West Virginia State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Decrease preterm and low birthweight infants.	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.	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.	***Inactive -*** *ESM LRC.1 - Number of first time pregnant women who have participated in the Lamaze International Evidence Based Labor Support Workshop.* ESM LRC.2 - Percentage of birthing facilities that have received Evidence-based Labor Support Training through the Perinatal Partnership.	NPM - Percent of cesarean deliveries among low-risk first births (Low-Risk Cesarean Delivery, Formerly NPM 2) - LRC	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM
Increase dental care specifically during pregnancy.	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.	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.	***Inactive -*** *ESM PDV-Pregnancy.1 - Establish a curriculum for WVU School of Dentistry on dental care for pregnant women.* ESM PDV-Pregnancy.2 - Expectant and recently postpartum mothers who receive oral	NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

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			health education.		NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Decrease smoking specifically among pregnant women and decrease smoke exposure among children in the household.	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.	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.	ESM SMK-Pregnancy.1 - Number of health care workers who have had Help2Quit maternity care provider training ESM SMK-Pregnancy.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 - Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal

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					Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Address substance use in pregnancy and in youth/teens.	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.	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.		SPM 2: Increase identification of pregnant women using substances during pregnancy.	
	Provide education to pregnant people on the importance of the post partum visit (PPV) and ensure knowledge of their insurance coverage for completion of this PPV from 0 to 100 individuals.	Develop no less than one (1) educational product on PPV to be disseminated at community baby showers.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

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				recommended care components (Postpartum Visit) - PPV	
Perinatal/Infant Health					
Increase breastfeeding, both initiation and continuation.	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.	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.	ESM BF.1 - Number of birthing facilities designated Baby-Friendly under the EMPower initiative ESM BF.2 - Percent of infants who are breastfeeding at time of discharge from a birthing facility ESM BF.3 - Percent of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
Decrease infant mortality with an emphasis on Sudden Unexplained Infant Death (SUID).	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.	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.	ESM SS.1 - Percent of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education ESM SS.2 - Percent of families enrolled in a home visitation program who received safe sleep education from a trained home	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D)	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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			visitation provider on the first visit after child's birth ESM SS.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	Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	
Child Health					
Decrease smoking specifically among pregnant women and decrease smoke exposure among children in the household.	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).	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.	ESM SMK-Household.1 - Percent of children in households where someone smokes.	NPM - Percent of children, ages 0 through 17, who live in households where someone smokes (Smoking - Household, Formerly NPM 14.2) - SMK-Household	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per

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					1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Address substance use in pregnancy and in youth/teens.	The VIPP Program and the Division of Infant, Child and Adolescent Health will work with partners to increase awareness of controlled substance use among	i. Partner with medical providers to align with best practices in prescribing controlled substances to ensure optimum outcomes.		SPM 3: Increase the awareness of controlled substance use among children ages 5-17.	

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	children ages 5-11.				
Decrease obesity among children.	The Division of Child and Adolescent Health will work with WIC and other partners to decrease obesity among children ages 2-4.	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.		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.	
	Increase the number and percentage of Medicaid-enrolled	Increase pediatric health care provider awareness of Medicaid-enrolled children without a medical home through the WV HealthCheck Program.	***Inactive -*** *ESM MH.1 - Number of*	NPM - Percent of children with and without special	NOM - Percent of children with special health care needs

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	children without a special health care need, ages 0 through 17, who have a medical home.		*stakeholders who receive education and resources regarding the National Resource Center For Patient/Family-Centered Medical Home in the last calendar year.* ***Inactive -*** *ESM MH.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.* ESM MH.3 - Number of children who receive Title V funded medically necessary medical foods. ESM MH.4 - Percent of CSHCN who are receiving care coordination services from the West Virginia CSHCN Program and who have a shared plan of care completed or updated within the last	health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	(CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

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			180 days.		
Adolescent Health					
Decrease injuries among youth and teens specifically related to teen suicide.	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.	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.	ESM BLY.1 - Number of positive youth development (PYD) focused trainings provided to youth, parents, professionals and community members ESM BLY.2 - Number of schools and/or youth serving organizations in target communities that have implemented a comprehensive bullying and/or violence prevention program ESM BLY.3 - Number of messages disseminated via social media ESM BLY.4 - Number of trainings provided to youth, parents, professionals and community members	NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Address substance use in pregnancy and in youth/teens.	The VIPP Program and the Division of Infant, Child and Adolescent Health will work with partners to increase awareness of controlled substance use among	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		SPM 3: Increase the awareness of controlled substance use among children ages 5-17.	

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	children ages 12-17.	storage and disposal of prescription medications and prescription monitoring in the home.			
Children with Special Health Care Needs					
Increase medical home for children with and without special health care needs.	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.	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. 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. Collaborate with Marshall University to expand WVU complex care clinic model CSHCN Program marketing to medical providers Demonstrate care coordination activities with behavioral health conditions; track referrals to children's crisis and referral line Educate transition aged foster children on their entitlement to retain Medicaid coverage until age 26 CSHCN non-compliance with medical, diagnostic, specialty appointments, with emphasis on post pandemic	***Inactive -*** *ESM MH.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.* ***Inactive -*** *ESM MH.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.* ESM MH.3 - Number of children who receive Title V funded medically necessary medical foods. ESM MH.4 - Percent of CSHCN who are receiving care coordination services	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

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			from the West Virginia CSHCN Program and who have a shared plan of care completed or updated within the last 180 days.		
Increase medical home for children with and without special health care needs.	To decrease the finance burden of out-of-pocket costs for CSHCN and their families.	Provide easily accessible, medically necessary nutrition services as a payer of last resort to improve access to care for CYSHCN Expand medical foods coverage for children with behavioral conditions Collaborate with WIC to market CSHCN Program medical foods coverage		SPM 5: Percent of CSHCN who pay more than $500 for their medical, health, dental, and vision care during the last 12 months.	
Increase medical home for children with and without special health care needs.	Increase the number and percentage of children with a special health care need enrolled in the WV CSHCN Program, ages 0 through 21, who have a medical home regardless of insurance type.	Provide care coordination services through the WV CSHCN Program to all enrolled children and their families to assist with the selection and identification of a medical home.	***Inactive -*** *ESM MH.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.* ***Inactive -*** *ESM MH.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 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

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			ESM MH.3 - Number of children who receive Title V funded medically necessary medical foods. ESM MH.4 - Percent of CSHCN who are receiving care coordination services from the West Virginia CSHCN Program and who have a shared plan of care completed or updated within the last 180 days.		
Cross-Cutting/Systems Building					
Increase in adolescents with and without special health care needs who receive services necessary to make transitions to adult health care.	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.	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. Complete transition readiness assessment for all enrolled CSHCN starting at age 14.		SPM 1: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care	