.

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

Prior to January 1, 2021, West Virginia had an emergency only benefit for adults. The benefit expansion allows for all adults including the perinatal population to have comprehensive oral health services. 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. The Oral Health Program will monitor claims data through the CMS 416 quarterly report to determine if pregnant women are utilizing these services.

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

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

Three Help 2 Quit trainings were provided with 130 total participants completing the training. Two provider champions have been identified to promote tobacco cessation with the medical provider community.

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.

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

The Perinatal Partnership partnered with the WV Breast and Cervical Cancer Screening Program (BCCSP) and Mountains of Hope to develop patient education materials. The materials highlight the link between cervical cancer and smoking. There were three discrete pieces developed and all focused on the importance of quitting smoking and receiving preventive health care, including regular screenings.

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

Three Coalition for Tobacco Free meetings were held with a total of 138 participants. A DFMB Community Health Worker smoking cessation training was held with 25 in attendance.

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 training process was delayed due to COVID and restrictions with office visits, along with a "go live" start date. A detailed training plan was developed by the PRSI epidemiologist to be used with providers. Provider contact was ongoing and approximately 15 provider agencies have been added to the new PRSI system to enter forms. RCCs and the RFTS Coordinator are working closely with local providers on the transition.

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 in the use of the on-line data system. Established an effective communication process between RFTS, the PRSI epidemiologist and Local Data Solutions. Providers were given a choice of an in-person training or virtual training on the use of the ePRSI system. It was a slow start getting providers engaged in the training. An increase in the number of providers being trained has occurred and some providers have started using the e-PRSI system. The production site for the ePRSI became live on April 1st, 2022. There are 19 providers offices who have requested for staff members to have accounts created to submit PRSIs on the site (some provider offices have

multiple users). Currently 47 staff members have accounts. The first official ePRSI was submitted on May 18th, 2022. The overall submission of ePRSIs so far is 42. Only two provider offices have submitted any ePRSIs. An increase in the number of providers requesting access has increased significantly over the last two months.

Inform providers of compliance rate in submission of PRSI forms.

Due to the delay in getting providers trained and using the ePRSI system, reports have not been generated to providers yet. The reports have been designed and will be shared at the Maternal Risk Screening Advisory Board meeting in October 2022.

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.

As part of a Managed Care Organization and private organization funding stream, 8 RFTS DCCs and home visitors are in the process of being trained and certified as doulas. The challenges faced are how to reimburse certified doulas in West Virginia and support newly trained doulas with insurance, marketing and hospital relationships. Discussions will be ongoing with Medicaid, the Perinatal Partnership, OMCFH and MCOs on how to implement effectively within the State.

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.

Work with RFTS Regional Lead Agencies to have at least 1 Lamaze Childbirth Educator providing virtual sessions for women unable to attend in-person. RFTS will also increase the number of Designated Care Coordinators providing the Enhanced Service of childbirth education by 10 new trained Childbirth Educators.

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.

RFTS will increase the number of certified childbirth educators across the State to include at least two in each of the eight regions. Childbirth educators will be trained to provide education virtually and in person.

RFTS is developing a birth plan training for new moms along with a resource kit that will help new moms better understand the birthing process, hospital preparation and the first few weeks at home with the new baby. This training will be provided to all home visitation programs and added to the new home visitor training.

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.

Continue the work with the obstetric and gynecology residency 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.

Continue the same activities with the goal of increasing the number of clinicians completing the course. Develop a process to survey participants six months and one year after completion to determine the impact of the training.

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.

Continue to trainings and develop a process to survey participants six months and one year after completion to determine the impact of the training.

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.

Continue to trainings and develop a process to survey participants six months and one year after completion to determine the impact of the training.

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 trainings and develop a process to survey participants six months and one year after completion to determine the impact of the training.

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.

Develop stronger linkages with the MCOs and home visitation on incentives and activities to support pregnant and postpartum women requesting to quit or reduce smoking.

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

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

Continue to trainings and develop a process to survey participants six months and one year after completion to determine the impact of the training.

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.

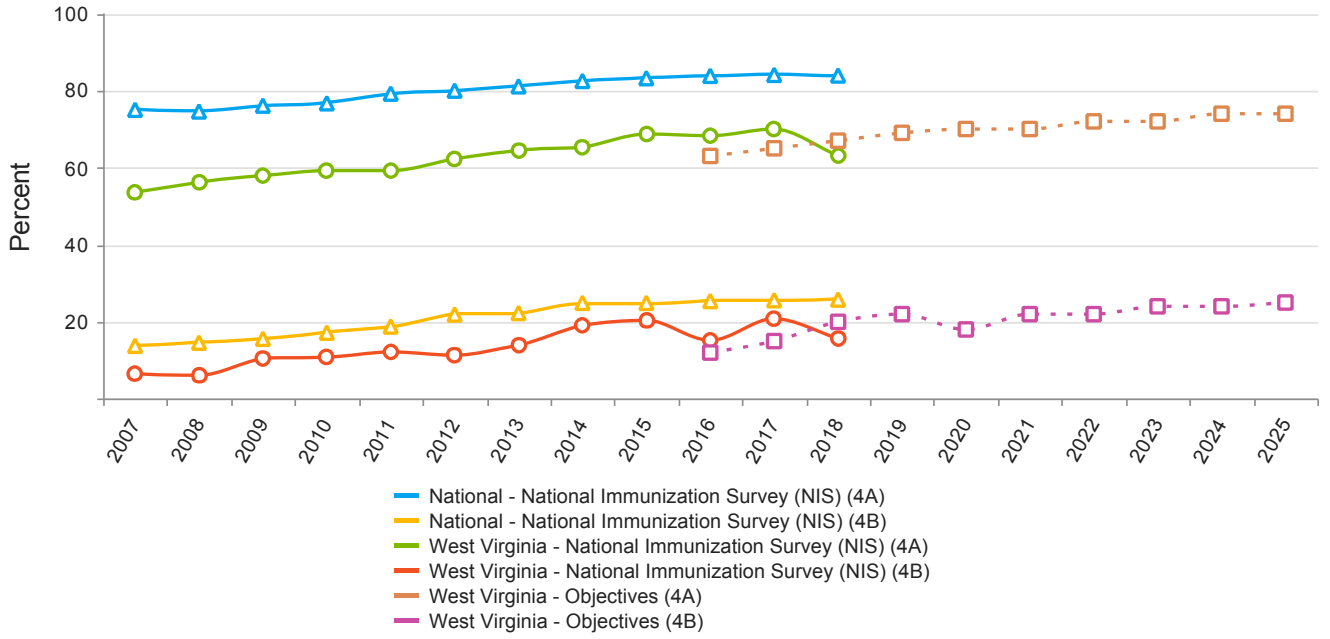
Inform providers of compliance rate in submission of PRSI forms.

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

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	65	67	69	70	70
Annual Indicator	65.4	68.6	68.2	69.9	63.0
Numerator	12,994	12,974	12,736	12,372	10,871
Denominator	19,882	18,907	18,666	17,711	17,259
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	72.0	72.0	74.0	74.0

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	15	20	22	18	22
Annual Indicator	19.0	20.2	15.2	20.9	15.8
Numerator	3,708	3,610	2,790	3,678	2,678
Denominator	19,555	17,857	18,401	17,602	16,920
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	22.0	24.0	24.0	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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	1	5	5	6	6
Annual Indicator	2	4	5	5	4
Numerator					
Denominator					
Data Source	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	8.0	8.0	10.0	10.0

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	65	67	65	66	68
Annual Indicator	64.5	64.9	66.2	66.8	66.7
Numerator	11,514	11,465	11,515	11,069	10,853
Denominator	17,865	17,662	17,405	16,579	16,275
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	70.0	70.0	72.0	72.0

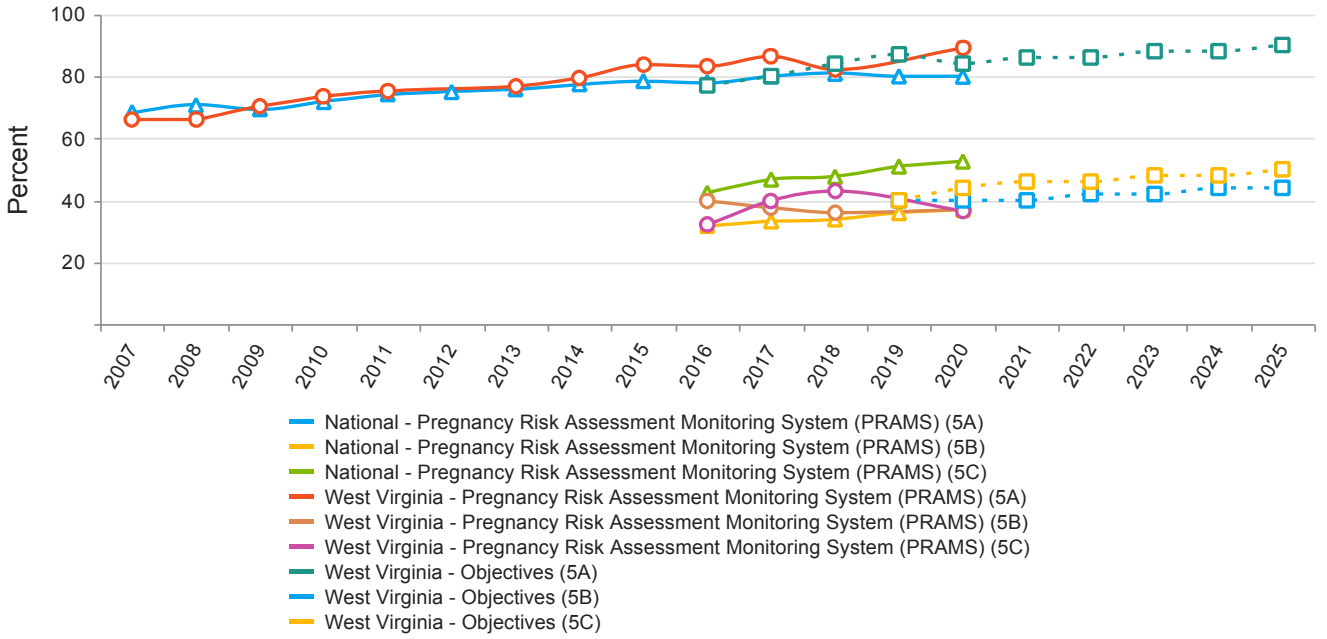
ESM 4.3 - Percent of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	5	9	13	12	14
Annual Indicator	8.8	11.1	11.7	11.9	17.3
Numerator	18	74	160	149	127
Denominator	204	668	1,367	1,256	735
Data Source	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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	16.0	18.0	20.0	22.0

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

Indicators and Annual Objectives



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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	80	84	87	84	86
Annual Indicator	83.7	86.6	82.0	82.0	89.2
Numerator	14,091	13,445	12,495	12,495	12,842
Denominator	16,839	15,534	15,245	15,245	14,394
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2018	2018	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	86.0	88.0	88.0	90.0

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

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	**2019**	**2020**	**2021**
Annual Objective		40	40	40
Annual Indicator	37.7	36.1	36.1	37.1
Numerator	5,742	5,401	5,401	5,222
Denominator	15,239	14,977	14,977	14,085
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2018	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	42.0	42.0	44.0	44.0

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

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	**2019**	**2020**	**2021**
Annual Objective		40	44	46
Annual Indicator	39.8	43.1	43.1	36.5
Numerator	6,129	6,470	6,470	5,106
Denominator	15,392	15,017	15,017	13,992
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2018	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	46.0	48.0	48.0	50.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	90	95	100	100	100
Annual Indicator	100	100	100	100	100
Numerator	25	25	25	21	21
Denominator	25	25	25	21	21
Data Source	Our Babies Safe and Sound	Our Babies Safe and Sound	Our Babies Safe and Sound	Our Babies Safe and Sound	Our Babies Safe and Sound
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	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					
	2017	2018	2019	2020	2021
Annual Objective	72	86	86	80	82
Annual Indicator	83.9	61.9	75	77.5	77.1
Numerator	177	599	804	816	628
Denominator	211	968	1,072	1,053	815
Data Source	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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	84.0	86.0	88.0	90.0

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	75	78	80	80	82
Annual Indicator	76.8	55	74.8	82.8	87.3
Numerator	730	820	1,554	1,689	1,554
Denominator	951	1,492	2,077	2,039	1,781
Data Source	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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	84.0	86.0	88.0	90.0

State Action Plan Table

State Action Plan Table (West Virginia) - Perinatal/Infant Health - Entry 1
Priority Need
Increase breastfeeding, both initiation and continuation.
NPM
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Objectives
The Division of Perinatal and Women's Health will work with partners to increase the percentage of infants ever breastfed from 68.6% in 2016 to 74% by 2025.
The Division of Perinatal and Women's Health will work with partners to increase the percentage of infants exclusively breastfed through six months from 20.9% 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

Increase Breastfeeding

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

Six new home visitors were trained as lactation consultants and pending certification. Additional lactation consultant trainings will occur in mid Summer 2022 to assist in reaching the goal of 15 home visitors trained.

WVHVP focused on getting additional home visitors trained as breastfeeding champions and potential messaging. Due to most of the year being virtual visits and challenges with working with community partners on breastfeeding friendly designations, this activity will be a focus over the upcoming year.

WVHVP reviewed privacy policies with social media to ensure the appropriate measures will be in place to develop the peer-to-peer support groups. As the year progressed, the project was delayed due to staffing changes at two of the local implementing agencies to pilot the project. This will continue to be an activity for the upcoming year while also developing a hybrid breastfeeding peer to peer support group with both social media and in person opportunities for families enrolled in home visiting.

WVHVP had three home visitors begin the training and certification process to become a doula. The three home visitors should become certified in late June 2022. Research into funding options, marketing and enhancements to the home visiting programs using a doula was explored.

Due to a delay in training for the breastfeeding champion and lactation consultants, the project was pushed back to mid-summer 2022. The challenges of Zoom fatigue from all the online trainings became a barrier to have a lengthy online training.

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

The WVBA Director facilitated the WVBA Steering Committee and conducted quarterly virtual meetings with WVBA membership. The membership remained steady and quarterly virtual meetings were completed.

There was an improved facebook presence with increased numbers of followers for the West Virginia Breastfeeding Alliance (WVBA) page. Updates to the website and incorporating the WVBI were completed. A social media calendar is being developed to promote activities.

A new “WV Breastfeeding Discharge Resources” document is in the development stages. The intent is to distribute to all delivering facilities as well as Prenatal and Pediatric outpatient care providers.

During the WV Perinatal Partnership Spring conference, the WV School of Osteopathic Medicine and the WIC July conference, discharge resources were shared with participants. The WVPP continued to explore prenatal breastfeeding education options with efforts of hybrid training platforms. Two potential curriculums were identified, including the “Development of Prenatal “schedule” and guide for providers”. Continued planning on a webinar to promote the materials and train providers and staff.

A Spring Training was completed with the Outpatient Breastfeeding Champion Program with 35 participants. The participants included Registered nurses, OB clinic supervisors, pediatric clinic staff, WIC and home visitors.

As a result of the increased interest in the Certified Breastfeeding Specialist Training the number of available seats were increased to twenty. Free or reduced priced tuition was offered to participants in underserved areas of the State.

Offer evidence-based provider training

COVID continued to cause barriers on recruitment for Baby Friendly hospitals. Due to nursing shortages, limited in person training and meetings no additional hospitals were added during the year.

Provide support to hospitals working to become *Baby Friendly*

Started recruitment of WV birthing hospitals for EMPower Best Practices Initiative, a hospital-based quality improvement project aimed at improving evidence-based maternity care practices supportive of optimal infant nutrition through skills-based competency training and ongoing technical assistance.

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 is still being developed. Continuing education opportunities for lactation support providers complete with Lactation Continuing Education Recognition Points (LCERPs) is also still being developed.

An evidence-based feeding for hospital nursing staff webinar including newborn intensive care unit (NICU) Breastfeeding Course was completed. A survey was developed and distributed for hospital department managers, staff and clinic staff on training needs.

LCERP applications for WVPP Spring Conference and WV State WIC conference in July in process. The development of applicable lactation CE "Bundles" with Lactation Education Resources, Inc. at a low or no cost started in May 2022. The following presentations occurred:

- Drug Free Mother Baby Community Health Worker Training: Breastfeeding in the Substance Use Disorder Population Webinar (completed January 5, 2022)
- Hospital Breastfeeding Initiation Tips for Evidence Based Labor Support Workshop (March 28)
- WV Think Kids NAS Panel (April 22, 19 live participants)

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

Experienced barriers obtaining infant birth/death data from Vital Statistics. Continued discussion on a process to access records from out-of-state hospitals, out-of-state medical examiners, and WV law enforcement to complete comprehensive case reviews for all infant mortalities.

Continued use of remote access to electronic Health Information Management systems/medical records, in accordance with Memoranda of Understanding. Conducted comprehensive case ascertainment of birth and death certificates, medical records, Birth Score, Newborn Screening, Child Fatality Review summaries, and other documents relevant to the case. Working on recommendations to develop written procedural guidelines for the infant and maternal mortality review process, to assure standardization and continuity of a well-developed process.

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

The OMCFH mailed monthly "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.

Completed a Counts the Kick webinar in October with 31 participants. Promoted the www.CountTheKicks.org website and provided free materials to delivering hospitals and OB offices. The West Virginia Nurse journal published an article on the initiative in the Winter 2021 issue.

The community baby showers were delayed due to COVID and unable to provide in-person community baby

showers. There were multiple virtual community events that RFTS participated in, however, in order to receive the full educational impact, the showers have been pushed back to summer 2022.

Activities continued to be delayed to COVID. Summer 2022 courses are planned to be offered if hospital staffing will enable adequate number of people to attend.

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

At least 87% of home visitors 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.

During the National Infant Safe Sleep month, a social media campaign reached over 8,000 people. 1,985 Sleep Baby Safe and Snug Board books were mailed to all hospital partners along with the new Safe Sleep Month Postcards and 1,054 Monthly Milestone Sticker Packets. A total of 7,247 hospital kits were sent to hospitals along with 11,220 safe sleep materials distributed.

Trainings provided to hospital and providers included Evidence Based Tools for Reducing Tobacco Exposure for Children and Families, Keeping WV Babies Safe, Infant Safe Sleep Education, and SUD and Stigma.

Increase Breastfeeding

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

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

Ensure that each home visiting agency (twenty-six) have a certified lactation consultant available for any mom requesting a lactation consultant during a virtual or in-person home visit.

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.

Work with breastfeeding partners on community base events spotlighting breastfeeding with a focus on education early in the pregnancy on breastfeeding and resources.

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.

WVHVP will work with the Perinatal Partnership and trained lactation consultants to complete the week-long series of Lunch and Learns. Topics will include: breastfeeding and MAT, supporting moms that may not be able to breastfeed, exclusively breastfeed verses some breastfeeding.

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

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

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

- 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

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.

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.

Provision of classes/meetings offering Lactation Continued Education Recognition Points (L-CERPs).

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

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

- Continue de-identified case review per established process to enable open discussion among panel members.
- Implement panel recommendations for post-review Quality Improvement of identified birthing hospitals, Emergency Departments, etc. in need of targeted outreach education/training as identified in the case review process. Develop best practice procedures to contact identified facilities with training needs.
- Expand existing perinatal outreach education by subrecipient grantee which most effectively allocates resources and prioritizes outreach education to facilities most in need.

Continue a strong collaboration with the safe sleep project, *Our Babies: Safe and Sound* to develop strong public

awareness messages targeting parents and providers.

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

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

Offer evidence-based provider training.

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

Work with early childhood programs (home visiting, head start, childcare) to promote with all pregnant women the CTK 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.

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.

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

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

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

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

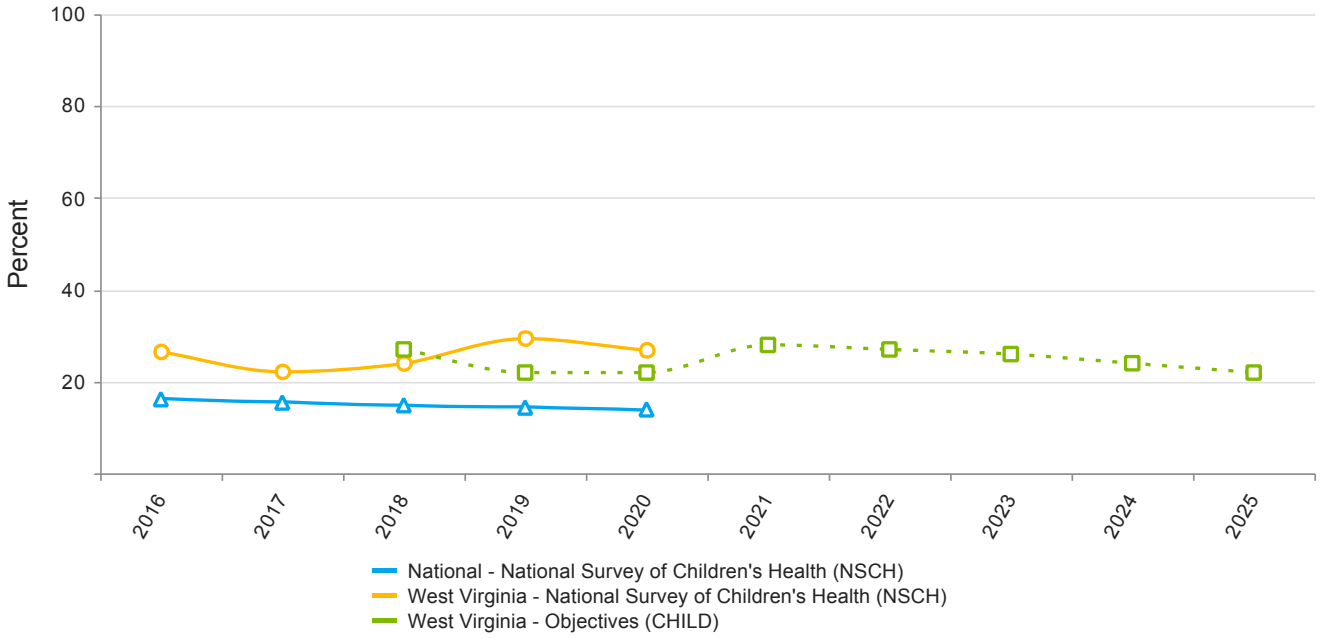
Work with hospitals to develop safe sleep policies.

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

Child Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		27	22	22	28
Annual Indicator	26.5	22.2	24.1	29.5	26.7
Numerator	97,972	82,198	88,702	105,832	93,477
Denominator	370,309	370,710	368,117	358,760	350,414
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	27.0	26.0	24.0	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**	**2021**
Annual Objective			25	28	27
Annual Indicator			28.6	28.3	26.7
Numerator			100,750	99,750	93,560
Denominator			352,397	352,397	350,414
Data Source			NSCH	NSCH	NSCH
Data Source Year			2019	2019	2019-2020
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	25.0	25.0	23.0	23.0

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	2021
Annual Objective			0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	200.0	250.0	300.0	350.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			16
Annual Indicator	16.6	16.5	16.5
Numerator			
Denominator			
Data Source	WIC	WIC	WIC
Data Source Year	2016	2018	2018
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.8	15.5	15.0	14.4

State Action Plan Table

State Action Plan Table (West Virginia) - Child Health - Entry 1	
Priority Need	
Decrease smoking specifically among pregnant women and decrease smoke exposure among children in the household.	
NPM	
NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes	
Objectives	
The Office of Maternal, Child and Family Health will work with partners to reduce the percentage of children in households where someone smokes from 22.2% in 2017 to 18% by 2025.	
The Office of Maternal, Child and Family Health will work with partners to reduce the percentage of your who currently use electronic vapor products (including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens and mods on at least 1 day during the 30 days before the survey).	
The Office of Maternal, Child and Family Health will work with partners to reduce the percentage of youths who currently smoke cigarettes (on at least 1 day during the 30 days before the survey).	
Strategies	
i. Offer evidence-based cessation curriculums to pregnant women, recently delivered women, mothers and other household members via home visiting services.	
ii. Provide evidence based adolescent curriculum prevention programs in schools and tobacco/e-cigarette use prevention training for teachers.	
iii. Disseminate prevention information, resources and materials to schools and the communities throughout the state including brochures, posters, social media posts, website posts, YouTube, etc.	
ESMs	Status
ESM 14.2.1 - Percent of children in households where someone smokes.	Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

Address substance use in pregnancy and in youth/teens.

SPM

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

Objectives

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

Strategies

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

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

Priority Need

Decrease obesity among children.

SPM

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

Objectives

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

Strategies

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

ii. 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.”

iii. 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.

iv. 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.

v. Analyze statewide height, weight, and BMI data for WV HealthCheck/EPSDT population.

vi. WV HealthCheck will conduct a survey of at least 100 individual medical providers that provide EPSDT/HealthCheck services regarding childhood obesity, intervention/referral, and community resources.

vii. WV HealthCheck will provide outreach during community events (ie. health fairs, community events) and disseminate resources and provide education to at least 50 families on USDA MyPlate and 5210 recommendations.

viii. Distribute WIC resources to families to upon initial HealthCheck enrollment of any child age 0-5 years of age to encourage increased WIC participation rates.

ix. Analyze extent to which Farm to ECE has an impact on healthy eating habits in children.

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

Home visitation programs continued to utilize evidence-based home visiting services for women that want to quit or reduce smoking. Smoking cessation referrals were made to the Quit Line. SCRIPT services continued to be challenged due to the home visits being virtual during the pandemic. The CO monitors were not able to be used to capture the most current CO values.

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

It is well documented that smoking and the use of e-cigarettes are unsafe for kids, teens, and young adults. Nicotine can harm the developing adolescent brain, particularly the areas of the brain that control attention, learning, mood, and impulse control. Additionally, young people who use e-cigarettes may be more likely to smoke cigarettes in the future, including when they become pregnant and/or parents.

Research also suggests that adolescent smokers are less likely to quit if they become pregnant, compared to adult smokers. Smoking cessation interventions are recommended for this population to avoid the harmful effects of prenatal tobacco exposure (PTE) on the offspring of pregnant adolescents. This is particularly important because these mothers more likely become pregnant again and many will increase their level of tobacco use as they mature.

Prior to the COVID19 pandemic, the Adolescent Health Initiative (AHI) received an overwhelming number of requests for vaping information and prevention/cessation programs from nearly every high and middle school in the state. The AHI identified the curriculum program *CATCH My Breath*. *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. However, continual fluctuation of COVID19 rates and local outbreaks caused many counties to vary week to week between in-person and remote learning throughout 2021. This, in addition to the many social distancing and safety protocols, made it very difficult for schools to establish a routine, keep students on track with their core classes, and allow the AHCs entry to provide curriculum classes and presentations. However, the significant decrease in remote learning prevented virtual access to students. The pandemic also 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 school year providing mental health support, resources and trainings. Despite these numerous challenges, the AHCs were able to provide tobacco and vaping prevention education to over 1,400 students.

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.

Due to COVID19, school open houses, health fairs and community events were severely limited during much of 2021. However, there were a few events where the AHCs were able to distribute information including the Mason County Fair, the Lincoln County Recovery Event and Back to School Bashes in Cabell and Wood Counties, although attendance was very low at these events. The AHI was also able to facilitate a vaping prevention poster contest that had 75 participants. Ironically, the increase in in-person learning in 2021 made distributing printed information more difficult than in the height of the pandemic. Even though students were in class, no one except from school personnel was allowed in schools for much of the school year. When schools were remote learning, the AHI was able to utilize daily homework/assignment packets and daily lunch deliveries to distribute prevention materials. These avenues were no longer available in 2021 but school access remained severely restricted. Despite these barriers, the AHI distributed over 3,000 pieces of tobacco/vaping prevention and health related literature and shared 247 social media posts.

Substance use in youth/teens

Partner with medical providers to align with best practices in prescribing controlled substances to ensure

optimum outcomes.

Alarming trends have been observed in West Virginia with regards to the prescribing of stimulants, a first-line pharmacological treatment for attention-deficit/hyperactivity disorder (ADHD). The 2019 estimated prevalence of ADHD in children 3-17 years of age in West Virginia was much higher than the national average at 13.2% versus 8.6% respectively. Moreover, in some counties in West Virginia up to one in four children within certain age groups were being prescribed a stimulant. While prescription stimulants may be first line therapy for ADHD where appropriate, the medications are controlled substances due to their risk for dependence, addictive properties, and potential for diversion. Likewise, these medications should only be prescribed where an appropriate corresponding diagnosis exists.

The initial plan was to develop an assessment, evaluation, and treatment guideline for ADHD in children and adolescents to be disseminated via academic detailing (educational outreach to medical providers) throughout the state. After additional analyses of stimulant prescribing trends in West Virginia, it has become evident that stimulant use in West Virginia is higher than national averages in children, adolescents, and adults. Harms are associated with the abuse potential of prescription stimulants without an appropriate diagnosis, and without appropriate assessment or follow-up; cardiac effects, growth impacts, and tic disorders may go unaddressed. Therefore, as a necessary preventive measure to ensure appropriate diagnoses are occurring and safe stimulant prescribing habits are implemented in the state with the highest rate of overdose deaths in the U.S., this educational effort was expanded to also target West Virginia's adult population. Braided Title V and Centers for Disease Control and Prevention (CDC) now support this endeavor.

Facilitated by the West Virginia University School of Pharmacy with support from the OMCFH, a panel of experts from across the state first convened in November 2021 for the purpose of creating a statewide resource, i.e., treatment guideline, for managing attention-deficit/hyperactivity disorder (ADHD) in West Virginia. Comprising four practicing Psychiatrists, four practicing Licensed Psychologists, four practicing Pediatricians, three practicing Family Physicians, three practicing Pharmacists, three professional educators (two from the north and one from the southern part of the state), one Licensed Social Worker, the Medical Director and Pharmacy Director for West Virginia Medicaid, the West Virginia State Health Officer, the Executive Director of the West Virginia Board of Pharmacy (the state's PDMP authority), and the OMCFH Director and Physician Director, this expert panel convened again in January, February and March 2022. To date, drafting of the West Virginia ADHD treatment guideline is approximately 80% complete.

Obesity among children

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 childcare centers each year.

WVBPH partners with KEYS4Healthy Kids (KEYS). KEYS is a partnership of community stakeholders that focus on creating policy, systems, and environmental (PSE) changes that support healthy eating, active living, and childhood obesity prevention. Key 2 a Healthy Start is a statewide initiative that was launched by KEYS.

In 2017, KEYS launched KEY 2 a Healthy Start, which involved 3 full-day trainings over the course of a year on nutrition, physical activity, and parent engagement. Centers completed a pre- and post- NAP SACC (Nutrition and Physical Activity Self-Assessment for Child Care), which is a quality improvement self-assessment. Centers who participated received site visits, one-on-one consultation, and became a part of the KEYS Peer Learning Network (PLN). Funding for KEY 2 a Healthy Start was provided by Claude Worthington Benedum (Benedum) Foundation and the WV Family Nutrition Program, which serves as WV's SNAP-Ed Program.

Between October of 2020 and September of 2021, 55 NAP SACC Assessments were collected and 31 centers participated/received training.

These learning collaborative workshops are free to child care centers and participants receive WV STARS credits for professional development. In addition, participating sites receive physical activity equipment, MyPlate portion plates for each child 2-5 years of age in their center, indoor/outdoor garden elements (based on preference), and parent outreach materials.

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.

The Earlier, the Better Initiative was launched in 2020 with funding provided by the Benedum Foundation. As part of this initiative, KEYS developed a recognition award for child care centers who demonstrated best practices (≥60%) in nutrition and physical activity.

In fall of 2020, KEYS opened applications for the 2021 Champion NAP SACC Award. During the first year, the applicants had to have previously completed KEY 2 a Healthy Start in order to be eligible. Applicants submitted a NAP SACC, and the top applicants' scores were validated by a researcher CAMC Research Institute via EPAO (Environment and Policy Assessment and Observation). In April of 2021, 10 centers received the WV Champion NAP SACC Center Award (WVCNCA). The winners received a plaque, a promotional video featuring their center, and a monetary award of $3,000. The winners were announced at Celebrating Connections.

Applications for the 2022 WV Champion NAP SACC Center Award opened in October 2021 to all licensed child care centers in the state, regardless of whether they completed KEY 2 a Healthy Start. After following the same process from the previous year, 15 child care centers received the award. The winners were announced at the Celebrating Connections Conference.

In addition to the WV Champion NAP SACC Center Award, KEYS offered Healthy Environment Awards to centers. If selected, the center was awarded $1,000 to continue to enhance their learning environment. Applications were accepted in 3 different areas: Farm to Early Childhood Education (ECE); Natural Learning Environment; and Healthy Celebrations. In 2021, four centers were awarded.

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

The Great Beginnings Infant/Toddler Conference was held in September of 2021, and many child care providers attended. Participants of the conference received STARS credit for professional development.

During the conference, participants were introduced to the WV Breastfeeding Friendly Child Care Designation (WVBFCCD), which was developed by the WVDHHR Infant/Toddler Division and supported by additional partners, including WV Perinatal Partnership, WV WIC, WV Breastfeeding Alliance, and KEYS 4 HealthyKids' the Earlier, the Better Initiative. Presenters discussed the history of the initiative, the 10 Steps that were adapted for child care to increase breastfeeding duration, and training efforts and resources that are currently available.

Through collaboration and partnership, efforts are being made to increase the availability of training resources available to providers and other community partners; for example, the WV Breastfeeding Alliance and the Perinatal Partnership are working toward developing a WV Breastfeeding Institute. The Institute would offer trainings and resources, follow-up support programs, and certified breastfeeding specialist training. There are plans to offer scholarships to providers to take courses on breastfeeding and to eventually offer free or low-cost Continued Medical Education (CME). At this time, there has not been an established STARS training.

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, 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). After applying, centers are offered assistance and support along the way: Child Care Nurse Health Consultants, Child Care Health Educations and Infant/Toddler Specialists are available to lend their expertise and support. Training, educational materials and resources to create a breastfeeding space are made available.

This initiative was promoted and presented at the Great Beginnings Conference that was held virtually on September 23, 2021. The presentation described the components of the WVBFFD, including its history and purpose along with the training efforts and resources currently in use.

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 child care providers has been developed and implemented. Upon the completion of the 10 Steps, providers receive a certificate of designation and a monetary award of up to $1,000. The first Breast Feeding Friendly Child Care Designation certificate was presented to a child care facility on September 2, 2021. Announcement was made at Great Beginnings Conference. Since the initiation of the designation 15 centers have applied and a total of 5 have been awarded the designation.

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."

5210 is a set of recommendations for obesity prevention which stands for 5 servings of fruit and vegetables per day, 2 hours or less of screen time per day, 1 hours of physical activity per day, and 0 sugary beverages. A marketing and social media campaign was initiated this year. Keys4Healthy Kids has developed a music video featuring the message and offers a video that provides a tutorial for the dance.

In addition to the campaign for 5210, KEYS staff has been conducting trainings for healthcare providers on utilizing the American Academy of Pediatrics (AAP) "5210 Pediatric Obesity Clinical Decision Support Chart." Dr. Jamie Jeffrey and team conducted a pre-workshop for 34 providers on 5210 Pediatric Obesity Clinical Decision Support Chart and prescription program (RX) during the WV AAP annual spring meeting held in April 2022. Each participant who attended the pre-workshop received a copy of the "5210 Pediatric Obesity Clinical Decision Support Chart" valued at $40.00. A Maintenance of Certification (MOC) II session was also offered on pediatric obesity and 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 "Rxs" with goal setting and tracking.

This is currently an ongoing initiative. The 5210 "Pediatric Obesity Clinical Decision Support chart" and the 5210 RX program in which providers write a prescription for physical activity, drinking water, or other healthy practices was presented during the Spring AAP annual meeting in April of 2022.

Through funding from WVBPH patients from provider practices have been able to participate KEYS cooking demonstrations virtually and in-person. From October of 2020 to September 2021, 24 cooking demonstrations have taken place with 188 participants.

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.

WV HealthCheck staff continued to provide WIC information on food packages as well as the eligibility guidelines to providers via virtual and face to face visits at routine intervals during the year. In addition to this, all new HealthCheck enrollees under the age of 5 that are not enrolled in managed care will be starting to receive WIC brochures in HealthCheck initial welcome packets in the upcoming year.

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.

Currently this initiative has not been accomplished. The Leap of Taste Standards have not been re-launched and partnerships have not been able to be secured to move this initiative forward.

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

KEYS connects child care providers to local farmers through kids pop up markets. Between October 2020 and

September of 2021, 61 kids pop up farmer's markets were conducted. Kids were given vouchers to purchase fresh produce at the market. Approximately 500 kids were served at these markets and $13,395.00 in vouchers were redeemed. Child care centers are also offered leftover produce at discounted rates to encourage the center to cook and serve healthy meals to the children in their care.

Additionally, KEYS offers garden-based learning opportunities to child care centers. KEYS conducted 3 trainings this year – 2 virtually and one in-person. Each training is led by a garden coordinator that helps centers learn to garden and how to incorporate gardening into the curriculum. After the training, the garden coordinator visits each site to offer one-on-one support.

Furthermore, through the Earlier, the Better Initiative KEYS piloted the first Central Kitchen. Two centers in Marion County participated in the pilot. Central Kitchens receive fresh, local produce, prepare chef-led meals from scratch, and then finally distribute the meals to child care centers. The nutritional-density of these meals exceeds CACFP standards.

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

Licensing regulations will not be reviewed again until 2023. Opportunity for review and improvements have not been formally discussed as of this year. Opportunity during the next year will be available via the WV Early Childhood Advisory Committee (ECAC) meetings which discusses many topics involving early childhood education included prevention of pediatric obesity through the KEYS program and the earlier the better initiative.

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

Develop a resource list for families on evidence-based smoking cessation strategies by region. Partner with the WV Quit Line and Tobacco Free Moms projects as a referral source. Incorporate the referral process into a new online resource/referral platform that will ease the referral process for both home visitors and families.

Add a smoking cessation training for all home visitors that is completed by a certified Smoking Cessation Specialist. Update the SCRIPT process with the most current handouts and "best practices" for pregnant women and utilize a tiered incentive process for women who successfully meet goal to reduce or quit smoking.

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. Knowledge about nicotine addiction and vaping seems to be growing, however the AHCs have found many students and parents still believe vaping is safe. Many still view vaping as a "safe" alternative to smoking for teens and pregnant mothers. Schools are also reporting a significant increase in Tetrahydrocannabinol (THC) laced vaping devices. Prevention information and programming specific to THC vaping is very limited. The AHI will address these gaps in needed trainings and information by providing evidence-based curriculum programs in schools and professional development training for teachers, both in-person and virtually; while continually researching developing trends to provide the most current and accurate information.

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.

In partnership with the West Virginia University School of Pharmacy and in coordination with a panel of experts from across the state, the draft West Virginia ADHD treatment guideline will be finalized no later than the fall of 2022. Upon completion of the draft, various sections will be appraised by subject matter experts within the expert panel before posting in a shared location for all panel members to review and comment. Supplemental information and reference materials for use in the evaluation, diagnosis and treatment of ADHD in West Virginia will be included. The finalized West Virginia ADHD treatment guideline will be accessible via public website by the end of 2022. To

promote uptake and increase dissemination of the finalized West Virginia ADHD treatment guideline, academic detailing will be initiated statewide via four full-time trained pharmacists no later than late-spring 2023. The intent of this effort is to facilitate prescribing behavioral changes to better align with evidenced-based, guideline-recommended, best practice. Initially, higher burden counties in West Virginia will be identified through public health surveillance of prescription drug monitoring program (PDMP) data to allow for a targeted academic detailing approach. As an incentive for providers to participate in academic detailing sessions, continuing education (CE) will be provided.

Lastly, a plan to assess impact of the West Virginia ADHD treatment guideline will be developed. The proposed evaluation plan will include survey administration to monitor provider impact and behavioral changes, evaluation of prescription stimulant prescribing trends in West Virginia, and analyzing and evaluating West Virginia Medicaid claims data for stimulant prescribing patterns when an ADHD diagnosis is not present.

Obesity among children

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

WV HealthCheck will continue to participate and collaborate with WV Early Childhood Advisory Committee (ECAC) to support efforts put forward by the WV Breastfeeding Alliance to establish the WV Breastfeeding Institute. The WV HealthCheck program director will participate in ECAC meetings and support all efforts in planning and dissemination of training programs developed for Breast Feeding Institute to health care providers and childcare agencies that the OMCFH partner with to enhance knowledge among health care providers and community partners including childcare centers.

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 OMCFH and WV HealthCheck will continue collaborating with KEYS4Healthy Kids to support training of at least 10 providers within the year on the "5210 Pediatric Obesity Clinical Decision Support Chart". A meeting with medical director for KEYS4Health Kids will be established in the next 3 months to discuss HealthCheck and OMCFH support of initiative.

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 3 months, WV HealthCheck director will establish a meeting with medical director for KEY4Healthy Kids to discuss the 5210 Prescription (Rx) Initiative. The discussion will allow HealthCheck staff and KEYS4Healthy Kids to develop an integrated work plan with expectations and roles. The overall goal at the end of the year will be that at least 5 provider practices are participating in prescribing produce, physical activity, or another healthy habit to children.

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

Licensing regulations are to be reviewed in 2023. HealthCheck Director will attend WV ECAC meetings. WV ECAC has a subcommittee on policy that provides information and support on ECE licensing standards. WV HealthCheck and OMCFH will work to support initiatives to fullest extent regarding ECE licensing standards. Licensing standards will be discussed with KEYS4Healthy Kids medical director in upcoming meeting to be scheduled within next 3 months to discuss licensing standards and improvements that may be supported by the OMCFH.

Analyze statewide height, weight, and BMI data for WV HealthCheck/EPSDT population

In the upcoming year, WV HealthCheck will complete analysis of height, weight, and body mass index (BMI) data from a representative sample of HealthCheck/EPSDT visits for children ages 0 through 20 years of age. The information collected and analyzed by an OMCFH epidemiologist will serve to provide data driven decisions around childhood obesity rates of the Medicaid population. The information will be shared with BPH partners and medical providers and provide baseline data for quality improvement initiatives within the Office of Maternal, Child and Family Health. Height, weight, and BMI data was collected as a part of medical review of 2020 annual well-child visits.

WV HealthCheck will conduct a survey of at least 100 individual medical providers that provide EPSDT/HealthCheck services regarding childhood obesity, intervention/referral, and community resources.

Within the next year, WV HealthCheck director and epidemiologist will construct survey for medical providers to assist in determining each HealthCheck regions practices, interventions, and resources for clients who are diagnosed with childhood obesity. The survey will ask providers about what determines intervention, if referrals are made, and any community resources that they are aware of or utilize for children who have an elevated BMI. Based upon this survey, needs of WV HealthCheck providers will be evaluated and intervention developed to address needs.

WV HealthCheck will provide outreach during community events (ie. Health Fairs, Community events) and disseminate resources and provide education to at least 50 families on USDA MyPlate and 5210 recommendations.

WV HealthCheck will provide educational handouts and promotional materials to at least 50 families during community events to educate on healthy habits to prevent childhood obesity. This material will include information regarding 5-2-1-0 healthy habits and USDA MyPlate initiatives to encourage healthy lifestyle and nutrition habits among the pediatric population. WV HealthCheck Specialists attend numerous community events in which they meet families that may not have access to a primary caregiver or physician and have never received information on healthy nutrition practices.

Distribute WIC resources to families to upon initial HealthCheck enrollment of any child age 0-5 years of age to encourage increased WIC participation rates.

WV HealthCheck Program Specialists distribute WIC resources to health care providers every year. However, in the past HealthCheck has not distributed WIC resources with the emphasis on enrollees. Through the HealthCheck Outreach Specialists, who are responsible for effective informing of well-child visits for fee-for-service clients, WIC brochures will be offered in initial EPSDT/HealthCheck welcome letters for any child entering that is 0-5 years of age.

In addition to this, WV HealthCheck director will engage Managed Care Organizations (MCO) to inquire if WIC information is provided to children receiving the EPSDT benefit through the MCO.

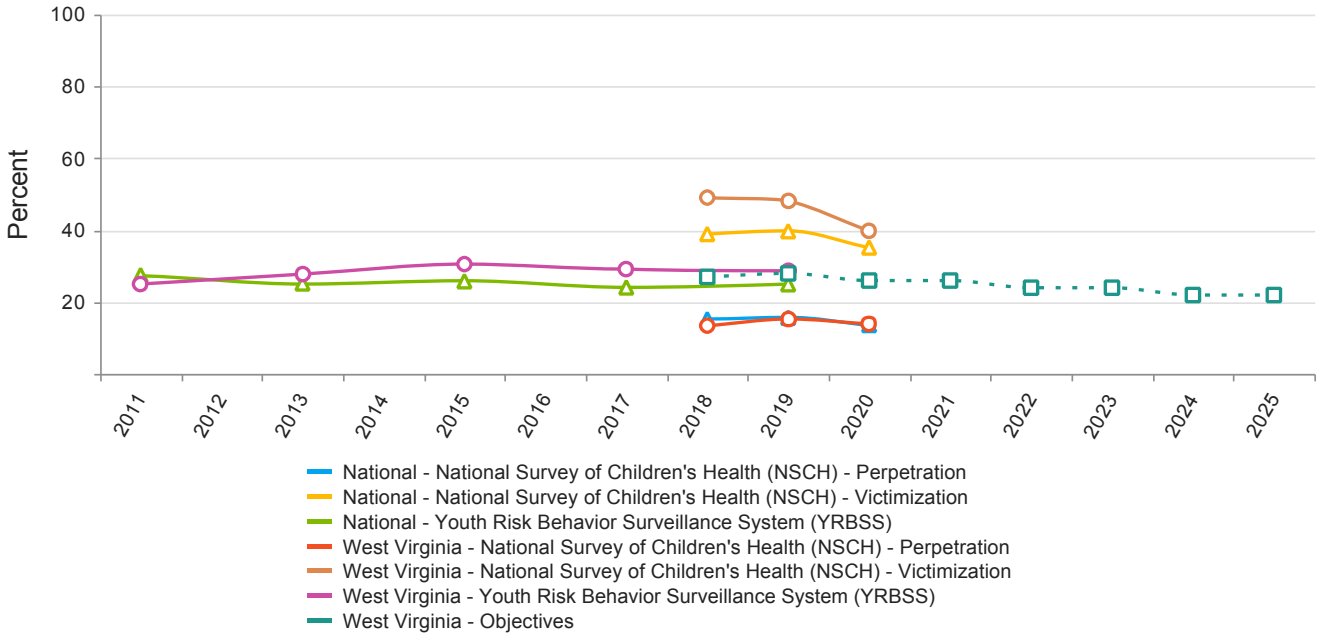
Analyze extent to which Farm to ECE has an impact on healthy eating habits in children.

A research study was conducted by Dr. Jamie Jeffrey, KEYS4Healthy Kids medical director, to look at the effect of biweekly kids' pop-up farmers markets on children's eating habits in 2021. Results have not been finalized but are intended to be finalized within the year. The study includes 9 centers that participated in the intervention (pop-up markets biweekly) and 10 centers in the control group (did not receive any pop-up markets). Once finalized results are received, this will allow for data driven decisions and recommendations to be made on the effectiveness of Farm to ECE efforts.

Adolescent Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	25	27	28	26	26
Annual Indicator	30.5	29.1	29.1	28.7	28.7
Numerator	23,959	22,608	22,608	22,112	22,112
Denominator	78,632	77,715	77,715	77,035	77,035
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2017	2017	2019	2019

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			28	26	26
Annual Indicator			13.6	15.2	14.1
Numerator			16,987	18,340	16,805
Denominator			124,901	120,396	119,261
Data Source			NSCHP	NSCHP	NSCHP
Data Source Year			2018	2018_2019	2019_2020

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**	**2021**
Annual Objective			28	26	26
Annual Indicator			49.1	48.0	39.8
Numerator			61,001	57,581	47,541
Denominator			124,257	120,074	119,576
Data Source			NSCHV	NSCHV	NSCHV
Data Source Year			2018	2018_2019	2019_2020

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				
	2022	**2023**	**2024**	**2025**
Annual Objective	24.0	24.0	22.0	22.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	87	95	112	100	110
Annual Indicator	92	110	144	71	82
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	115.0	120.0	125.0	130.0

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	13	17	32	38	39
Annual Indicator	16	30	38	30	31
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	39.0	39.0	40.0	40.0

ESM 9.3 - Number of messages disseminated via social media

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	85	100	135	125	140
Annual Indicator	98	130	122	111	88
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	150.0	155.0	160.0	165.0

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	105	114	100	110	112
Annual Indicator	112	97	102	59	55
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	115.0	118.0	120.0	122.0

State Performance Measures

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	41.6	20	20	22	29
Annual Indicator	17	16.8	19.9	25	29.6
Numerator	3,380	22,582	25,058	30,365	35,854
Denominator	19,936	134,548	125,615	121,321	121,234
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2017	2018	2018-2019	2019-2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	33.0	35.0	38.0	40.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	200.0	250.0	300.0	350.0

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

ESMs	Status
ESM 9.1 - Number of positive youth development (PYD) focused trainings provided to youth, parents, professionals and community members	Active
ESM 9.2 - Number of schools and/or youth serving organizations in target communities that have implemented a comprehensive bullying program	Active
ESM 9.3 - Number of messages disseminated via social media	Active
ESM 9.4 - Number of trainings provided to youth, parents, professionals and community members	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

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

Priority Need

Increase in adolescents with and without special health care needs who receive services necessary to make transitions to adult health care.

SPM

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

Objectives

The Division of Infant, Child, and Adolescent Health will increase the percentage of adolescents (12-17) with and without special health care needs who received services necessary to make transitions to adult health care from 20.2% (CSHCN) and 20.0% (non-CSHCN) to 40% by 2025 for both populations.

Strategies

i. Provide academic detailing to pediatric primary care physicians on the importance of adopting a transition policy including Got Transition's resources: the Six Core Elements of Health Care Transition sample tools and measurements.

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

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

Priority Need

Address substance use in pregnancy and in youth/teens.

SPM

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

Objectives

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

Strategies

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

ii. Provide educational information and resources to youth, parents, schools and the community about the harmful affects of drug abuse and misuse, safe storage and disposal of prescription medications and prescription monitoring in the home.

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 Adolescent Health Initiative (AHI) is a Title V health promotion project that maintains a comprehensive and holistic view of an adolescent's health and well-being. The AHI uses a PYD framework, developed by Search Institute, to look beyond individual risk behaviors to focus on the overlap between behaviors, their underlying common causes, and successful interventions. The Search Institute's Developmental Assets® are 40 research-based, positive experiences and qualities that influence young people's development, helping them become caring, responsible, and productive adults. Over time, studies of more than 5 million young people consistently show that the more assets that young people have, the less likely they are to engage in a wide range of high-risk behaviors and the more likely they are to thrive.

In early 2020, the AHI partnered with West Virginia University-Parkersburg to conduct surveys in schools throughout Region 5 to access 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).

However, during the COVID19 pandemic, youth ecological systems have been in turmoil, with disruptions in daily routines, interruptions in information and communication across settings and drastic and abrupt changes in rules and processes. Throughout most of 2020 and 2021, school systems have juggled ever-changing guidelines and restrictions while bouncing to and from remote and in-school class formats. While challenging to implement with COVID19 restrictions and class setting instability, the need for PYD programming and activities is more prevalent than ever.

While many schools returned to (mostly) in-class learning in 2021, continued COVID19 restrictions and closures made implementation, at times, even more challenging than in 2020. The regional Adolescent Health Coordinators' (AHCs) access to schools were still severely limited and for the most part, they could no longer access students remotely. Community meetings and events continued to be very limited as well. Despite these continued challenges, the AHI participated in 85 trainings, presentation and events focused on positive youth development to encourage resiliency, empowerment, leadership, tolerance, youth-adult connectedness, etc. Nearly 9000 youth, parents/families, community leaders, professionals, and school personnel attended.

Highlights include (but aren't limited to):

- *Sexual Orientation/Gender Identity 101*
- *Adaptive Yoga for Teens*
- *Social Emotional Competency*
- *A Framework for Understanding Poverty*
- *Developmental Assets*
- *Intentional Relationships Workshop*
- *Inclusive Relationships Workshop*
- *Trauma and Discomfort with Racial Conversations*
- *Welcoming Schools/Diversity*
- *Youth Mental Health First Aid Overview*
- *How to Build Developmental Assets*
- ***I Can**: Overcome by Supporting each Other (Homelessness); Have Control my managing my anger and avoid violence; Graduate by deciding to stay in school; and, Speak Series*
- *Developing Star Leaders*
- *LGBTQ Resources for Schools*

- *Handle with Care 1.0 and Grad Class*
- *Success in the New Economy*
- *Be An Askable Parent*
- *The Bright Side*

The AHI also worked with youth teams to do more than 20 community service and youth focused projects. Some examples are as follows: *The Giving Room* to provide food, clothing, personal hygiene supplies and school supplies for students in need; wrote thank you notes to doctors WVU Medicine for their hard work during the pandemic; *Calhoun County Caring Closet* - constructed dress racks and shelves for clothing, shoes, food, personal hygiene, school supplies and prom dresses were donated for the girls; wrote letters to all virtual students to ensure they felt connected to the school; *Backpack Blessings* provided weekend food bags to student's pre-school through 8th grade; *Operation South Paw* - volunteered and donated supplies and food to the Humane Society to help with the animals left at the shelter or abandoned; *Youth Moves*, a youth empowerment workgroup; *Back to School Bash* at a local mall - distributed 100 crayons, 600 single section notebooks, 600 five-section notebooks, 1,000 yellow highlighters, 5,000 pencils, 864 backpacks; and *Teen Boot Camp Cooking Class*.

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 began utilizing the AHC (Adolescent Health Coordinators) regional network to conduct YRBS surveys across the state. In late 2021, The AHCs conducted YRBS surveys in 57 in 29 of WV's 55 counties. A total of 1,776 students were enrolled, however due to absences, quarantines, and localized closures related to COVID19 and multiple winter storms, only 883 were able to complete the surveys. Additionally, COVID19 restrictions did not permit the AHCs to conduct the surveys in the spring of 2021, delaying implementation until November 2021. Because of this delay, 2021 YRBS data is not available as of May 2022.

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/.

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.

Beginning 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 32 schools utilizing an array of comprehensive programs. These programs have expanded to include bullying, all forms of violence including sexual violence, suicide prevention, cyber safety, trauma, mental health, and diversity. These programs include:

- *Connections Matter*
- *Signs of Suicide*
- *Coaching Boys into Men*
- *Darkness to Light*
- *Healthy Grand Families*
- *4-H Stress Management*
- *Teen Safety*
- *Positive Action*
- *Cyber Civics*
- *SafeTalk*

Also in 2017, the AHI partnered with the DHHR's Bureau for Behavioral Health and Health Facilities to certify 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. A total of 6,338 youth and adults attended these programs, including the following:

- *Teen Mental Health First Aid*
- *Youth Mental Health First Aid*
- *Mental Health Application Grad Class*
- *Handle With Care During COVID and The Big Transition for Kids*
- *Handle With Care: Responding to Child Abuse During a Pandemic*
- *Handle With Care: Using the Principles of Diversity, equity, and Inclusion to Protect Children and Families*
- *Handle with Care 1.0*
- *Handle with Care Grad Class*
- *Overcoming ACEs*

In addition to the above, the AHCs provided the following trainings and presentations:

- *Social Media Safety*
- *Diversity Resources for Schools*
- *Ending the Silence*

- *Sexual Orientation and Gender Identity 101*
- *I CAN Be Happy by Facing Negativity*
- *I CAN Be Strong by Tackling Bullying and Peer Pressure*
- *I CAN Find Hope: The Bully, the Bullied and the Bystander*
- *I CAN Find Hope by Seeking Help for Suicidal Thoughts*
- *Notice, Listen, and Connect*
- *Sensitivity Training*
- *Suicide Safe, Recognizing and responding on the Front Line*
- *Step Up; be a Leader, Make a Difference*
- *Strategies, Tips, and Activities for the Classroom: Building Connections and Developing Empathy*
- *Welcoming Schools; Preventing Bias-Based Bullying*
- *Welcoming Schools: Creating Schools That Welcome All Genders*
- *Welcoming Schools: Connect WV 3.0*
- *Welcoming Schools: Graduate Class*

In total, 16,248 youth, parents, school staff and community members attended the AHI's 54 trainings and workshops. The AHI also posted 287 messages, links and resources on social media; and disseminated 14,350 brochures, life-line cards, fact sheets and other literature on bullying prevention, suicide prevention, depression and mental health, violence prevention, cyber safety and ACEs.

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.

The VIPP has been unable to disseminate any related data due to staffing vacancies in the VIPP program.

Transition

Provide education and resources to pediatric primary care physicians on the importance of adopting a transition policy (via MCH Workforce Development communication plan and Medical Advisory Board)

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 education and resources to pediatric primary care physicians by the WV HealthCheck Program.

The HealthCheck Program will survey primary care providers for inclusion of a formal transition policy by their practice. These survey results will inform future provider education efforts and resource needs.

Complete transition readiness assessment/transition services 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.

The CSHCN Program will partner with the WVU CED Paths for Parents' Parent Network Specialists and the Family to Family Health Information Center to complete transition readiness assessments for transition age YSHCN. Youth will be referred to the Parent Network Specialists upon age 14 for completion of the transition readiness assessment. The results of the transition readiness assessment will be submitted to the CSHCN Program social worker. The results will be shared with the child's PCP and other medical home providers. Appropriate transition services will be provided pending the results of the transition readiness assessment.

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

These transition services include information on the entitlement for foster youth to retain their Medicaid coverage until age 26 if they consent to continued participation in the child welfare system after age 18. The CSHCN Program will educate enrolled foster child before the youth turns 18 and ages out of foster care. This education will be ongoing until the young adult is discharged from the CSHCN Program at age 21. Educational forms have been developed for CSHCN Program staff to facilitate transition for foster youth.

The CSHCN Program will also educate CPS workers on this entitlement.

Substance use in youth/teens.

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

Alarming trends have been observed in West Virginia with regards to the prescribing of stimulants, a first-line pharmacological treatment for attention-deficit/hyperactivity disorder (ADHD). The 2019 estimated prevalence of ADHD in children 3-17 years of age in West Virginia was much higher than the national average at 13.2% versus 8.6% respectively. Moreover, in some counties in West Virginia up to one in four children within certain age groups were being prescribed a stimulant. While prescription stimulants may be first line therapy for ADHD where appropriate, the medications are controlled substances due to their risk for dependence, addictive properties, and potential for diversion. Likewise, these medications should only be prescribed where an appropriate corresponding diagnosis exists.

The initial plan was to develop an assessment, evaluation, and treatment guideline for ADHD in children and adolescents to be disseminated via academic detailing (educational outreach to medical providers) throughout the state. After additional analyses of stimulant prescribing trends in West Virginia, it has become evident that stimulant use in West Virginia is higher than national averages in children, adolescents, and adults. Harms are associated with the abuse potential of prescription stimulants without an appropriate diagnosis, and without appropriate assessment or follow-up; cardiac effects, growth impacts, and tic disorders may go unaddressed. Therefore, as a necessary preventive measure to ensure appropriate diagnoses are occurring and safe stimulant prescribing habits are implemented in the state with the highest rate of overdose deaths in the U.S., this educational effort was expanded to also target West Virginia's adult population. Braided Title V and Centers for Disease Control and Prevention (CDC) now support this endeavor.

Facilitated by the West Virginia University School of Pharmacy with support from the OMCFH, a panel of experts from across the state first convened in November 2021 for the purpose of creating a statewide resource, i.e.,

treatment guideline, for managing attention-deficit/hyperactivity disorder (ADHD) in West Virginia. Comprising four practicing Psychiatrists, four practicing Licensed Psychologists, four practicing Pediatricians, three practicing Family Physicians, three practicing Pharmacists, three professional educators (two from the north and one from the southern part of the state), one Licensed Social Worker, the Medical Director and Pharmacy Director for West Virginia Medicaid, the West Virginia State Health Officer, the Executive Director of the West Virginia Board of Pharmacy (the state's PDMP authority), and the OMCFH Director and Physician Director, this expert panel convened again in January, February and March 2022. To date, drafting of the West Virginia ADHD treatment guideline is approximately 80% complete.

Provide educational information and resources to youth, parents, schools and the community about the harmful affects of drug abuse and misuse, safe storage and disposal of prescription medications and prescription monitoring in the home.

In 2017, West Virginia began collecting data on adolescent prescription misuse on the Youth Risk Behavior Surveillance (YRBS) survey. When compared to the 2017 YRBS, the survey in 2019 (the most recent available) 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. This type of misuse is even more prevalent among older adolescents and young adults. A study by Johns Hopkins Bloomberg School of Public Health suggests that stimulant misuse by adolescents 12 and up, as much as 60% is by young adults aged 18-25. The study found it's common for college students to use stimulants to deal with academic pressures and "cram" for tests. (https://publichealth.jhu.edu/2016/adderall-misuse-rising-among-young-adults)

Prescription monitoring is also an important factor in preventing abuse. Two-thirds of teens who report abusing prescription medication get it from friends, family and acquaintances, including their home medicine cabinets. Providing education on proper storage and disposal is important to prevent misuse, not only in the home but in the community. (https://drugfree.org/prescription-over-the-counter-medicine/)

To address these concerns and misconceptions, the AHI provided education and information to a total of 3,451 youth, parents, school staff and staff from other community or youth serving organizations. Trainings and programs included (but not limited to):

- *Healthy Grand Families*
- *Making Smart Choices*
- *Botvin Life Skills*
- *4-H Stress Management*
- *I CAN Be Healthy: Choosing Balance in Life*
- *Connections Matter*
- *Adaptive Yoga*
- Search Institute's *Intentional Relationships*
- *The Bright Side*
- *Be An Askable Parent*

In addition, the AHI participated in events such as;

- *Red Ribbon Week* activities across the state, including a video contest
- *Art Mural Contest*; the theme was *HOPE* for substance misuse prevention

- *Recovery Center Fall Fest*
- *Reaching for Recovery*
- Partnered with 14 students to build and distribute “recovery benches” that were placed around the county in memory of loved ones lost to addiction and overdose

The AHI also coordinated peer support groups to help students cope with stress, trauma, and grief; and distributed 1,452 pieces of literature and information on the harmful effects of substance misuse.

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 School*s, 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.

In the coming fiscal year, 3 regional AHCs will be transitioning to other opportunities. The AHI will work with subrecipient agencies to select successors for these positions and ensure vital PYD initiatives, such as the STARS program, continues to grow. The AHI also has an opportunity to work with two inner city housing projects to offer a *Family Night Out* twice a month. The idea is to give parents and caregivers a break, provide an opportunity to connect youth with mentors, provide resources and link families with necessary services. Implementation is scheduled for the summer of 2022.

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 again partnered with WVDE to conduct new surveys in 2021, however the YRBS was not conducted until late in 2021.The AHI will continue to work with the WVDE to collect, promote and disseminate data as it becomes available, and offer with the YRBS in the future. 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 also conducts youth needs assessments and Child PTSD Symptom Screeners in teen pregnancy prevention curriculum classes. To date, over 3,000 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 to introduce the concept of *bystander intervention* as an effective strategy to prevent bullying and sexual violence. 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 other 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, the AHI faced challenges with COVID19 which changed the traditional training model. Additionally, the 3 new incoming AHCs will need to be trained and receive certifications for program implementation. In the coming year, the AHI will seek the necessary training for new staff and work with existing staff to further refine both in-person and virtual training programs.

The WVDE partnered the *Prevention Collaborative* (a statewide coalition of violence prevention partners, including FRIS, VIPP and AHI) to develop a body safety toolkit for schools. The toolkit can be found at: https://wvde.us/leadership-system-support/body-safety-and-sexual-abuse-prevention-toolkit/body-safety-education-toolkit/**.** In the coming year, the *Prevention Collaborative* will continue to update and promote the toolkit but also develop an online resource guide. Lastly, the one of the AHCs is working with partners on the development of a phone app for resources. If successful, the AHI would like to expand the idea statewide.

Transition

Provide education and resources to pediatric primary care physicians on the importance of adopting a transition policy (via MCH Workforce Development communication plan and Medical Advisory Board)

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 education and resources to pediatric primary care physicians by the WV HealthCheck Program.

The HealthCheck Program will survey primary care providers for inclusion of a formal transition policy by their practice. These survey results will inform future provider education efforts and resource needs.

Complete transition readiness assessment/transition services 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.

The CSHCN Program will partner with the WVU CED Paths for Parents' Parent Network Specialists and the Family to Family Health Information Center to complete transition readiness assessments for transition age YSHCN. Youth will be referred to the Parent Network Specialists upon age 14 for completion of the transition readiness assessment. The results of the transition readiness assessment will be submitted to the CSHCN Program social worker. The results will be shared with the child's PCP and other medical home providers. Appropriate transition services will be provided pending the results of the transition readiness assessment.

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

These transition services include information on the entitlement for foster youth to retain their Medicaid coverage until age 26 if they consent to continued participation in the child welfare system after age 18. The CSHCN Program will educate enrolled foster child before the youth turns 18 and ages out of foster care. This education will be ongoing until the young adult is discharged from the CSHCN Program at age 21. Educational forms have been developed for CSHCN Program staff to facilitate transition for foster youth.

The CSHCN Program will also educate CPS workers on this entitlement.

Substance use in youth/teens.

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

In partnership with the West Virginia University School of Pharmacy and in coordination with a panel of experts from across the state, the draft West Virginia ADHD treatment guideline will be finalized no later than the fall of 2022. Upon completion of the draft, various sections will be appraised by subject matter experts within the expert panel

before posting in a shared location for all panel members to review and comment. Supplemental information and reference materials for use in the evaluation, diagnosis and treatment of ADHD in West Virginia will be included. The finalized West Virginia ADHD treatment guideline will be accessible via public website by the end of 2022. To promote uptake and increase dissemination of the finalized West Virginia ADHD treatment guideline, academic detailing will be initiated statewide via four full-time trained pharmacists no later than late-spring 2023. The intent of this effort is to facilitate prescribing behavioral changes to better align with evidenced-based, guideline-recommended, best practice. Initially, higher burden counties in West Virginia will be identified through public health surveillance of prescription drug monitoring program (PDMP) data to allow for a targeted academic detailing approach. As an incentive for providers to participate in academic detailing sessions, continuing education (CE) will be provided.

Lastly, a plan to assess impact of the West Virginia ADHD treatment guideline will be developed. The proposed evaluation plan will include survey administration to monitor provider impact and behavioral changes, evaluation of prescription stimulant prescribing trends in West Virginia, and analyzing and evaluating West Virginia Medicaid claims data for stimulant prescribing patterns when an ADHD diagnosis is not present.

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.” Nationally, prescription and over-the-counter drugs are the most commonly misused substances by Americans aged 14 and older, after marijuana, alcohol, and tobacco cigarettes.

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 mantel (understanding rules/laws) of our brains continue to develop until we reach our early- to mid-twenties. Our brains are becoming hardwired during adolescence; negative behaviors developing into neuropathways (like addiction) can become lifelong problems.

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 pregnancy, sexually transmitted infections, using illicit drugs and engaging in other risky behaviors.

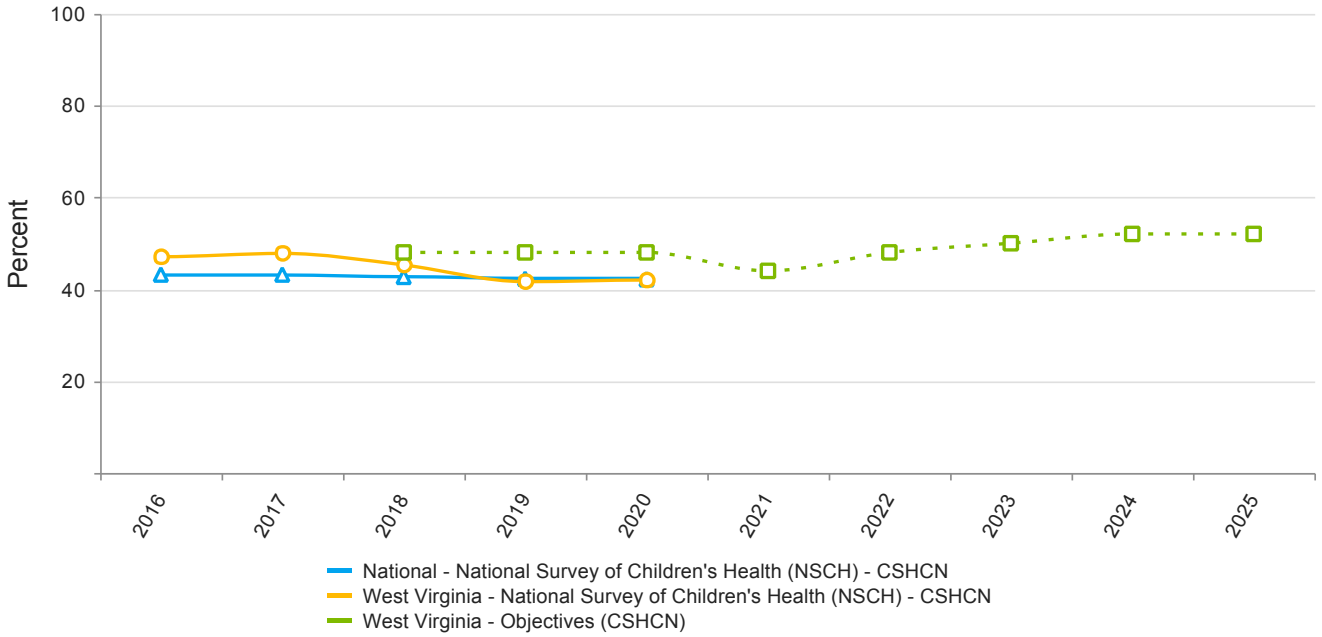
The major source for non-medical use stimulants is family and friends, nearly 70% of which have a prescription. There has been increased legislation and public pressure requiring doctors and pharmacies to better monitor how (and how often) they prescribe drugs. While provider education is key to preventing over prescribing, prescription drugs must also be monitored in homes and the community. The AHI will educate parents, grandparents, school personnel and the community on how to safeguard their medications, monitor their use and prevent theft and/or misuse.

Children with Special Health Care Needs

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		48	48	48	44
Annual Indicator	47.0	47.9	45.2	41.8	41.9
Numerator	42,772	43,240	40,169	36,658	34,916
Denominator	91,107	90,358	88,838	87,648	83,316
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	48.0	50.0	52.0	52.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of stakeholders who receive education and resources regarding the National Resource Center For Patient/Family-Centered Medical Home in the last calendar year.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	CSHCN	CSHCN	CSHCN
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	3.0	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	2021
Annual Objective			30
Annual Indicator	30	30	30
Numerator	34,200	30,798	31,849
Denominator	114,000	102,660	106,164
Data Source	Medicaid	CMS 416	CMS 416
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	35.0	40.0	45.0	50.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			290
Annual Indicator	270	284	327
Numerator			
Denominator			
Data Source	CSHCN	CSHCN	CSHCN and NBS
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	310.0	330.0	350.0	370.0

State Performance Measures

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	41.6	20	20	22	29
Annual Indicator	17	16.8	19.9	25	29.6
Numerator	3,380	22,582	25,058	30,365	35,854
Denominator	19,936	134,548	125,615	121,321	121,234
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2017	2018	2018-2019	2019-2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	33.0	35.0	38.0	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 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

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

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

NOM 25 - Percent of children, ages 0 through 17, who were 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.

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

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

Medical Home

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

The initial response to the Public Health Emergency (PHE) and the continued response of the PHE to date has been the aim of the CSHCN Program administration team and staff. However, the CSHCN Program reviewed the Advancing Systems of Services for CYSHCN the National Resource Center for Patient/Family-Centered Medical Home (NRC-PFCMH) to develop educational materials outlining the importance of the PCMH for all children, specifically CYSHCN.

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

The CSHCN Program revisited implementing a practice standard SDOH screening to be completed at each health supervision visit. Evidential data has been gathered and a final SDOH Screen has been developed.

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

During the COVID-19 pandemic, CSHCN Program nutrition clinics quickly transitioned to telehealth (telehealth-to-home model) through the spring of 2021. Due to growing concerns about the ability to obtain accurate and reliable measurements and an adequate visual assessment of the children, nutrition clinics were all held in person starting in fall 2021, with exceptions made at the Registered Dietitians discretion. Appointments were scheduled to allow for proper sanitation and social distancing. All CSHCN Program staff wore personal protective equipment (PPE) per COVID-19 protocols. PPE were offered to CYSHCN and their families attending clinic.

In early 2022, the CSHCN Program (and parents across the US) faced a baby formula shortage. Four children contracted *Cronobacter sakazakii*. The source was suspected to be their formula. As a result, a major formula producer in the US, Abbott, closed the plant pending the investigation and to be thoroughly disinfected. With shortages of highly specialized formulas, medical-fragile children were transitioned to other formulas. This caused a ripple effect through the industry. Combined with ongoing supply chain issues has resulted in formula shortages across the board. The CSHCN Program Registered Dietitian is working with the vendors and payers to identify sources of formulas. She is also working with the families to identify sources of formulas, including other families sharing resources, and helping children transition to available formulas or alternatives, such as blended diets. Unfortunately, this is causing a great hardship with many of the CSHCN Program participants as they are on highly specialized formulas for a variety of medical reasons and transitioning formulas can result in adverse health effects.

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 initial response to the Public Health Emergency (PHE) and the continuation of the PHE to date has been the aim of the CSHCN Program administration team and staff. While working to ensure the mitigation of community transmission and individual protection against disease and balancing the complex and resource-intensive care needed for CSHCN and their families, it has become clear there will be long-term impacts to our workload and capacity. CSHCN staff have resigned or retired and there are challenges related to rebuilding our infrastructure. Therefore, efforts to incorporate the PHE long-term response into our regular work has been a challenge as our strategies have become defining our new regular work. The CSHCN Program dedicated staff resources to identify and address gaps caused by the PHE. Generally, families of CSHCN have increased financial burdens but during the initial PHE, disruptions in healthcare coverage occurred because of income reductions and job loss, often resulting in loss of employer-sponsored health insurance. To prevent gaps in care, changes in federal policy, like the adoption of the Medicaid expansion in the Affordable Care Act, provisions in the Families First Coronavirus Response Act (FFCRA) which required states to ensure continuous Medicaid enrollment and the Centers for Medicare and Medicaid Services (CMS) blanket waivers were issued. Additionally, some families required other supports which may have included unemployment benefits, Administration for Children and Families resources (including Temporary Assistance for Needy Families), and Supplemental Security Income, which provides cash assistance to many families of children with disabilities and chronic illnesses.

CSHCN staff have been supporting families by working with their healthcare providers and systems to ensure successful transitions to Medicaid managed care, fee-for-service Medicaid and identification of underutilize health benefits. CSHCN administrative staff have partnered with to ensure appropriate services and support during the PHE, as well as to ensure compliance with federal requirements that impact both Title V and Title XIX. WV CSHCN administrative team collaborated with other State programs and bureaus, as well as family peer support agencies to provide CSHCN staff the resources to support CSHCN and their families. Resources included:

- WV Healthcheck to ensure all necessary services to children as mandated by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions of Medicaid law were provided
- Health insurance premium payment programs to support and maintain employer-sponsored health insurance for children eligible for Medicaid, including those who receive Medicaid through home and community-based service programs like waivers
- Home and community-based services such as waivers and other options to provide targeted services and Medicaid coverage for eligible populations without waiting lists
- Utilizing Telehealth services where available

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

During this year, performance gaps have been identified with the current referral and care coordination process. The CSHCN Program receives referrals from Medicaid MCO's and foster care data of children diagnosed with NAS and IUSE (96.1 and 04.49). FY 2021, 147 referrals were received where it is estimated that overall incidence of NAS was 85.8 and 12.7 per 1000 livebirths in the Medicaid and privately insured groups, respectively for West Virginia residents (https://doi.org/10.1111/ppe.12728). The program has determined that the low referral rate is due to despite a standardized statewide definition of NAS, there is not meaningful and accurate data to assess rates of substance exposure and NAS. Many babies who have been exposed in utero to substances are born with a host of other co-morbidities. While these other conditions are typically documented, in utero exposure to substances and NAS often are not included and may be coded incorrectly. Therefore, the condition does not get coded and billed consistently.

Most children diagnosed with NAS and IUSE referred to the CSHCN Program are also Medicaid beneficiaries, qualifying due to receiving foster care services or a stay in the NICU. These children are often lost to follow-up after hospital discharge, or they leave foster care. Contacting the family after categorial eligibility for the program has ended, has proven difficult due to return home or adoption. Additionally, after discharge from the hospital, the PCP is not necessarily notified of the NAS/IUSE.

The WV NAS Surveillance System, Project WATCH/WV Birth Score, is a screening tool that identifies infants who are more likely to be at-risk of death within the first year of life. The "Score" currently includes ten factors with categorical weights. Factors include birth weight, maternal age, previous pregnancies, maternal education, maternal tobacco use, congenital anomalies, APGAR, number of PNC visits, IUSE and gestational age. A score greater than or equal to 17 is considered "High" or at risk. Project WATCH/ WV Birth Score refers to the primary care physician, Right From the Start, and WV Newborn Hearing Program. Currently, the Project Watch/WV Birth Score Program has not established an automatic referral process using surveillance data.

CSHCN will provide case management to infants diagnoses with NAS

Children diagnosed with NAS and IUSE referred to the CSHCN Program are often lost to follow-up. Contacting the family after categorial eligibility for the program has ended, has proven difficult. Additionally, after discharge from the hospital, the PCP is not necessarily notified of the NAS/IUSE.

Transition

Provide education and resource to pediatric primary care physicians on the importance of adopting a transition policy (via MCH Workforce Development communication plan and Medical Advisory Board)

COVID-related restrictions on visiting provider's offices limited the OMCFH's ability to provide in office academic detailing. As a result, the CSHCN Program has pivoted their approach to utilize the program's medical advisory board and HealthCheck to provide education and resources to pediatric primary care physicians on the importance of adopting a transition policy.

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

CSHCN Program care coordinators are provided with caseload reports of children at transition-appropriate ages: 14, 16, 18, and 21 years of age. Transition services provided by the CSHCN Program care coordinators include transition support from pediatric to adult healthcare. This process begins with a transition readiness assessment at age 14. Legal changes that take place in privacy and consent at age 18 are introduced at age 16. Traditionally, transition to adult healthcare providers takes place at age 18; however, with this population of medically complex children with pediatric-onset conditions, adult providers are not always equipped to treat them, and these children stay with their pediatric providers beyond age 18. Regardless, a conversation with adolescents and their families about transitioning providers begins around age 16. As does a conversation about health insurance coverage after age 18. In 2021, 133 children received these transition supports. In 2021, there were 665 YSHCN enrolled to the CSHCN Program between the ages of 14 and 20.

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

The CSHCN Program Director created education materials for the CSHCN Program care coordination teams on foster children's entitlement to retain Medicaid coverage until the age of 26. These materials are encompassed in the full transition plan that is pending approval.

Medical Home

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

The CSHCN Program will develop educational materials outlining the importance of the PCMH for all children, specifically CYSHCN by using resources from the Advancing Systems of Services for CYSHCN the National Resource Center for Patient/Family-Centered Medical Home (NRC-PFCMH). Educational resources, after Office approval will be shared.

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

Once a practice standard SDoH screening is approved, a procedure will be developed to implement the screening at each health supervision visit and address reimbursement for each screen. 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 will continue to monitor COVID-19 concerns but plans to continue holding in person nutrition clinics.

The CSHCN Program Director of Nursing and the CSHCN Registered Dietitian 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 and can be therapeutic in nature. 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.

The CSHCN Program Registered Dietitian will monitor the ongoing formula shortage and provide appropriate assistance.

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 review Medicaid claims data to evaluate telemedicine utilization during the pandemic response. The program hopes to identify underserved regions that already have difficulty accessing providers due to travel and target care coordination efforts to inform clients of telemedicine options and identify potential barriers.

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

The CSHCN Program Admin team will develop a formal care coordination procedure for those children diagnosed with NAS/IUSE. Using claims data, the Care Coordination team will ensure the PCP has been informed of the diagnosis and will ensure the PCP is aware of the HealthCheck Program Preventive Health Screen form which encompasses the Survey of Well-being of Young Children (SWYC). The CSHCN Admin will develop a process for on-going data and performance analysis related to the formal NAS/IUSE care coordination procedure.

CSHCN will provide case management to infants diagnoses with NAS.

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 2022. CSHCN Program staff will receive training on how to best communicate with parents of children diagnosed with NAS or IUSE to obtain positive outcomes.

Transition

Provide education and resources to pediatric primary care physicians on the importance of adopting a transition policy (via MCH Workforce Development communication plan and Medical Advisory Board)

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 education and resources to pediatric primary care physicians by the WV HealthCheck Program.

The HealthCheck Program will survey primary care providers for inclusion of a formal transition policy by their practice. These survey results will inform future provider education efforts and resource needs.

Complete transition readiness assessment/transition services 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.

The CSHCN Program will partner with the WVU CED Paths for Parents' Parent Network Specialists and the Family to Family Health Information Center to complete transition readiness assessments for transition age YSHCN. Youth will be referred to the Parent Network Specialists upon age 14 for completion of the transition readiness assessment. The results of the transition readiness assessment will be submitted to the CSHCN Program social worker. The results will be shared with the child's PCP and other medical home providers. Appropriate transition services will be provided pending the results of the transition readiness assessment.

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

These transition services include information on the entitlement for foster youth to retain their Medicaid coverage until age 26 if they consent to continued participation in the child welfare system after age 18. The CSHCN Program will educate enrolled foster child before the youth turns 18 and ages out of foster care. This education will be ongoing until the young adult is discharged from the CSHCN Program at age 21. Educational forms have been developed for CSHCN Program staff to facilitate transition for foster youth.

The CSHCN Program will also educate CPS workers on this entitlement.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

The Office 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. Key informant input is continuously sought for program planning and quality improvement.

Input from key informants is used in development of the application and annual report. Input was gathered from the following key informants within the five population domains:

Domain	Key Informant
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 State Prevention Steering Team Leadership to Prevent Teen Pregnancy Task Force 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 key informant 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 and the Children with Special Health Care Needs Medical Advisory Board (covering the CSHCN domain).

III.G. Technical Assistance

In recent 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, specifically those in leadership roles. 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 includes those with 20 plus years of maternal and child health experience and impacts 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.

The OMCFH again seeks assistance in working with local, state and federal partners to address health inequity to improve the health of all 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 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 overall population. It is difficult to explain how small numbers when reported even as a multi-yearly rate seem extremely higher than overall numbers. Guidance on how to best communicate this language to the general public would be most helpful.

Technical assistance relating to social determinants of health and how to incorporate into all programs housed in OMCFH may be requested. It has been noted in past Title V Block Grant reviews of the lack of narrative around this topic and some progress has been made to include this language. More detailed guidance from the federal level would be of great importance to assist in the expansion of inclusive language relating to how OMCFH has included social determinants of health throughout programs in future applications.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - INTERAGENCY AGREEMENT.pdf

V. Supporting Documents

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

Supporting Document #01 - OMCFH ADVISORIES 2022-2023.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - WV org charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: West Virginia

	FY 23 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	$ 2,582,874	(41.6%)
B. Children with Special Health Care Needs	$ 1,994,991	(32.1%)
C. Title V Administrative Costs	$ 521,721	(8.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,099,586	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 14,881,084	
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)	$ 26,718,824	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 41,599,908	
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)	$ 47,805,443	
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)	$ 29,692,155	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 77,497,598	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,116
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	$ 342,682
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)	$ 451,668
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,206,323
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,340,457
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000
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 Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 5,246,033
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) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 1,500,000
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 Oral Disease Prevention Program	$ 370,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Grants to States to Support Oral Health Workforce	$ 400,000

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 393,095
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) > Centers for Disease Control and Prevention (CDC) > Association of University Centers on Disabilities	$ 94,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Overdose Data to Action	$ 7,332,338
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Firearm Injury Surveillance through Emergency Rooms	$ 149,968
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Emergency Department Surveillance of Non	$ 146,985

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,176,181 (FY 21 Federal Award: $ 6,205,535)		$ 5,876,223	
A. Preventive and Primary Care for Children	$ 2,166,784	(35.1%)	$ 1,968,773	(33.5%)
B. Children with Special Health Care Needs	$ 1,852,961	(30%)	$ 1,822,262	(31%)
C. Title V Administrative Costs	$ 460,678	(7.5%)	$ 593,774	(10.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 4,480,423		$ 4,384,809	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 13,272,503		$ 12,148,778	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 45,804	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 21,193,138		$ 21,136,166	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 34,465,641		$ 33,330,748	
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)	$ 40,641,822		$ 39,206,971	
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)	$ 29,431,884		$ 19,998,487	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 70,073,706		$ 59,205,458	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 93,426
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 291,198	$ 408,310
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 135,510	$ 128,422
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 330,349	$ 381,998
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 458,227	$ 161,558
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,021,000	$ 1,801,162
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 2,333,044	$ 574,260
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 5,885,415	$ 5,565,142
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 167,533
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 262,411	$ 43,134
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 120,000	$ 38,589
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,717,445	$ 544,794

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 1,875,468	$ 1,493,964
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 600,000	$ 179,192
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 7,479,323	$ 4,122,209
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 370,000	$ 308,145
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 400,000	$ 238,318
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 4,817,494	$ 3,591,892
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control Research and State and Community Bates Programs		$ 132,764
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enhanced State Surveillance of Opioid-Involved Morbidity & Mortality		$ 165
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > EPIDEMILOGY & LAB CAPACITY FOR PREVENTION & CONTROL		$ 23,510

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: We will be in compliance with the 30-30-10 when we complete our final FY21 expenditures by September 30, 2022	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: $2,543,908.96 BTT settlement has caused the reduction in the funding to BTT We will be in compliance with the 30-30-10 when we complete our final FY21 expenditures by September 30, 2022	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: We will be in compliance with the 30-30-10 when we complete our final FY21 expenditures by September 30, 2022	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: New AUCD agreement expenses	

Data Alerts:

- The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater than 10% of the Federal Allocation, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 155,617	$ 191,365
2. Infants < 1 year	$ 758,526	$ 372,431
3. Children 1 through 21 Years	$ 2,582,874	$ 1,968,773
4. CSHCN	$ 1,994,991	$ 1,822,262
5. All Others	$ 191,806	$ 927,618
Federal Total of Individuals Served	$ 5,683,814	$ 5,282,449

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 770,380	$ 253,754
2. Infants < 1 year	$ 515,466	$ 418,803
3. Children 1 through 21 Years	$ 2,645,462	$ 715,981
4. CSHCN	$ 9,837,598	$ 10,373,204
5. All Others	$ 323,511	$ 233,021
Non-Federal Total of Individuals Served	$ 14,092,417	$ 11,994,763
Federal State MCH Block Grant Partnership Total	$ 19,776,231	$ 17,277,212

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 1,249,350	$ 1,515,889
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 155,617	$ 191,365
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 1,093,733	$ 1,324,524
2. Enabling Services	$ 500,858	$ 329,800
3. Public Health Services and Systems	$ 4,455,327	$ 4,030,534
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)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 1,156,478
Other		
Payroll, Indirect Cost		$ 359,411
Direct Services Line 4 Expended Total		$ 1,515,889
Federal Total	$ 6,205,535	$ 5,876,223

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 1,045,080	$ 361,146
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 770,380	$ 238,462
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 274,700	$ 122,684
2. Enabling Services	$ 33,058,960	$ 28,514,385
3. Public Health Services and Systems	$ 7,495,868	$ 4,455,217
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		$ 4,423
Physician/Office Services		$ 70,655
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 286,068
Direct Services Line 4 Expended Total		$ 361,146
Non-Federal Total	$ 41,599,908	$ 33,330,748

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: 18,380 **Data Source Year: 2021**

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	18,254 (99.3%)	210	58	58 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Cystic Fibrosis
Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	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, ßeta-Thalassemia	S,C Disease
S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency
Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy		

2. Other Newborn Screening Tests

Program Name	(A) 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	17,151 (93.3%)	40	0	0 (0%)
Newborn Hearing Screening	17,521 (95.3%)	906	8	8 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Long-term follow-up is provided through WVU Pediatrics/Genetics for those infants with genetic conditions. OMCFH provides follow-up for those infants needing metabolic formula/supplements for PKU, Tyrosinemia and Organic Acidemia disorders. 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.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2021**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: 2020 Vital Statistics preliminary data	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2021**
	Column Name:	**Data Source Year Notes**
	Field Note: Newborn Screening Lab results	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: Newborn Screening Lab results	
4.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: Newborn Screening Lab results	
5.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: OMCFH follow-up nurse results	
6.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**

	Field Note: OMCFH follow-up nurse results	
7.	**Field Name:**	**CCHD Critical Congenital Heart Disease - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: 2021 Birth Score Program data - occurrence births failed -40 not screened - 814 screened/no data - 15	
8.	**Field Name:**	**CCHD Critical Congenital Heart Disease - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: 2021 Birth Score Program data	
9.	**Field Name:**	**CCHD Critical Congenital Heart Disease - Total Number Confirmed Cases**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: WV is working to establish a group of pediatric cardiologists who will review screening data and ECHO results for infants who have a positive result. Ideally, the group will have representatives from regional areas across that state and the screening data/tracking will be shared with the appropriate cardiologist for identified regions. WV does not have funding for CCHD screening program- therefore tracking and follow up is limited without dedicated staff.	
10.	**Field Name:**	**CCHD Critical Congenital Heart Disease - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: WV is working to establish a group of pediatric cardiologists who will review screening data and ECHO results for infants who have a positive result. Ideally, the group will have representatives from regional areas across that state and the screening data/tracking will be shared with the appropriate cardiologist for identified regions. WV does not have funding for CCHD screening program- therefore tracking and follow up is limited without dedicated staff.	

11.	**Field Name:**	**Newborn Hearing Screening - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: 2021 Birth Score Program data - occurrence data failed - 906 not screened - 340	
12.	**Field Name:**	**Newborn Hearing Screening - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: 2021 Birth Score Program data	
13.	**Field Name:**	**Newborn Hearing Screening - Total Number Confirmed Cases**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: Newborn Hearing Screening Program data 8 identified with hearing loss	
14.	**Field Name:**	**Newborn Hearing Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: Newborn Hearing Screening Program data 8 identified with hearing loss all referred to BTT, CSHCN and WV Hands and Voices - 5 enrolled, 1 declined services, 1 unable to contact, 1 non-resident	

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 2021

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

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	9,148	48.0	0.0	50.0	2.0	0.0
2. Infants < 1 Year of Age	11,677	48.0	0.0	50.0	2.0	0.0
3. Children 1 through 21 Years of Age	240,210	44.0	0.0	51.0	5.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	7,512	65.0	0.0	30.0	5.0	0.0
4. Others	38,553	21.0	0.0	71.0	8.0	0.0
Total	299,588					

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	17,323	Yes	17,323	88.0	15,244	9,148
2. Infants < 1 Year of Age	18,372	Yes	18,372	97.0	17,821	11,677
3. Children 1 through 21 Years of Age	425,991	Yes	425,991	75.0	319,493	240,210
3a. Children with Special Health Care Needs 0 through 21 years of age^	102,878	Yes	102,878	51.0	52,468	7,512
4. Others	1,341,349	Yes	1,341,349	35.0	469,472	38,553

^Represents a subset of all infants and children.

Form Notes for Form 5:

The process for determining which counts to include in Form 5 have expanded over time. More detail is included in the note for each category of individuals served.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2021**
	Field Note: MCH Maternity Services - referrals from Medicaid for determination of eligibility for prenatal services provided by OMCFH - 300 Maternal Risk Screening - screening completed on first prenatal care visit of resident women for identification of possible high risk pregnancy - 8,848	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	Field Note: Infants with abnormal/unacceptable newborn metabolic screens - 210 Infants who failed/not screened newborn hearing - 1,238 Infants who failed/not screened CCHD - 869 Childhood Lead Poisoning Program elevated blood lead level follow-ups - 2 Birth Score - 65% of all births referred for follow-up services EPSDT/HealthCheck expected infant visits CMS 416 table - 8173	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: EPSDT/HealthCheck CMS 416 table eligibles who should receive at least 1 initial or periodic screen - 214,557 Childhood Lead Poisoning Program elevated blood lead follow-ups - 511 Adolescent Health Initiative participants - 18,763 Family Planning clients <21 years old - 6,379	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: CSHCH infants - 189 CSHCN clients - 3,166 BTT clients - 4,157	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**
	Field Note: Family Planning clients >21 years of age - 23,958 BCCSP clients - 1,933 WISEWOMAN clients - 88 Adolescent Health Initiative participants >21 years of age - 12,569	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**

Field Note:
MCH Maternity Services - referrals from Medicaid for determination of eligibility for prenatal services provided by OMCFH - 300
Maternal Risk Screening - screening completed on first prenatal care visit of resident women for identification of possible high risk pregnancy - 8,848
RFTS - positive pregnancy test referrals from Medicaid - 4,731
Home Visitation pregnant participants - 1,241

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**

Field Note:
Infants with abnormal/unacceptable newborn metabolic screens - 210
Infants who failed/not screened newborn hearing - 1,238
Infants who failed/not screened CCHD - 869
Childhood Lead Poisoning Program elevated blood lead level follow-ups - 2
Home Visitation infants <1 year of age - 1,406
Newborn screens completed on 97% of all births
Birth Score completed on 96% of all births
EPSDT/HealthCheck expected infant visits, CMS 416 table - 8,173
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 - last 3 months of 2021 was not conducted due to transition to electronic death certificate) - completed on 92% of all births due to returned mail

3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
EPSDT/HealthCheck CMS 416 table eligibles who should receive at least 1 initial or periodic screen - 214,557
Childhood Lead Poisoning Program elevated blood lead follow-ups - 511
Adolescent Health Initiative participants - 18,763
Family Planning clients <21 years old - 6,379
Home Visitation participants - 2,621
Students enrolled in state school system - 250,899

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
CSHCH infants - 189
CSHCN clients - 3,166
BTT clients - 4,157
Children enrolled in special education with the state school system - 44,812

5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**

Field Note:
Family Planning clients >21 years of age - 23,958
BCCSP clients - 1,933
WISEWOMAN clients - 88
Adolescent Health Initiative participants >21 years of age - 12,569
Home Visitation participants >21 years of age - 2,306
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 2021

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	18,737	17,096	628	357	24	87	83	413	49
Title V Served	17,801	16,241	597	339	23	83	79	392	47
Eligible for Title XIX	12,179	11,112	408	232	16	57	54	268	32
2. Total Infants in State	17,894	15,613	770	447	37	161	0	866	0
Title V Served	16,889	14,832	732	425	35	153	0	712	0
Eligible for Title XIX	11,632	10,148	501	291	24	105	0	563	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: 2020 preliminary Vital Statistics data - total occurrence births 18,380 - Hispanic not deducted from each race count (357 Hispanic could be of any race)	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: calculated at 95%	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: calculated at 65%	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: 2020 preliminary Vital Statistics data - total infants <1 year 17,447 - Hispanic not deducted from each race count (447 Hispanic could be of any race)	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: calculated at 95%	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: calculated at 65%	

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

State: West Virginia

A. State MCH Toll-Free Telephone Lines	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 642-8522	(800) 642-8522
2. State MCH Toll-Free "Hotline" Name	WV OMCFH 800 number	WV OMCFH 800 number
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"		9,002

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	http://www.wvdhhr.org.mch/	http://www.wvdhhr.org.mch/
4. Number of Hits to the State Title V Program Website		68,688
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	(304) 558-5388
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	(304) 558-5388
Extension	
Email	Teresa.D.Marks@wv.gov

3. State Family or Youth Leader (Optional)	
Name	Shellie Mellert
Title	PPIE/Project DOCC Grant Coordinator
Address 1	Marshall Pediatrics
Address 2	2915 3rd Avenue
City/State/Zip	Huntington / WV / 25705
Telephone	(304) 691-1393
Extension	
Email	mellert@marshall.edu

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: West Virginia

Application Year 2023

No.	Priority Need
1.	Decrease smoking specifically among pregnant women and decrease smoke exposure among children in the household.
2.	Decrease infant mortality with an emphasis on Sudden Unexplained Infant Death (SUID).
3.	Decrease preterm and low birthweight infants.
4.	Decrease injuries among youth and teens specifically related to teen suicide.
5.	Increase breastfeeding, both initiation and continuation.
6.	Address substance use in pregnancy and in youth/teens.
7.	Increase medical home for children with and without special health care needs.
8.	Decrease obesity among children.
9.	Increase dental care specifically during pregnancy.
10.	Increase in adolescents with and without special health care needs who receive services necessary to make transitions to adult health care.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Decrease smoking specifically among pregnant women and decrease smoke exposure among children in the household.	Revised
2.	Decrease infant mortality with an emphasis on Sudden Unexplained Infant Death (SUID).	Continued
3.	Decrease preterm and low birthweight infants.	Continued
4.	Decrease injuries among youth and teens specifically related to teen suicide.	Continued
5.	Increase breastfeeding, both initiation and continuation.	Continued
6.	Address substance use in pregnancy and in youth/teens.	New
7.	Increase medical home for children with and without special health care needs.	Continued
8.	Decrease obesity among children.	Revised
9.	Increase dental care specifically during pregnancy.	New
10.	Increase in adolescents with and without special health care needs who receive services necessary to make transitions to adult health care.	New

Form 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
2020	79.2 %	0.3 %	13,629	17,218
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
2019	83.7	7.0	143	17,090
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 ≤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
2016_2020	17.5	4.4	16	91,461
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
2020	9.3 %	0.2 %	1,604	17,315
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
2020	12.0 %	0.3 %	2,082	17,315
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
2020	28.7 %	0.3 %	4,977	17,315
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
2020/Q3-2021/Q2	1.0 %			
2019/Q4-2020/Q3	2.0 %			
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
2019	5.6	0.6	101	18,179
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
2019	6.1	0.6	111	18,136
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
2019	3.9	0.5	71	18,136
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**
2019	2.2	0.4	40	18,136
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**
2019	154.4	29.2	28	18,136
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**
2019	148.9	28.7	27	18,136
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
2019	43.6	1.7	723	16,575
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 ≤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
2019_2020	16.6 %	1.5 %	56,504	340,347
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**
2020	23.0	3.6	40	173,621
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
2020	38.5	4.3	80	207,560
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
2018_2020	15.1	2.2	48	318,301
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
2018_2020	13.5	2.1	43	318,301
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
2019_2020	23.2 %	1.5 %	83,316	358,771
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
2019_2020	18.2 %	2.8 %	15,161	83,316
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
2019_2020	2.5 %	0.5 %	7,760	307,088
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
2019_2020	13.0 %	1.4 %	39,695	305,631
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
2019_2020	52.1 %	4.3 %	30,847	59,255
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
2019_2020	90.4 %	1.1 %	323,931	358,493
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
2019_2020	21.9 %	2.2 %	35,430	161,496
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
2017	73.9 %	3.4 %	14,000	19,000
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
2020_2021	47.3 %	1.6 %	161,281	340,975
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
2020	59.7 %	3.3 %	61,876	103,576
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
2020	92.2 %	1.9 %	95,525	103,576
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
2020	91.4 %	1.9 %	94,625	103,576
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
2020	22.5	0.7	1,139	50,594
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
2020	16.0 %	1.9 %	2,332	14,579
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
2019_2020	2.7 %	0.7 %	9,528	357,773
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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	24	26	25	25	24
Annual Indicator	27.0	27.6	27.3	26.3	26.9
Numerator	1,652	1,654	1,598	1,528	1,498
Denominator	6,116	5,989	5,845	5,811	5,571
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	24.0	23.0	23.0	22.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	65	67	69	70	70
Annual Indicator	65.4	68.6	68.2	69.9	63.0
Numerator	12,994	12,974	12,736	12,372	10,871
Denominator	19,882	18,907	18,666	17,711	17,259
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	72.0	72.0	74.0	74.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	15	20	22	18	22
Annual Indicator	19.0	20.2	15.2	20.9	15.8
Numerator	3,708	3,610	2,790	3,678	2,678
Denominator	19,555	17,857	18,401	17,602	16,920
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	22.0	24.0	24.0	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	80	84	87	84	86
Annual Indicator	83.7	86.6	82.0	82.0	89.2
Numerator	14,091	13,445	12,495	12,495	12,842
Denominator	16,839	15,534	15,245	15,245	14,394
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2018	2018	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	86.0	88.0	88.0	90.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	**2019**	**2020**	**2021**
Annual Objective		40	40	40
Annual Indicator	37.7	36.1	36.1	37.1
Numerator	5,742	5,401	5,401	5,222
Denominator	15,239	14,977	14,977	14,085
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2018	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	42.0	42.0	44.0	44.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	**2019**	**2020**	**2021**
Annual Objective		40	44	46
Annual Indicator	39.8	43.1	43.1	36.5
Numerator	6,129	6,470	6,470	5,106
Denominator	15,392	15,017	15,017	13,992
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2018	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	46.0	48.0	48.0	50.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	25	27	28	26	26
Annual Indicator	30.5	29.1	29.1	28.7	28.7
Numerator	23,959	22,608	22,608	22,112	22,112
Denominator	78,632	77,715	77,715	77,035	77,035
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2017	2017	2019	2019

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			28	26	26
Annual Indicator			13.6	15.2	14.1
Numerator			16,987	18,340	16,805
Denominator			124,901	120,396	119,261
Data Source			NSCHP	NSCHP	NSCHP
Data Source Year			2018	2018_2019	2019_2020

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**	**2021**
Annual Objective			28	26	26
Annual Indicator			49.1	48.0	39.8
Numerator			61,001	57,581	47,541
Denominator			124,257	120,074	119,576
Data Source			NSCHV	NSCHV	NSCHV
Data Source Year			2018	2018_2019	2019_2020

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				
2022	**2023**	**2024**	**2025**	
Annual Objective	24.0	24.0	22.0	22.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		48	48	48	44
Annual Indicator	47.0	47.9	45.2	41.8	41.9
Numerator	42,772	43,240	40,169	36,658	34,916
Denominator	91,107	90,358	88,838	87,648	83,316
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	48.0	50.0	52.0	52.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	38	40	36	38	40
Annual Indicator	39.3	35.6	36.0	36.0	28.0
Numerator	6,554	5,622	5,633	5,633	4,157
Denominator	16,685	15,797	15,656	15,656	14,835
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2018	2018	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	42.0	44.0	46.0	48.0

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	25	24	23	22	22
Annual Indicator	25.1	24.7	23.9	23.0	21.4
Numerator	4,591	4,590	4,337	4,161	3,697
Denominator	18,305	18,551	18,138	18,106	17,312
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	20.0	20.0	18.0	18.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		27	22	22	28
Annual Indicator	26.5	22.2	24.1	29.5	26.7
Numerator	97,972	82,198	88,702	105,832	93,477
Denominator	370,309	370,710	368,117	358,760	350,414
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	27.0	26.0	24.0	22.0

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					
	2017	2018	2019	2020	2021
Annual Objective	41.6	20	20	22	29
Annual Indicator	17	16.8	19.9	25	29.6
Numerator	3,380	22,582	25,058	30,365	35,854
Denominator	19,936	134,548	125,615	121,321	121,234
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2017	2018	2018-2019	2019-2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	33.0	35.0	38.0	40.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: based on Indicator 4.15 of NSCH 2016	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2017 NSCH CSHCN 13.1 and non CSHCN 20.8 previous years only reported on CSHCN	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2018 NSCH CSHCN 20.2 and non CSHCN 19.6 previous years only reported on CSHCN	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2018 - 2019 NSCH CSHCN 25.6 and non CSHCN 24.7	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2019 - 2020 NSCH CSHCN 32.7 and non CSHCN 28.0	

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			8
Annual Indicator	6.9	8.1	6.6
Numerator	776	737	585
Denominator	11,203	9,059	8,848
Data Source	PRSI	PRSI	PRSI
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6.0	6.0	5.0	5.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2019 PRSI data - based upon the number of completed PRSI forms and the number of women reporting substance use during pregnancy	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 PRSI data - based upon the number of completed PRSI forms and the number of women reporting substance use during pregnancy	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2021 PRSI data - based upon the number of completed PRSI forms and the 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	2021
Annual Objective			0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	200.0	250.0	300.0	350.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: will begin academic detailing in 2021	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Education and training on awareness is still being developed.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: A lack of peer-to-peer relationships hindered true academic detailing to be provided by HealthCheck Specialists. VIPP staffing vacancies also contributed to a lack of progress in this area. Outreach and education was provided to prescribers by the HealthCheck Specialists throughout the APR period. However, this falls short of true academic detailing. Project leadership has determined that in the future academic detailing will be conducted by licensed healthcare professionals to build rapport and connection among healthcare peers.	

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			16
Annual Indicator	16.6	16.5	16.5
Numerator			
Denominator			
Data Source	WIC	WIC	WIC
Data Source Year	2016	2018	2018
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.8	15.5	15.0	14.4

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: WIC PC 2016 data	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: WIC PC 2018 data	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: WIC PC 2018 data	

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.

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			100
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: data collection will begin with CY 2020	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 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.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Due to the inability to collect the measure as initially created this ESM is being dropped and a new measure created.	

ESM 2.2 - Percentage of birthing facilities that have received Evidence-based Labor Support Training through the Perinatal Partnership.

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	40.0	50.0	60.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	1	5	5	6	6
Annual Indicator	2	4	5	5	4
Numerator					
Denominator					
Data Source	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	8.0	8.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note:	according to Baby Friendly USA website as of 6-25-21
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note:	according to Baby Friendly USA website as of 4-29-22

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	65	67	65	66	68
Annual Indicator	64.5	64.9	66.2	66.8	66.7
Numerator	11,514	11,465	11,515	11,069	10,853
Denominator	17,865	17,662	17,405	16,579	16,275
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	70.0	70.0	72.0	72.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: WV resident births only - denominator does not include unknown breastfeeding at discharge	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: WV resident births only - denominator does not include unknown breastfeeding at discharge	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: WV resident births only - denominator does not include unknown breastfeeding at discharge	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: WV resident births only - denominator does not include unknown breastfeeding at discharge	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: WV resident births only - denominator does not include unknown breastfeeding at discharge	

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	5	9	13	12	14
Annual Indicator	8.8	11.1	11.7	11.9	17.3
Numerator	18	74	160	149	127
Denominator	204	668	1,367	1,256	735
Data Source	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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final	Final	Final

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The 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.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

	Field Note: The 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.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Indicator reflects data collected from 1/1/2019-12/31/2019. The denominator includes 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.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The 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.	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The indicator reflects data collected from 1/1/2021-12/31/2021. The denominator includes only those infants who reached 6 months of age by December 31, 2021. 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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	90	95	100	100	100
Annual Indicator	100	100	100	100	100
Numerator	25	25	25	21	21
Denominator	25	25	25	21	21
Data Source	Our Babies Safe and Sound	Our Babies Safe and Sound	Our Babies Safe and Sound	Our Babies Safe and Sound	Our Babies Safe and Sound
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 25 of 25 in state birthing hospitals trained plus Garret Memorial in MD because of proximity to WV	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 25 of 25 in state birthing hospitals trained plus Garret Memorial in MD because of proximity to WV	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 25 of 25 in state birthing hospitals trained plus Garret Memorial in MD because of proximity to WV	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 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.	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 21 of 21 in state birthing hospitals trained	

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					
	2017	2018	2019	2020	2021
Annual Objective	72	86	86	80	82
Annual Indicator	83.9	61.9	75	77.5	77.1
Numerator	177	599	804	816	628
Denominator	211	968	1,072	1,053	815
Data Source	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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	84.0	86.0	88.0	90.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The 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.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

	Field Note: The 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	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Indicator reflects data collected from 1/1/2019-12/31/2019. The denominator includes 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.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The 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.	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The indicator reflects data collected from 1/1/2021-12/31/2021. The denominator includes families with a child less than 1 year of age during the reporting period (CY 2021) who received their first postpartum home visit on or after 1/1/2021. 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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	75	78	80	80	82
Annual Indicator	76.8	55	74.8	82.8	87.3
Numerator	730	820	1,554	1,689	1,554
Denominator	951	1,492	2,077	2,039	1,781
Data Source	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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	84.0	86.0	88.0	90.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The 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.

2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Indicator reflects data collected from 1/1/2019-12/31/2019. The denominator includes infants enrolled in a home visitation program who were aged less than 1 year during the reporting period. The numerator includes those infants from the denominator whose caregivers indicated that the infant was always placed to sleep on their backs, without bed-sharing, and free of soft-bedding. Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based Option, and Right From the Start.

3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The 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.

4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
The indicator reflects data collected from 1/1/2021-12/31/2021. 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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	87	95	112	100	110
Annual Indicator	92	110	144	71	82
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	115.0	120.0	125.0	130.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	13	17	32	38	39
Annual Indicator	16	30	38	30	31
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	39.0	39.0	40.0	40.0

Field Level Notes for Form 10 ESMs:

None

ESM 9.3 - Number of messages disseminated via social media

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	85	100	135	125	140
Annual Indicator	98	130	122	111	88
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	150.0	155.0	160.0	165.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	105	114	100	110	112
Annual Indicator	112	97	102	59	55
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	115.0	118.0	120.0	122.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Number of stakeholders who receive education and resources regarding the National Resource Center For Patient/Family-Centered Medical Home in the last calendar year.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	CSHCN	CSHCN	CSHCN
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	3.0	7.0	7.0	7.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	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.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Program thought it would be best to continue delay implementation of this project because of 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	2021
Annual Objective			30
Annual Indicator	30	30	30
Numerator	34,200	30,798	31,849
Denominator	114,000	102,660	106,164
Data Source	Medicaid	CMS 416	CMS 416
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	35.0	40.0	45.0	50.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note:	
	based upon DOJ data request indicating 113,781 members with a well child exam in calendar year 2019	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note:	
	no progress was made on this strategy due to COVID CMS 416 total eligible receiving at least one initial or periodic screen	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note:	
	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	2021
Annual Objective			290
Annual Indicator	270	284	327
Numerator			
Denominator			
Data Source	CSHCN	CSHCN	CSHCN and NBS
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	310.0	330.0	350.0	370.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: CSHCN and NBS clients	

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

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			50
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Oral Health Program	Oral Health Program	Oral Health Progam
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: will begin collecting for 2021-2022 school year	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: work towards establishing curriculum is ongoing	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: This ESM is being dropped due to no movement in the development of the curriculum at the WVU School of Dentistry. A new ESM was developed focusing on the education of pregnant women and recently postpartum women on importance of oral health.	

ESM 13.1.2 - Expectant and recently postpartum mothers who receive oral health education.

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	10.0	15.0	25.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
This new ESM was developed to address data regaring pregnant women population and oral health education Data collection will begin in the Fall of 2022.

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	150	350	350	300	300
Annual Indicator	334	44	217	245	137
Numerator					
Denominator					
Data Source	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	320.0	320.0	340.0	340.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
there was delay in contact agreement which limited the number of trainings provided in the time period allowed after signing of the contract but is expected to resume previous trainings as provided in the past

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

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			60	50	55
Annual Indicator			41.5	52.7	73
Numerator			85	178	197
Denominator			205	338	270
Data Source			WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	60.0	65.0	70.0	75.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Indicator reflects data collected from 1/1/2019-12/31/2019. The denominator includes women who were enrolled in a home visitation program and indicated use of tobacco products at that time. The numerator includes those women from the denominator who received a referral for tobacco cessation services within 3 months of enrollment. Programs included: Healthy Families America, Parents as Teachers, Early Head Start-Home Based option. Right From the Start was not included due to a change in the referral reporting during the calendar year.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The 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.

3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
The indicator reflects data collected from 1/1/2021-12/31/2021. 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	2021
Annual Objective			25	28	27
Annual Indicator			28.6	28.3	26.7
Numerator			100,750	99,750	93,560
Denominator			352,397	352,397	350,414
Data Source			NSCH	NSCH	NSCH
Data Source Year			2019	2019	2019-2020
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	25.0	23.0	23.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2019 NSCH single year survey	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: based upon 2019 NSCH single year survey	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2019-2020 NSCH NPM 14.2	

Form 10
State Performance Measure (SPM) Detail Sheets

State: West Virginia

SPM 1 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
Population Domain(s) – Adolescent Health, Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the percent of adolescents with and without special health care needs who have received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents with and without special health care needs, ages 12 through 17, whose families report that they received the services necessary to transition to adult health care **Denominator:** Number of adolescents, ages 12 through 17
Healthy People 2030 Objective:	AH-R01 Increase the proportion of adolescents who get support for their transition to adult health care Additionally, the following would apply: AH-02 Increase the proportion of adolescents who speak privately with a provider at a preventive medical visit MICH-20 Increase the proportion of children and adolescents with special health care needs who have a system of care
Data Sources and Data Issues:	The revised National Survey of Children's Health (NSCH) beginning in 2017. States can use data from the 2009-2010 NS-CSHCN as a baseline.
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.

SPM 2 - Increase identification of pregnant women using substances during pregnancy.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase identification of pregnant women using substances during pregnancy utilizing the PRSI form and increase the number of women referred for treatment.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of pregnant women reporting substance use on the PRSI form. **Denominator:** Number of PRSI forms received.
Healthy People 2030 Objective:	Increase abstinence from illicit drugs among pregnant women - MICH-11.
Data Sources and Data Issues:	The PRSI form will be utilized as the data collection system. The leading barrier of the PRSI form is the number of providers not complying with state mandate for completing the form. With the transition from paper to a web based system it is hoped this barrier will decrease.
Significance:	The Prenatal Risk Screening Instrument (PRSI) is intended to promote early and accurate identification of prenatal risk factors. Prenatal Risk Screening Instrument is to be completed by the physician/clinician at the first prenatal visit. If the patient answers “Yes” to any pregnancy or medical risk factor, a Maternal Fetal Medicine consultation should be considered. Data gathered through the PRSI will be used to develop procedures, policy, and obtain funding to address prenatal risk. The goal is to improve birth outcomes for mother and infant. Completion and submission of this form is required by State Law.

SPM 3 - Increase the awareness of controlled substance use among children ages 5-17.
Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active
Goal:	Increase the provider, family and general public awareness of controlled substance use among children ages 5-17.
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of controlled substance prescribing providers who received academic detailing regarding substance use. **Denominator:**
Healthy People 2030 Objective:	Increase the proportion of adolescents who think substance abuse is risky — SU-R01.
Data Sources and Data Issues:	PDMP for number of prescribing providers and VIPP Program for number of prescribing providers receiving academic detailing.
Significance:	Studies have shown that non-medical use of controlled substances, e.g. stimulants, during childhood results in an increased risk of SUD in adulthood.

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

Measure Status:	Active
Goal:	Decrease obesity rates in children, ages two to four, from 16.6% (WIC data 2016) to 14.4% by 2022.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children ages two to four participating in WIC who are obese as defined as BMI at or above the 95th percentile on the CDC growth charts for age and sex. **Denominator:** Total number of children ages two to four participating in WIC.
Healthy People 2030 Objective:	Reduce the proportion of children and adolescents with obesity — NWS-04
Data Sources and Data Issues:	Data are from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Participant and Program Characteristics (WIC PC). WIC PC is a biennial census in even years for participating children two to four year in age. Data are analyzed by CDC's Obesity Prevention and Control Branch. Data issues include recent decline in participation rates in WV even though poverty rates are stable and/or increasing.
Significance:	West Virginia, unfortunately, has led the nation in adult obesity and chronic disease rates including diabetes, hypertension and cardiovascular disease. WV adolescents are following the same trend of continually increasing overweight and obesity rates leading to early morbidity and an economic strain on health insurance costs. Nationally, obesity prevalence in children aged two to four years participating in WIC decreased from 15.9% in 2010 to 13.9% in 2016 and during 2010–2014, decreased in 34 of the 56 WIC states/territories. WV was only one of three states that had increasing obesity rates (from 14.4% in 2010 to 16.4% in 2014). WV must start earlier to address primary prevention efforts in young children. Research has shown that obesity prevention efforts from elementary school to adulthood have been inadequate, and mostly unsuccessful, to slow the obesity epidemic. However, obesity prevention initiatives in Early Care and Education (ECE) settings show promising results; not only for successfully decreasing obesity rates over a short time period (2010-2014), but also across all ethnic groups (The State of Obesity: Better Policies for a Healthier America 2018, Trust for America's Health, Robert Wood Johnson Foundation, 2018). Other successful initiatives have actually widened the disparity gap. Equitable access to early education addresses the deleterious effects of poverty on children's development. According to the Centers for Disease Control and Prevention (CDC), it is easier to influence children's food and activity choices when they are young. The ECE setting can directly influence what children eat and drink and how active they are, which builds a foundation for healthy habits. For this reason, early education is included in the CDC Health Impact in 5 Years (HI-5) because it reaches entire populations of people at once and requires less individual effort.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: West Virginia

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: West Virginia

ESM 2.1 - Number of first time pregnant women who have participated in the Lamaze International Evidence Based Labor Support Workshop.
NPM 2 – Percent of cesarean deliveries among low-risk first births

Measure Status:	Inactive - Replaced
Goal:	Increase the number of first time pregnant women, fathers, families and support persons who have participated in the Lamaze International Evidence Based Labor Support Workshop.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of first time pregnant women who participated in the Lamaze International Evidence Based Labor Support Workshop. **Denominator:**
Data Sources and Data Issues:	Vital Statistics and Perinatal Partnership
Evidence-based/informed strategy:	Lamaze® International uses a contemporary curriculum that supports birth as normal, natural, and healthy, and empowers expectant women and their partners to make informed decisions. https://www.lamaze.org/
Significance:	Research shows that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of one-on-one support. A Cochrane meta-analysis states the association with a statistically significant reduction in the rate of cesarean deliveries.

ESM 2.2 - Percentage of birthing facilities that have received Evidence-based Labor Support Training through the Perinatal Partnership.
NPM 2 – Percent of cesarean deliveries among low-risk first births

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percentage of birthing facilities that are using the most up-to-date labor support strategies.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of birthing facilities that completed evidence-based labor support training during the reporting period</td></tr>
<tr><td>Denominator:</td><td>Total Number of birthing facilities in the state</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Perinatal Partnership Training records and Vital Statistics</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Strategy: Extending targeted outreach to hospitals with high rates of cesarean delivery. (mchevidence). By providing training to all birthing facilities, providers will have increased knowledge on labor support to reduce cesarean delivery for low risk births.
Kennell J, Klaus M, McGrath S, Robertson S, Hinkley C. Continuous emotional support during labor in a US hospital. a randomized controlled trial. JAMA. 1991;265(17):2197-2201.
Hodnett ED, Lowe NK, Hannah ME, et al. Effectiveness of nurses as providers of birth labor support in North American hospitals: a randomized controlled trial. JAMA. 2002;288(11):1373- 1381.</td></tr>
<tr><td>Significance:</td><td>Raising awareness and education among maternity providers of the benefits of labor support. Research shows that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of one-on-one support.</td></tr>
</table>

ESM 4.1 - Number of birthing facilities designated Baby-Friendly under the EMPower initiative
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of birthing facilities designated Baby-Friendly under the EMPower initiative from 5 in 2020 to 10 by 2025.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of birthing facilities designated as Baby-Friendly by Baby Friendly USA. **Denominator:**
Data Sources and Data Issues:	Vital Statistics and Baby Friendly USA
Evidence-based/informed strategy:	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.
Significance:	Birthing facility utilization the Ten Steps to Successful Breastfeeding will encourage breastfeeding and increase the percent of infants who are ever breastfed and breastfed exclusively through 6 months.

ESM 4.2 - Percent of infants who are breastfeeding at time of discharge from a birthing facility
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the percentage of infants who are breastfeeding at time of discharge from a birthing facility to 74% by 2025.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants who are breastfeeding at time of discharge from birthing facilities **Denominator:** Number of live infant discharged from a birthing facility
Data Sources and Data Issues:	Vital Statistics
Evidence-based/informed strategy:	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: https://www.ncbi.nlm.nih.gov/pubmed/26289058
Significance:	Birthing facility utilization the Ten Steps to Successful Breastfeeding will encourage breastfeeding and increase the percent of infants who are ever breastfed and breastfed exclusively through 6 months.

ESM 4.3 - Percent of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the percentage of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age **Denominator:** Number of infants enrolled in an evidence-based home visitation program who have reached six months of age
Data Sources and Data Issues:	OMCFH home visitation programs
Evidence-based/informed strategy:	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.
Significance:	Breastfeeding can reduce post neonatal mortality rate per 1,000 live births and reduce Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

ESM 5.1 - Percent of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	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.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of birthing hospitals in the state that have been trained using the “Say YES to Safe Sleep” curriculum **Denominator:** Number of birthing hospitals in the state
Data Sources and Data Issues:	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.
Evidence-based/informed strategy:	Kuhlmann S, Ahlers-Schmidt CR, Lukasiewicz G, Truong TM. Interventions to improve safe sleep among hospitalized infants at eight children's hospitals. Hosp Pediatr. 2016;6(2):88-94. Link: https://www.ncbi.nlm.nih.gov/pubmed/26753631
Significance:	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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Provide Safe Sleep education on the first visit after child's birth to 88% of families enrolled in a home visitation program</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of families (with a child less than 1 year) enrolled in a home visitation program who received safe sleep education on the first visit after child's birth from a trained home visitor</td></tr>
<tr><td>Denominator:</td><td>Number of families enrolled in a home visitation program with a child aged less than 1 year during the reporting period</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be collected from OMCFH Home Visitation Programs.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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: https://www.mchevidence.org/tools/npm/5-safe-sleep.php</td></tr>
<tr><td>Significance:</td><td>Increasing the number of families who receive Safe Sleep education will help to reach those families who did not receive the education in the hospital and will also serve to reinforce the message for those families who did receive the education prior to hospital discharge. Many families feel more comfortable having conversations and asking questions with their trusted home visitor with whom they have built a good relationship. Safe Sleep education delivered during home visits will help to overcome barriers related to safe sleep practices.</td></tr>
</table>

ESM 5.3 - Percent of infants enrolled in a home visitation program that are always placed to sleep on their backs, without bed-sharing or soft bedding
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</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>Denominator:</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>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be collected from OMCFH Home Visitation Programs.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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. https://www.mchevidence.org/tools/npm/5-safe-sleep.php</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

ESM 9.1 - Number of positive youth development (PYD) focused trainings provided to youth, parents, professionals and community members
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Foster positive and nurturing relationships between young people and caring adults within their communities.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of PYD trainings provided to youth, parents, professionals and community members **Denominator:**
Data Sources and Data Issues:	Data will be provided by Adolescent Health grantees
Evidence-based/informed strategy:	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. https://www.search-institute.org/wp-content/uploads/2018/01/DataSheet-Assets-x-Gender-2018-update.pdf https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html
Significance:	By fostering strong youth-adult relationships, the OMCFH is supporting well-researched protective factors against bullying and many other risk behaviors. This approach is further supported by statewide data WV OMCFH collected in 2015-2016.

ESM 9.2 - Number of schools and/or youth serving organizations in target communities that have implemented a comprehensive bullying program
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Implement comprehensive, evidence-based bullying prevention programming in schools and communities
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of schools and/or youth serving organizations that have implemented a comprehensive bullying program **Denominator:**
Data Sources and Data Issues:	Data provided by the Adolescent Health grantees, the Violence and Injury Prevention grantees and the WV Dept. of Education
Evidence-based/informed strategy:	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. https://link.springer.com/article/10.1007/s42380-019-0007-4
Significance:	By encouraging the implementation of comprehensive prevention programs, the WV OMCFH is supporting a systematic approach to reducing bullying among youth in WV schools and communities

ESM 9.3 - Number of messages disseminated via social media
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Increase awareness about bullying, cyberbullying and the associated negative outcomes, while promoting positive behaviors, educating on bystander skills and supporting WVDE Policy 4373
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of social media messages. **Denominator:**
Data Sources and Data Issues:	Data will be provided by Adolescent Health grantees
Evidence-based/informed strategy:	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. https://journals.sagepub.com/doi/10.1177/1524839911433467
Significance:	The utilization of social media is an evidence-based youth violence prevention strategy that will be used in combination with other strategies. By implementing a combination of strategies, the WV OMCFH is supporting stronger and more sustainable improvements in health and safety than the implementation of a single strategy

ESM 9.4 - Number of trainings provided to youth, parents, professionals and community members
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Increase awareness about bullying, cyberbullying and the associated negative outcomes, while promoting positive behaviors, educating on bystander skills and supporting WVDE Policy 4373
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of trainings provided to youth, parents, professionals and community members **Denominator:**
Data Sources and Data Issues:	Data will be provided by Adolescent Health grantees
Evidence-based/informed strategy:	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. https://www.cdc.gov/violenceprevention/pdf/yv-technicalpackage.pdf
Significance:	By educating youth and adults as part of a comprehensive approach to reducing youth violence and victimization, the WV OMCFH is supporting stronger and more sustainable improvements in health and safety than the implementation of a single strategy

ESM 11.1 - Number of stakeholders who receive education and resources regarding the National Resource Center For Patient/Family-Centered Medical Home in the last calendar year.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Improve the medical community's knowledge and adoption of the Patient-Centered Medical Home model of primary care.
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of stakeholders who receive education and resources regarding the National Resource Center for Patient/Family-Centered Medical Home **Denominator:**
Data Sources and Data Issues:	CSHCN Program will inform this ESM. This measure will require a consistent definition and application for "stakeholder."
Evidence-based/informed strategy:	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.
Significance:	The AAP endorses the Patient-Centered Medical home as the optimal way to provide comprehensive, coordinated, and ongoing care to children. This ESM will allow the CSHCN Program to gauge stakeholder and community education on the Patient-Centered Medical Home.

ESM 11.2 - Percent of well-child exams received by Medicaid members age 0-21 with a documented social determinants of health screening (as identified by claims data) in the last calendar year.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Improve the percentage of well-child exams received by Medicaid members age 0-21 with a documented social determinants of health screening.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</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>Denominator:</td><td>Number of well-child exams received by Medicaid members age 0-21 in the last calendar year.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The CSHCN Program will utilize Medicaid claims data to inform this ESM. Inconsistent billing and coding may cause issues with this ESM.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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

Measure Status:	Active
Goal:	Ensure children in need of medically necessary medical foods are served.
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of children who receive Title V funded medically necessary foods. **Denominator:**
Data Sources and Data Issues:	CSHCN Program
Evidence-based/informed strategy:	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.
Significance:	Necessary to ensure coverage for medically necessary nutrition services to children.

ESM 13.1.1 - Establish a curriculum for WVU School of Dentistry on dental care for pregnant women.
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Inactive - Replaced
Goal:	Increase the number of pregnant women with preventive dental visits during pregnancy by establishing a curriculum for WVU School of Dentistry on dental care for pregnant women.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of students completing the dental care curriculum for pregnant women. **Denominator:**
Data Sources and Data Issues:	WVU School of Dentistry
Evidence-based/informed strategy:	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.
Significance:	Through ongoing work of the Oral Health Program on perinatal oral health quality improvement, it is understood that there are many challenges around dental care during pregnancy. The national consensus statement is currently the best resource to create a standard knowledge base for dental care during pregnancy. Education of prenatal care providers on this topic should increase the number of pregnant women who are referred for dental care during pregnancy and increase the number of pregnant women receiving dental services.

ESM 13.1.2 - Expectant and recently postpartum mothers who receive oral health education.
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Increase the number of expectant and recently post-partum mothers who receive oral health education by 10% in the next year in order to increase the awareness of women regarding the importance of oral health.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of expectant and recently post-partum mothers who receive oral health education **Denominator:** Number of births in West Virginia
Data Sources and Data Issues:	OMCFH, OHP, State partners, Vital Statistics
Evidence-based/informed strategy:	The Oral Health Program will work with dental hygiene students and state partners to provide oral health education to expectant and recently postpartum mothers. The Oral Health Program has made connections for students to educate the targeted population at health fairs and community events through state partnerships and scheduled community health events. The national consensus statement will be used to develop educational tools on dental care as it is the best resource to create a standard knowledge base for dental care during pregnancy.
Significance:	Oral Health promotion and oral disease prevention in parents and children; referral to dental home.

ESM 14.1.1 - Number of health care workers who have had Help2Quit maternity care provider training
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Increase the number of health care workers who have had Help2Quit maternity care provider training
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of health care providers who have had Help2Quit maternity care provider training **Denominator:**
Data Sources and Data Issues:	WV Perinatal Partnership
Evidence-based/informed strategy:	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: https://www.mchevidence.org/tools/npm/14-smoking.php
Significance:	Decreasing the percentage of women who smoked during pregnancy and the percentage of children in households where someone smokes can reduce the following: rate of severe maternal morbidity per 10,000 delivery hospitalizations, maternal mortality rate per 100,000 live births, percent of low birth weight deliveries (<2,500 grams), percent of very low birth weight deliveries (<1,500 grams), percent of moderately low birth weight deliveries (1,500-2,499 grams), percent of preterm births (<37 weeks), percent of early preterm births (<34 weeks), percent of late preterm births (34-36 weeks), percent of early term births (37, 38 weeks), perinatal mortality rate per 1,000 live births plus fetal deaths, infant mortality rate per 1,000 live births, neonatal mortality rate per 1,000 live births, post neonatal mortality rate per 1,000 live births, preterm-related mortality rate per 100,000 live births, sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births, and percent of children in excellent or very good health.

ESM 14.1.2 - Percent of women enrolled in HV who reported using any tobacco products at enrollment and were referred to tobacco cessation within 3 months of enrollment.
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Increase the percentage of clients who are referred to smoking cessation services within the first 3 months of enrollment in a home visitation program.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women enrolled in home visitation who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment. **Denominator:** Number of women enrolled in home visitation who reported using tobacco or cigarettes at enrollment and were enrolled for at least 3 months.
Data Sources and Data Issues:	OMCFH Home Visitation Programs
Evidence-based/informed strategy:	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: https://www.mchevidence.org/tools/npm/14-smoking.php
Significance:	Decreasing the percentage of women who smoke during pregnancy and the percentage of children in households where someone smokes can reduce the following: rate of severe maternal morbidity per 10,000 delivery hospitalizations, maternal mortality rate per 100,000 live births, percent of low birth weight deliveries (<2,500 grams), percent of very low birth weight deliveries (<1,500 grams), percent of moderately low birth weight deliveries (1,500-2,499 grams), percent of preterm births (<37 weeks), percent of early preterm births (<34 weeks), percent of late preterm births (34-36 weeks), percent of early term births (37, 38 weeks), perinatal mortality rate per 1,000 live births plus fetal deaths, infant mortality rate per 1,000 live births, neonatal mortality rate per 1,000 live births, post neonatal mortality rate per 1,000 live births, preterm-related mortality rate per 100,000 live births, sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births, and percent of children in excellent or very good health.

ESM 14.2.1 - Percent of children in households where someone smokes.
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
Goal:	Decrease the number of households where someone smokes.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of children ages 0-17 who live in households where there is household member who smokes.</td></tr><tr><td>**Denominator:**</td><td>Number of children ages 0 through 17</td></tr></table>
Data Sources and Data Issues:	NSCH
Evidence-based/informed strategy:	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: https://www.mchevidence.org/tools/npm/14-smoking.php
Significance:	Children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections; and SIDS

Form 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 2021

	Access				Linkages	
Data Sources	(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	Monthly	1	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