Maternal and Child Health Services Title V Block Grant

West Virginia

FY 2025 Application/ FY 2023 Annual Report

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West Virginia Department of HEALTH

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH
BUREAU FOR PUBLIC HEALTH
Office of Maternal, Child and Family Health

Sherri A. Young, DO, MBA, FAAFP
Cabinet Secretary

Justin Davis
Interim Commissioner

July 1, 2024

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, 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 2025.
2. Fiscal Year 2023 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 Teresa Marks, Title V CYSHCN Director, Office of Maternal, Child and Family Health, at (304) 414-0634. Questions and/or comments regarding the business management responsibilities should be directed to Shayne Ballard, Director, Division of Grants Administration and Reporting Department at (304) 352-6719.

Sincerely,

Tara L. Buckner
Chief Financial Officer

Teresa Marks, Title V CYSHCN Director
Office of Maternal, Child and Family Health

TLB/TM/vc

Enclosures

350 Capitol Street, Room 427 • Charleston, West Virginia 25301 • 304.558.5388 • 304.558.2183 (fax) • dhhr.wv.gov

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 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 2021 Title V application/Annual Report guidance.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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 (and without) special health care needs by involving multiple stakeholders across West Virginia (WV). The Title V Needs Assessment identifies needs based on data/outcomes and partners with community and stakeholders to develop systems-level 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.

The OMCFH engages multiple stakeholders across WV to develop and support interventions with the greatest potential to achieve optimal results. These partnerships work together to support data collection activities and assess the availability of care, service utilization, and quality of health services for the maternal and child health populations. The OMCFH strives to maximize state and federal funding streams to administer population-based surveillance and service systems, coordinate with other agencies to eliminate duplicate services, provide safety-net services to address 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, populations served, and desired outcomes.

Historically, the OMCFH has engaged multiple stakeholders, leveraged longstanding relationships and braided federal and non-federal funds to accomplish objectives outlined in its State Action Plan. Key partnerships include the WV Perinatal Partnership, academic institutions, medical facilities, advisory boards, health care providers, the WV Department of Education, and families.

With assistance from stakeholders and OMCFH staff, the following performance measures under the five population domains have been developed. These have been updated to reflect the 2025 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 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 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 public awareness of harmful effects.

CSHCN

Increase the percentage of children with special health care needs, which 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. Leveraging the authority and both the interagency and private sector coordination requirements of Social Security statutes and regulations, the OMCFH maximizes the use of Federal and State funding streams to administer population-based surveillance and service systems; work in partnership with other agencies to ensure nonduplication 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 analyses. The State of WV remains committed to its mothers and children through continued support of OMCFH and its programs. Generally, the Title V MCH Block Grant along with other federal funding enables the OMCFH to maintain its workforce and continue moving forward. The OMCFH also leverages its partnerships to provide staffing for public health awareness, epidemiologic support, clinics, and case abstraction activities.

The OMCFH uses Title V MCH Block Grant resources to implement many of its programs and projects, especially those that are not specifically mandated by State law. For example, Title V MCH Block Grant funds assure support for breastfeeding, adolescent health, injury prevention, maternal and infant mortality, services for children and youth with special health care needs (cyshcn), and health system interventions to improve the medical management of children and youth who present with academic or behavioral problems and/or symptoms of inattention, hyperactivity, or impulsivity (i.e., cyshcn). While these programs and projects are broadly supported, little or no state funds are allocated for their operations. Title V MCH Block Grant funding assures infrastructure and support for these vital activities, while state funds are prioritized for efforts required by law. This strategy allows Title V MCH Block Grant funds to complement the efforts supported by the State.

III.A.3. MCH Success Story

Beginning in late 2022, the OMCFH has been working with the Bureau for Public Health (BPH) Office of Epidemiology and Prevention Services (OEPS) to establish referral process for infants with confirmed Hepatitis C and/or perinatal Hepatitis C exposure. With the increase in syphilis cases and the continued prevalence of intrauterine substance exposure (IUSE), the WV OMCFH is leading the effort to utilize existing state policy and the care coordination services of its Children with Special Health Care Needs (CSHCN) Program to meet the needs of these children and families.

Pursuant to the authority of WV State Code (§16-3) and the corresponding legislative rule (R. §64-7) related to reportable diseases, events, and conditions, the CSHCN Program has begun receiving referrals from the OEPS when children less than 60 months old are confirmed as a positive hepatitis C case. The CSHCN Program is working with the BPH Commissioner's Office to establish an outreach letter from the State Health Officer (SHO) to educate families on the outreach and offer services from the CSHCN Program. Including syphilis and children born with neonatal abstinence syndrome (NAS), this population is increasing in West Virginia. The Program's goal will be to provide care coordination services for these children, including follow-up linkage to care for treatment for hepatitis C at 36 months of age and older to ameliorate these conditions as applicable. The CSHCN Program is excited about this partnership with OEPS and the opportunity to utilize reportable disease data in meaningful ways for children and families in West Virginia.

III.B. Overview of the State

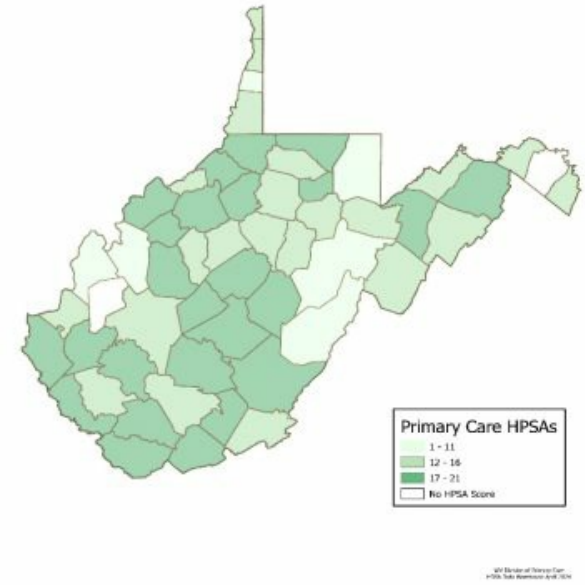
The OMCFH is the WV Title V agency and housed within the Bureau for Public Health (BPH) under the Department of Health as of January 1, 2024. The Title V agency previously was under the umbrella of former Department of Health and Human Resources (DHHR) which has been split into three departments: WV Department of Health (DH), WV Departments of Human Services (DoHS), and WV Department of Health Facilities (DHF). These departments are now overseen by a newly created Office of Shared Administration. Although the new organizational structure is now split, these offices remain within the Diamond Building. The proximity of the Bureaus still allows easy interaction and collaboration with the Bureau for Children and Families, the Bureau for Medical Services (Medicaid), the Bureau for Behavioral Health, the Office of Nutrition Services (i.e., Special Supplemental Nutrition Program for Women, Infants, and Children/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 (WV Birth to Three/BTT) 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 interstates and one east/west interstate 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.

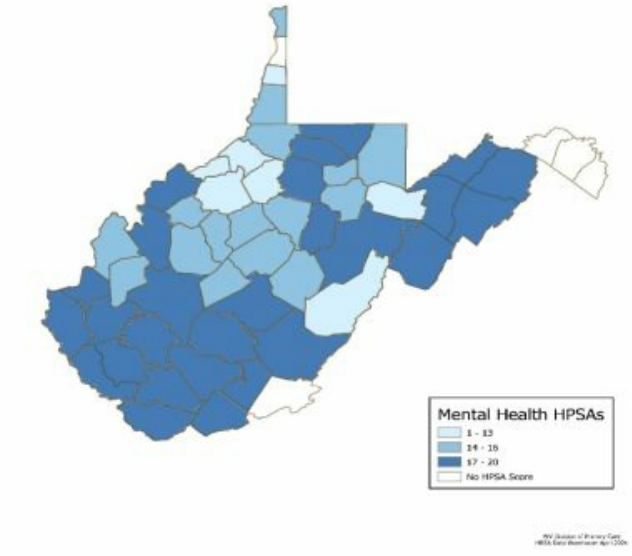
WV is surrounded by Pennsylvania, Maryland, Virginia, Ohio, and Kentucky and is commonly referred to as a South Atlantic state. The Appalachian Mountains extend through the eastern portion of the state, giving WV the highest elevation of any state east of the Mississippi River.

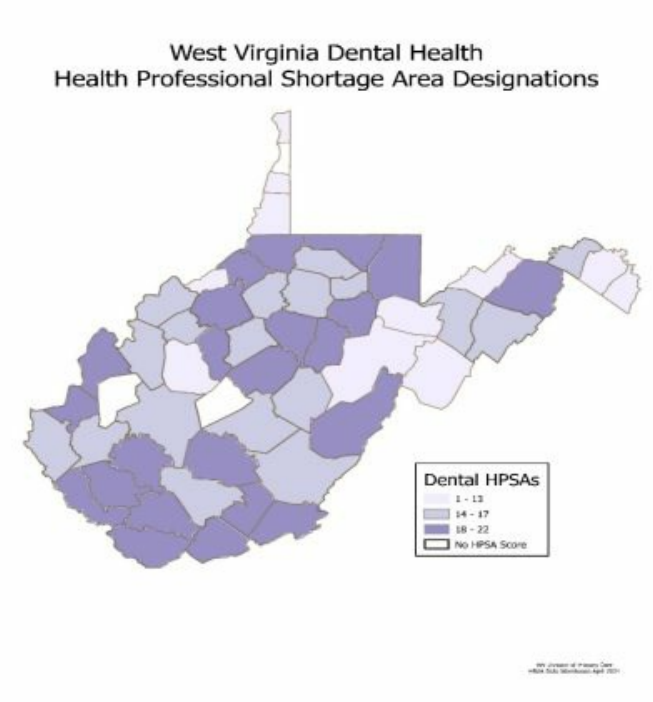
WV reached its population peak a half century ago with 2,005,552 residents counted in the 1950 US Census. The State's population has not exceeded 2 million since then but has fluctuated between 1.7 and 1.9 million depending on the State's economy. Charleston, the state capitol and largest city, and Huntington 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



West Virginia Mental Health
Health Professional Shortage Area Designations





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 aged 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 16,593 births in 2022 (cumulative data). Because of its older population, as of 2021, WV now ranks second among the states in the percentage of its residents enrolled in Medicare (24.9%, compared to a national average of 18.7%). Older West Virginians value their independence, self-sufficiency, and preservation of the family homestead. This lifestyle is demonstrated by the fact that residents maintain one of the highest percent of home ownership in the nation at 74.5% compared to 65.7% nationally. Almost 85% of individuals aged 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 2022, the percentage of obese adults reached 41.0%; 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 2022, WV was ranked 48th with 30.2% of the population reporting being physically inactive. Other health issues affecting the state include high rates of diabetes, obesity, 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 17.4% in 2022. In 2022, WV ranked 50th in terms of smoking with 21.0% of the adult population indicating that they currently smoke daily. This percentage has remained stable over the past 10 years, unaffected by the numerous public health interventions to reduce smoking although, according to the 2022 WV Pregnancy Risk Assessment Monitoring System (PRAMS) data, smoking during the last three months of pregnancy has decreased to 10.3% after

decreasing from 24.9% in 2018 to 18.3% in 2020.

The report did however list the following strengths for the state: low prevalence of excessive drinking, low prevalence of high-risk HIV behaviors and a high per capita public health funding. The report also highlighted a 44% decrease in occupational fatalities, a 16% increase in diabetes a 16% decrease in premature death.

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 20 birth hospitals and one birth center in the State as of 2024. Currently, there are two children's hospital located in the state, one in Charleston, WV called Women and Children's Hospital under the CAMC umbrella and a new children's hospital in Morgantown, WV called WVU Medicine Children's Hospital that opened in Fall 2022. There are limited pediatric specialists in WV with most located at one of the three tertiary care centers. 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 65 Rural Health Clinics in WV, 294 Federally Qualified Health Center (FQHC) sites providing services in the State, 12 short term hospitals outside of urban areas and 21 critical access hospitals. Five-point nine percent of WV residents lack health insurance (Kaiser, 2022). According to the Economic Research Service, the average per capita income for WV residents in 2021 was $48,488 and rural per capita income lagged at $44,733.

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 few changes 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 2022) found that 5.7% of WV children are currently uninsured, this data however is not comparable to previous years NSCH data due to weighting changes that occurred. But according to the 2021 WVCHIP Report there are only 3.5% children currently uninsured.

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 federally qualified health centers (FQHCs), free/charitable 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 DH 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:

1. Children with Special Health Care Needs (CSHCN): 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)*
2. West Virginia Birth to Three (BTT): Provides therapeutic and educational services for children aged 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)*
3. Health Check (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*)
4. Oral Health Program (OHP): Provides statewide coordination for oral health activities including planning, school-based sealants, fluoride efforts, workforce shortages, and community involvement. (*WV §16-41*)
5. 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)*
6. 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)*
7. Newborn Hearing Screening (NBS): 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)*
8. Maternal Risk Screening (MRS): 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)*

9. Family Planning Program (FPP): 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)*
10. Breast and Cervical Cancer Screening Program (BCCSP): 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)*
11. 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)*
12. 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)*
13. Infant and Maternal Mortality Review Panel (IMMRP): 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 2025 Application/FY 2023 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 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 five years despite challenges of the COVID pandemic, the ongoing drug epidemic, changes in Bureau leadership and the dissolvement of the West Virginia Department of Health and Human Resources (DHHR) that split the entity into 3 separate Departments, placing OMCFH under the West Virginia Department of Health (DH), Bureau for Public Health (BPH). West Virginia has made improvements in the measures identified.

Smoking – Maternal

Tobacco use remains high across all West Virginia 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 West Virginia 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 9.27% of women in 2022 smoked during the last trimester of pregnancy, this is drastically lower than the 24.9% of women that reported smoking in the three months before pregnancy in 2018.

Maternal smoking three months before pregnancy is most common among mothers at or below 100% Federal Poverty Level (FPL), those who receive Medicaid, and those with less than a high school degree; 28.3% and 17.8% of those mothers without a high school degree reported smoking in the 3 months before pregnancy and the last trimester of pregnancy, respectively, in 2022. This is an improvement from 2019 when 48.2% and 37.8% of those same mothers reported higher rates of smoking. 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 like 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.

Over the last five years, PRAMS data showed that the number of homes with infants where smoking was allowed decreased have varied from year to year. It decreased from 5.8% in 201 to 1.87% in 2021. In 2022, an increase was noted in the smoking that was allowed in at least part of the home 7.24% of homes.

Although legislation surrounding home environment regulation is difficult, at the end of the 2024 West Virginia legislative session, West Virginia became the 12th state to ban lighting up in cars with children present as a secondary offense CDC reports there is no safe level of exposure to secondhand smoke, and although violators can only be fined if they are pulled over for another offense, this could help reduce the risk associated with exposure to smoke in a more confined space when compared to a home.

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.

Over the past year, the Infant and Maternal Mortality Review Panel (IMMRP) has reviewed 2018, 2019 and 2020 infant deaths, and in the month of March the Panel met and reviewed infant deaths for 2021, but do not have summary data at this time. The Panel has yet to review 2022, but due to legislative changes the upcoming review timelines are not scheduled. For calendar year 2018, 129 infant deaths were reviewed by the IMMRP. The manner of death was listed as 72 (56%) natural, 27 (21%) undetermined, two (2%) homicide and seven (5%) accidental. For calendar year 2019, 112 infant deaths were reviewed by the IMMRP. The manner of death was listed as: 66 (59%) natural, 30 (27%) undetermined, 10 (9%) unknown, and six (5%) accidental. For calendar year 2020, 112 infant deaths were reviewed by the IMMRP. The manner of death was listed as 75 (67%) natural, 21 (19%) undetermined, one (1%) homicide, four (3%) unknown, and 11 (10%) accidental.

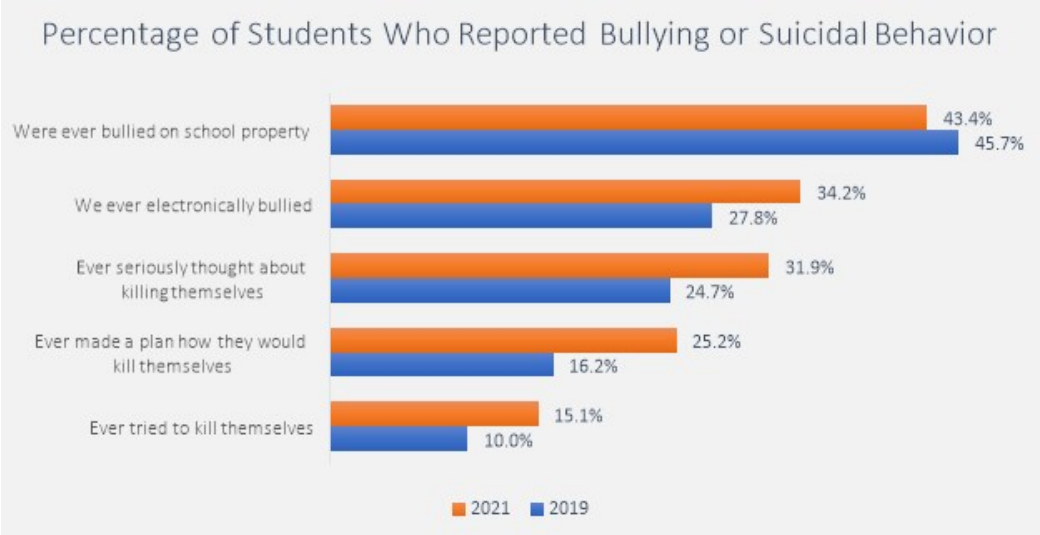
Infant mortality rates have changed in West Virgnia over the current Needs Assessment period, seeing a decrease in infant mortality rates from 7.28 infant deaths per 1,000 live births (calculated as 139 infant deaths divided by 19,070 resident births- 2016 Health Statistics Center Data). The infant mortality rate for West Virginia in 2018 was 7.1 infant deaths per 1,000 live births (calculated as 129 infant deaths divided by 18,243 resident births - 2018 Health Statistics Center data). In 2018, the CDC reported the U.S. infant mortality rate as 5.7 infant deaths per 1,000 live births. The infant mortality rate for West Virginia in 2019 was 6.2 infant deaths per 1,000 live births (calculated as 112 infant deaths by 18,090 resident births - 2019 DHHR HSC data). In 2019, the CDC reported the U.S. infant mortality rate as 5.6 infant deaths per 1,000 live births. The infant mortality rate for West Virginia in 2020 was 6.5 infant deaths per 1,000 live births (calculated as 112 infant deaths divided by 17,327 resident births - 2020 DHHR HSC data). In 2020, the CDC reported the U.S. infant mortality rate as 5.4 infant deaths per 1,000 live births.

Premature Birth

West Virginia preterm birth rates have varied over the last 5 years but have remained steady. In 2018, 11.9% of births were preterm, increasing to 12.6% in 2019. The West Virginia Health Statistics Center reports cumulative data from 2022 showing 12.9% of births were preterm. This was a slight increase in overall preterm births from 2020, which was reported as 12.0%.

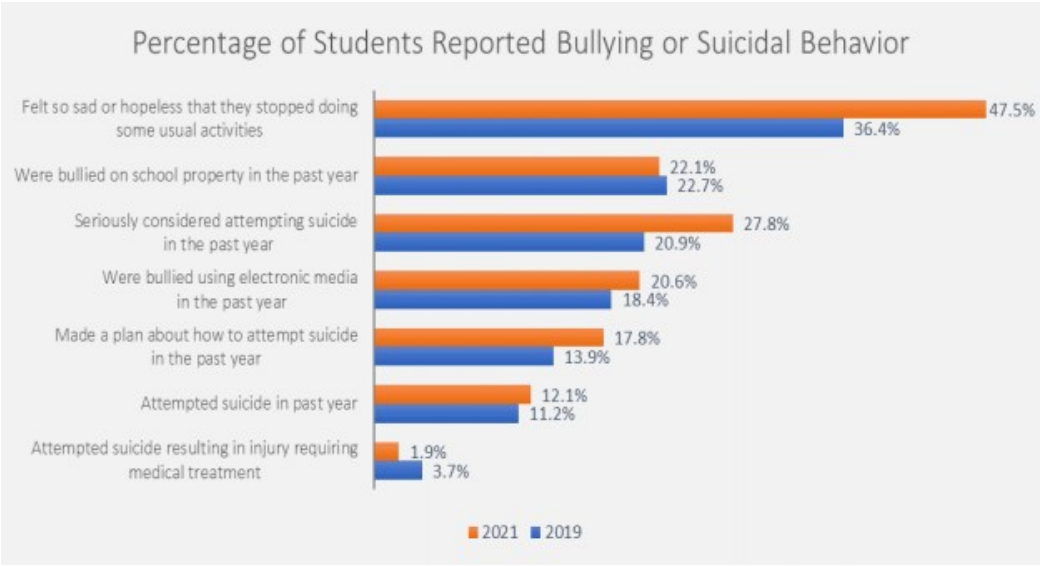
Bullying and Suicidal Behaviors (middle school)

The 2019 and 2021 West Virginia Youth Risk Behavior Survey revealed the following trends 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 and 2021 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) 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 neonatal abstinence syndrome (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 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 fourteen an increase from the 12 facilities last reporting year.

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 (CPS) 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 previously served over 7,000 children at any given time. The state has been working to address SUD through different initiatives and programs and as of October 2023, the former WV DHHR reported that the number of children currently in foster care had decreased to 6,222.

In 2019, Maternal Risk Screening (MRS) data indicated that 6.9% of pregnant respondents reported a problem with drug or alcohol and 9.5% reported problems with drugs or alcohol in the past. In 2023 a decrease has been seen with MRS indicating 7.0% of pregnant respondents reported a problem with drugs or alcohol currently and 8.6% reported problem with drugs or alcohol in the past. In 2022, 7.0% of pregnant respondents reported a problem with drugs or alcohol currently and 8.6% reported problem with drugs or alcohol in the past. MRS also found that, of those Prenatal Risk Screening Instruments (PRSIs) submitted in 2023, 2.3% reported current opioid abuse treatment and 1.6% reported previous opioid abuse treatment, a decrease from 2.8 and 2.8 respectively in 2019.

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 percentage of WV resident infants with IUSE has decreased from just below 14% in 2017 to 12.9% in 2023 and the percent of infants born with signs of NAS has decreased from 5.48% in 2017 to 3.90% in 2023.

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 (2021) 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 – 3.6% v. US – 2.7%); ever use synthetic marijuana (WV – 6.3% v. US – 6.5%); ever use methamphetamines (WV – 0.8% v. US – 1.8%); and ever injected any illegal drug (WV – 1.3% v. US – 1.4%).

Examining WV 2021 YRBSS data comparing males and females, female respondents were more likely to: ever used cocaine (female – 4.0% v. male – 0.8%); ever used methamphetamines (female – 1.1% v. male – 0.4%); ever used ecstasy (female – 3.3% v. male – 5.8%); and ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (female – 17.7% v. male – 7.0%).

Analysis of data from West Virginia's Prescription Drug Monitoring Program (PDMP), also known as the Controlled Substance Monitoring Program (CSMP), shows that adolescent males ages 5-17 were more likely than females (13%, 7%) to have been prescribed a stimulant in 2023 and increase from 12.6% in males and 6.2% in females seen in 2021. According to the 2022 National Survey on Children's Health, this number is considerable higher than the national average (males-7.1%, females-3.9%). Additionally, in some counties in the states, the prescribing of stimulants greatly exceeds the prevalence of attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) in the population, specifically for males, with the highest county having 22% of males ages 5-17 with a stimulant prescription compared to 12% for females. The state saw an increase in stimulant prescribing from 2022-2023 for both males and females ages 5-17 with a percent increase of 4% and 7% respectively after a decrease was noted from 2020-2021.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

Data from the National Immunization Survey (NIS) 2020 Breastfeeding Report Card indicated at the start of this five-

year cycle, WV's ever breastfed rate was 69.9% (based on 2017 births), the most recent 2022 report card indicates a decrease to 59.8% (based on 2019 births). However, breastfeeding data from NIS from most recent data in 2020 indicates WV's ever breastfed rate at 73.6% an increase from 2019. The WV Health Statistics Center reports infants breastfeeding at time of discharge after delivery as 67.6% in 2022 (cumulative) and 68.7% in 2023 (cumulative), an increase from 66.2% in 2019. At the beginning of this Needs Assessment cycle the report card also lists WV's total maternity practices in infant nutrition and care (mPINC) score for 2018 at 76 compared to the US national average of 79. Most recent data available in 2020 list WVs at 80, compared to the US National score of 81.

In 2019, 71.6% of WV PRAMS mothers indicated they ever breastfed, increasing to 75.6% in 2022 and only 44.1% in 2019 women were still breastfeeding at the time of the survey (4-9 months postpartum), increasing to 52.6% in 2022. In 2022, among women who weren't breastfeeding at the time of the survey, around 13.9% of women indicated they breastfed for less than a week, a decrease from 17.8% in 2019. This however is less when compared to the 40.9% that breastfed greater than 8 weeks in 2022, an increase from the 28.3% seen in 2019.

Medical Home and Transition

In the 2021/2022 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 down from 43.3% in 2020/2021. Fifty-nine-point four percent of CSHCN in WV received needed care coordination. The CSHCN Program is well-positioned to improve this metric to return the numbers to the previous combined year's numbers, while also aiming to increase the metrics overall.

While not a component of the medical home measure, transition services are integral to ensuring youth with special health care needs (YSHCN) receive services in a well-functioning system. Upon reaching adulthood, these youth face changing insurance, health care providers, and potentially losing community services and support 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.

	2017/2018		2018/2019		2019/2020		2020/2021		2021/2022	
	WV	US	WV	US	WV	US	WV	US	WV	US
YSHCN who received services necessary for transition to adult health care, ages 12 - 17	20.2%	18.9%	25.6%	22.9%	32.7%	22.5%	35.0%	20.5%	29.0%	22.1%
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	43.6%	47.0%	50.4%	50.5%	58.6%	51.8%	57.8%	49.9%	53.9%	51.9
YSHCN whose doctor actively worked with them to gain skills to manage his/her health and health care	65.0%	66.8%	70.2%	69.7%	74.0%	68.2%	72.7%	66.5%	78.7%	75.7%
YSHCN whose doctor actively worked with them to understand the changes in health care that happen at age 18	32.9%	34.4%	35.6%	35.7%	44.5%	36.0%	45.6%	34.0%	43.4%	33.9%
YSHCN whose doctors discussed the shift to providers who treat adults, if needed	18.8%	20.0%	26.2%	24.8%	30.8%	25.7%	33.2%*	24.0%	27.7%	24.0%

Please interpret with caution.

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 (2020) for WIC participants ages 2-4 that are obese is 16.5% (remaining unchanged from the 2018 prevalence. in West Virginia, ranking fifth

nationally behind Delaware, Massachusetts, California, and Maryland.

Oral Health and Pregnancy

In 2019, WV PRAMS data showed that 41.9% of women received teeth cleanings prior to pregnancy, decreasing to 31.8% in 2022. There was an increase seen in the women who had their teeth cleaned during pregnancy increasing from 31.5% in 2019 to 37.1% in 2022.

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

2024 Application/2022 Annual Report – Needs Assessment Update

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,176,181	$5,876,223	$6,205,535	$5,868,790
State Funds	$13,272,503	$12,148,778	$13,146,376	$11,936,001
Local Funds	$0	$0	$0	$0
Other Funds	$0	$45,804	$0	$1,809
Program Funds	$21,193,138	$21,136,166	$22,300,975	$20,462,108
SubTotal	$40,641,822	$39,206,971	$41,652,886	$38,268,708
Other Federal Funds	$29,431,884	$19,998,487	$29,724,428	$21,654,587
Total	$70,073,706	$59,205,458	$71,377,314	$59,923,295

	2023		2024	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,205,535	$5,446,687	$6,227,187	
State Funds	$14,881,084	$11,936,001	$15,002,759	
Local Funds	$0	$0	$0	
Other Funds	$0	$1,809	$0	
Program Funds	$26,718,824	$20,758,082	$24,738,938	
SubTotal	$47,805,443	$38,142,579	$45,968,884	
Other Federal Funds	$29,692,155	$30,345,100	$31,058,076	
Total	$77,497,598	$68,487,679	$77,026,960	

	2025	
	Budgeted	Expended
Federal Allocation	$6,227,187	
State Funds	$14,833,519	
Local Funds	$0	
Other Funds	$0	
Program Funds	$40,242,063	
SubTotal	$61,302,769	
Other Federal Funds	$31,081,839	
Total	$92,384,608	

III.D.1. Expenditures

The OMCFH expects to allocate approximately $61,302,769 in resources for FY 2024. These funds are comprised of State, Federal, and private resources. Title V Block Grant funds in the amount of $6,227,187 are used to provide the foundational structure for the Office. Specifically, the funds are used to ensure and facilitate health system improvements, 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 $14,833,519 in State funds and will generate $40,242,063 in program income. The total state match provided is $55,075,582. 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 39% for preventive and primary care for children and 36.1% 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 10.0% for administrative costs, complying with the 10% limit.

The Office served 296,550 pregnant women, infants less than one year of age, and children ages one through 21 years of age (including CYSHCN ages 0 – 21), and others during annual report year 2023. Over 8,800 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. Over 11,100 infants received newborn screening services and Birth Score referrals, and over 12,306 children with special health care needs received direct, enabling, or public health services through Title V supported programs, services, and systems.

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, Maternal Infant Early Childhood Home Visitation, Early Hearing Detection & Intervention, Oral Health, and Pediatric Mental Health Care Access. 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, Preventing Maternal Mortality: Supporting Maternal Mortality Review Committees, Pregnant People-Infant Linked Longitudinal Surveillance, 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 in States and Rape Prevention and Education.
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 available resources and partnerships to optimize health across the lifespan, for all people. WV Department of Health (DH) leadership relies on the OMCFH 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 OMCFH places great value on partnerships and leverages its relationships to accomplish many of the goals outlined in its State Action Plan. Key external partners include the State's Perinatal Quality Collaborative (PQC). i.e., the WV Perinatal Partnership; academic institutions, e.g., WV University and Marshall University; medical and programmatic advisory boards/councils; health care providers; the WV Department of Education; and families. OMCFH actively convenes medical and programmatic advisory boards but also serves in leadership roles for many external groups. For example, staff serve on the WV Perinatal Partnership Central Advisory Council; the Executive Committee of the WV Developmental Disabilities Council; and the Steering Committee of the State's cancer coalition, i.e., Mountains of Hope.

The Title V supported 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 (registered professional nurses and licensed social workers) work to facilitate a team approach to health care, with coordination across multiple services and settings, in accordance with the National 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 support.

Per 42 CFR 441.61, care coordination, including aspects of case management, is an integral component of Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Accordingly, care coordination for children (with and without special health care needs) is integrated within Title V supported OMCFH programming to ensure prompt access to high-quality child health services for children eligible for benefits under Titles V and XIX of the Social Security Act. Likewise, the OMCFH works closely with the State Medicaid Agency to establish/interpret standards, policies and procedures for health care services, provides education to enhance implementation, promotes quality of care, and assesses progress.

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

- Enhancing the review process and data collection for infant and maternal mortality;
- 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 Family Planning, 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.

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. Experience gained from administrative oversight of varied grant requirements, program models, funding streams and data-driven decision making places the OMCFH in a unique position to effectively design and deliver evidence based MCH services. The OMCFH uses a leadership team management approach with the Office Director, Associate Office Director, Division Directors, Early Intervention/Part C (Birth to Three) Director, the OMCFH Medical Director, and State Dental Director actively participating in decision-making and strategic planning. Below are brief biographical sketches of the current Senior Management and key staff:

Teresa Marks, MS
WV Title V Director (Interim) – *anticipated effective 7/15/2024*
HHR Office Director 3 – Director (Interim), Office of Maternal, Child and Family Health (OMCFH) – *anticipated effective 7/15/2024*
WV Title V CYSHCN Director
HHR Office Director 2 – Associate Director, OMCFH
Education:
MS, Healthcare Administration, Marshall University, 2019
BA, Secondary Education, Marshall University, 2001
Professional:
Associate Director/WV Title V CYSHCN Director, OMCFH/BPH (2023-Present)
Director, Division of Children's Specialty Care/WV Title V CYSHCN Director, OMCFH/BPH (2022-2023)
Director, Division of Infant, Child and Adolescent Health/Title V CYSHCN Director, OMCFH/BPH (2019-2022)
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 & 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)

Jennifer Hancock, PsyD
HHR Program Manager 2 – Director, Division of Women's and Family Health (DWFH)
Education:
PsyD, Marshall University, 2013
MA, Psychology, 2009
MA, English, Marshall University, 2005
BA, English, West Virginia University, 1999
Professional:
Director, OMCFH/DWFH (2023-Present)
Psychologist, Charleston Area Medical Center Cancer Center (2015-2023)
Clinical Faculty, West Virginia University School of Medicine Charleston Division Psychology Internship (2015-2023)
Psychologist, Cabin Creek Health Systems (2013-2015)

Sharon Hill, MPH
Epidemiologist 4 – Director, Division of Epidemiology, Evaluation and Population-based Surveillance (DEEPS)
Education:
DrPH, Capella University, (2018-present); anticipated graduation date 2025
MPH, West Virginia University, 2014
BS, Biology, West Virginia State University, 1995
Professional:
Director, OMCFH/DEEPS (2022-Present)
Director, Division of Epidemiologic Evaluation, OEPS/BPH (2021-2022)
Senior Epidemiologist, WVU Office of Health Affairs/School of Public Health (2020-2021)
Program Manager, Division of Infectious Disease Epidemiology, OEPS/BPH (2019-2020)
Senior Research Associate, Center for Health Education Research Institute, Charleston Area Medical Center (2015-2020)
Epidemiologist, Division of Statistical Services, HSC/BPH (2008-2014)
Epidemiologist, Division of Infectious Disease Epidemiology, OEPS/BPH (2005-2008)
Microbiologist, Division of Microbiology, OLS/BPH (2000-2004)

Julie Jackson, MSDH
HHR Program Manager 2 – Director, OMCFH/Division of Community Health (DCH)
Education:
MSDH, Dental Hygiene, West Liberty University, 2022
RBA, General Studies, West Virginia State University, 2015
AS, Dental Hygiene, West Virginia Institute of Technology, 2002
Professional:
Director, OMCFH/DCH (2023-Present)
Program Manager, WV Oral Health Program (2018-2023)
Oral Health Workforce Coordinator, WV Oral Health Program (2016-2018)
Teacher, Boone County (WV) Schools (2015-2016)
Dental Hygienist, Nagy & Majestro DDS (2014-2015)
Dental Hygienist, Kanawha Valley Dental Group (2006-2014)

Jackie Newson
HHR Program Manager 2 – Director, OMCFH/Division of Infant, Child, Adolescent and Young Adult Health (DICAYAH)
Professional:
Director, OMCFH/DICAYAH (2023-Present)
Director, WV Home Visitation Program (2010-2023)
Senior Program Specialist, WV Family Planning Program (2002-2010)
Program Assistant, WV Family Planning Program (1995-2002)

Regina "Mel" Woodcock, MA, IMH-E
HHR Program Manager 1 – WV Birth to Three (BTT) Director
Education:
MA, Special Education, West Virginia University
BA, Elementary Education
Professional:

Interim Director, WV Birth to Three, OMCFH/BPH (2023-Present)
CSPD/Policy Specialist, WV Birth to Three, OMCFH/BPH (2001-2023)
Director, Early Intervention Program, Appalachian Community Health Center, (1991-2001)

Kathryn Oscanyan, **MPH**
Epidemiologist 3 – WV MCH Epidemiologist
Education:
MPH, West Virginia University, 2008
BS, Biology, West Virginia University, 2005
Professional:
MCH Epidemiologist, OMCFH/BPH (2023-Present)
WV Home Visitation Epidemiologist, OMCFH/BPH (2011-2023)
WV Violence & Injury Prevention Epidemiologist, OMCFH/BPH (2011-2015)
Research Assistant, WVU (2008-2011)

David Didden, MD
Physician Director – OMCFH Medical Director
Medical Director for Overdose Prevention and Innovation Projects
Education:
Doctor of Medicine, University of Virginia School of Medicine, Charlottesville, VA, 1999
Professional:
Physician Director, WV Office of Maternal, Child, & Family Health, (2020-Present)
Medical Director, Overdose Prevention, and Innovation Projects, (2020-Present)
Physician Director, Jefferson County (WV) Health Department, (2013-2019)

Jason Roush, DDS
WV State Dental Director
Education:
Doctor of Dental Surgery, West Virginia School of Dentistry, Morgantown, WV 1998
Professional:
State Dental Director, WV Oral Health Program, OMCFH/BPH (2010-Present)
Medicaid Dental Director, Bureau of Medical Services (2010-Present)

The Office participates in West Virginia's civil service employment system that is governed by its Division of Personnel (DOP). The DOP works with agencies to establish criteria for personnel classifications, develop registers of qualified applicants and assures that agencies follow established policies and procedures. As the post-pandemic employment environment continues to have a lack of employees available in the job market, efforts for retention of current employees have become paramount. The Office makes every effort to increase employee salaries as allowable within DOP policy, as well as encourage current employees to apply for vacant internal positions as they are applicable and qualified. The DOP has also increased the market salary rate for several classifications, allowing the Office to be more competitive in the job market for recruitment of new employees. Both recruitment and 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).

To improve workforce capacity, the OMCFH leadership actively participates in offerings 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 can participate in various Department of Health 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, 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.

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 WV 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 Office has filled all its Division Director positions across its six new Divisions since reorganization in late 2023/early 2024. This accomplishment is due in large part to the leadership of our WV Title V Director, James "Jim" Jeffries, and the support of our Commissioner's Office. At the time of this report, Jim has announced his retirement planned for Monday, July 8, 2024. Jim's knowledge, support, experience, and leadership will be sorely missed in the months and years to come, but his legacy in WV Title V is in the employees of the OMCFH that he has adeptly mentored each day and in the services that the OMCFH provides to WV families daily. His presence in the OMCFH will be greatly missed, but we will still see him around Charleston in the grocery store stocking Coca Cola™ or coaching under the Friday night lights at Sissonville High School.

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.

WV has worked to develop a culture of family engagement that reflects the communities served. Families are well represented, respected and equal partners in the work we are doing. Their voices need to guide the program work and decision making when we are discussing new projects, form changes, workgroup activities and community events.

OMCFH will re-convene Family Advisory Focus Groups (FAFG) for families who receive Title V MCH services on a regional basis. Eight regional HealthCheck specialists will work with OMCFH programs to ensure families and representatives are present for the regional meetings to be held twice annually. The parents will be provided with a stipend for participating in the meetings and their role in decision-making. The hope is to amply the parent voice. OMCFH will start incorporating racial equity activities, ensure equity training resources are available for staff and review program data and policies with a racial equity lens.

As the FAFGs are developed, OMCFH will utilize both parent leaders within existing programs and the WV Family-to-Family Health Information Center to encourage and empower parents to participate. Family-to-Family Health Information Centers are family-led centers funded by HRSA to provide critical support to families caring for children and youth with special health care needs. They will assist with needs assessments, focus groups and activity development for children and families.

OMCFH will utilize the FAFGs to develop a plan for OMCFH to broaden the discussion on social determinants of health and trauma on families served. In addition, presentations will be shared with public and private partners on the work within the family advisory focus groups to further strengthen the role of families in addressing social determinants of health and two generation traumas. This work will provide parent input in federal grant applications and embed the knowledge into day-to-day activities within OMCFH.

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 cyshcn populations. Through these collaborations, children with special needs and their families have an opportunity to participate in the design of community-based programs which promote 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 support 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. Parent Network Specialists continue to cultivate parent leaders, connect families, build informal support systems for families, and ensure a parent voice for systemic changes. The OMCFH continues to work in partnership with the WVUCED and serve as a partner involved in the West Virginia's Family-to-Family Health Information Center (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 to transition to adult health care; and (3) ensuring that all children have access to adequate insurance coverage. This approach provides 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 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 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 video training and then attend a student lecture presentation by those parents they met in the video. The last component, the parent interview, provides an 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.

The OMCFH provides 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 initiative 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. 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.

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).

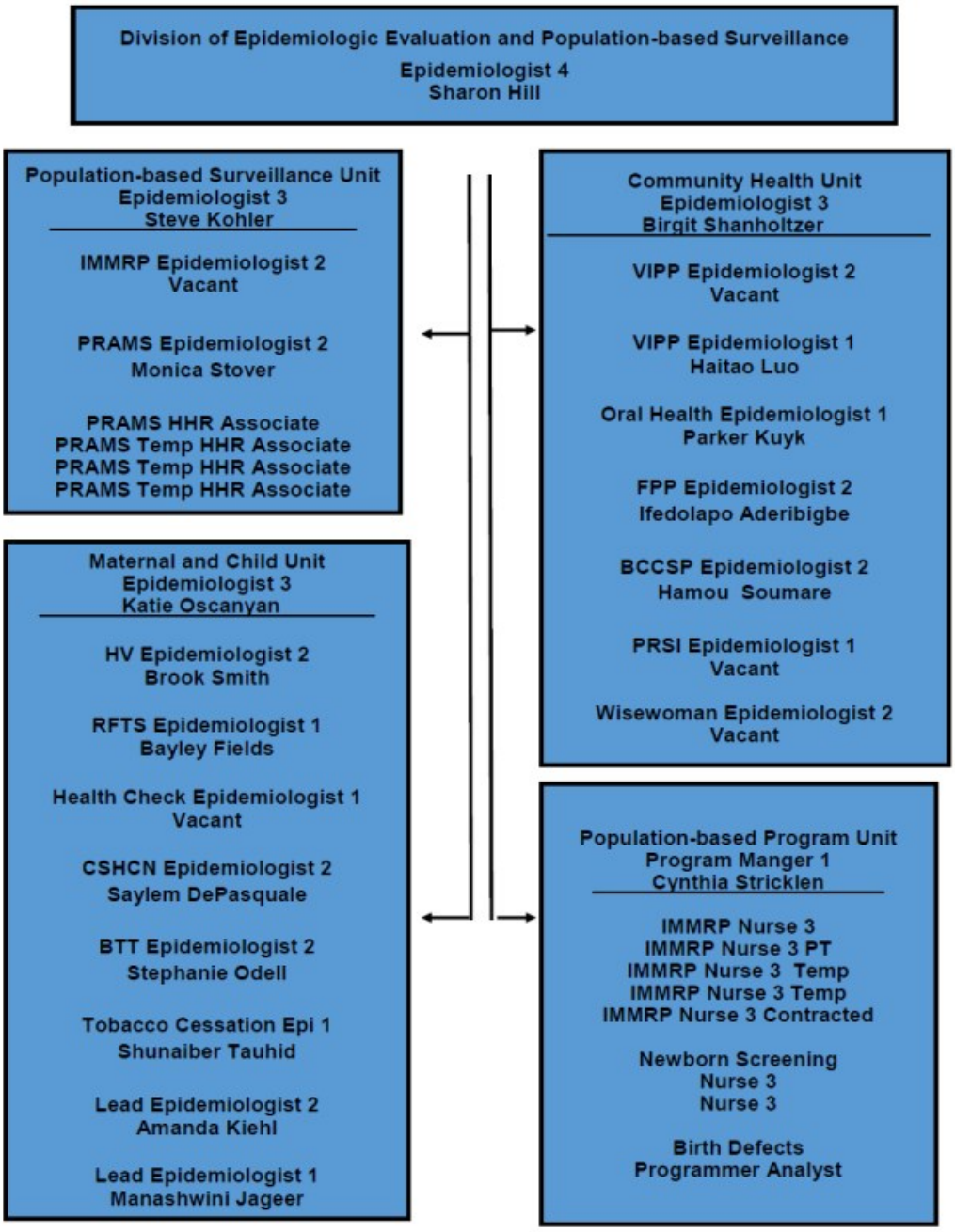
OMCFH has also done work to enhance recruitment and retention plans for Epidemiologists. The Division formerly called Research, Evaluation and Planning has been reorganized and renamed the Division of Epidemiologic Evaluation and Population-based Surveillance. The Division Director position has been reclassified from Program Manager 2 to an Epidemiologist 4. The new organization structure of this division is provided below. This new structure provides higher level of support to the Epidemiologists within OMCFH and provides a career ladder within the office.

The Office also 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 epidemiology capacity is encouraged. This year OMCFH paid for 4 Epidemiologists to take part in the Johns Hopkins Summer Institute, each taking one or two Epidemiology courses to enhance their skills. OMCFH also 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. 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.

Most 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.

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


Division of Epidemiologic Evaluation and Population-based Surveillance
Epidemiologist 4
Sharon Hill
Population-based Surveillance Unit
Epidemiologist 3
Steve Kohler
IMMRP Epidemiologist 2
Vacant
PRAMS Epidemiologist 2
Monica Stover
PRAMS HHR Associate
PRAMS Temp HHR Associate
PRAMS Temp HHR Associate
PRAMS Temp HHR Associate
Maternal and Child Unit
Epidemiologist 3
Katie Oscanyan
HV Epidemiologist 2
Brook Smith
RFTS Epidemiologist 1
Bayley Fields
Health Check Epidemiologist 1
Vacant
CSHCN Epidemiologist 2
Saylem DePasquale
BTT Epidemiologist 2
Stephanie Odell
Tobacco Cessation Epi 1
Shunaiber Tauhid
Lead Epidemiologist 2
Amanda Kiehl
Lead Epidemiologist 1
Manashwini Jageer
Community Health Unit
Epidemiologist 3
Birgit Shanholtzer
VIPP Epidemiologist 2
Vacant
VIPP Epidemiologist 1
Haitao Luo
Oral Health Epidemiologist 1
Parker Kuyk
FPP Epidemiologist 2
Ifedolapo Aderibigbe
BCCSP Epidemiologist 2
Hamou Soumare
PRSI Epidemiologist 1
Vacant
Wisewoman Epidemiologist 2
Vacant
Population-based Program Unit
Program Manger 1
Cynthia Stricklen
IMMRP Nurse 3
IMMRP Nurse 3 PT
IMMRP Nurse 3 Temp
IMMRP Nurse 3 Temp
IMMRP Nurse 3 Contracted
Newborn Screening
Nurse 3
Nurse 3
Birth Defects
Programmer Analyst

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 Epidemiologic Evaluation and Population-based Surveillance (DEEPS) and the Project Director is the Division Director who is a Senior Epidemiologist within the Bureau for Public Health (Epidemiologist 4). Having senior epidemiological leadership 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, 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. DEEPS currently houses three Epidemiologist III supervisors who oversee the MCH Epi Unit consisting of 17 Epidemiologists that support OMCHF programs. Three additional Epidemiologist positions are being developed to build additional support for OMCFH programs.

Recent Accomplishments:

SAS

OMCFH has purchased updated SAS software for all Epidemiologists within OMCFH. The Epidemiology unit has also had several members participate in training courses given by SAS. SAS is also being used to create back up files for many of the databases to ensure continuity if data stored in other software is lost. Analysis codes have been created and shared across the unit and plans are in place to begin using SAS as the primary analysis tool within OMCFH.

Tableau

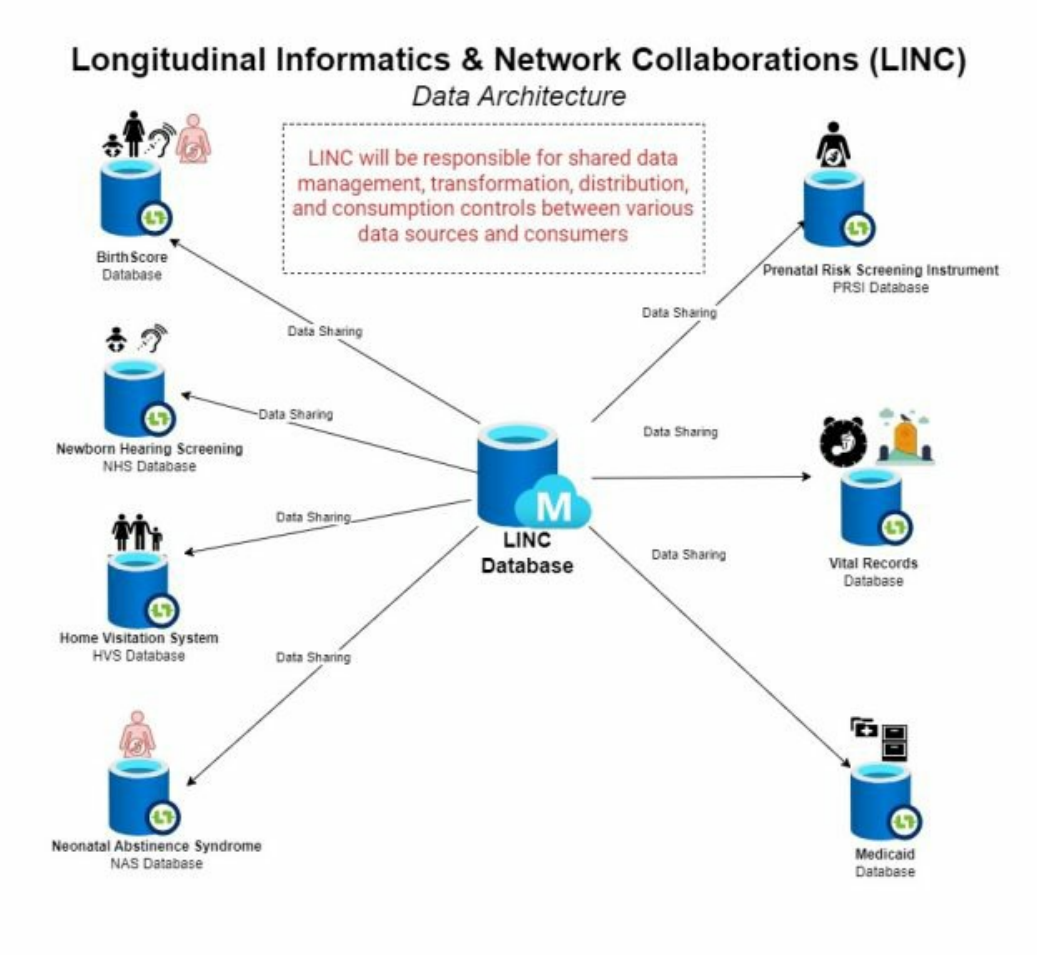
BPH has acquired additional software for the Epidemiologists across the bureau to use for analysis and dissemination of public health data. OMCFH plans to use this software to build public facing dashboards to report surveillance and evaluation data concerning maternal, child, and family data in a timely fashion. This software can also be used to display OMCFH specific measures to show progress towards goals identified within the OMCFH State Plan.

Longitudinal Surveillance

OMCFH has begun working with vendor Local Data Solutions (LDS) to link OMCFH data systems together to create a longitudinal surveillance system. Because many of OMCFH data systems are hosted by LDS, plans are currently underway to build the Longitudinal Informatics & Network Collaboration (LINC), a web-based data linking hub will be responsible for hosting and managing stand-alone shared data and services for OMCFH. This will include management application programming interface (API) and metadata services and will provide a central location that will facilitate user access and system access to multiple data sources. Users will be able to access the system directly or through other software systems that have direct LINC data API integration enabled.

LINC will be a central place for data management, transformation, distribution, and consumption controls. Users will be able to manage their own data or request access to other data sources. Plug-in components will allow OMCFH

Programs and ventures, i.e., Maternal, Infant, and Early Childhood Home Visitation Home Visitation System (HVS), Project Watch (aka Birth Score), Newborn Hearing Screening (NHS) and Prenatal Risk Screening Instrument (PRSI – aka uniform maternal risk screening tool), to pull in data from other data sources into their respective systems to cross check and improve data accuracy. Vital statistics and WV Medicaid data will also be incorporated into this system.



Maternal and Infant Mortality

WV also continues to utilize the Fetal & Infant Mortality Review (FIMR) database and continues to capture infant mortality data and the CDC Maternal Mortality Review Information App (MMRIA) database to capture more extensive data on maternal deaths. However, OMCFH is looking to decrease lag in time between death and review and add additional sources of data for the abstraction process. Building data capabilities for chart abstraction included partnering with the WV Health Information Network (HIE) to expand access to clinical records to improve data quality. To further improve data quality, WV has also joined the NASPHIS State and Territorial Exchange of Vital Events (STEVE) system to improve the out of state record exchange. These changes, along with hiring additional nurse abstractors has enabled WV to expedite the review process to hopefully have all maternal and infant deaths abstracted within one year of death, reviewed by the IMMRP panel within 18 months of death, and be included in the annual legislative report within two years. Currently, OMCFH is reviewing the 2021, 2022, and 2023 infant and maternal deaths and expects the legislative report due in December 2024 to include these reviews and recommendations made by the review committees.

PRAMS

In May 2023, the WV PRAMS program implemented their web survey module, complementing the existing mail and phone survey data collection methods. This additional data collection method aims to assist with increasing response rates for the WV PRAMS survey.

Maternal Morbidity

West Virginia's Department of Health, Office of Maternal, Child and Family Health (OMCFH) applied for the State Maternal Health Innovation funding opportunity (HRSA-24-047), planning to build additional severe maternal mortality surveillance as a major component of the application. If funded, the proposed project would enhance maternal health surveillance and data capacity by modeling the Maryland Maternal Health Innovation Program, MDMOM, from Johns Hopkins University (Wolfson et al., 2022). Using the American College of Obstetricians and Gynecologists (ACOG) and the Alliance for Innovation on Maternal Health (AIM) definitions for Severe Maternal Mortality (SMM), SMM cases will be identified through hospital discharge records and OMCFH nurse abstractors will be used to abstract hospital records, provider records, and OMCFH data to help offer a more complete picture of the mother's care prior to the hospitalization under review. These case studies, case summaries, or aggregate data would be provided back to the participating hospital for review.

This project has the potential to provide more information on maternal health in West Virginia than is available currently. Providing additional data on prenatal risk screenings, prenatal care, and other data outside of the inpatient record could help identify innovative ways to address severe maternal morbidity statewide while still improving the care provide within the hospital stay. In short, this project could benefit both the hospitals in the AIMS work to improve care within the hospitals and how OMCFH supports women's health across West Virginia.

National Survey of Children's Health

West Virginia intends to sponsor a general oversampling of the 2025 National Survey of Children's Health to provide more precise population and National Performance Measure estimates, specifically for children and youth with special health care needs. Without oversampling, the estimates provided have wide confidence intervals. More precise estimates will allow the Office of Maternal, Child, and Adolescent Health to better ascertain their progress towards improving the system of care for CSHCN. The oversampling methodology aims to double the 2025 base sample. The Census Bureau estimates to achieve this by adding an additional 4,800 West Virginia addresses must be sampled at a cost of $20.15 per address and $96,720 total. The data will be available in the fall of 2026.

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 2022, OMCFH reclassified the director position for the research division from a program manager 2 to and Epidemiologist 4. This reclassification provides OMCFH with higher level Epidemiologic management not previously available to the offices within BPH. Previously, only the BPH State Epidemiologist position used this classification.

Currently, OMCFH employs one Epidemiologist IV, three Epidemiologist IIIs, ten (3 are vacant) Epidemiologist IIs and seven (2 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), 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 can capture and analyze statistical information across a wide range of public health topics impacting maternal and child health. The OMCFH has access children's records, occurrence births, birth defects using a passive system, newborn hearing screening, newborn metabolic screening, State Unintentional Drug Overdose Reporting System (SUDORS), 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, infant and maternal mortality review, childhood lead poisoning, Medicaid eligibility, breast and cervical cancer screening and foster children data.

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.

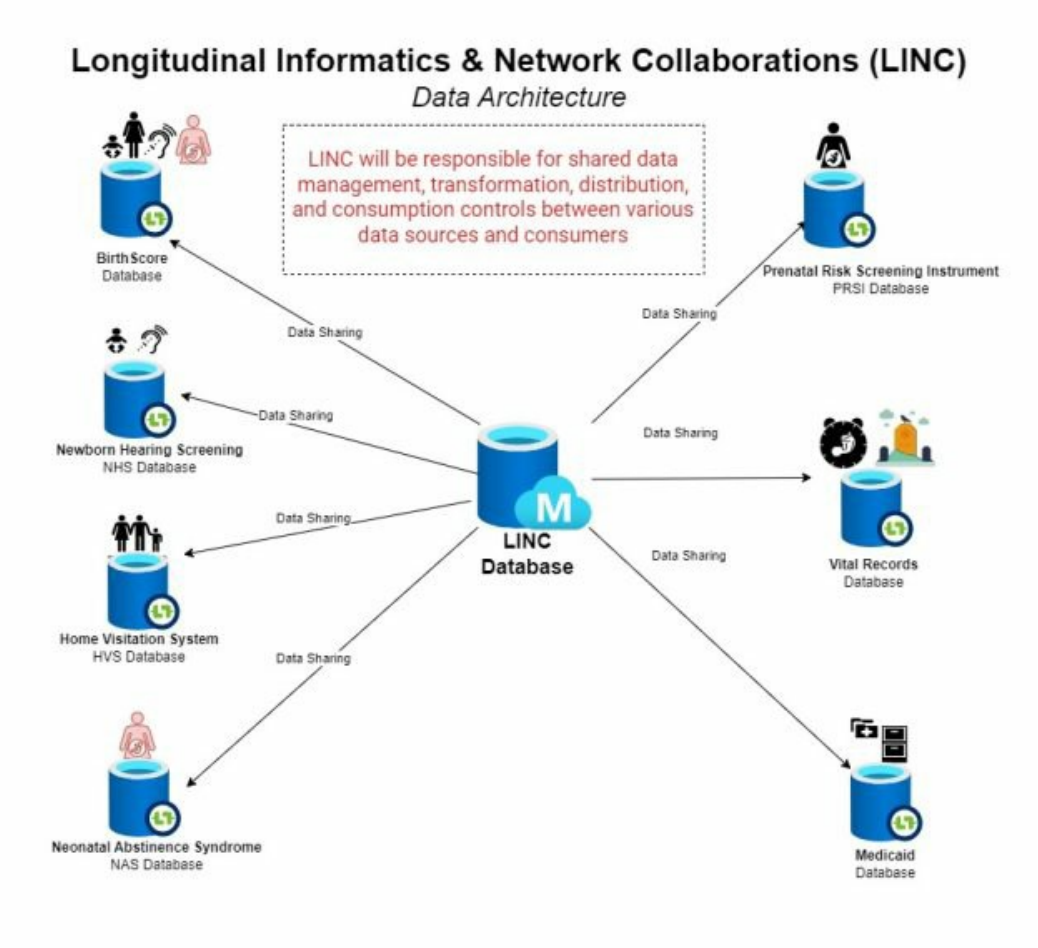
The Hospital Association also provides data on hospital discharges and OMCFH's has developed a partnership with the state's Health Information Exchange, The WV Health Information Network (WVHIN). This partnership provides access to patient records for the abstraction process. OMCFH is also working with WVHIN to develop reports that can provide the necessary information needed for IMMRP more quickly. The WVHIN is also in discussions for providing health records for the longitudinal surveillance system that is being developed.

OMCFH intends to sponsor a general oversampling of the 2025 National Survey of Children's Health to provide more precise population and National Performance Measure estimates, specifically for children and youth with special health care needs. Without oversampling, the estimates provided have wide confidence intervals. More precise estimates will allow the OMCFH to better ascertain their progress towards improving the system of care for CSHCN.

The oversampling methodology aims to double the 2025 base sample. The Census Bureau estimates to achieve this by adding an additional 4,800 West Virginia addresses and data will be available in the fall of 2026.

OMCFH obtained funding from the Centers for Disease Control and Prevention to develop a WV Neonatal Abstinence Syndrome (NAS) Surveillance System. So far, OMCFH has imported 2023 NAS vital registration birth data, WV Birth score data, and WV Hospital Discharge data into the system. The WVHIN is working to produce a data file for NAS from the HIE using ICD10 codes and electronic health record notes that will also be added to the system. To increase data collection capabilities, OMCFH currently employs one nurse abstractor that reviews these records, requests, and abstracts medical records for the NAS cases, and enters the additional data into the system as part of the WV NAS Surveillance System. NAS cases will be determined using the Council of State and Territorial Epidemiologist Maternal and Child Health's Updated Neonatal Abstinence Syndrome Case Definition for analysis and reporting purposes.

A longitudinal surveillance system that will eventually link all OMCFH data sources together is under development. OMCFH is working with a vendor (Local Data Solutions) to develop the Longitudinal Informatics & Network Collaborations (LINC), a web-based data linking hub that will be responsible for hosting and managing stand-alone shared data and services. This will include management API and metadata services and will provide a central location that will facilitate user access and system access to multiple data sources. Users will be able to access the system directly or through other software systems that have direct LINC data API integration enabled. LINC will be a central place for data management, transformation, distribution, and consumption controls. Users will be able to manage their own data or request access to other data sources. Plug-in components will allow OMCFH Programs and ventures, i.e., Maternal, Infant, and Early Childhood Home Visitation Home Visitation System (HVS), Project Watch (aka Birth Score), Newborn Hearing Screening (NHS) and Prenatal Risk Screening Instrument (PRSI – aka uniform maternal risk screening tool), to pull in data from other data sources into their respective systems to cross check and improve data accuracy.



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

Currently, the OMCFH is not heavily involved in the state's emergency preparedness and response planning activities. With the restructuring of the former Department of Health and Human Resources and leadership changes within the Center for Threat Preparedness (CTP), there is opportunity to approach this topic with fresh perspectives. The existing emergency operations plan for the former DHHR 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 is currently working with a vendor to link all OMCFH data systems with vital statistics and Medicaid. While this work isn't specifically for preparedness planning, using this linked data retrospectively will allow OMCFH to compare health issues pre and post COVID19 to determine how that public health emergency may have impacted the health of women, infants, and children in West Virginia.

On April 2, 2024, certain areas of the state were impacted significantly by a severe weather event that resulted in ten confirmed tornadoes, high straight-line winds, and subsequent flooding from storm-associated rains. This event set a state record for the most tornadoes observed in the state on any calendar day. As expected with such an event, multiple power outages, downed trees, and structures, and flooding impacted residents, especially the lives of our most vulnerable children and youth with special health care needs (cyshcn). Over the next year in collaboration with the CTP, Emergency Preparedness, and the Office of Emergency Medical Services (OEMS), the OMCFH will develop a resource guide of the most up-to-date state and community resources available to educate and inform families of cyshcn so they are as best prepared to deal with future adverse weather conditions as possible.

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 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.

One of the many strengths of the OMCFH is the formalized agreement between the OMCFH and the MCOs. The collaboration between the OMCFH and the MCOs benefit from the use of data to support policy initiatives as well as providing cogent analysis in the areas of public health surveillance, resource management and quality and performance measurement which in turn improves the administration of the Medicaid program and outcomes for the Medication population. Together the MCOs and OMCFH programs have the capacity to reduce fragmentation and offer a seamless approach to meeting children's needs; deliver needed supports and services in a cost-effective manner; offer a continuum of acute care services, which include an array of home and community-based services. This partnership will assist with the already established MOU joint responsibilities of a comprehensive quality approach across care services, stakeholder involvement in the development of processes improve outcomes of families enrolled. The MOU also ensures joint provision of necessary data on a mutually acceptable schedule to facilitate client care. In addition, the activities outline will ensure the MOU requirement to enhance partnerships between primary care providers and socially necessary services serving our most vulnerable population of children within the foster care system.

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 the OMCFH.

A multi-tiered process within the OMCFH which also incorporates new technology with web-based resource and referral platforms has increased capacity no not only reach partners, such as the medical community, local community partner, private business partners, faith-based communities, and families. This muti-tiered approach represents the concept of "it takes a village" to raise a child and family.

The OMCFH recognizes the knowledge and expertise from public and private partners to provide an insight on previous and ongoing efforts that have and will continue to enable commitment and willingness to pool resources at both the State and local levels.

The OMCFH will strive to utilize public and private partnerships to incorporate relationships on three levels: 1) Individual/Family; 2) Community; and 3) Coordinated Provider System. At the individual and family level, the OMCFH goal will be to reduce disparities in the health and well-being of pregnant and parenting families. At the community level, the goal will be to work with local partners and parents to ensure a strong collaborative is present to identify and provide comprehensive coordinated services across multiple sectors which would ensure that continuum of care. The OMCFH will continue to work at the state level to strengthen and enhance systems of care for families served into the broader public health system, deepening state capacity to provide some level of public health care to

all families. In addition, the OMCFH will take a facilitating role to leverage civic leadership and fiscal resources from both traditional and nontraditional partners to provide that continuum of care needed to reach the goal of improved maternal, infant, and family outcomes in WV. The overarching goals will be to: 1) Focus on child and family needs and outcomes; 2) Signal the importance of key issues with all partners involved; 3) Be accountable and transparent to funders, policymakers, and families; 4) Engage multiple agencies and organizations from varied backgrounds, and families to work towards the same outcomes; 4) Improve and sustain the quality of programs for families.

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

Since the last report, there have been significant changes in the organizational structure of the former Department of Health and Human Resources (DHHR), which ceased to exist on December 31, 2023. The State Title V Agency is organizationally located within one of three new state-level Departments (the West Virginia Department of Health/WVDH) and remains within the Bureau for Public Health. The State Title XIX Agency (WV Medicaid) is now in a sister Department (the West Virginia Department of Health Services/WVDoHS) and is itself a bureau within its Department (WV Bureau for Medical Services/BMS). Despite these changes, the Departments are still primarily collocated in downtown Charleston and maintain a close working relationship across many areas. At the time of this report, the annual IAA is routing for final signatures and a draft copy is included.

This partnership extends to significant financial support for 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. 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.

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. As a result, Right From the Start also increased home visitation services for up to one year. 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.

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. The WV HealthCheck Program 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., AAP *Bright Futures* Guidelines, 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.

The Bureau for Medical Services, Center for Managed Care implemented a new 1915 (b) waiver effective March 1, 2021 called Mountain Health Promise (MHP). The MHP program serves specialized managed care for children and youth. Mountain Health Promise assists children in foster care, kinship care and adoptive care. Aetna Better Health of West Virginia is the single managed care organization for MHP. Members eligible for the Children with Serious Emotional Disorder Waiver (CSEDW) are automatically enrolled with Aetna Better Health of West Virginia. The OMCFH continues to work closely with Aetna and the relationship has grown in a positive direction, including no less than monthly meetings and ongoing communication related to care coordination for those members also enrolled in the CSHCN Program. Continued efforts to enhance information sharing and create a "meeting place" for a child's medical home team and his/her records include the recent allocation of an Aetna RN with a Health IT background to work with OMCFH staff as upgrades take place to the EHR portal for MHP, Family Central (formerly Family Connect). In the future, CSHCN staff will have enhanced access to enrolled CSHCN's medical records, including medical service claims and the MCO care plan, to provide improved care coordination services in collaboration with its Medicaid partner. 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.

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

State Action Plan Introduction

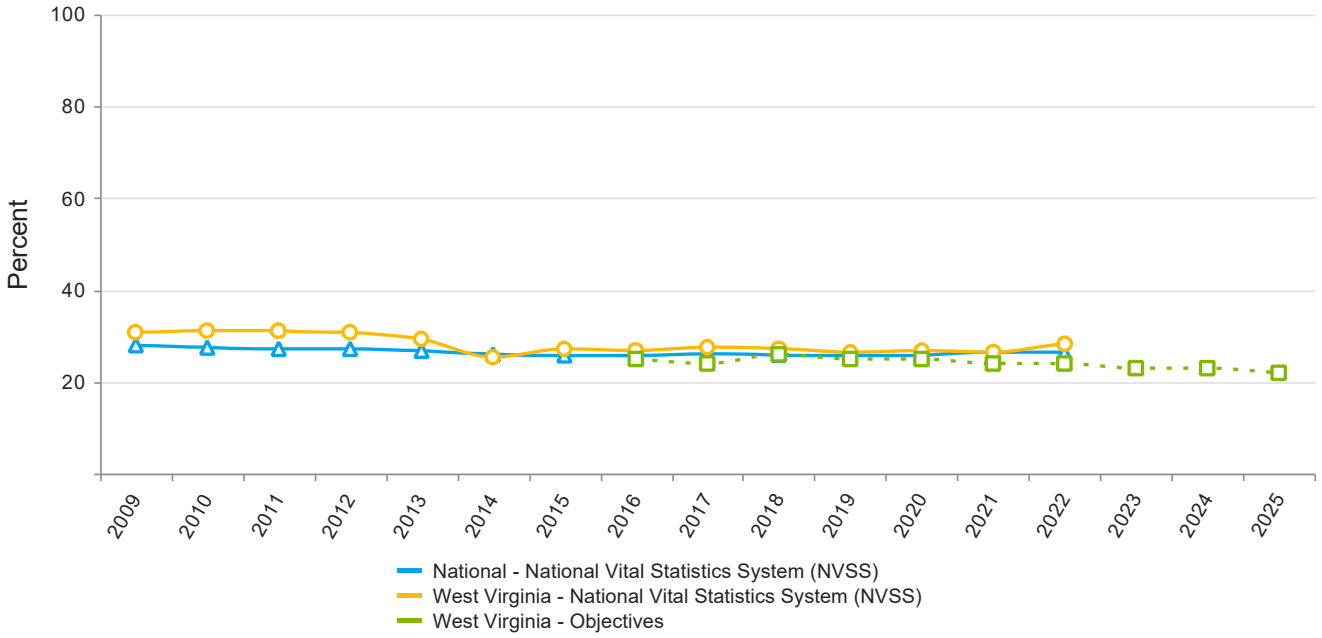
West Virginia approaches the State Action Plan from a perspective of addressing each priority identified in the 5 Year Needs Assessment. Detailed strategies are then developed to address each of these priorities. Strategies are based upon the ability of each program's capacity to implement activities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

Women/Maternal Health

National Performance Measures

NPM - Percent of cesarean deliveries among low-risk first births (Low-Risk Cesarean Delivery, Formerly NPM 2) - LRC

Indicators and Annual Objectives



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	25	25	24	24	23
Annual Indicator	27.3	26.3	26.9	26.6	28.3
Numerator	1,598	1,528	1,498	1,475	1,560
Denominator	5,845	5,811	5,571	5,554	5,509
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	23.0	22.0

Evidence-Based or –Informed Strategy Measures

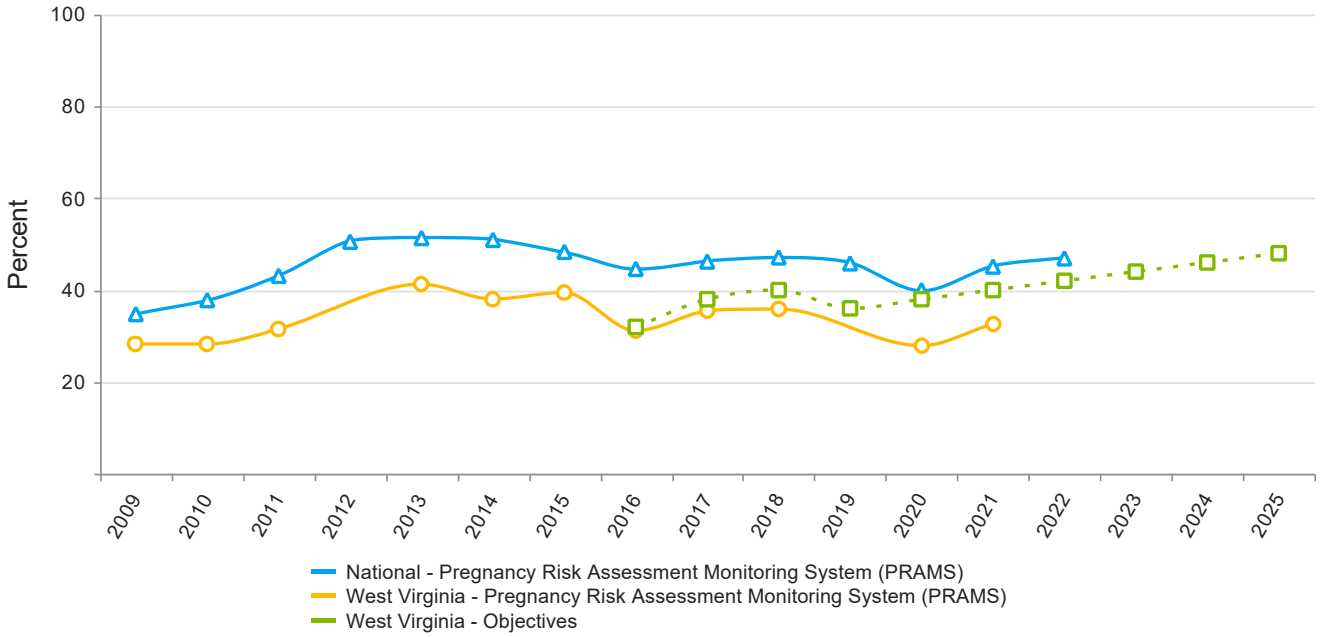
ESM LRC.2 - Percentage of birthing facilities that have received Evidence-based Labor Support Training through the Perinatal Partnership.

Measure Status:	Active

State Provided Data			
	2021	2022	2023
Annual Objective			40
Annual Indicator	38.1	33.3	38.1
Numerator	8	7	8
Denominator	21	21	21
Data Source	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	50.0	60.0

NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy
Indicators and Annual Objectives



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	36	38	40	42	44
Annual Indicator	36.0	36.0	28.0	32.7	32.7
Numerator	5,633	5,633	4,157	4,827	4,827
Denominator	15,656	15,656	14,835	14,750	14,750
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2018	2020	2021	2021

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	36	38	40	42	44
Annual Indicator					37.1
Numerator					5,323
Denominator					14,367
Data Source					PRAMS
Data Source Year					2022
Provisional or Final ?					Final

Annual Objectives		
	2024	2025
Annual Objective	46.0	48.0

Evidence-Based or –Informed Strategy Measures

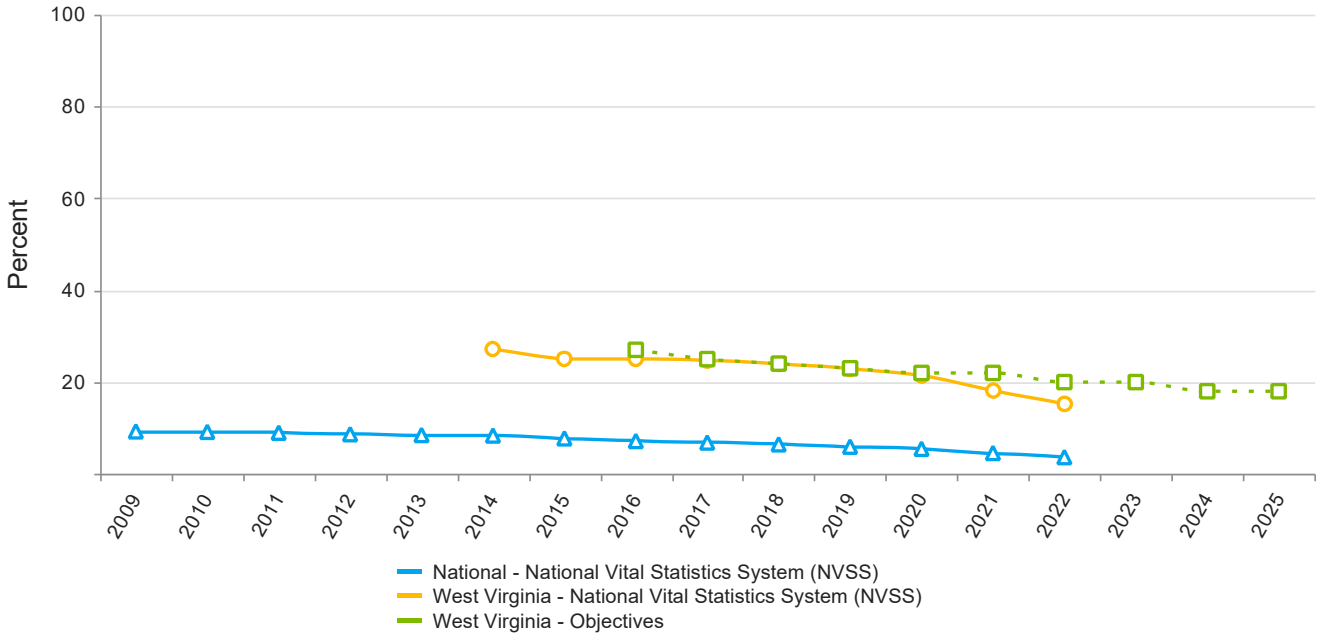
ESM PDV-Pregnancy.2 - Expectant and recently postpartum mothers who receive oral health education.

Measure Status:	Active

State Provided Data			
	2021	2022	2023
Annual Objective			10
Annual Indicator	0.6	1	3.5
Numerator	100	165	606
Denominator	17,327	16,595	17,550
Data Source	Oral Health Progam/Vital Statistics	Oral Health Program/Vital Statistics	Oral Health Program/Family Resource Network
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives		
	2024	2025
Annual Objective	15.0	25.0

NPM - Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	23	22	22	20	20
Annual Indicator	23.9	23.0	21.4	18.2	15.3
Numerator	4,337	4,161	3,697	3,134	2,589
Denominator	18,138	18,106	17,312	17,190	16,913
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	18.0	18.0

Evidence-Based or –Informed Strategy Measures

ESM SMK-Pregnancy.1 - Number of health care workers who have had Help2Quit maternity care provider training

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	350	300	300	320	320
Annual Indicator	217	245	137	413	304
Numerator					
Denominator					
Data Source	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives		
	2024	2025
Annual Objective	340.0	340.0

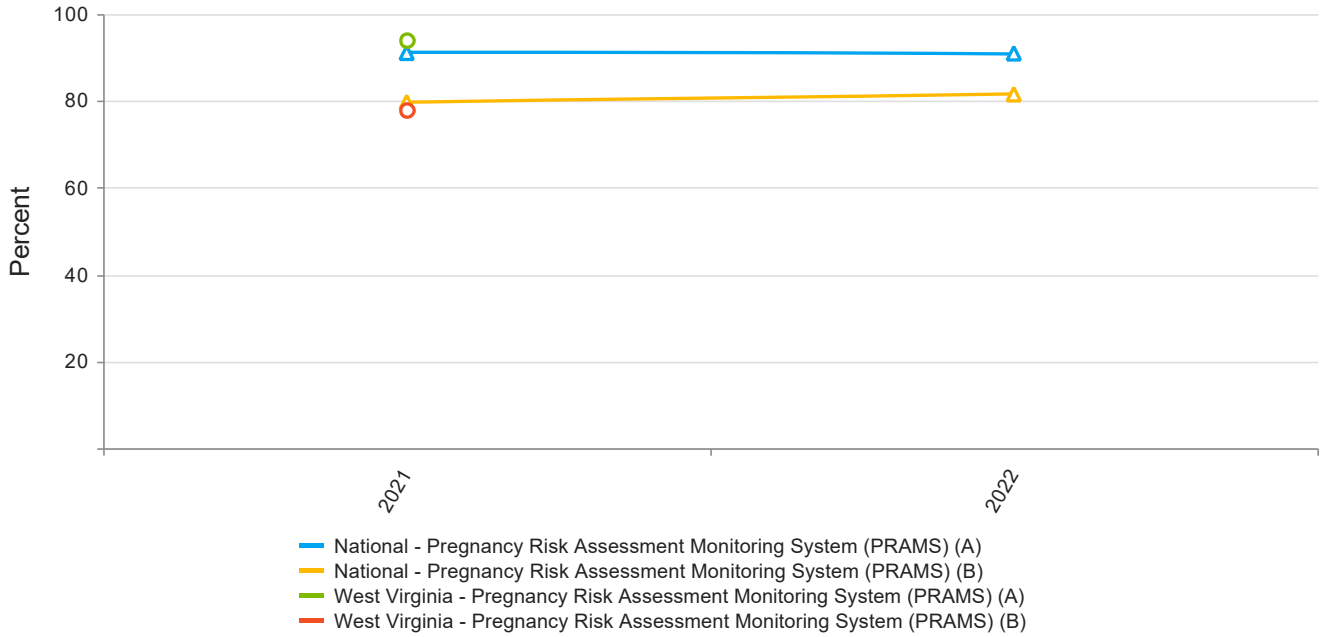
ESM SMK-Pregnancy.2 - Percent of women enrolled in HV who reported using any tobacco products at enrollment and were referred to tobacco cessation within 3 months of enrollment.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	60	50	55	60	65
Annual Indicator	41.5	52.7	73	68.3	62.5
Numerator	85	178	197	211	272
Denominator	205	338	270	309	435
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	70.0	75.0

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 recommended care components (Postpartum Visit) - PPV
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	93.8
Numerator	13,792
Denominator	14,711
Data Source	PRAMS
Data Source Year	2021

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	77.7
Numerator	10,607
Denominator	13,659
Data Source	PRAMS
Data Source Year	2021

Evidence-Based or –Informed Strategy Measures

None

State Performance Measures

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

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			8	6	6
Annual Indicator	6.9	8.1	6.6	7	5.2
Numerator	776	737	585	605	440
Denominator	11,203	9,059	8,848	8,651	8,521
Data Source	PRSI	PRSI	PRSI	PRSI	PRSI
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	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 - Percent of cesarean deliveries among low-risk first births (Low-Risk Cesarean Delivery, Formerly NPM 2) - LRC	
Five-Year 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 LRC.1 - Number of first time pregnant women who have participated in the Lamaze International Evidence Based Labor Support Workshop.	Inactive
ESM LRC.2 - Percentage of birthing facilities that have received Evidence-based Labor Support Training through the Perinatal Partnership.	Active
NOMs	
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	

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

Priority Need

Increase dental care specifically during pregnancy.

NPM

NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy

Five-Year 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 PDV-Pregnancy.1 - Establish a curriculum for WVU School of Dentistry on dental care for pregnant women.	Inactive
ESM PDV-Pregnancy.2 - Expectant and recently postpartum mothers who receive oral health education.	Active

NOMs

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

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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 - Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy

Five-Year 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 SMK-Pregnancy.1 - Number of health care workers who have had Help2Quit maternity care provider training	Active
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.	Active

NOMs

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 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

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

NPM

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 recommended care components (Postpartum Visit) - PPV

Five-Year Objectives

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.

Strategies

Develop no less than one (1) educational product on PPV to be disseminated at community baby showers.

ESMs Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

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.

State Action Plan Table (West Virginia) - Women/Maternal Health - Entry 5

Priority Need

Address substance use in pregnancy and in youth/teens.

SPM

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

Five-Year 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

The OMCFH, in partnership with the Perinatal Partnership's CDC Perinatal Quality Collaborative capacity grant, is participating in the Risk Appropriate Care (RAC), a quality improvement strategy that endeavors to assure that babies are born in a hospital with the appropriate level of nursery, and that mothers with high-risk conditions give birth in a facility that is best prepared to meet their needs. The OMCFH participates in the Pre-Term Birth workgroup. An analysis of preterm birth incidence in each facility, as well as by county of mother residence was completed using data from Project Watch. There were 9,601 infants born preterm out of 86,447 singleton births during the 5-year reporting period between May 2018 and April 2023. The rate of preterm birth was 111 per 1000 live births (11.11%). The rate of preterm birth was statistically significantly higher during the pandemic at 11.41% vs. 10.64% during the pre-pandemic time. Out of the 55 counties in West Virginia, there were 6 counties where the preterm birth rate was more than 14% (140 per 1000 live births) (Boone, Wyoming, Mingo, Mason, and Mineral). The preterm birth rate was significantly higher in urban vs. rural regions of the state. Using the NCHS classification system, data showed that metropolitan areas had significantly higher rates of preterm birth. This includes small metro and medium metro areas vs. non-core regions.

Preterm birth increased as the maternal age increased. The black race had the highest rate of preterm births than any other race. Those with less than a college education had higher rates of preterm birth. Pregnant individuals enrolled in the Medicaid health insurance program had higher rates of preterm birth compared to those on private health insurance. Those with diabetes (Type 1, Type 2, gestational) were more likely to have a preterm birth compared to those with no diabetes. The preterm birth rate increased as the number of pregnancies increased. Smoking and substance use during pregnancy included opioids, cannabinoids, stimulants, antidepressants, sedatives, gabapentin, and alcohol use in pregnancy were associated with preterm birth.

Preterm birth increases the risk of infant death before hospital discharge, low birth weight (< 5 lbs. 8 oz), NICU admission, low 5-minute Apgar score (< 7), longer length of hospital stay, and high Birth Score. Moreover, preterm birth infants were less likely to be exclusively breastfed for the duration of their hospital stay from their birth to the hospital discharge.

To expand community outreach, the OMCFH supports efforts to promote education on risk factors for pre-term birth. The WV Perinatal Partnership (WVPP), in partnership with the Marshall University Office of Minority Health, held a live webinar with in-person and online offerings at Marshall University on November 30, 2023. Information regarding risk factors for preterm birth, preterm birth risk statistics, and information on self-care for pregnant women was presented.

A session on Harnessing Breast and Cervical Cancer Screening Program (BCCSP) and WV Family Planning (WVFPP) Health Visits to Identify and Manage Undiagnosed Hypertension, Emphasizing Preconception Care was conducted at the Second Annual Breast and Cervical Cancer Screening Training Collaborative on April 9, 2024. Post-test results showed a 34% increase in learning about low-dose aspirin being safe for pregnant women with high risk factors for hypertension. The Training Collaborative included BCCSP and WVFPP providers and staff, community health workers, volunteers, and Medicaid Managed Care Organizations. There were 134 attendees in total, with 62 of those in-person and 72 virtual.

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

Promote Doulas in WV Perinatal Care

The Doula Advisory Committee meets bi-monthly and is represented by the OMCFH Division of Women's and Family Health (DWFH), the OMCFH Division of Infant, Child, Adolescent, and Young Adult Health (DICAYAH), obstetricians, nurse midwife, representative from a Medicaid Managed Care Organization, doula, labor and delivery nurse, and WV Perinatal Partnership. The committee is currently reassessing the committee members' make-up, with plans to broaden representation to include community members, including parents and community organizations.

The DWFH Special Projects Coordinator was hired in March 2024 with funds from the Preventive Services Block Grant. This temporary position coordinates special projects related to Women's and Family Health. Work on the

Doula Listening Sessions was initially delayed due to a lag in hiring this position. Work is now back on track. The Division has secured facilitators and Listening Sessions are scheduled for July and August 2024.

The OMCFH is obtaining technical assistance from nearby states on implementing doulas into perinatal healthcare. The WVPP held a Doula Day in March 2024, and sessions included representatives from New York and North Carolina, with information on payment schedules, residency training, health disparities and building supportive partnerships. OMCFH Physician Director and DWFH and DICAYAH Division Directors participated in meetings in February 2024 with the Maryland Department of Health and is currently scheduling site visits.

The OMCFH is collaborating with the WVPP on doula initiatives. Lunch and Learns on Doulas were presented in January and March 2024 at Logan Medical Center and Charleston Area Medical Center Women's and Children's. Attendees included obstetricians, Nursing Directors, Nurse Managers and Labor and Delivery staff. Themes emerging from these sessions included increased awareness of the role of doulas and lack of trust in doulas due to the labor and delivery nurses having no prior relationship with the doulas.

To increase reach, a Doula Directory is being created on the Perinatal Partnership website as well as on the OMCFH Home Visiting Resource Directory. To date, 27 doulas have provided contact information and agreed to be listed in the directory. The term "directory" is being used to avoid confusion with "registering" doulas in the state, which is not a current requirement. There are 39 doulas participating in a network (email group) who receive regular information from the director of the WVPP doula project. To date, more than 50 doulas have participated in the Doulas of North America (DONA) training.

Love Your Birth Control

To promote optimal spacing during pregnancy, the Love Your Birth Control (LYBC) continues to be provided free to any healthcare facility or community group that requests training. From July 2023 to March 2024, five sessions were held. A session at the West Virginia School for Osteopathic Medicine included healthcare providers, medical students, and community health workers. In the last quarter of 2023, two training courses were held for a total of 25 participants. One training course for 30 individuals was held at the Bluefield School of Nursing in March 2023. The Doula Day Workshop included the LYBC course on March 25, 2023, in which 28 people, including 15 doulas, were trained. Materials were displayed and distributed at the Perinatal Summit in September 2023 with new contacts arranging future training.

OMCFH encourages and supports community outreach on perinatal health issues. The Perinatal Partnership conducted community outreach at the Fifth Annual Minority Health Fair in Huntington in September 2023. Materials on hypertension, preterm birth, contraception, smoking cessation, and substance use in pregnancy were distributed.

Provide Lamaze childbirth education

A Lamaze two-day Seminar for Lamaze Certified Childbirth Educators was held in May 2023. OMCFH supports the WVPP credentialing of this program. One Lamaze Evidence-Based Labor Support 1-day course for intrapartum nurses with doulas added to the invitation was conducted on June 1, 2023, in Lewisburg with a total of 10 attendees. The West Virginia Home Visitation Program developed a Home Visitor Resource Directory which included locations of certified Lamaze childbirth educators for use with referrals for prenatal clients requesting Lamaze education.

Promote childbirth education for first-time mothers statewide.
Count the Kicks, a stillbirth prevention program, has provided no-cost literature for hospitals and clinics through the support of OMCFH. There are business sized cards and refrigerator magnets, brochures and posters encouraging mothers to count the baby's kicks in a 10-minute window each day, beginning in the third trimester. In addition, a robust mobile phone app is downloadable for mothers with no charge.

A Count the Kicks webinar was held in November 2023 for stillbirth prevention training for healthcare professionals and community workers. A Count the Kicks webinar was held in February 2024 for doulas. There were 28 in attendance. The webinar included information regarding having movement monitoring conversations with expectant parents and how to use the Count the Kicks app.

Between October and December 2023, 4,455 pieces of Count the Kicks materials were sent out to healthcare professionals and community workers. From January 2024 to March 2024, 2,515 pieces of Count the Kicks

materials were sent out to healthcare professionals and community workers. This included 700 magnets for use as a visible reminder on the refrigerator about the importance of monitoring fetal movement.

The Count the Kicks app, a free tool for women in the 3rd trimester saw 104 new users and 20 returning users during October to December 2023, and 1,439 people in West Virginia visited the Count the Kicks website for an average of 480 people per month and a 49% increase from the 1st quarter. The Count the Kicks app, a free tool for women in the 3rd trimester saw 83 new users and 8 returning users during this quarter. During January to March 2024, 327 people in West Virginia visited the Count the Kicks website for an average of 109 people per month.

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.

The OMCFH has addressed diversity, equity and inclusion in provider education via collaboration with the WVPP, which in turn partnered with the March of Dimes and local presenters to provide education on Diversity, Equity and Inclusion to providers throughout the state. Representatives from the delivering hospitals have completed their education and began conducting presentations for their hospital staff in the fall of 2023. Additionally, curriculum for POST BIRTH, Obstetric Emergency in the ED and fetal monitoring courses include information on racism and bias. Special emphasis was placed on the topic of healthcare provider bias toward black women and impoverished women as well as a focus on hypertension in pregnancy. These efforts were performed in conjunction with the Alliance for Innovation on Maternal Health (AIM) hypertension and hemorrhage bundle activities in collaboration with WV ACOG and the WV Hospital Association.

The OB Emergency skills training was held at several hospitals during this last reporting year. Topics covered were severe hypertension/preeclampsia/eclampsia, postpartum hemorrhage, anaphylactoid syndrome (code blue), breech vaginal delivery, and neonatal resuscitation program drills. The Noelle simulator as well as the Resus-a-blue baby were used for the drills.

An Obstetric Emergencies in the ED was held in April 2023 at Wetzel County Hospital. There were 11 in attendance including emergency department nurses and local EMS. From July 2023 to September 2023, an OB emergency skills training was conducted over two days at Reynolds Memorial Hospital with 24 RNs and 1 MD attending (2 Registered Nurses from Weirton Medical Center & 1 Registered Nurse from Wheeling Hospital attended).

In October 2023, OB Complications in the Emergency Department was presented at the Summersville Arena and Conference Center. There were participants from Summersville and Braxton hospitals as well as local EMTs and FQHCs in the area. Included in the attendance were 5 MDs, 27 nurses and 17 “others”. The event was well received with primarily positive evaluations.

Training was provided at WVU Ruby and Camden Clark Medical Center in November 2024. This training, along with POST BIRTH discharge education, was held at Wheeling Hospital in November 2024 for OB and emergency department staff and residents attending.

Advanced Fetal Monitoring classes were held in Lewisburg and Bridgeport with 18 in attendance (17 Registered Nurses & 1 Certified Nurse Midwife). In October 2023, an Association of Women’s Health, Obstetric & Neonatal Nurses (AWHONN) Advanced Fetal Monitoring course was held at Princeton Community Hospital with participants from Princeton Community Hospital and Greenbrier Valley Medical Center. There were 11 Registered Nurses in attendance, one certified nurse midwife and one physician.

An Intermediate Fetal Monitoring class was held at Stonewall Jackson Hospital in Weston with 4 Registered Nurses in attendance. An AWHONN Intermediate Fetal Heart Monitoring course was presented at Weirton Medical Center in March 2024. There were 9 Registered Nurses in attendance including the nurse manager and nurse educator.

The AWHONN Obstetric Patient Safety (OPS) course was held twice in early December and led by staff from AWHONN. The classes were attended by a total of 15 Registered Nurses and 1 obstetrician. Four Registered Nurses and 1 Physician have completed their “teach back” for the OPS course and are now able to teach the OPS class. Previously there were no instructors in the state. An additional Registered Nurse is an instructor candidate and anticipates completing the required “teach back” in March 2024. This course is a combination of online didactic education and in-classroom short didactic presentations followed by simulation and skills stations. Topics include the following: general information regarding maternal mortality in the United States, maternal mental health, cardiac complications, sepsis, malignant hyperthermia, preeclampsia, and severe hypertension, anaphylactoid syndrome of

pregnancy, postpartum hemorrhage, quantitative blood loss, prolapsed umbilical cord, uterine rupture and post birth warning signs. A presentation was held at Weirton Medical Center with a total attendance of 21, including nurses, physicians, and case managers. Materials were distributed and discussion around post discharge care was conducted with full participation of their team.

The OMCFH also supports the West Virginia Perinatal Summit, which was held in early September with 220 in attendance. Topics covered during the Summit included:

- Current State of Perinatal Health in West Virginia
- Intimate Partner Violence, Substance Use, and Substance Use Coercion:
- Implications for Perinatal Providers
- Learning from Lived Experience: A Conversation with Peer Recovery Support
- Specialists
- Brexanolone and New Frontiers—Recent Innovations in Perinatal Psychiatry
- HRSA Resources for Advancing Maternal health in West Virginia.
- Creating an Inclusive and Affirming health System
- Freestanding Birth Center Updates and How to Facilitate Seamless Transfers of Care
- Adolescent Pregnancy Prevention
- Congenital Syphilis: An overview of Cases in the Mountain State
- Dynamics and Impact of Human Trafficking
- Perinatal Mood and Anxiety Disorders—A Real Mother!
- What Can Postpartum Support International WV Do for You?
- Enhanced Recovery After Surgery for Postoperative Cesarean Delivery Pain: Current Trends
- Perinatal Hepatitis C Exposure: A Multidisciplinary Approach to Management in the Mountain State
- 10,000-foot View: WV State Perinatal Priorities
- Health Consequences to Offspring due to Exposure from Vaping During Pregnancy
- Avoiding Pot Holes: Navigating the Cautionary Trail of Cannabis
- Advanced Life Support in Obstetrics (ALSO) courses, an emergency provider training, was offered pre-Summit with 6 Registered Nurse participants.

The AIM Task Force created and supported an Obstetrical Hemorrhage Escape Room at the WV Perinatal Summit. Multiple teams went through the creative learning activity and positive feedback was received. This escape room is available to travel among the hospitals to utilize for additional training on-site.

The Severe Hypertension Pregnancy Escape Room materials from the 2022 Summit have been available to loan to birthing facilities. Five birthing facilities have used the materials to present this opportunity on-site to their staff. Of approximately 220 attendees, there were 166 evaluations submitted to Survey Monkey. The presentations were highly rated, and largely positive comments were noted.

A Perinatal Spring Conference was held in April 2023 for nurses, physicians, doulas, social workers, and home visitors. There were 104 in attendance with 59 post-conference evaluations completed. The evaluations were positive overall. There was a break-out session for doulas offered. Topics included the following: Avoiding Unnecessary Supplementation, Risk Appropriate Care, Continuous Labor Support, Project Watch Update, Social Determinants of Health: Acceptance of Deviance, Bereaved Motherhood: Supporting Mothers with Substance Use Disorder, Peer Counseling for Mothers with Substance Use Disorder, The Golden Hour, What was Old is New – Syphilis: Diagnosis, Care and Treatment, The Business of Doula Care, and Intimate Partner Violence.

Implement Nurse Family Partnership for first time moms in highest risk counties

WVHVP is near completion of the implementation phase of NFP. The agency profile was developed and approved by the National model. The population characteristics and service area analysis were completed. The organizational mission, culture and structure was finalized and submitted to the National Center. Letters of support from medical partners, community stakeholders and agencies that will be relevant to the success of the program were completed. A draft of advisory board members has been submitted to the National center for review and approval and a contracted staff to provide initial nursing support has been completed. Services will be started in Kanawha County by late Fall 2024.

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 perinatal surveillance ended in December 2023. OHP plans to conduct BSS for the adult population during 2023/2024.

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

The Oral Health program updated the surveillance plan. Perinatal surveillance ended in December 2023. OHP plans to conduct BSS for the adult population beginning in the Fall of 2024.

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

OMCFH continues to participate in the Tobacco Free Families Advisory Council.

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

A Help2Quit/tobacco education training was held in coordination with the WV Oral Health Coalition at Stonewall in August 2023. The tobacco physician champions training included over 120 Oral Health providers.

Help2Quit provider trainings were presented during West Virginia University Grand Rounds with 140 residents/providers and Marshall University Grand Round Training with 44 residents and providers participating in Fall 2023.

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

Right From the Start, the Medicaid case management home visiting model, continued to implement an evidence-based tobacco cessation model to women requesting to quit or reduce smoking. The model utilizes care coordination Designated Care Coordinators (DCCs) to check with clients during home visits on reduction and cessation progress. The DCCs use educational materials, including a handbook and small incentives. In early 2024, a tobacco treatment counseling component was added to the RFTS SCP project. The OMCFH Smoking Cessation Epidemiologist worked with the 8 Regional Care Coordinators (RCCS) to recruit DCCs who were interested in providing a higher level of education and counseling to clients as a billable enhanced service through Medicaid. The selected DCCs were involved in an extensive training program with the Epidemiologist, who is a trained Certified Tobacco Treatment Specialist. A cohort of four DCCs were provided 1–2-hour sessions with role plan twice a month from January 2024 to June 2024. Each of the four DCCs applied for and received a full scholarship to attend the West Virginia University School of Dentistry Certified Tobacco Treatment Specialist training in May 024. The three-month-long, self-paced training will include a final exam before the DCCs can be certified.

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

Baby and Me Tobacco Free Program (BMTFP) – Most of the women who participate in the Baby and Me Tobacco Free Program have Medicaid. Half (50%) of program enrollees have a high school diploma or equivalent and 24% did not graduate from high school. From January 2021 to March 2023, 201 women have enrolled in the program. There were 463 telehealth referrals, with a 43% enrollment rate.

Efforts to promote the program have included training for OB/Gyn offices, and at the WVU Council for Tobacco Treatment Training Program (CTTTP) training in Spring 2023.

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

RFTS provided information to maternity care providers on the number of DCCs providing tobacco cessation services, including the number of pregnant women enrolled that indicate they want to quit or reduce smoking.

Address substance use in pregnancy and in youth/teens

The WVHVP submitted a proposal through the Pediatric Mental Health Access federal grant that was approved for increasing workforce development through Nurse Family Partnership. This braided funding opportunity will work in the southern part of the State (Mingo, Boone, Mercer and Fayette counties that works with foster children, adoption agencies and early childhood programs that provides services throughout four identified high-risk counties to support a NFP nurse and social worker, along with initial costs for an infant mental health consultant on a contractual basis. For that combination of counties, the teen birth rates for the 15-19 age group were:

- Mingo with a birth rate of 41.4
- Boone with a birth rate of 40.6
- Mercer with a birth rate of 38.6
- Fayette with a birth rate of 34.4

The activities outlined with the WV PMHCA expansion funds will engage social service agencies and OB providers and pediatricians to refer teen moms impacted by substance use or behavioral concerns to a NFP team. The team will consist of a registered nurse, social worker, mental health consultant and an early childhood specialist that will also focus on the mom and child through age two. The two-generational approach will assess social determinants of health, emotional well-being, domestic violence, and secondary trauma which will assist with developing a case plan.

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

The RFTS Regional Lead Agencies provided at least one visit quarterly with OB providers within their region to discuss the importance of accurate and timely submission of the PRSI form. Barriers identified by providers were shared with OMCFH so that troubleshooting activities could be provided. The OMCFH PRSI epidemiologist and RFTS coordinator supported new providers with initial login registration and navigating the system once a password had been established.

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

The Division of Women's and Family Health Quality Assurance Coordinator (QAC) was promoted from the position of Tracking and Follow-Up Nurse 3 for the Breast and Cervical Cancer Screening Program (BCCSP) in November 2024. Due to staffing issues in BCCSP, the QAC has continued to contribute to BCCSP as the program onboards and trains new clinical staff. Work on the quality initiative project has also been delayed as the Division awaits the results of the Logistical Regression project to identify pregnancy risk factors which will influence new updates to the PRSI. Once the Maternal Risk Screening Advisory Board revises the PRSI form, the QAC will engage obstetrical care providers and nursing/healthcare staff in a quality improvement initiative related to implementing the electronic PRSI into their healthcare practices, including interviews to identify challenges related to maternal risk screening, opportunities to streamline processes, and innovative ways to improve compliance. A candidate for the epidemiology position to focus on the PRSI has been identified and is set to begin employment in July 2024.

Inform providers of compliance rate in submission of PRSI forms.

Reports will be developed and shared with providers on a regular basis.

Decrease preterm and low birthweight infants

The OMCFH will continue to participate in partnership with the West Virginia Perinatal Partnership (WVPP) in the Risk Appropriate Care (RAC), a quality improvement strategy that endeavors to assure that babies are born in a hospital with the appropriate level of nursery, and that mothers with high-risk conditions give birth in a facility that is best prepared to meet their needs. OMCFH will continue to participate on the WVPP Quality Improvement Advisory Council to consider recommendations for implementing strategies based on Project Watch Data related to Pre-Term and Very Pre-Term Birth.

Promote low-dose aspirin use in pregnancy to prevent preterm birth related to hypertension.

The OMCFH will partner with the WVPP to develop a pilot project on low-dose aspirin use in high-risk pregnancies in two hospitals or provider groups. The project will provide low-dose aspirin use education at the appropriate level for home visitors, doulas, pharmacists, providers, and anyone caring for pregnant patients to encourage expectant mothers to follow protocols.

The OMCFH is sponsoring a Special Topics in Women's Health Conference in September 2024. Attendees will include primary care providers, oncologists, women's health providers, nurses, and behavioral health providers. Sessions will include Reproductive Justice and a Decision Aid Tool for Sterilization to support informed consent for sterilization, onco-fertility and sexuality in women cancer survivors, and ethical issues related to in vitro fertilization.

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

Promote Doulas into Perinatal Care

The Doula Advisory Committee will continue to meet bi-monthly to operationally define the role of doulas and educate providers on how doulas can support their practices in addressing postpartum maternal mental health outcomes and health disparities, Plans include broadening membership to include representatives from the community (a parent and pregnant individual), Right From the Start (RFTS) direct care coordinator (DCC), peer recovery coach doula, Hospital Association, and agency Federally Qualified Health Centers (FQHCs). The OMCFH will continue to participate on the Medicaid Payer Group to promote payment for doula services.

Eight Listening Sessions will be conducted with healthcare workers and families across the state to operationally define the role of doulas and educate providers on how doulas can support their practices in addressing postpartum maternal and mental health outcomes and health disparities. These listening sessions are being held in July and August 2024. Results from these sessions will be shared with the listening session participants and at the OMCFH Special Topics in Women's Health Conference scheduled for September 17, 2024, Annual Home Visiting Conference, and with the Doula Advisory Committee. Recommendations from these listening sessions and Hospital Lunch and Learns will be used to inform future goals related to Doula Initiatives.

Observing live births is a barrier for doulas obtaining DONA certification due to hospital limits on visitors in the labor and delivery rooms and lack of hospital policies for doulas. To mitigate this challenge, the OMCFH is exploring implementing doula residency programs in WV birthing hospitals. To obtain technical assistance, the OMCFH has scheduled a site visit with the Lived Experience Accessible Doula Program (LEADoula) in North Carolina in September 2024 at the University of North Carolina School of Medicine. Braided funding through the WVPP has been allocated to provide payment hospital incentives to establish these residency programs.

The OMCFH will continue to support maintenance of a doula directory for professionals and parents and will continue to collaborate with the WVPP to support doula education and training. Doulas will also be listed on the WV Home Visitation Program (WVHVP) Childbirth Education Enhanced Services Directory.

Love Your Birth Control

The OMCFH will continue to collaborate with the WVPP to offer the Love Your Birth Control course to promote optimal spacing during pregnancy and improve individuals' understanding of birth control options. The Love Your Birth Control course will continue to be provided free to any healthcare facility or community group that requests training. Additionally, starting June 2024, the course will be offered virtually.

Provide Lamaze childbirth education.

In collaboration with the WVPP, the OMCFH will continue to provide 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. An evaluation component is added to this work to assess the impact of this training on the workforce over time. RFTS will work to increase the number of clients enrolled in the enhanced services component for Lamaze childbirth education and provide a director of Lamaze trained DCCs to providers within each region. The certified Lamaze Childbirth educators' contact information will also be listed in the Childbirth Education Enhanced Services Directory developed by the WVHVP.

Promote childbirth education for first-time mothers statewide.

The WVHVP developed a Childbirth Education Enhanced Services Directory that will be provided to OB providers, hospitals and primary care providers with contact information listed by county. The certified Lamaze Childbirth educators' contact information will also be listed in the findhelp online resource referral platform. The findhelp platform will provide a streamlined referral process for providers and self-referral options for birthing parents. The resource directory will be incorporated in the HMG Coordinated Intake Process and providers listed will be encouraged to claim their site within the findhelp platform for easily managed referral/resource linkages. A final review is occurring, and the directory will be released in early Fall 2024 with changes updated as needed based upon the contact information shared in the document.

The goal will continue to be add an additional 10 enhanced services providers statewide and to ensure the providers are strategically located within different regions to provide access to care. RFTS will also develop the enhanced service component to a hybrid model to best meet the needs of birthing parents. As the enhanced service component of childbirth education training continues, the intent is to train DCCs to provide education both virtually and in-person to better meet the birthing parents request for education.

Due to staffing changes within RFTS, the initial activity to incorporate the voice of the birthing parents into the enhanced services work has been delayed until Summer 2024. A pre and post survey will be developed that can be completed by the participants. The results will be evaluated and shared with the RFTS enhanced service providers to ensure the training meets the needs of the birthing parents enrolled. The survey will be designed to measure both virtual and in person training to ensure training is equitable regardless of training mode.

As a result of the discussion on Real WV Moms, the topic advanced to more than just working with first time moms, but families overall. The content will continue to be pregnancy, postpartum mental and physical health, and the importance of prenatal care. The targeted population for the campaign has changed and the focus falls into both women's and family health, adolescent and child health and workforce development. West Virginia has a higher prevalence of adolescents identifying as transgender and grandparents raising grandchildren, which affects the changing landscape of families in the state. Many of our materials for the State's Home Visiting program are targeted to traditional families, creating a stronger divide in health equity. To better identify targeted workforce training needs, public health input from key stakeholders is required. Both behavioral health providers' and maternal social support workforce's strengths include conceptualizing how psychosocial issues affect a person's quality of life. However, this workforce may lack the basic knowledge about a person's physical health concerns. There is an overall need for targeted workforce development and training to address these inequities. Listening sessions on Real WV Families are being conducted in July 2024, and the results will be presented at the Special Topics in Women's Health Conference in September 2024. Results from these listening sessions will inform future workforce needs and program development.

The OMCFH will collaborate with the WVPP to provide delivery hospitals and emergency departments with education on bereavement care to those families who experience the loss of a baby by miscarriage, fetal demise, stillbirth, and infant death.

In coordination with the WVPP, the OMCFH will update 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. This update will include shared decision making and a culturally sensitivity which also supports breastfeeding and mental health.

Count the Kicks will be promoted via literature, phone app, online resources, and continuing education webinars to nurses, physicians, midwives, and doulas to enhance knowledge related to fetal movements and how to instruct their patients to count fetal movements in utero.

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.

The OMCFH will continue to collaborate with the WVPP to facilitate Grand Rounds on Implicit Bias in Racial and Impoverished Families in each of the obstetrics and gynecology residency training programs.

Additionally, the collaboration will continue to 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.

Implement Nurse Family Partnership for first time moms in highest risk counties.

The WVHVP will support the implementation of Nurse Family Partnership which is an evidence-based, community health program with 45 years of research showing significant improvements in the health and lives of first-time teen moms and their children affected by social and economic inequality. NFP has proven outcomes and the impact for teen prenatal and parents, especially those impacted by two-generational trauma and experiencing socio-economic inequality. NFP will pair specially trained registered nurses with vulnerable teens who are pregnant with their first child, starting early in the pregnancy and continuing through the child's second birthday. During home visits, nurses will monitor and respond to symptoms of postpartum depression and postpartum psychosis/schizoaffective disorder. NFP will also provide around care, referring women to social services, legal counsel, and group community outings. Pregnant teens and their child will be provided with an initial assessment, case management and supportive counseling.

The initial implementation was planned for Spring 2024 but has been delayed pending final Model implementation approval. As part of the HMG coordinated intake process, NFP will be available through limited capacity within Kanawha County. Using a blended funding stream of MIECHV, Medicaid, state funds and Title V block grant, Kanawha County is the first county for services to be implemented. The county was determined by the number of first-time moms and staffing capacity of registered nurses that are Bachelor degreed. A subrecipient agreement will be effective in September 2024 for services to begin.

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 (OHP) will continue partnerships with both the WVPP and the West Virginia Family Resource Networks (FRNs) to determine the appropriate event locations to access the perinatal population for 2024-2025. Registered dental hygienists, staffed by the OHP, will continue to attend FRN sponsored Community Baby Showers statewide to provide oral health education and supplies to this population. The OHP will continue working with the WVPP to strengthen medical/dental collaboration through providing oral health educational materials to providers. The OHP also partners with other OMCFH programs to provide oral health education and materials to allow for consistent messaging among all programs regarding oral health initiatives.

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

West Virginia's current Adult Dental 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's use of available dental services. The Oral Health Program will monitor 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.

The OMCFH and the WVPP will continue to facilitate training for obstetrical and pediatric tobacco cessation champions, continue to identify, training 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.

Vaping has been indicated by many of the families enrolled, and as a result, WVHVP will add vaping educational materials to the list of items shared with families. WVHVP will work with the States's Division of Tobacco Prevention to utilize the materials developed in two reports: *WV Youth and Vaping a Dangerous Combination* and *Truth Initiative*, a report on vaping in the workplace. WVHVP staff will also work with the Smoking Cessation Epidemiologist to determine if materials in the new FDA Online Vaping Prevention and Education Resource Center are appropriate for use with families enrolled.

The focus of any training completed with providers and home visiting programs is to determine the effectiveness of the training and how the training content is being used in daily practice. The WVHVP team will utilize their existing epi team and CQI team to implement a series of surveys through Google that will measure impact with home visitors and DCCs that completed training.

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

The OMCFH and the WVPP will continue to provide training and intervention programs specifically for obstetrical and pediatric providers to reduce smoking before, during, and after pregnancy. In addition, efforts will continue to identify, train and support providers on best practice tobacco/nicotine cessation interventions during pregnancy and to promote a consistent and unified message about cessation of smoking in pregnancy. The PP will 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, and develop a recognition plan for physician practices that participate in training as leaders addressing smoking before, during and after pregnancy. The WVPP 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. The Tobacco Free Families Advisory Council will continue to meet quarterly to provide relevant updates and information.

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

Home visiting programs will continue to use evidence-based curriculums with all families served. Two additional evidence-based models, Nurse Family Partnership and Maternal Health Outreach Worker (MIHOW) have been added to the list of models being used to ensure a coordinated intake system is in place that meets the need of any family enrolled based upon the initial assessment.

The smoking cessation epi will work with the WV Tobacco Prevention program, the WV Quitline, and the Tobacco Free Advisory Board to update the toolkit based upon recent recommendations and reports generated. The toolkit will include materials on vaping.

RFTS will work with the DCCs trained as certified tobacco treatment specialist (CTTS) to provide hybrid smoking cessation services through enhanced services. RFTS will provide an in-depth review of the counties with the highest rates of pregnant women to smoke to ensure there will be DCC coverage providing the service.

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

RFTS will share the value add-on elements provided by the MCOs to clients enrolled. An exhibit will occur at the Perinatal Summit with RFTS to approximately 180 providers. WVHVP will work with the MCOs to ensure exhibits at the community-based baby showers targeting pregnant women.

OMCFH submitted a proposal through the preventive block grant for additional funding support to develop a workflow by which referrals for pregnant individuals identified as smoking during pregnancy by the PRSI can be referred to BMTFP. These referrals will be a priority for referral and enrollment through this project. The SMART objective for the project will be: "By September 30, 2025, increase the percentage of referrals from all sources that enroll in BMTFP by 5%.

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

RFTS will provide information to maternity care providers on the number of DCCs providing tobacco cessation training, including the number of pregnant women enrolled that indicate they want to quit or reduce smoking. Data reports will be provided that indicate the number of women enrolled, the number of women that quit or reduced smoking. The trained DCCs will work with maternity care providers to include smoking cessation as part of enhanced services available. Regional reports will be developed to be shared with providers and community partners. To streamline the process for referral, the tobacco cessation specialists will be listed on findhelp and referrals made through the resource/referral platform.

Address substance use in pregnancy and in youth/teens

WVHVP will work in the southern part of the State (Mingo, Boone, Mercer, and Fayette counties that works with foster children, adoption agencies and early childhood programs that provides services throughout four identified high-risk counties to support a NFP nurse and social worker, along with initial costs for an infant mental health consultant on a contractual basis. For that combination of counties, the teen birth rates for the 15-19 age group are:

- Mingo with a birth rate of 41.4
- Boone with a birth rate of 40.6
- Mercer with a birth rate of 38.6
- Fayette with a birth rate of 34.4

The activities outlined with the WV PMHCA expansion funds will engage social service agencies and OB providers and pediatricians to refer teen moms impacted by substance use or behavioral concerns to a NFP team. The team will consist of a registered nurse, social worker, mental health consultant and an early childhood specialist that will also focus on the child through age two. The two-generational approach will assess social determinants of health, emotional well-being, domestic violence, and secondary trauma which will assist with developing a case plan.

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

The RFTS case management home visiting model will continue to 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.

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

The RCCs will continue to collaborate with the Division of Women's and Family Health Quality Assurance Coordinator (QAC) on education needed with OB providers to encourage a higher completion rate of the PRSI form in the electronic database. A survey is being developed for OB providers and front-line staff asking about the barriers related to PRSI submission. The results of the survey will be shared with the Maternal Risk Screening Advisory Board to lead the work on revising the PRSI form and processes needed for successful electronic submission.

The Division of Women's and Family Health Quality Assurance Coordinator (QAC) will engage obstetrical care providers and nursing/healthcare staff in a quality improvement initiative related to implementing the electronic PRSI into their healthcare practices, including interviews to identify challenges related to maternal risk screening, opportunities to streamline processes, and innovative ways to improve compliance.

The QAC will conduct a literature review to determine best practices for electronic maternal risk screening implementation in obstetrical offices.

Inform providers of compliance rate in submission of PRSI forms.

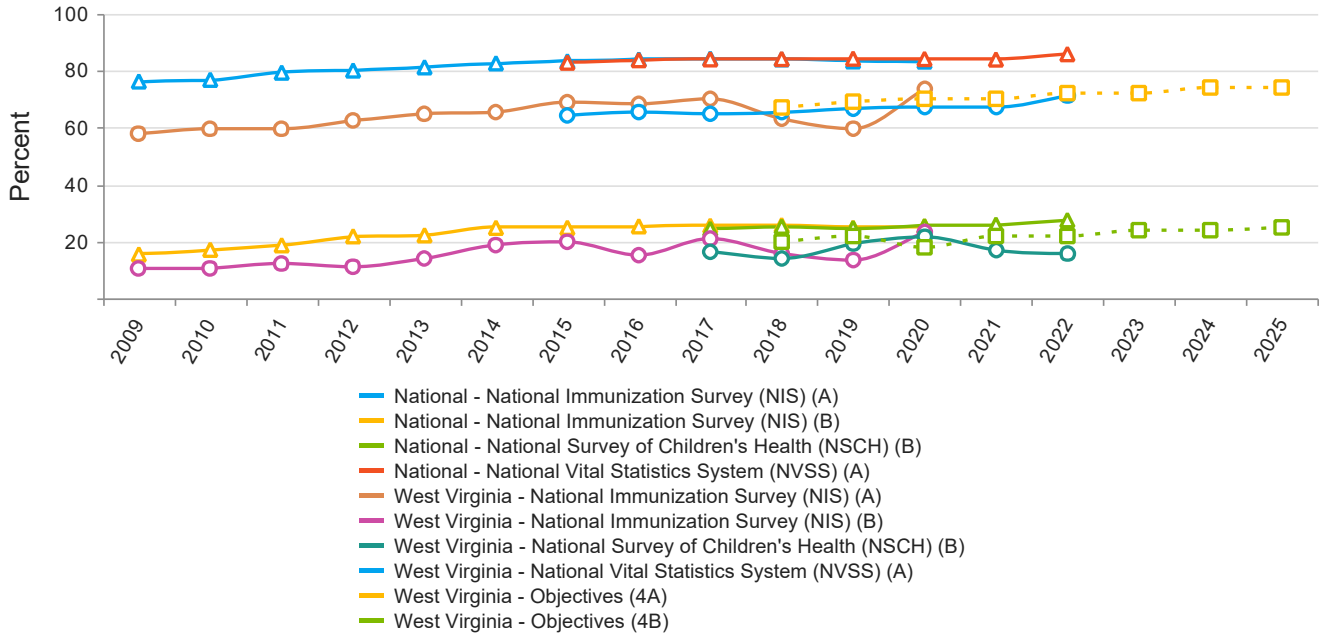
Reports will be developed and shared with providers on a regular basis.

Post Block Review Note: Activities to address postpartum visit measures will be included in the Plan for the Upcoming Year after further development.

Perinatal/Infant Health

National Performance Measures

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
Indicators and Annual Objectives



NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	69	70	70	72	72
Annual Indicator	68.2	69.9	63.0	59.8	73.6
Numerator	12,736	12,372	10,871	9,602	11,171
Denominator	18,666	17,711	17,259	16,051	15,185
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2023
Annual Objective	72
Annual Indicator	70.9
Numerator	11,332
Denominator	15,974
Data Source	NVSS
Data Source Year	2022

Annual Objectives		
	2024	**2025**
Annual Objective	74.0	74.0

NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	22	18	22	22	24
Annual Indicator	15.2	20.9	15.8	13.8	23.4
Numerator	2,790	3,678	2,678	2,168	3,453
Denominator	18,401	17,602	16,920	15,656	14,743
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2023
Annual Objective	24
Annual Indicator	15.6
Numerator	6,316
Denominator	40,563
Data Source	NSCH
Data Source Year	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	24.0	25.0

Evidence-Based or –Informed Strategy Measures

ESM BF.1 - Number of birthing facilities designated Baby-Friendly under the EMPower initiative

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	5	6	6	8	8
Annual Indicator	5	5	4	4	4
Numerator					
Denominator					
Data Source	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	10.0	10.0

ESM BF.2 - Percent of infants who are breastfeeding at time of discharge from a birthing facility

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	65	66	68	70	70
Annual Indicator	66.2	66.8	66.7	70.5	68.4
Numerator	11,515	11,069	10,853	11,168	11,270
Denominator	17,405	16,579	16,275	15,840	16,476
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	72.0	72.0

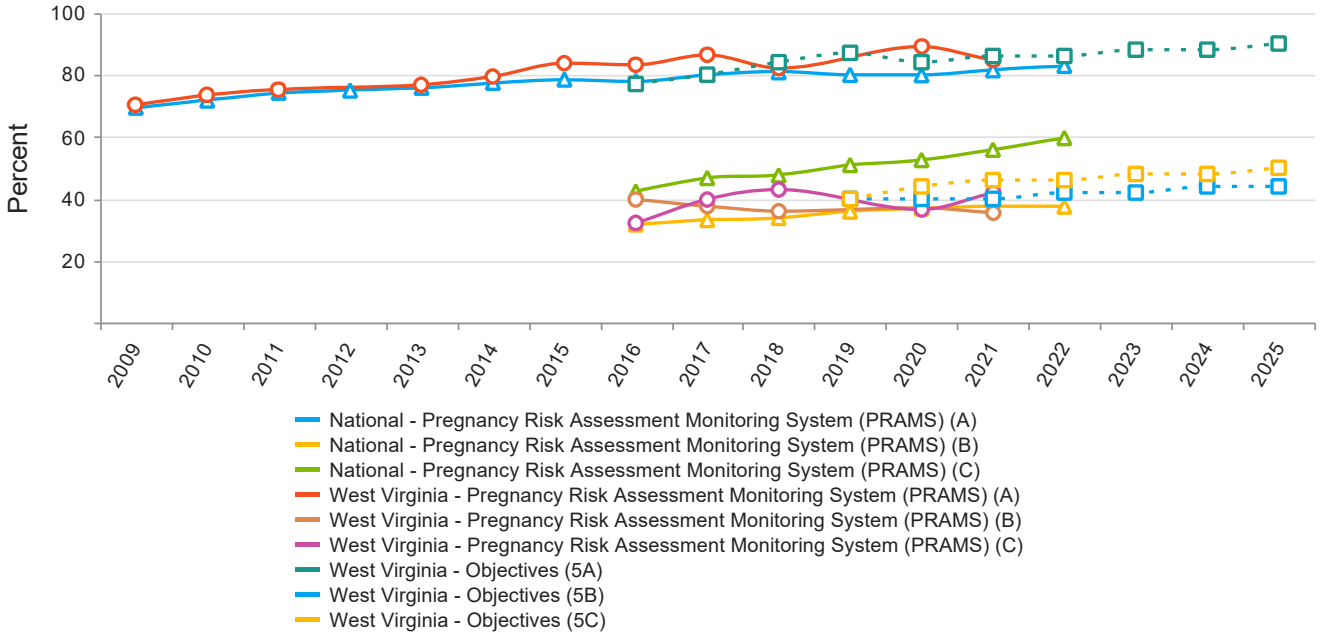
ESM BF.3 - Percent of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age

Measure Status:	Active				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	13	12	14	16	18
Annual Indicator	11.7	11.9	17.3	17.1	18.4
Numerator	160	149	127	148	164
Denominator	1,367	1,256	735	867	889
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	20.0	22.0

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) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Indicators and Annual Objectives



NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	87	84	86	86	88
Annual Indicator	82.0	82.0	89.2	84.5	84.5
Numerator	12,495	12,495	12,842	12,086	12,086
Denominator	15,245	15,245	14,394	14,309	14,309
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2018	2020	2021	2021

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	87	84	86	86	88
Annual Indicator					83.3
Numerator					11,489
Denominator					13,794
Data Source					PRAMS
Data Source Year					2022
Provisional or Final ?					Final

Annual Objectives		
	2024	2025
Annual Objective	88.0	90.0

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	40	40	40	42	42
Annual Indicator	36.1	36.1	37.1	35.4	35.4
Numerator	5,401	5,401	5,222	4,937	4,937
Denominator	14,977	14,977	14,085	13,963	13,963
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2018	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	40	40	40	42	42
Annual Indicator					31.3
Numerator					4,191
Denominator					13,406
Data Source					PRAMS
Data Source Year					2022
Provisional or Final ?					Final

Annual Objectives		
	2024	**2025**
Annual Objective	44.0	44.0

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	40	44	46	46	48
Annual Indicator	43.1	43.1	36.5	42.1	42.1
Numerator	6,470	6,470	5,106	5,891	5,891
Denominator	15,017	15,017	13,992	13,983	13,983
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2018	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	40	44	46	46	48
Annual Indicator					52
Numerator					6,970
Denominator					13,395
Data Source					PRAMS
Data Source Year					2022
Provisional or Final ?					Final

Annual Objectives		
	2024	**2025**
Annual Objective	48.0	50.0

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Federally available Data (FAD) for this measure is not available/reportable.

Evidence-Based or –Informed Strategy Measures

ESM SS.1 - Percent of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	100	100	100	100	100
Annual Indicator	100	100	100	100	100
Numerator	25	21	21	21	21
Denominator	25	21	21	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	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives		
	2024	2025
Annual Objective	100.0	100.0

ESM SS.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					
	2019	2020	2021	2022	2023
Annual Objective	86	80	82	84	86
Annual Indicator	75	77.5	77.1	80.9	83.1
Numerator	804	816	628	796	876
Denominator	1,072	1,053	815	984	1,054
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	88.0	90.0

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	80	80	82	84	86
Annual Indicator	74.8	82.8	87.3	88.3	89
Numerator	1,554	1,689	1,554	1,641	1,722
Denominator	2,077	2,039	1,781	1,859	1,934
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	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 - 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
Five-Year 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 BF.1 - Number of birthing facilities designated Baby-Friendly under the EMPower initiative	Active
ESM BF.2 - Percent of infants who are breastfeeding at time of discharge from a birthing facility	Active
ESM BF.3 - Percent of infants enrolled in an evidence-based home visitation program who were exclusively breastfed through six months of age	Active

NOMs
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

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 - 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) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Five-Year 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 SS.1 - Percent of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education	Active
ESM SS.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 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	Active

NOMs

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

Increase Breastfeeding

The WV Home Visitation Program (WVHVP) converted a breastfeeding education training for home visitors to an online self-paced course through Articulate within the Early Childhood Training and Registry System. During the last year, 52 participants completed the training. The training was developed to support and encourage breastfeeding in an introductory course designed to teach basic skills to home visitors. Topics included how to create a breastfeeding friendly program, best practices in breastfeeding education, vocabulary, and definitions, and how to encourage breastfeeding with families.

Use evidence-based curriculums to promote breastfeeding.

The WV Breastfeeding Alliance exhibited at Great Beginnings Early Childhood conference September 28-30, 2023, in Morgantown to share Breastfeeding Friendly Childcare information and resources, with more than 250 conference attendees.

Home visiting programs continued to use the National model required evidence-based curriculums for any family enrolled. Each model (PAT, HFA, EHS-HBO, RFTS, MIHOW) provides education based upon the model guidelines and provides handouts to the family. The MIHOW model was recognized through the Maternal, Infant and Early Childhood Home Visiting (MIECHV) federal funding stream as an evidence-based model. MIHOW was designed as a prenatal model utilizing women who were at one time enrolled in the program to provide the services to encourage the peer-to-peer model. The paraprofessional model has been in WV for over 30 years and has shown positive results for breastfeeding. A home visiting program in the Northern Panhandle of WV transitioned to MIHOW completely in the counties served by the agency

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

The OMCFH continues to collaborate with WIC to promote the Certified Breastfeeding Specialist (also known as Core Lactation Consultant) course. In addition, OMCFH in collaboration with the Home Visiting Program and Perinatal Partnership have shared and promoted the Pacify App, which WV WIC has available to its participants.

Provide assistance with pathway to International Board-Certified Lactation Consultant (IBCLC) designation

The OMCFH continues to support IBCLC Certification and education through a collaboration with the Perinatal Partnership. The Institute for the Advancement of Breastfeeding & Lactation Education (IABLE) courseware is developed to provide evidence-based and clinically applicable materials that will elevate the level of knowledge and skills among healthcare providers, medical office staff, and other community supporters. Course instructors are physicians who practice breastfeeding medicine. The first set of available courses is geared for physicians and other providers such as nurse practitioners, physician assistants, midwives, and students of these professions. To date, more than 57 hours of Free lactation CME/CE have been utilized.

The following courses are being offered to a wide variety of interested people who will encourage and assist breastfeeding mothers. There are programs for health care providers, community workers, doulas, and for those whose goal it is to become IBCLCs.

- Certified Breastfeeding Specialist Course (Core Lactation Consultant Course)
  This basic, online lactation management course is for those who wish to educate and support breastfeeding families through pregnancy, breastfeeding initiation, and the normal course of lactation. The course has a 45-hour minimum requirement. A total of 89 individuals have enrolled in the course since January 2024.
- Outpatient Breastfeeding Champion Course by IABLE (International Board-Certified Lactation Consultant®) is a basic, clinically focused course for any person who is a medical or community breastfeeding supporter. The course provides instruction on how to answer the most common breastfeeding questions that a breastfeeding mother and her family have throughout the course of lactation, into toddlerhood and beyond. There is a 52+ hour instructional requirement. Breakdown of the 17 most recently enrolled in CBS course: 8 WIC; 3 Home Visitors; 6 Hospital RNs. The next Outpatient Breastfeeding Champion (OBC) Course is scheduled for June 14 & 21 and is now being promoted.

The Outpatient Breastfeeding Champion Program of IABLE is scheduled for June 2024 with a plan to offer

scholarships to doulas.

The IABLE eCourse has been purchased by a variety of healthcare professionals including physicians, nurse practitioners, Certified Lactation Counselors, and nurses.

Offer evidence-based provider training

EMPower Best Practices is 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. Four WV Hospitals were recruited for the EMPower Breastfeeding Enhancing Maternity Practices: WVU Medicine Jefferson Medical Center, WVU Medicine St Joseph's Hospital, Mon Health Stonewall Jackson Memorial, and WVU Medicine Wheeling Hospital. The five WV hospitals designated as Baby Friendly include MonHealth in Morgantown, St Mary's Medical Center in Huntington, WVU Medicine in Berkeley, WVU Medicine United Health Center in Bridgeport (currently working on re-designation), and MonHealth Stonewall Jackson Memorial Hospital in Weston.

West Virginia hospitals enrolled in the CHAMPS program include Princeton Community Hospital, Thomas Memorial Hospital, Reynolds Memorial Hospital, CAMC Women and Children's, Davis Medical Center, Cabell Huntington Hospital. Planning is underway for outreach to hospitals not participating in CHAMPS, EMPower or already designated as Baby Friendly. These hospitals include the following: Logan Regional Medical Center, Weirton Medical Center, Raleigh General Hospital, Camden Clark Hospital, Grant Memorial Hospital, and Greenbrier Valley Medical Center.

The WV Provider e-Course Page continues to provide free CME/CE for medical providers and healthcare staff.

The Primary Care Breastfeeding Medicine course was held virtually in October 2023 and included 50 in-person participants at the WV School of Osteopathic Medicine with obstetric, pediatric, and family medicine (2nd, 3rd, and 4th year students and residents, local providers) plus ten participants from WVU obstetrics, pediatrics and family medicine who attended virtually. The next phase will include all those participating in the upcoming 2024 lactation webinars.

The WV Breast Alliance Director participated in the Rural Health Immersion event at WV School of Osteopathic Medicine March 23-25, 2024, which centered around substance use in pregnancy and care of infants experiencing NAS. Presentations on "Why Breastfeeding Matters" and participation in a standardized patient clinical simulation – working with a mother in recovery needing support breastfeeding were given to Association of Higher Education Commission scholars.

Provide support to hospitals working to become Baby Friendly

The Perinatal Partnership worked in coordination with the OMCFH to support the hospitals recognized as Baby Friendly to keep their endorsement. Technical assistance was provided as new hospital staff were hired.

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

The Evidence Based Infant Feeding course has 19 enrolled participants, with one completed coursework from the neonatal intensive care unit at WVU Children's Hospital.
OMCFH collaborates with the WV Breastfeeding Alliance, which uses social media to promote breastfeeding. Currently WV Breastfeeding has 1.9K followers on social media with frequent posts related to breastfeeding, new mothers, and babies. There has been an increase in activity on social media with posts about preparing to breastfeed, infant risk center, pumps, nutritional benefits of breastmilk (1,860); Academy of Breastfeeding Medicine (1,933); CHAMPS (largest reach 2,444); with a close 2nd of poll about choosing not to breastfeed (2,431).

In the ZipMilk resource, there are 13 IBCLCs, 7 Breastfeeding Specialists, Lactation Counselors, and Breastfeeding Educators, and 52 WIC Breastfeeding Peer Counselors listed. Participation has been promoted via social media and plan to analyze current WVBA members to further outreach.

The OMCFH continues to support WV Breastfeeding Alliance activities to support environmental changes to encourage breastfeeding. A Real WV article was published on Aug. 10, 2023, which promoted the WV State Fair Nursing Mothers stations and the new workplace protections for nursing mothers. There were two State Fair Nursing Mothers stations in 2024, with average daily usage of 15-30 mothers at each station.

Monroe Day Care received Breastfeeding Friendly Childcare Designation in September 2023. A Nursing Mothers Station was available at the Healing Appalachia gathering September 21-23, 2023, with 10-15 mothers using the space daily, and breastfeeding resources were available.

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

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

- Continued de-identified case review using revised abstraction and review processes to complete reviews within one of the deaths. Currently, 2021 infant deaths have been reviewed and 2022 infant deaths are being abstracted. The goal is to have all deaths through 2023 reviewed by March of 2025 and all 2024 cases by December of 2025.
- 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.

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 (Safe Sleep)

The OMCFH has worked to assure that pediatric, family practice, FQHCs and primary care practices have access to Safe Sleep educational materials and incorporate into their anticipatory guidance.

The Annual Competency Training, *Support Caregivers*, was held on June 19th and 20th, 2023 via Zoom. Presentations included Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment: What You Need to Know, Shaken Baby 101, Helping Mothers Cope with Newborn Crying and Sleep: Promoting Safe Sleep and Maternal Mental Health and Why Support Attachment and Mother's Mental Health Lowers the Risk of Child Maltreatment. There were approximately 75 participants each day. The conference surveys were positive overall. Nursing CEUs and WV Stars Credit were given to participants.

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

Home visiting programs continued to provide safe sleep education to families enrolled in programs. The education provided supported both the model curriculum and requirements and the States' Our Baby Safe and Sound messaging. The WVHVP worked with both the WV Perinatal Partnership and Our Baby Safe and Sound to ensure a unified message. Discussion started on how to provide more in-depth information for families indicating concerns about safe sleep environments, car seats and childcare. Discussion also started on the best way to incorporate recommendations from OB providers and community partners on safe sleep measures with families based upon chart abstractions with the Infant Mortality Review Board.

Work with hospitals to develop safe sleep policies

The OMCFH is collaborating with the WVPP to pursue coverage of safe sleep education and other anticipatory guidance as Medicaid-eligible billable enhanced services. This is an ongoing topic of discussion with the Perinatal Payers Workgroup.

Increase Breastfeeding

The OMCFH will continue to collaborate with the West Virginia Breastfeeding Alliance (WVBA) and West Virginia Breastfeeding Institute (WVBI). The educational offerings and activities will be updated to include cultural sensitivity to provide individualized care and support for breastfeeding families.

Activities to support and promote breastfeeding will include distribution of prenatal breastfeeding education materials for patients to hospitals, home visitors, providers, midwives, doulas, and childbirth educators. The OMCFH will work to leverage WVBA communication social media to increase participation in statewide lactation efforts by working with BPH communications to promote these posts.

The OMCFH will support the WVBA in maintenance of a Lactation Support Directory through ZipMilk, a website that helps mothers and providers locate breastfeeding sources. In collaboration with the Perinatal Partnership, a nursing leadership survey at all birthing hospitals to identify the level of lactation support available to patients will be completed, and technical assistance will be provided to hospitals working on the Ten Steps to Successful Breastfeeding and/or Baby Friendly Designation.

Use evidence-based curriculums to promote breastfeeding.

The OMCFH will continue to work in partnership with the WVBI and WVBA to train community-based providers including doulas and home visitors on supporting breastfeeding through the Outpatient Breastfeeding Champion Program of IABLE (Institute for Breastfeeding and Lactation Education).

The OMCFH will continue to partner with the Perinatal Partnership to provide instruction and continuing education for all levels including Certified Breastfeeding Specialist Training, Assistance with pathway to International Board-Certified Lactation Consultant (IBCLC) designation, provider training modules, Primary Care course and Comprehensive Course for Clinical Breastfeeding Medicine scholarships, and the Evidence-Based Feeding Course for Hospital Nursing Staff and NICU Breastfeeding Courses.

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

The OMCFH supports participation in the Lactation Benefit Workgroup with Office of Nutrition Services/WIC and Payors to improve breast pump, lactation services and donor milk coverage, which is coordinated through the WVBA.

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

The WV Breastfeeding Alliance will continue to work with hospitals and provider offices to ensure staff are trained on breastfeeding and securing certified lactation consultants. The Breastfeeding Champion training will also be provided to home visiting programs, WIC and providers for participants that may not be able to commit to being a lactation support specialist, but provide consistent messaging related to breastfeeding.

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

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

The OMCFH will continue to mail back sleep materials to all families upon receipt of birth certificate information. The materials will align with best practices and offer additional links for more information regarding safe sleep.

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 (Safe Sleep).

The current Safe Sleep materials were developed in 2015 as a part of the plan to develop materials that were designed for hospitals and early childhood partners. The Say Yes to Safe Sleep for Babies toolkit included brochures, posters, and recorded trainings with dose 1 messaging occurring within the hospitals and dose 2 occurring if a family enrolled in home visiting. Both the pandemic and staffing changes in the required programs made it difficult to convey the messaging as intended. The increased substance use challenges with families, nontraditional families and method of messaging reflected a need to change not only the messaging process, but also the content. The intent was to complete this activity during the previous year, however, staffing changes within both the OMCFH and the Baby Safe and Sound program staff delayed the work. Meetings will begin in late summer 2024 and go through to Winter 2025 to take into consideration IMMRP recommendations, best practices, and focus groups. An updated toolkit will be developed that utilizes a Readiness Checklist for hospitals and early childhood programs. Once materials are developed, a designed key contact person will be assigned, safe sleep teams recruited, and other champions and a participation agreement will be completed. The initial orientation training will be completed, and an audit process will be used to identify adherence measures to be practiced internally and to document compliance.

Programs will be asked to develop and/or review policies around safe sleep and be set as the standard of care. Sample policies will be shared with the partners. All staff must complete the updated online training and follow-up as needed. Teams will be expected to participate in peer-sharing conference calls, collect and report data and order updated materials for their programs or birthing hospital.

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

The current Safe Sleep materials will be updated to reflect the concerns and recommendations from the IMMRP and the review by OMCFH. The OMCFH will work with the IMMRP, Perinatal Partnership and TEAM for WV Children to update brochures, flyers, and marketing campaigns. As part of the process, focus groups and surveys will be completed to ensure messaging is addressing the risks most associated with unsafe sleep practices. Updated safe sleep training for child protective service workers, early childhood partners and hospital nursing staff will be completed. A social media campaign will be developed to be used by families and caregivers. The messaging will align with the data indicators reflecting the increased number of grand families raising their grandchildren and the increased number of nontraditional families. Messaging will be respectful of families living environments (homeless, couch surfing, and unstable housing), but address the critical need for increased safe sleep messaging in unstable environments.

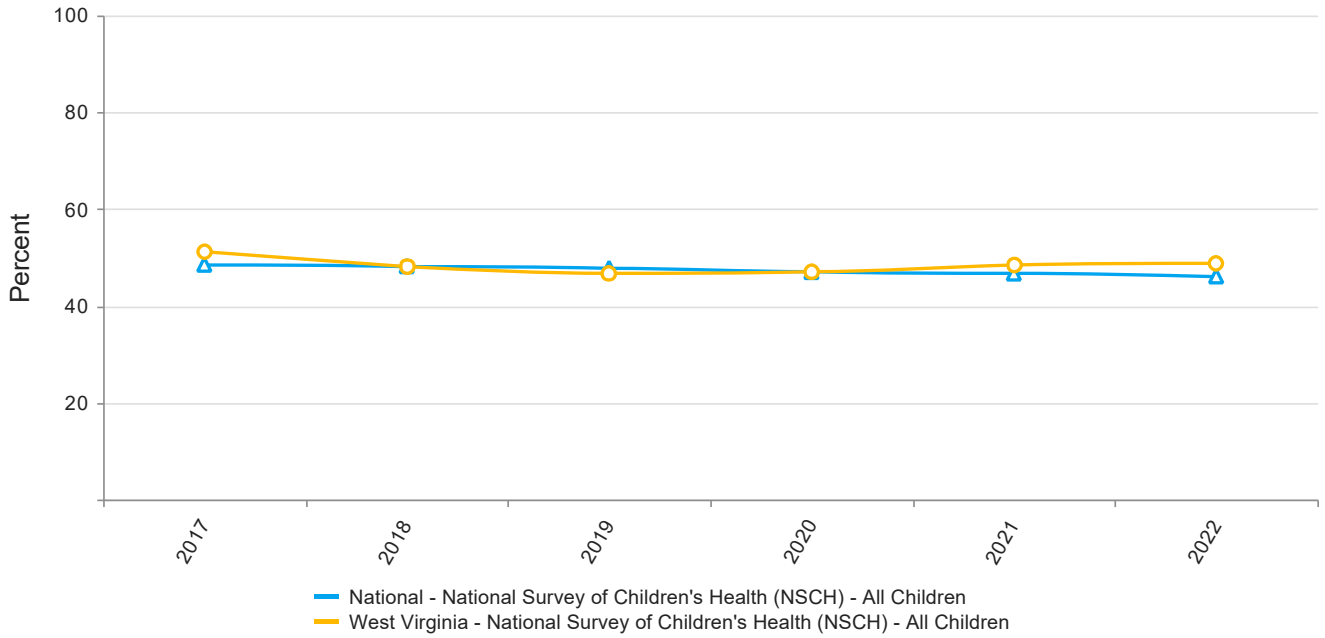
Work with hospitals to develop safe sleep policies.

As the current Safe Sleep materials are updated, the OMCFH and relevant partners will work with hospitals to update safe sleep policies to reflect current concerns and recommendations from the IMMRP. Safe Sleep training will be conducted for hospital nursing staff. Hospitals will continue to be key partners in providing safe sleep environments during the hospital stay to model appropriate safe sleep behaviors for new families.

Child Health

National Performance Measures

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
Indicators and Annual Objectives



NPM MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	48.7
Numerator	174,190
Denominator	357,508
Data Source	NSCH-All Children
Data Source Year	2021_2022

Evidence-Based or –Informed Strategy Measures

ESM MH.3 - Number of children who receive Title V funded medically necessary medical foods.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			290	310	330
Annual Indicator	270	284	327	280	314
Numerator					
Denominator					
Data Source	CSHCN	CSHCN	CSHCN and NBS	CSHCN and NBS	CSHCN and NBS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	350.0	370.0

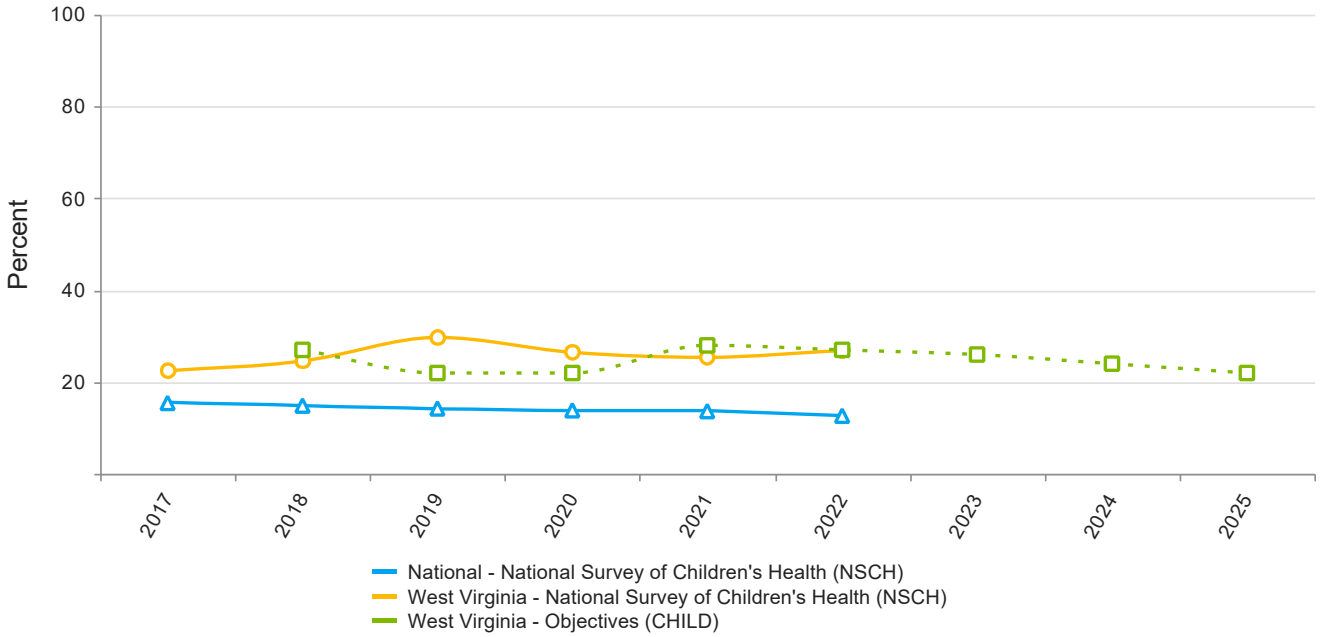
ESM MH.4 - Percent of CSHCN who are receiving care coordination services from the West Virginia CSHCN Program and who have a shared plan of care completed or updated within the last 180 days.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	16.3	8.6
Numerator	597	347
Denominator	3,657	4,029
Data Source	CSHCN Program Comprehensive Tracking System	CSHCN Program Comprehensive Tracking System
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	17.0	20.0

NPM - Percent of children, ages 0 through 17, who live in households where someone smokes (Smoking - Household, Formerly NPM 14.2) - SMK-Household
Indicators and Annual Objectives



NPM SMK-Household - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	22	22	28	27	26
Annual Indicator	24.1	29.5	26.7	25.1	26.8
Numerator	88,702	105,832	93,477	87,237	93,934
Denominator	368,117	358,760	350,414	347,889	350,556
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	24.0	22.0

Evidence-Based or –Informed Strategy Measures

ESM SMK-Household.1 - Percent of children in households where someone smokes.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	25	28	27	25	25
Annual Indicator	28.6	28.3	26.7	25.1	26.8
Numerator	100,750	99,750	93,560	87,237	93,949
Denominator	352,397	352,397	350,414	347,889	350,556
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	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	2022	2023
Annual Objective			0	200	250
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	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	2022	2023
Annual Objective			16	15.8	15.5
Annual Indicator	16.6	16.5	16.5	16.5	16.5
Numerator					
Denominator					
Data Source	WIC	WIC	WIC	WIC	WIC
Data Source Year	2016	2018	2018	2020	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	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 - Percent of children, ages 0 through 17, who live in households where someone smokes (Smoking - Household, Formerly NPM 14.2) - SMK-Household	
Five-Year 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 SMK-Household.1 - Percent of children in households where someone smokes.	Active

NOMs

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 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

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

NPM

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

Five-Year Objectives

Increase the number and percentage of Medicaid-enrolled children without a special health care need, ages 0 through 17, who have a medical home.

Strategies

Increase pediatric health care provider awareness of Medicaid-enrolled children without a medical home through the WV HealthCheck Program.

ESMs	Status
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.	Inactive
ESM MH.3 - Number of children who receive Title V funded medically necessary medical foods.	Active
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.	Active

NOMs

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

State Action Plan Table (West Virginia) - Child 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.

Five-Year 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 4

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.

Five-Year 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.

Right From the Start, the Medicaid case management home visiting model, continued to implement an evidence-based tobacco cessation model to women requesting to quit or reduce smoking. The model utilizes care coordination Designated Care Coordinators (DCCs) to check with clients during home visits on reduction and cessation progress. The DCCs use educational materials, including a handbook and small incentives. In early 2024, a tobacco treatment counseling component was added to the RFTS SCP project. The OMCFH Smoking Cessation Epidemiologist worked with the 8 Regional Care Coordinators (RCCS) to recruit DCCs who were interested in providing a higher level of education and counseling to clients as a billable enhanced service through Medicaid. The selected DCCs were involved in an extensive training program with the Epidemiologist, who is a trained Certified Tobacco Treatment Specialist. A cohort of four DCCs were provided 1–2-hour sessions with role plan twice a month from January 2024 to June 2024. Each of the four DCCs applied for and received a full scholarship to attend the West Virginia University School of Dentistry Certified Tobacco Treatment Specialist training in May 024. The three-month-long, self-paced training will include a final exam before the DCCs can be certified.

Provide evidence-based adolescent curriculum prevention programs in schools and tobacco/e-cigarette use prevention training for teachers. (NPM 14.2, ESM 14.2.1)

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 are more likely to become pregnant again and many will increase their level of tobacco use as they mature. The WV Youth Risk Behavior Survey (YRBS) showed a dramatic increase in vaping/e cigarette use among students in 2019 (see table below).

To address this issue, the AHI identified the curriculum program CATCH My Breath. CATCH My Breath is a free, evidence-based youth vaping prevention program with published evidence of reducing students' likelihood to vape. It was developed by The University of Texas Health Science Center at Houston (UTHealth) School of Public Health and backed by research funded by the National Institutes of 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. CATCH My Breath (CMB) utilizes a peer-led teaching approach and meets National and State Health Education Standards.

The AHI began limited implementation in 2021 and continued to expand into 2023, as COVID restrictions lifted. The AHI worked with the WV Department of Health's Division of Tobacco Prevention (DTP) to provide CMB professional development training teachers and school personnel across the state. Two statewide training courses (one virtual, one in person) were offered, and incentives were given to participating schools. Other partnerships include Berkeley County Schools Safety Collaborative, the Cabell County Tobacco Coalition, WVU Prevention Resource Center Community Tobacco Coalition, WVU Prevention Resource Center Community Partnership, and County Family Resource Networks and Prevention Coalitions across the state. The AHI's vaping prevention efforts even gained attention across the state line. Valley Health of Virginia sent an employee to shadow the Region 8 Adolescent Health Coordinator as she conducted classes, in hopes of replicating WV's programming.

The 2021 YRBS data (the most recent available) shows a notable decline in e-cigarette use since the AHI began working with schools to target this issue. Ifs also notable that even though cigarette smoking declined in 2019, the percentage of decline increased in 2021.

YRBS Measure (High School)	2017	2019	2021
Ever used electronic vapor products	44.4	62.4	49.6
Currently used electronic vapor products	14.3	35.7	27.5
Ever tried cigarette smoking	39.5	38.5	34.0
Currently smoked cigarettes	14.4	13.5	7.6

The AHI provided prevention programming to a little over 1,000 participants in 2021, increasing to over 2,500 in 2022. Thanks to the partnerships and collaborative efforts the AHI developed around this issue, more than 7,000 students, teachers, parents, and the community received vaping and tobacco prevention education in 2023.

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

School open houses, health fairs, etc. have never returned to pre-COVID-19 levels. However, the AHCs were able to participate in some school-centered activities and community-wide events to disseminate information. A few activity highlights include:

- *Be a Smartie, Don't Use Tobacco Products* at Valley Health in Mason County, WV
- *Prevention Day at the Capitol,* during the state legislative session
- *Super Saturday* at the Mountain Health Arena
- *Tyler County Resource Fair*
- "Back to School Bashes" in Cabell, Tyler, Calhoun, Jackson, Roane and Ritchie Counties
- *Repack Your Backpack*
- *Wood County Fall Fest*
- Oak Hill High School *Family Engagement Night*
- Lewis County *Community Block Party*
- *Valley Health Fair*
- Several Trunk or Treat events across the state

In addition to the above, the AHI distributed over 2,600 pieces of tobacco/vaping prevention and health related literature and shared nearly 60 social media posts.

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

In the application year, collaboration with the WVU School of Pharmacy continued related to ADHD diagnosis and treatment, including the safer use of prescription of stimulants. The website wvadhd.org now hosts the finalized guidelines, "WVACC Guidelines: A West Virginia Guide to Evidence-Informed Evaluation, Diagnosis, and Treatment of ADHD and Comorbid Concerns", in a clickable, easy-to-navigate website. As of February 2024, the entire PDF document, resources, and guideline materials are available for download following extensive review by WVU legal, a scientific editor, the expert panel, and WVDOH. In addition, programmatic continuing medical education courses have been developed and are advertised on this site. Website traffic is monitored to report ongoing use of the page.

Various short key messages materials and longer presentations to allow for staff "lunch and learns" or just longer educational sessions have been employed via academic detailing and/or clinical education. Surveys have been implemented (pre and post educational session) to ensure clinician perception of the academic detailing is effective and helpful to their practice. To aid in scheduling and outcomes performance reporting of the academic detailing program, an internal database was created and is utilized to track detailing encounters, materials and educational sessions delivered, contact attempts to providers, and other relevant outcomes. Further, Calendly, an online scheduling platform, is fully integrated with the database, but the forward facing Calendly platform allows for WV Clinicians to schedule academic detailing sessions with a detailer in their area without contacting the program. Prior to February 2024, when the guidelines were yet to be approved for distribution, a "soft" launch of the lunch and learns

were offered by request at conferences attended by the academic detailing team. After February 2024, a full programmatic launch of academic detailing was employed targeting counties of high prescribing in each of the detailers' territories. As of 06/07/2024, over 300 academic detailing sessions have occurred, inclusive of in-person, virtual, lunch and learn format. It should be noted that this number is underrepresented due to the current inability to track detailing encounters if the participant does not have an NPI.

Several continuing medical education programs were developed and were hosted by the WVU School of Pharmacy. A half-day virtual training was hosted prior to guideline launch in June 2023 on the evaluation, diagnosis, and treatment of ADHD (42 participants requested credit). A full-day in-person training on the evaluation and diagnosis of ADHD and nonpharmacological treatments was hosted in August 2023 (76 participants requested credit), and a repeat of this conference is set to be hosted on June 28, 2024. Also, a lunch series hosted the second Thursday of the month on various topics relating to ADHD has been made available since August 2023 with approximately 40 participants monthly. Ongoing efforts to provide academic detailing lunch and learn sessions as continuing medical education have been made and are nearly finalized for topic "Evaluation and Diagnosis of ADHD" session.

West Virginia University's School of Pharmacy has also attended various continuing education conferences for various clinician types throughout the state as both a speaker and an exhibitor. Members of the academic detailing team have either presented or been available for attendees to discuss the new guidelines to promote awareness and promote uptake of the new guidelines and participation with the academic detailing team. Conferences for pediatrics, family medicine, school nursing, medical school alumni, rural health association and more were attended to name a few.

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

The in-depth analysis of EPSDT exams was placed on a temporary hold due to HealthCheck vacancies. Both the HealthCheck Director and epidemiologist positions were vacant for several months during the year.

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

The survey of medical providers was placed on a temporary hold due to HealthCheck vacancies. Both the HealthCheck Director and epidemiologist positions were vacant for several months during the year.

WV HealthCheck will provide outreach during community events (i.e., Health Fairs, Community events) and disseminate resources and provide education to at least 100 families on USDA MyPlate recommendations.

The HealthCheck program specialists distributed over 1500 resources to families at community resource fairs, baby showers and regional collaborative meetings. Materials included Nutrition Matters from Nutrition Matters, Inc., and MyPlate booklets along with Sugar Shockers on the importance of drinking water instead of sugary drinks.

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

Materials were distributed very early into the grant cycle but were discontinued due to WIC guideline changes. OMCFH worked with WIC on how to support WICs work on disseminating materials to pediatric providers on the new resources. Due to DHHR organizational structure changes, which included logo and branding changes on printed materials, a delay occurred in the planning process. Materials were recently finalized, and distribution plans are being completed.

Distribute via HealthCheck Specialists AAP Clinical Practice Guidelines for Evaluation and Treatment of Children and Adolescents with Obesity and Provide information for Project ECHO surrounding those guidelines on LMS learning system.

The activity was placed on a temporary hold due to HealthCheck vacancies. Both the HealthCheck Director and epidemiologist positions were vacant for several months during the year.

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

RFTS will expand the tobacco cessation project to include two additional DCCs in the upcoming year. The four DCCs currently participating in the WVU School of Dentistry Certified Tobacco Treatment Specialist training will begin serving additional RFTS clients through the Medicaid enhanced service component.

Once certified as a CTTS, the DCCs will partner with other evidence-based home visiting programs (PAT, HFA, MIHOW and EHS) to provide the tobacco cessation project for Medicaid eligible women and caregivers. This will include the use of carbon monoxide (CO) monitors as a motivational tool in the cessation intervention. The CO monitor will provide an estimate of the level of dependency and the degree of harm from smoking. With the addition of the other evidence-based home visiting model, a goal of an additional 30 pregnant smokers will receive the smoking cessation project.

Provide evidence-based adolescent curriculum prevention programs in schools and tobacco/e-cigarette use prevention training for teachers. (NPM 14.2, ESM 14.2.1)

The OMCFH has not completed the Title V Needs Assessment for the coming year and the 2023 YRBS data is not yet available. However, the AHI anticipates vaping and tobacco use will remain a priority area for adolescents and the state's overall population.

After reviewing the most currently available data, if vaping continues to be a Title V priority for WV, the AHI hopes to continue expanding their evidence-based curriculum programming such as CATCH My Breath, but also explore other programs such as the American Lung Association's INDEPTH program, NOT (Not on Tobacco), the School E-Cigarette Toolkit, etc. The AHI will reinforce these programs by encouraging schools and students to participate in individual-level interventions such as SmokeSCREEN, a video game geared toward 10–16-year-olds, and This Is Quitting, a text messaging program developed by the Truth Initiative. The AHI will continue to provide information on JUUL products, due to their continued availability (as of March 2024), despite the ban by the U.S. Food and Drug Administration in 2022. The AHI will also work with the WV Department of Education, the DTP, and other partners to offer 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, website posts, YouTube videos, etc.

If vaping and tobacco prevention remains a Title V priority for WV in the coming year, the AHI will utilize the social learning theory as an important strategy in primary prevention programming in schools and communities. The AHI will disseminate prevention information, resources, and materials throughout the state in schools, community centers, School-Based Health Centers, and other youth-serving organizations. The AHI is also developing a new and improved website that will offer information and resources as well as digital and video campaigns such as The Real Cost Campaign provided the Centers for Disease Control and Prevention and truth® Campaign by the Truth Initiative.

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

Ongoing data analysis of WV PDMP stimulant trends and WV Medicaid data has been an integral part in selecting the initial counties to target for academic detailing sessions. An ongoing partnership with the WV Board of Pharmacy and WVU School of Pharmacy will allow for monitoring of the program's effectiveness with regards to stimulant prescribing trends to be in line with evidence-based recommendations. In addition, Medicaid data analysis will allow for monitoring of prescribing of stimulants without an ADHD diagnosis. Further data analysis is planned for monitoring and evaluating the effectiveness of the academic detailing program.

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

HealthCheck will work with Medicaid and OMCFH nurse abstractors to complete a randomized chart review of 500 pediatric clients. Once the data has been abstracted, the HealthCheck epidemiologist will complete the data analysis and provide a report summarizing the findings. The report will be shared with pediatric providers by region

and be used to develop targeted materials for programs working with children. The report will be shared with the Early Childhood Advisory Council Health Committee for review and a guiding document for the Childhood Obesity workgroup within that committee.

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

The HealthCheck epidemiologist will work with the OMCFH Medical Director and other pediatric champions to develop the survey. Once developed HealthCheck will partner with the West Virginia Chapter of American Academy of Pediatrics to disseminate the survey. Survey results will be analyzed and shared with the annual WVAAP, school-based health center and primary care association meetings for discussion.

WV HealthCheck will provide outreach during community events (i.e., Health Fairs, Community events) and disseminate resources and provide education to at least 100 families on USDA MyPlate recommendations.

HealthCheck specialists will review the most current educational materials appropriate for community events for distribution to at least 1800 families statewide. A community engagement tool will be developed by the HealthCheck epidemiologist for the program specialists to use to capture the number of contacts made at each community event. Healthcheck will focus targeted efforts on the counties with the highest childhood obesity rates.

Healthcheck specialists will work with at least one Parents as Teachers (PAT) home visiting program site per each HealthCheck region to complete Roll & Read events as part of the community outreach and engagement activities. PAT and HMG will partner to host the Roll & Read events which are a community awareness opportunity promoting health literacy, physical activity, healthier eating changes and parent child interaction. The events feature a walk and stroller event for families, reading stations for each page of the book and community partners hosting each of the stations promoting their materials and a make and take activity. Each station will have enough space for children to gather and for children to be able to read/or be read the page assigned by the community partner's station. Each family that visits a station will participate in the planned activity based upon the station's assigned page of the book. Since this activity is the most successful outside, the first of the events will occur starting in the Fall. This will give the LTSAE workgroup time to secure space at each of the locations, recruit community partners, work on promotional materials and ensure well-planned and executed events.

The projected milestones will include at least eighty-four community partners engaged that will promote LTSAE across their local service area. Five hundred families will receive materials on LTSAE and are encouraged to download the LTSAE app.

HealthCheck will utilize the regional family advisory councils to complete listening sessions on messaging that would resonate with families. The regional family advisory councils will also provide input on the barriers related to healthy eating (price, grocery store availability, transportation). This information along with the provider survey and chart abstraction will help develop a HealthCheck childhood obesity strategic plan that will coordinate with the ECAC Health Committee Obesity workgroup.

Distribute WIC resources to families upon initial HealthCheck enrollment of any child 0-5 years of age to encourage increased WIC participation rates.
Discussion will occur on which counties have seen decreases in WIC services, and how HealthCheck specialists can best support provider outreach concerning WIC. Information will also be shared on how families can use WIC through Farmer's Markets, pop up gardens, and food deserts where only convenience and dollar stores are located. WIC partners will be asked to be involved in the obesity prevention workgroup.

Distribute via HealthCheck Specialists AAP Clinical Practice Guidelines for Evaluation and Treatment of Children and Adolescents with Obesity and Provide information for Project ECHO surrounding those guidelines on LMS learning system.

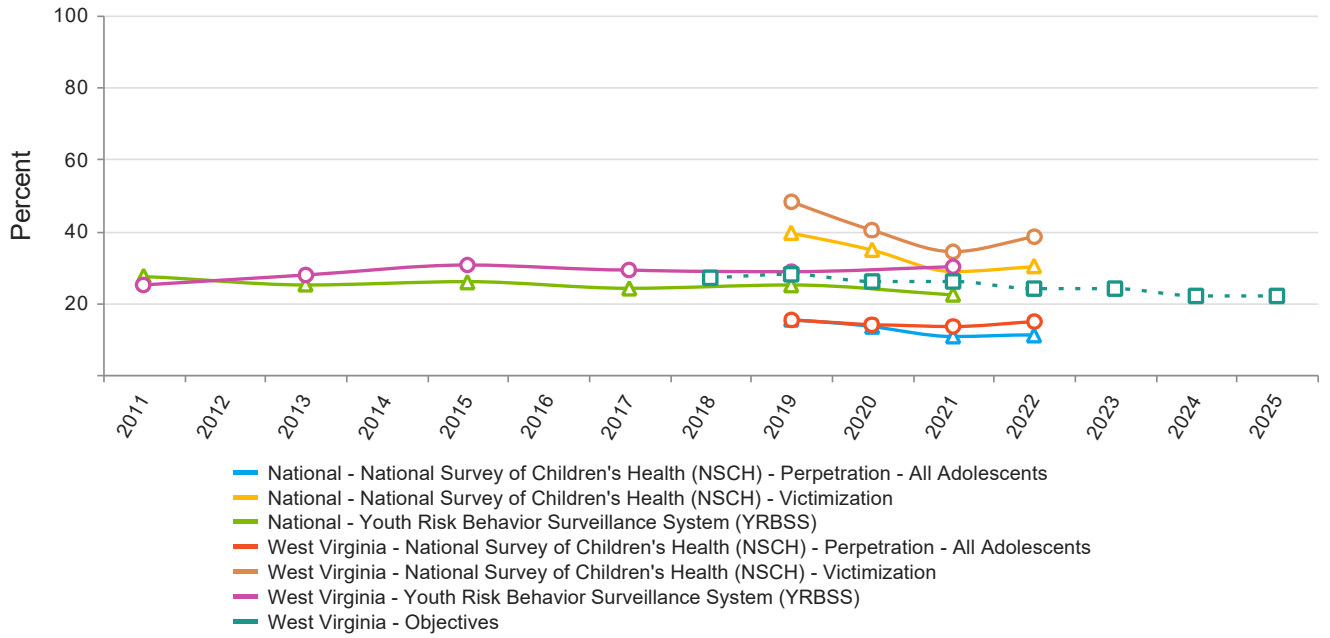
This activity will be removed for the grant period for the upcoming year to focus on some restructuring within the HealthCheck program. A focus will be on increasing the number of well-child visits completed and the behavioral health screening education component with providers. Once the survey of providers and analysis of obesity chart abstractions have been completed, HealthCheck will request guidance from the OMCFH Pediatric Medical Advisory Board on a Project ECHO series that would best support providers with working with children with elevated BMIs, and obesity.

Post Block Review Note: Activities to address children's medical home measures will be included in the Plan for the Upcoming Year after further development.

Adolescent Health

National Performance Measures

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
Indicators and Annual Objectives



NPM BLY - Adolescent Health

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	28	26	26	24	24
Annual Indicator	29.1	28.7	28.7	30.0	30.0
Numerator	22,608	22,112	22,112	22,801	22,801
Denominator	77,715	77,035	77,035	75,901	75,901
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2019	2019	2021	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration - All Adolescents					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	28	26	26	24	24
Annual Indicator	13.6	15.2	14.1	13.7	15.0
Numerator	16,987	18,340	16,805	17,034	19,207
Denominator	124,901	120,396	119,261	123,920	128,357
Data Source	NSCHP	NSCHP	NSCHP	NSCHP	NSCHP-All Adolescents
Data Source Year	2018	2018_2019	2019_2020	2020_2021	2021_2022

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Victimization					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	28	26	26	24	24
Annual Indicator	49.1	48.0	39.8	34.2	38.3
Numerator	61,001	57,581	47,541	42,536	49,222
Denominator	124,257	120,074	119,576	124,235	128,357
Data Source	NSCHV	NSCHV	NSCHV	NSCHV	NSCHV-All Adolescents
Data Source Year	2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	22.0	22.0

Evidence-Based or –Informed Strategy Measures

ESM BLY.1 - Number of positive youth development (PYD) focused trainings provided to youth, parents, professionals and community members

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	112	100	110	115	105
Annual Indicator	144	71	82	106	111
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	108.0	110.0

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	32	38	39	39	35
Annual Indicator	38	30	31	33	48
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	37.0	38.0

ESM BLY.3 - Number of messages disseminated via social media

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	135	125	140	150	310
Annual Indicator	122	111	88	307	110
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	312.0	314.0

ESM BLY.4 - Number of trainings provided to youth, parents, professionals and community members

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	100	110	112	115	72
Annual Indicator	102	59	55	70	77
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	74.0	76.0

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	2022	2023
Annual Objective			0	200	250
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	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 - 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

Five-Year 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 BLY.1 - Number of positive youth development (PYD) focused trainings provided to youth, parents, professionals and community members	Active
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	Active
ESM BLY.3 - Number of messages disseminated via social media	Active
ESM BLY.4 - Number of trainings provided to youth, parents, professionals and community members	Active

NOMs
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

State Action Plan Table (West Virginia) - Adolescent 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.

Five-Year 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.

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 utilizes a positive youth development approach as a part of a comprehensive and holistic view of an adolescent's health and well-being. Positive youth development, or PYD, is based on a body of research suggesting that certain "assets" or positive influences, can help young people succeed and reduce negative outcomes. Researchers have evaluated many programs that target specific issues (violence, substance use, teen pregnancy, etc.) using a PYD approach. There is a growing body of evidence that PYD programs can prevent a variety of risk behaviors among young people and improve social and emotional outcomes.[1]

In early 2020, the AHI partnered with West Virginia University-Parkersburg to conduct surveys in schools to assess the impact of the AHI's PYD programming on students when compared to students who did not receive AHI's program. 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, the turmoil, instability, and isolation during the COVID19 pandemic is reflected in the most current statewide data. In the 2021 WV Youth Risk Behavior Survey (YRBS), 29.3% of students responded that their mental health was mostly or always not good, however that number jumped to almost 37% during the pandemic. The 2021 YRBS also showed increases in sadness and suicide measures from 2019.

	2019	2021
Felt sad or hopeless	36.7	42.3
Seriously considered attempting suicide	18.8	22.2
Actually attempted suicide	8.9	10.2

In 2023, all schools had returned to in-class learning, but some COVID19 restrictions continued, and the number of school and community events had not returned to pre-COVID levels. There were also some vacancies and turnover among the Adolescent Health Coordinators. Despite these challenges, the AHI participated in 111 trainings, presentations and events focused on positive youth development to encourage resiliency, empowerment, leadership, tolerance, youth-adult connectedness, etc. Over 17,000 youth, parents, community leaders, professionals, school personnel and many others attended.

Highlights include (but aren't limited to):

- *Developmental Guidance trainings: Coping skills; Strengths and Challenges; Self-Esteem and Building Confidence*
- *Healthy Grand Families: Sexual Orientation/Gender Identity; Response to Addiction*
- *Building Relationships and Managing Emotions*
- *Environmental Strategies for Community Change*
- *Youth Advocacy Training*
- *Wellness Recovery Action Plan*
- *Getting to Know You*
- *Cope2Thrive*
- *Chair Yoga*
- *STARS Can!*
- *How to Build Developmental Assets*
- *Empower U:Kick-off Tea Party*
- *Navigating Challenging Family Situations*
- *Empower U Tie Dye Activity*
- *Ohio County Student Grief Support Group*

- *Developing Star Leaders*
- *Teen Boot Camp Cooking Class (high school and middle school)*
- *Handle with Care Conference*
- *THINK Conference*
- *Night to Shine*
- *Lean on Me*
- *Stress Management and Coping Skills*
- *How Not to Fall for a Jerk*
- *Vision Board/Future Planning*
- *Fayette County Teen Court*
- *Girls on the Run*
- *ACES to PACES*

The AHI also partnered with 15 youth teams to do 9 community service and youth focused projects. Students donated 510 hours of service and collaborated with 73 organizations. Approximately 3,513 individuals and 13 animals benefitted from their projects.

Lastly, the impact of PYD in AHI's Sexual Risk Avoidance Education program was measured for the 2022-23 school year. While the program's primary focus is pregnancy prevention, the program has a strong emphasis on PYD to reduce multiple correlating risk factors. The program served 1,660 youth from ages 10-19, providing 10+ hours of curriculum programming in school-based settings. Overall, program participants reported that the program made them more likely to engage in healthy behaviors, set goals, identify healthy relationships and that they felt positive about the program. Eighty-seven percent of the participants said they felt respected all or most of the time during the program and 83% felt they could ask questions and discuss topics freely.

Has the program made you much more likely (1), somewhat more likely (2), about the same (3), less likely (4)or much less likely to (5)….	1	2	3	4	5
Resist peer pressure.	43%	30%	20%	3%	3%
Manage emotions in healthy ways	39%	33%	22%	3%	3%
Think about consequences before making a decision.	37%	36%	22%	3%	3%
Make plans to reach your goals.	50%	31%	17%	1%	1%
Care about doing well in school.	43%	28%	25%	2%	2%
Better understand what makes a relationship healthy.	54%	34%	10%	1%	1%
Talk to a trusted adult.	41%	32%	22%	2%	2%

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 it has been conducted every two years since. In 2019, the WVDE recruited the AHI's regional Adolescent Health Coordinator (AHC) network to administer the YRBS surveys in schools across the state. In late 2021, the AHCs conducted YRBS surveys in 29 of WV's 55 counties. COVID19 restrictions made survey implementation impossible during the Spring, so it was delayed until the Fall. However, the YRBS returned to the "normal" Spring schedule in 2023. A total of 36 high schools and 50 middle schools were selected to be surveyed.

The high school 2021 YRBS data shows notable decreases in many risk behaviors since implementation began in 1993, such as: alcohol use (53% vs. 23%); sexual intercourse (63% vs. 30%); and cigarette smoking (77% vs. 18%). There are also significant decreases in school violence indicators:

- Recently carried a weapon on school property (14% vs. 3%)
- Were in a physical fight on school property in the past year (17% vs. 6%)

Despite this, the percentage of students that reported they did not feel safe going to school more than doubled (4% vs. 9%). The percentage of students bullied at school remained level from 2009 (the first year available) to 2017 at

about 24%. This declined in 2019 (20%) and declined even more in 2021 (15%). It's likely that the limited class time due to COVID19 is a contributing factor to the sharp decline in 2021, however the 2019 decline is encouraging. Electronic bullying remained at approximately 16% from 2011 to 2021, however this number peaked at 24% in 2015, so this indicator is also currently declining. Despite these gains, increasingly more students report feeling sad or hopeless from 1999 to 2021 (30% vs. 42%). Suicide attempts and students who have seriously considered suicide have both been trending upwards since 2011 (13% vs. 22% and 6% vs. 10%).

The 2021 YRBS for middle school students shows that some related measures reflect only slight decreases:

- Ever carried a weapon (41% in 2001 vs. 40% in 2019)
- Were ever bullied on school property (47% in 2009 vs. 46% in 2021)

The percentage of students who got in a physical fight decreased significantly decreased (58% in 2001 vs. 44% in 2021). However, in-school bullying remained level, despite the limited class time in 2020 and 2021, and electronic bullying remained fairly level from 2013-2019 but rose significantly in 2021 (27% vs. 34%). The number of students who seriously considered suicide hovered at around 20% from 2001-2017. This number increased to 25% in 2019 and jumped considerably to 32% in 2021. The percentage of middle-schoolers who have attempted suicide has doubled since 2001 (8% vs. 15%), with most of that increase occurring between 2019-2021.

These indicators are dramatically worse among LGBTQ students with 85% indicating they feel sad and hopeless and 30% have attempted suicide . Bullying is also significantly higher with over 40% reporting they are bullied online and in-school. While this data represents a very small number of student respondents (less than 100), it is indicative of how vulnerable this population is.

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.

The AHI's regional AHCs introduced the idea of a bystander intervention and evidence-based programming to schools and communities back in 2017. Program implementation began with 6 schools in FY2018 and has now expanded to 48 schools utilizing an array of comprehensive programs. These programs include the prevention of bullying and all forms of violence including sexual violence, suicide prevention, cyber safety, trauma, mental health, and diversity. These programs include:

- *Connections Matter*
- *Signs of Suicide*
- *Second Step*
- *Darkness to Light*
- *Healthy Grand Families*
- *Oleweus*
- *Too Good for Drugs and Violence*
- *SafeTalk*

All regional AHCs are required to be trained in *Youth Mental Health First Aid* (YMHFA). The YMHFA program 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. The 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 6,703 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: 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*
- *Sexual Orientation and Gender Identity 101*
- *Bounce Back (resiliency)*
- *Question, Persuade and Respond: Suicide Prevention and Megan's Law Training*
- *Ending the Silence*
- *Bystander Intervention*
- *Where's the Line*
- *Shedding Light on Mental Health Awareness Conference*
- *Stressless and Mindfulness*
- *Mindfulness*
- *Talk Saves Lives*
- *Supporting LGBTQ+ Students in the Classroom*
- *I Think I Am Stressed*
- *Suicide Safe, Recognizing and responding on the Front Line*
- *Step Up; be a Leader, Make a Difference*
- *Kindness: Being Kind to Others*

In total, 9,765 youth, parents, school staff and community members attended the AHI's 77 trainings and workshops. The AHI also posted 110 messages, links, and resources on social media; and disseminated 8,773 brochures, life-line cards, fact sheets and other literature on bullying prevention, suicide prevention, depression and mental health, violence prevention, cyber safety, and ACEs.

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

In the application year, collaboration with the WVU School of Pharmacy continued related to ADHD diagnosis and treatment, including the safer use of prescription of stimulants. The website wvadhd.org now hosts the finalized guidelines, "WVACC Guidelines: A West Virginia Guide to Evidence-Informed Evaluation, Diagnosis, and Treatment of ADHD and Comorbid Concerns", in a clickable, easy-to-navigate website. As of February 2024, the entire PDF document, resources, and guideline materials are available for download following extensive review by WVU legal, a scientific editor, the expert panel, and WVDOH. In addition, programmatic continuing medical education courses have been developed and are advertised on this site. Website traffic is monitored to report ongoing use of the page. Various short key messages materials and longer presentations to allow for staff "lunch and learns" or just longer educational sessions have been employed via academic detailing and/or clinical education. Surveys have been implemented (pre and post educational session) to ensure clinician perception of the academic detailing is effective and helpful to their practice. To aid in scheduling and outcomes performance reporting of the academic detailing program, an internal database was created and is utilized to track detailing encounters, materials and educational sessions delivered, contact attempts to providers, and other relevant outcomes. Further, Calendly, an online scheduling platform, is fully integrated with the database, but the forward facing Calendly platform allows for WV Clinicians to schedule academic detailing sessions with a detailer in their area without contacting the program. Prior to February 2024, when the guidelines were yet to be approved for distribution, a "soft" launch of the lunch and learns were offered by request at conferences attended by the academic detailing team. After February 2024, a full programmatic launch of academic detailing was employed targeting counties of high prescribing in each of the detailers' territories. As of 06/07/2024, over 300 academic detailing sessions have occurred, inclusive of in-person, virtual, lunch and learn format. It should be noted that this number is underrepresented due to the current inability to track detailing encounters if the participant does not have an NPI.

Several continuing medical education programs were developed and were hosted by the WVU School of Pharmacy. A half-day virtual training was hosted prior to guideline launch in June 2023 on the evaluation, diagnosis, and treatment of ADHD (42 participants requested credit). A full-day in-person training on the evaluation and diagnosis of ADHD and nonpharmacological treatments was hosted in August 2023 (76 participants requested credit), and a

repeat of this conference is set to be hosted on June 28, 2024. Also, a lunch series hosted the second Thursday of the month on various topics relating to ADHD has been made available since August 2023 with approximately 40 participants monthly. Ongoing efforts to provide academic detailing lunch and learn sessions as continuing medical education have been made and are nearly finalized for topic "Evaluation and Diagnosis of ADHD" session.

West Virginia University's School of Pharmacy has also attended various continuing education conferences for various clinician types throughout the state as both a speaker and an exhibitor. Members of the academic detailing team have either presented or been available for attendees to discuss the new guidelines to promote awareness and promote uptake of the new guidelines and participation with the academic detailing team. Conferences for pediatrics, family medicine, school nursing, medical school alumni, rural health association and more were attended to name a few.

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

In 2017, West Virginia began collecting data on adolescent prescription misuse on the Youth Risk Behavior Surveillance (YRBS) survey. From 2017 to 2021 (the most recent data available, prescription misuse among high school students has remained around 12%. However, the data shows prescription misuse has increased significantly for middle school students from 2017 to 2021 (3.6% to 10.8%). While the data is still somewhat limited, this is a concerning trend.

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.[2]

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.[3]

West Virginia's opioid epidemic began in the 1990s and continues to have the highest rate of drug overdose deaths in the nation (80 per 100,000).[4] This crisis has so severely overwhelmed WV communities and families that they can think of little else. This has made it difficult to garner and maintain interest specific to stimulant abuse. But the data shows methamphetamine overdoses are equally concerning. Methamphetamine and opioid polysubstance overdose deaths have risen sharply in WV, from only 18 in 2015, to a peak of 468 in 2020. The AHI is working to raise awareness of this emerging threat among adolescents and communities as a whole.
During the reporting period, the AHI provided education and information to a total of 2,694 youth, parents, school staff and staff from other communities or youth serving organizations. Trainings, events, and programs included (but not limited to):

- *Understanding Addiction*
- *Making Smart Choices*
- *Too Good for Drugs*
- *I CAN Be Clean by Staying Drug Free*
- *Substance Abuse in Youth*
- *Drugs: Safe Storage and Disposal*
- *The More You Know*
- *Youth Substance Use Disorders*
- *Adolescent OTC, Prescription, and Inhalant Abuse Awareness*
- *Bowling to Strike Out Drugs*
- *Prevention Day at the Capitol*

- *Drug and Alcohol Facts Week in multiple counties*
- *Back to School Bashes and Community Block Parties across the state*
- *Red Ribbon Week activities across the state*
- *Distributed nearly 2,000 pieces of literature and information on the harmful effects of substance misuse*

The AHI also coordinated peer support groups to help students cope with stress, trauma, and grief; including students who have lost a parent, friend, or loved-one to overdose.

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[1] Positive Youth Development | The Administration for Children and Families (hhs.gov)

[2] https://publichealth.jhu.edu/2016/adderall-misuse-rising-among-young-adults

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

[4] https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm

Adolescent Health - Application Year

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 will continue to maintain a comprehensive and holistic view of adolescents' health and well-being. The AHI looks beyond individual risk behaviors to focus on the overlap between behaviors, their underlying common causes, and successful interventions. Extensive research into positive youth development (PYD) steered the program to a more comprehensive approach in 1993. No matter what priority needs are identified in the coming year, the OMCFH believes supportive factors must be available to adolescents in general and on an individual basis to reduce negative outcomes.

The AHI Director and community based AHCs have a longstanding association with the West Virginia Department of Education and have facilitated many training sessions for school administrators, teachers, school nurses, and other school personnel on PYD models, including Risk and Protective factors and the Search Institute's 40 Developmental Assets®. Additionally, all AHI staff serve on multiple school and community-based boards and coalitions, which include representatives from all sectors of the community including youth. 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/or other risk behaviors prioritized by the upcoming needs assessment.

The AHI will continue to analyze the impact of PYD programming in our Title V Sexual Avoidance Education programming, utilizing surveys developed by the HHS/Administration for Children and Families.

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.

Since 2019, the WV Department of Education (WVDE) has 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 since 2020. The AHI will continue to work with the WVDE to promote and disseminate data as it becomes available but will assist the OMCFH's Division of Epidemiologic Evaluation and Population-based Surveillance (DEEPS) with YRBS grant implementation and survey administration, with the WVDE providing support where needed.

The OMCFH will utilize this data for the upcoming needs assessment, but also realizes the importance of sharing available data so other stakeholders can identify and implement relevant programming in addition to what the Office is able to support and implement.

The AHI also conducts youth needs assessments and Child PTSD Symptom Screeners in teen pregnancy prevention curriculum classes. In the 2022-23 school year, the AHI administered 1,388 needs assessments, 419 trauma screeners and made 54 referrals for services. The AHI will continue to collect data from these assessments throughout 2024-25 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 partnered with the WV 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 training in Adverse Child Experiences (*ACEs*) and *Trauma Informed Schools,* and *Handle with Care* evidence-based models. The AHI believes these programs will continue to be needed to support any needs identified in OMCFH's needs assessment. 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.

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

optimum outcomes.

Ongoing data analysis of WV PDMP stimulant trends and WV Medicaid data has been an integral part in selecting the initial counties to target for academic detailing sessions. An ongoing partnership with the WV Board of Pharmacy and WVU School of Pharmacy will allow for monitoring of the program's effectiveness with regards to stimulant prescribing trends to be in line with evidence-based recommendations. In addition, Medicaid data analysis will allow for monitoring of prescribing of stimulants without an ADHD diagnosis. Further data analysis is planned for monitoring and evaluating the effectiveness of the academic detailing program.

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

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."[1] 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.[2] This trend is echoed in the WV YRBS data, particularly for middle schoolers (3.6 in 2017, 6.3 in 2019, and 10.8 in 2021).

A common misperception is that prescription drugs are safer or less harmful than other kinds of drugs, particularly in a state overwhelmed with heroine and fentanyl addiction. The state, as a whole (government, communities, families, schools, etc.), is largely focused on the opioid crisis and leading the nation in opioid overdose deaths. However, more emphasis is needed around the fact that WV also leads the nation in stimulant overdose deaths.[3] The current stimulant epidemic is closely tied to the ongoing opioid epidemic, with as individuals report using stimulants to balance out the sedative effects of opioids or to manage withdrawal symptoms.[4] For this reason, the AHI anticipates adolescent substance use will remain a priority area in WV.

The Adolescent Health Initiative (AHI) will educate parents, children, schools, and the community on the impact of prescription drug misuse 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. The AHI will also provide regional and statewide professional development training featuring programs like Generation RX. In partnership with Concord University, the AHI's trainings will provide graduate credit hours and continuing education units to teachers, social workers and other professionals who complete the training and teach the curriculum in their school and/or community.

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

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

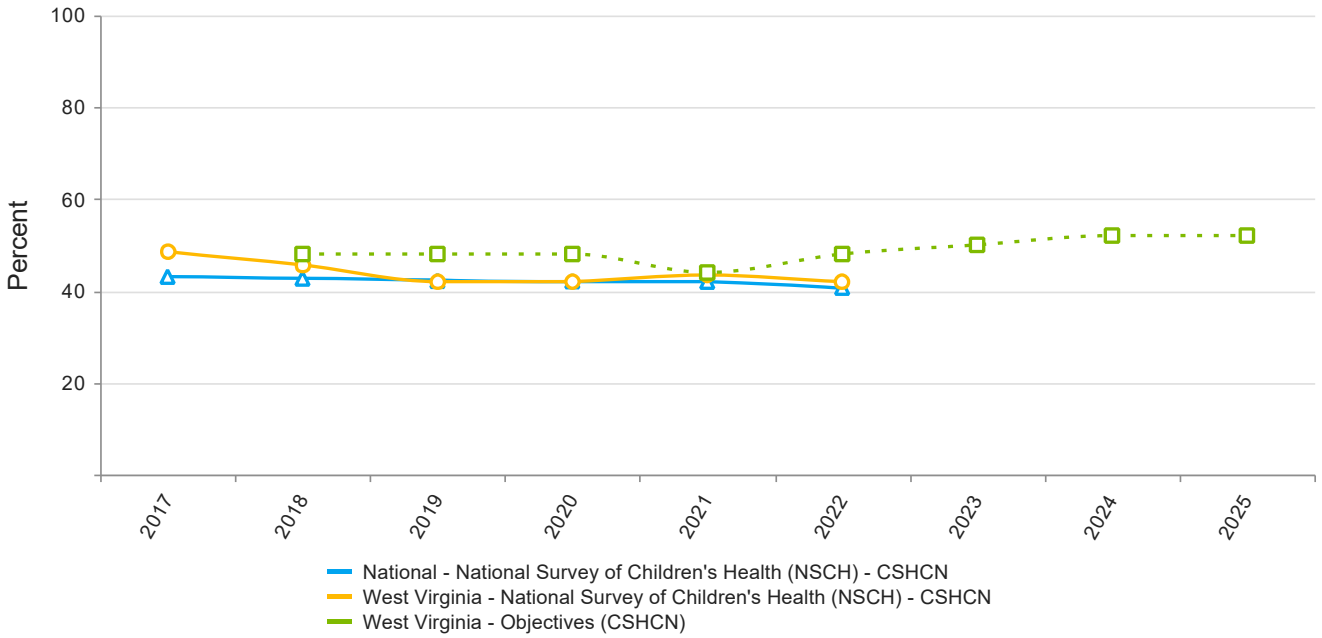
[3] https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html, all stimulants, 2021

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10102888/

Children with Special Health Care Needs

National Performance Measures

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
Indicators and Annual Objectives



NPM MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	48	48	44	48	50
Annual Indicator	45.2	41.8	41.9	43.3	41.9
Numerator	40,169	36,658	34,916	33,839	36,683
Denominator	88,838	87,648	83,316	78,078	87,498
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	52.0	52.0

Evidence-Based or –Informed Strategy Measures

ESM MH.3 - Number of children who receive Title V funded medically necessary medical foods.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			290	310	330
Annual Indicator	270	284	327	280	314
Numerator					
Denominator					
Data Source	CSHCN	CSHCN	CSHCN and NBS	CSHCN and NBS	CSHCN and NBS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	350.0	370.0

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.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	16.3	8.6
Numerator	597	347
Denominator	3,657	4,029
Data Source	CSHCN Program Comprehensive Tracking System	CSHCN Program Comprehensive Tracking System
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	17.0	20.0

State Performance Measures

SPM 5 - Percent of CSHCN who pay more than $500 for their medical, health, dental, and vision care during the last 12 months.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	26.8	26.2
Numerator	20,925	22,886
Denominator	78,078	87,331
Data Source	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2020/2021	2021/2022
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	27.0	27.0

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 - 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

Five-Year 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.

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

ESMs	Status
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.	Inactive
ESM MH.3 - Number of children who receive Title V funded medically necessary medical foods.	Active
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.	Active

NOMs
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

State Action Plan Table (West Virginia) - Children with Special Health Care Needs - Entry 2

Priority Need

Increase medical home for children with and without special health care needs.

NPM

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

Five-Year Objectives

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.

Strategies

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.

ESMs	Status
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.	Inactive
ESM MH.3 - Number of children who receive Title V funded medically necessary medical foods.	Active
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.	Active

NOMs

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

State Action Plan Table (West Virginia) - Children with Special Health Care Needs - Entry 3

Priority Need

Increase medical home for children with and without special health care needs.

SPM

SPM 5 - Percent of CSHCN who pay more than $500 for their medical, health, dental, and vision care during the last 12 months.

Five-Year Objectives

To decrease the finance burden of out-of-pocket costs for CSHCN and their families.

Strategies

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

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

The Parent Partners in Education (PPIE) Project has continued to train physicians and medical students in the expanded Project DOCC curriculum. The curriculum was expanded to include the parent perspective of care received through the PCMH. This is the second complete grant year for the expansion. Along with the expansion of the curriculum, parent trainers have also increased. Both pediatric and family practice residents, as well as medical students, receive this training.

Training Overview (July 1, 2022 - June 30, 2023)

- Resident Trainings:
  - Participants: Five Pediatric Residents, eight Family Practice Residents, and four 4th-year medical students (MS4).
  - Sessions: Three-part training sessions.
    1. Overview and Local Resources:
       - Introduction to the project and local resources.
       - Discussion on the importance of being a medical home and creating a collaborative relationship.
       - Emphasis on the role of vaccinations within a well-functioning medical home.
    2. Parent Home Visit Training:
       - Exposure to families in their own homes and communities.
       - Understanding the family's journey and adaptations to care for their children.
    3. Parent Interviews:
       - Learning to ask relevant questions during office visits.
       - Understanding the similarities and differences in caring for children with developmental disabilities.
       - Reinforcement of the family's role through pictures and stories.
- Third Year Medical Student Training:
  - Participants: 64 third-year medical students (MS3) across six training sessions.
  - Sessions: 1 1/2-hour grand round presentations by parents of children with disabilities/chronic illnesses.
    - Insights into the families' lifestyles, adaptations, equipment, and resources.
    - Understanding the concept and implementation of a medical home in practice

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

West Virginia House Bill 4193, introduced on January 10, 2024, focused on addressing social determinants of health (SDOH) through the establishment of the Minority Health Advisory Team and the authorization of a Community Health Equity Initiative Demonstration Project. The key elements of the bill include:

- Establishment of the Minority Health Advisory Team, the composition and duties aimed at addressing health disparities and improving health outcomes for minority populations;
- Development of the Community Health Equity Initiative Demonstration Project, authorized by the Commissioner of the Bureau for Public Health that includes objectives that address child and family poverty, educational limitations, and other SDOH, and development of a comprehensive community development plan to serve as a model for the state;
- Development of specific eligibility requirements for participation in the demonstration project and administration guidelines to ensure effective implementation and oversight;
- Detailed requirements for the development of the demonstration project plan. Selection criteria for communities to participate in the project. Involvement of state and local government agencies, nonprofit organizations, and private sector entities;
- Collaboration between local participants and state and federal health officials to conduct health impact

assessments;
- Regular reporting on the progress and outcomes of the demonstration project. Establishment of a termination date for the project to evaluate its effectiveness.

The primary objective of the demonstration project is to improve public health by addressing key SDOH such as child and family poverty and educational limitations. The plan aims to serve as a comprehensive community development model to be implemented statewide. Key components are the identification of state and local government agencies, nonprofit organizations, and private sector entities to participate, focused and directed use of resources to achieve anticipated outcomes and collaboration between local participants and health officials to assess the health impact of the project. This bill died in committee and did not pass out of the 2024 Regular Session.

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

Nutrition services are a vital part of the services that the CSHCN Program delivers. The CSHCN Program has always been a payor of last resort for nutrition services but other payor sources are dwindling as shown in the daily care coordination of nutrition cases. The need for nutritional services among the CSHCN pediatric population continues to grow exponentially as evidenced by the increase of nutrition referrals over the 2023 – 2024 year. The CSHCN Program is receiving more complex pediatric referrals that require nutrition services. This is also evidenced by the increased time that the CSHCN Eligibility Unit (EU) staff are spending on care coordinating referrals with nutritional needs and ensuring the nutrition formula/foods prescription is pertinent and directly related to a nutritional medical diagnosis. The subset of nutritional care coordination in the CSHCN EU is time consuming as all nutritional requests of the nutritional child are verified to current claims data and/or medical and clinical records which the CSHCN EU staff review and confirm.

The CSHCN Program receives numerous nutritional referrals from the Medicaid-managed care organization (MCO) daily directly via the CSHCN EU email. The CSHCN EU staff will be in direct contact with the MCO Case Manager and collaborate for the best coverage of the request for nutritional supplements. The CSHCN EU staff is in contact with various pediatric specialty children's hospitals and all state hospitals and specialists to confirm or clarify nutritional requests and prescriptions for the child. After the nutritional request meets CSHCN nutritional eligibility standards the child is enrolled into the program. The nutritional case is assigned to the designated CSHCN Regional Care Coordination Team for further comprehensive care coordination provided by Registered Professional Nurses and Licensed Social Workers. All aspects of the CSHCN nutrition cases are at one time reviewed or discussed by CSHCN staff and/or OMCFH Leadership in staff meetings or weekly multidisciplinary team (MDT) meetings.

CSHCN will provide case management to infants diagnosed with NAS.

In the past, NAS/intrauterine substance exposed (IUSE) referrals were enrolled into the CSHCN Program as a categorically eligible client based upon the related NAS/IUSE ICD-10 coding. Children experiencing NAS/IUSE are still considered categorically eligible for the CSHCN Program, but it is increasingly difficult to enroll these children due to the hesitancy of the family to participate. The CSHCN Program is still based on voluntary enrollment and participation, and it is reported by staff that most of the families of the NAS/IUSE children do not want their child involved in a state government program. CSHCN staff relay that families are voicing fear of the children being removed from their care or that child protective services will watch and monitor children with NAS/IUSE.

These diagnoses and coding were seen in the birth records and subsequent medical/clinical records as these children developed. A child's medical/clinical records would reflect comorbidities that seem to be associated with IUSE, especially those presenting with neurodevelopmental anomalies. This has not been the case for the past year because the NAS diagnosis is considered resolved at the birth admission and is not documented in most follow-up well child exams or interperiodic visits for the child. Perinatal substance exposure is also not documented in a child's medical records. The CSHCN Program has held meetings and discussions with internal and external partners to question the lack of the NAS/IUSE diagnoses carrying over into a child's medical records. The CSHCN Director of Nursing/Clinical Services and CSHCN staff are being informed that these diagnoses are stigmatizing to both a child and to its mother. Birthing facilities and medical homes are also considering the diagnoses as criminalizing to the families.

Collaborate with Marshall University to expand the WVU complex care clinic model.

The CSHCN Director of Nursing/Clinical Services with the CSHCN nursing staff are highly aware of the lack of pediatric specialists in Southern WV. The awareness is cemented by the medical facts and details as documented in the medical/clinical records and sociodemographic records of the CSHCN clients from this area. Challenges in this area include mountainous terrain and low population density. The lack of available transportation and access to healthcare services are both common social determinants that face all WV children but are more prevalent in this area of the state. The harshness of the terrain affects all daily aspects of being a child and/or parent in WV. Due to the changes in the provision of medical services, especially as evidenced through the pandemic, there is a true need for telehealth collaboration among Marshall University's School of Medicine and other healthcare providers across the southern and western parts of the state.

Demonstrate care coordination activities with behavioral health conditions (pathway to children's health services); track referrals to children's crisis and referral line.

The CSHCN Program currently does not provide mental/behavioral care coordination not related to a special physical health care need, yet the need for all mental/behavioral care coordination is paramount. Immediate goals for the upcoming year are for CSHCN staff members to become informed, trained and provided further education on the available mental/behavioral services within WV. Quarterly meetings between CSHCN and the Bureau of Social Services (BSS) have been proposed to strengthen the collaboration between the agency and CSHCN program to ensure continuity of care coordination for the foster population with an emphasis on behavioral services. Through the BSS and CSHCN relationship, the CSHCN program works with BSS on introductions and providing CSHCN program services to local foster placement agencies. As local foster placement agencies offer community-based treatment, short-term foster care, foster family resources, counseling, mental health support services, respite and 24/7 crisis support, CSHCN supports care planning in collaboration to assure quality care coordination with the whole child and family-centered medical home concepts in mind.

Increase understanding of CSHCN non-compliance with medical, diagnostic, specialty appointments, with emphasis on post pandemic.

The CSHCN Program continues to collaborate with the WV Managed Care Organizations (MCOs) by comparing kept appointments, identifying no shows for appointments, establishing trends and reasons of noncompliance. Collaborative plans of action to assist families with barriers or obstacles to accessing care are developed as needed.

The CSHCN Program is also developing teaching tools that inform and educate CPS workers on what defines a child with special physical health care needs. The goal of these tools are to help a CPS worker differentiate between a child with disabilities and a child with complex medical needs hopefully resulting in an increase in understanding of the urgency of the CSHCN CPS referral for medically complex children in state custody.

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

The PPIE project, through its robust training programs, equips future physicians with the knowledge of the importance of receiving care through a PCMH from the parent perspective. The CSHCN Program plans to develop with the PPIE additional curriculum to foster a deeper understanding and appreciation of the PCMH model to provide future physicians with the skills needed to improve the health outcomes and quality of life for families with CSHCN.

The PPIE project serves as a valuable example of how training and education can facilitate the successful implementation of the PCMH model, ultimately benefiting both healthcare providers and the families they serve. However, adoption of a preferred PCMH Model within the CSHCN Program and providing related training to CSHCN collaborators can significantly improve care quality, family satisfaction, and health outcomes.

Another aspect for the CSHCN Program to consider in the PPIE project should be an emphasis on the physical health components of assessing children with special health care needs. Residents and medical/health students typically do not receive conventional education and hands-on experiences in how to assess and evaluate a child with complex medical needs. The CSHCN Program is best positioned to continue to support the PPIE project with an increase in supporting teaching and training to the medical residents/health students of the physical presentation of each medically complex child. The resident students should be trained to work and collaborate with the parent/families of the medical complex child to determine what the baseline of health for the child is, as each complex child presents differently as unique to his/her health history. Placing medical emphasis on physically evaluating children with special health care needs should carry over into medical residents practice, specialty care and medical homes.

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

To effectively assess and improve the completion rate of SDOH screening at all well-child exams the CSHCN Program will collaborate with partners to:

- Educate providers about the importance of SDOH screening and how to effectively conduct these screenings
- Implement standardized screening tools such as the American Academy of Pediatrics (AAP) SDOH screening tool or other validated instruments.
- Integrate SDOH screening into EHR systems to ensure screenings are consistently conducted and documented.
- Establish a system for monitoring completion rates and reporting on progress
- Educate families about the purpose of SDOH screening and encourage their participation.

Additionally, the CSHCN Program will create standardized protocols for SDOH screening at all well-child exams, work with EHR vendors to integrate SDOH screening questions into the well-child visit templates and implement continuous quality improvement processes to enhance the screening process and address barriers to completion.

In April 2024, the CSHCN Director of Nursing/Clinical Services and nursing staff of the EU met with the West Virginia University (WVU) Chief Medical Information Officer/Associate Professor of Pediatrics and the WVU Assistant Program Director of the WVU Divisions of Internal Medicine/Pediatrics to discuss the collaboration of the CSHCN Program and WVU in establishing the WVU EPIC EHR as a standard EHR for well child exams. In creating an OMCFH-approved standard EHR format, the CSHCN Program can be instrumental in influencing the content of the components and formats that contribute to EHRs. With the rurality of WV and the lack of access to specialty care for children with special health care needs, the CSHCN Program can work with providers and medical homes to best capture the SDOHs that are vital for screening on the well child exams. The CSHCN Program is in the process of reviewing over 248 WVU EPIC Well Child exams that were obtained from a 2023 Department of Justice (DOJ) project. Registered nurse reviewers are in the process of drafting the tool that will be used to evaluate quality and content of the 248 WVU well child exams. After the tool is completed, it will then be internally reviewed and vetted by the OMCFH/Bureau Leadership and submitted to the WVU physicians working on this project. The end goal will be to have a standardized tool for the nurse reviewers to extrapolate information from the exams and report areas of need on the well child exams from EPIC.

By focusing on the completion rate of SDOH screening at well-child exams, the CSHCN Program and partners can play a pivotal role in addressing the broader determinants of health that affect children's well-being. Through comprehensive training, standardized protocols, and effective use of EHR systems, the CSHCN Program and partners can enhance the delivery of holistic care and contribute to better health outcomes for all children.

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 care coordinate the nutritional needs as they present. With finite funds available in Title V dollars, the CSHCN Program will continue to identify and review the medically complex nutrition cases and resource other payor sources. The CSHCN Program is currently collaborating with other Bureau and OMCFH programs to better screen nutritional referrals and payor sources that are first or supplemental. The program is taking a step back and reviewing current nutritional services and auditing medical foods cases to ensure duplication of services is not occurring. The CSHCN Program meets monthly with the Managed Care Organizations (MCOs) and continues to collaborate and discuss dual enrolled nutrition clients. CSHCN staff works daily with the MCO Case Managers and specialty providers that provide nutrition services for the CSHCN clients by care coordinating and acting in a liaison role.

OMCFH Leadership is heavily involved in the knowledge and awareness of the CSHCN nutrition services. All parties will continue to work together on trending nutrition issues for continued programmatic stewardship of the Title V dollars used to support these needs.

CSHCN will provide case management to infants diagnosed with NAS.

CSHCN will continue to conduct surveillance on the NAS/Intrauterine exposed referrals and currently enrolled with the updates and changes noted to the medical/clinical records. The program will continue to collaborate with the state Medicaid Managed Care Organizations (MCO), DHHR partners, state universities and external agencies to provide the specialty care coordination as needed.

The CSHCN Director of Nursing/Clinical Services continues to have concerns that IUSE will not be carried over into a child's medical record. The CSHCN Program will meet with the MCOs to discuss in detail their underwriting and case management of clients with NAS/IUSE diagnoses. The CSHCN Director of Nursing/Clinical Services and CSHCN staff are drafting a questionnaire to interview pediatric healthcare providers for their medical treatment plans and care implementation of the NAS/IUSE children. The outcome from these interviews will become the draft for a survey to be given to medical homes and providers to document the reality of what they are seeing in their practices regarding NAS/IUSE.

Collaborate with Marshall University to expand the WVU complex care clinic model.

The CSHCN Director of Nursing/Clinical Services will meet and collaborate with pediatric specialists from Marshall University to discuss the feasibility of establishing a complex medical pediatric clinic that will concentrate on special complex needs.

Demonstrate care coordination activities with behavioral health conditions (pathway to children's health services); track referrals to children's crisis and referral line.

The CSHCN Program currently does not provide mental/behavioral care coordination not related to a special physical health care need, yet the need for all mental/behavioral care coordination is paramount. Immediate goals for the upcoming year are for CSHCN staff members to become informed, trained and provided further education on the available mental/behavioral services within WV. Quarterly meetings between CSHCN and the Bureau of Social Services (BSS) will be proposed to strengthen the collaboration between the agency and CSHCN program to ensure continuity of care coordination for the foster population with an emphasis on behavioral services. Through the BSS and CSHCN relationship, the CSHCN program will work with BSS to be introduced and provide CSHCN program services to the local foster care agencies. As local foster care agencies offer community-based treatment, short-term foster care, foster family resources, counseling, mental health support services, respite and 24/7 crisis support, CSHCN desires to support care planning in collaboration to assure quality care coordination with the whole child and family-centered medical home concepts in mind.

Increase understanding of CSHCN non-compliance with medical, diagnostic, specialty appointments,

with emphasis on post pandemic.

The CSHCN Program will explore opportunities to capture data of the noncompliant CSHCN clients for their medical/health appointments. After a process for data collection is established, a process for identifying noncompliant CSHCN clients will be created, with a workflow that the CSHCN care coordination staff can follow. The intent of the workflow will be to guide CSHCN staff on assisting CSHCN families to maintain and keep medical appointments. There will be no punitive measures to this workflow; instead, the process will reflect understanding, compassion, and awareness of how difficult daily care for a child with special health care needs can be. A particular area of interest is teasing out noncompliant clients that occurred during the COVID-19 pandemic time frame. A defined communication script with open-ended questions will be created to be used in conversation with families to document both pandemic and non-pandemic related concerns about taking children to medical appointments.

Additionally, the CSHCN Program will continue to collaborate with the WV Managed Care Organizations (MCOs) by comparing kept appointments, identifying no shows for appointments, establishing trends and reasons of noncompliance. A collaborative plan of action to assist families with barriers or obstacles to accessing care will be developed.
Lastly, the CSHCN Program will develop a teaching tool that informs and educates CPS workers on what defines a child with special physical health care needs. The goal of this tool should help the CPS worker differentiate between a child with disabilities and a child with complex medical needs with an increase in understanding of the urgency of the CSHCN CPS referral for medically complex children in state custody.

Cross-Cutting/Systems Building

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					
	2019	2020	2021	2022	2023
Annual Objective	20	22	29	33	29
Annual Indicator	19.9	25	29.6	27.4	22.8
Numerator	25,058	30,365	35,854	34,333	29,223
Denominator	125,615	121,321	121,234	125,369	128,421
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	30.0	31.0

State Action Plan Table

State Action Plan Table (West Virginia) - Cross-Cutting/Systems Building - Entry 1

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

Five-Year 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

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.

Cross-Cutting/Systems Building - Annual Report

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

Cross-Cutting/Systems Building - Application Year

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

III.F. Public Input

The Office of Maternal, Child and Family Health formally makes its application and annual report available for review by the public on its website. Through this process, the Office receives requests for additional information from partner organizations, but input from the public is more limited through these venues.

To enhance input and feedback for its operations, the Office both coordinates and participates on numerous advisory boards throughout the year. Key informant input is continuously sought for program planning and quality improvement.

Input from key informants is used in the 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	WV Perinatal Partnership Infant and Maternal Mortality Review Panel Maternal Risk Screening Advisory Perinatal and Women's Health Medical Advisory Committee Office of Drug Control Policy
Perinatal and Infant Health	WV Perinatal Partnership Newborn Metabolic Screening Advisory Newborn Hearing Screening Advisory Infant and Maternal Mortality Review Panel Maternal Risk Screening Advisory
Child Health	OMCFH Pediatric Medical Advisory Board Child Fatality Review Team Childhood Lead Poisoning Advisory Bureau for Social Services Family Resource Networks WV Department of Education Governor's Early Childhood Advisory Council
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 Emergency Medical Services for Children WV Department of Education Parent Partners in Education Commission for the Deaf and Hard of Hearing
Adolescent Health	OMCFH Pediatric Medical Advisory Board WV Department of Education Prevent Suicide WV Coalition WV Sexual Violence Coalition WV Foundation for Rape Information and Services WV Violence and Injury Prevention Program Office of Drug Control Policy

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 WV Perinatal Partnership (i.e., West Virginia's Perinatal Quality Collaborative (PQC); covering the women/maternal health and perinatal/infant health domains), the OMCFH Pediatric Medical Advisory Board (covering the child health and adolescent health domains), and the West Virginia University Center for Excellence in Disabilities (state lead agency for Family-to-Family Health Information Center) and the Children with Special Health Care Needs Medical Advisory Board (covering the CSHCN domain).

III.G. Technical Assistance

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 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.

Finally, the Appalachia Region includes all of West Virginia and parts of 12 other states (Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia). According to a 2019 National Vital Statistic Report (1), in 2017, there were 275,493 births to women who lived in Appalachia, accounting for 7.2% of all births. People in Appalachia have worse health and health outcomes than those living in the rest of the United States, including rates of obesity and diabetes. Infants born to women in Appalachia have worse birth outcomes, as measured by rates of preterm birth, low birthweight, and infant mortality than those born to women in the rest of the United States. These adverse outcomes are associated with higher levels of teen childbearing, lower educational attainment, and less timely or no prenatal care. Additionally, there are persistent economic disparities in the region, as the Appalachian counties of these states reflected higher poverty rates compared with the rest of the United States.

The region includes 420 counties and 26.0 million people. There is a need to address the maternal and child health disparities across the entire state of West Virginia. To do this effectively, there is a need for technical assistance to create a multi-state approach to identify shared policy approaches to improve outcomes and reduce drivers of health disparities in our Appalachian communities.

1. *Driscoll AK, Ely DM. Maternal Characteristics and Infant Outcomes in Appalachia and the Delta. Natl Vital Stat Rep. 2019 Sep;68(11):1-15. PMID: 32501206.*

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - WV Interagency Agreement_DH and DoHS.pdf

V. Supporting Documents

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

Supporting Document #01 - OMCFH ADVISORIES 2024.pdf

Supporting Document #02 - 2024 Additional Success Story.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - West Virginia Department of Health-Organizational Charts 2024.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: West Virginia

	FY 25 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,227,187	
A. Preventive and Primary Care for Children	$ 2,431,618	(39%)
B. Children with Special Health Care Needs	$ 2,251,989	(36.1%)
C. Title V Administrative Costs	$ 620,535	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,304,142	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 14,833,519	
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)	$ 40,242,063	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 55,075,582	
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)	$ 61,302,769	
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)	$ 31,081,839	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 92,384,608	

OTHER FEDERAL FUNDS	FY 25 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 366,998
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 258,701
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,198,911
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 1,441,745
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 175,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 331,711
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)	$ 616,668
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 525,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,104,408
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,439,820
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 2,587,723
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	$ 1,100,000
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) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 525,000

OTHER FEDERAL FUNDS	FY 25 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 5,126,360
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 120,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Injury Prevention and Control	$ 5,339,590
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 1,119,204
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enchancing Reviews and Surveillance to Eliminate Maternal Mortality	$ 370,000

	FY 23 Annual Report Budgeted		FY 23 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,205,535 (FY 23 Federal Award: $ 6,367,323)		$ 5,446,687	
A. Preventive and Primary Care for Children	$ 2,582,874	(41.6%)	$ 1,982,618	(36.4%)
B. Children with Special Health Care Needs	$ 1,994,991	(32.1%)	$ 2,195,068	(40.3%)
C. Title V Administrative Costs	$ 521,721	(8.4%)	$ 489,394	(9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,099,586		$ 4,667,080	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 14,881,084		$ 11,936,001	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 1,809	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 26,718,824		$ 20,758,082	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 41,599,908		$ 32,695,892	
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		$ 38,142,579	
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		$ 30,345,100	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 77,497,598		$ 68,487,679	

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,116	$ 98,250
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020	$ 148,032
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 342,682	$ 382,542
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	$ 329,755
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,206,323	$ 1,910,227
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,340,457	$ 2,315,687
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 187,747
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 208,128
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 120,000	$ 39,999
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	$ 3,710,472
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	$ 6,173,194
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	$ 1,128,105

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 600,000	$ 204,108
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 370,000	$ 317,917
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Grants to States to Support Oral Health Workforce	$ 400,000	$ 183,445
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 393,095	$ 371,007
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	$ 4,475,881
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Association of University Centers on Disabilities	$ 94,000	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Overdose Data to Action	$ 7,332,338	$ 5,751,795
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Firearm Injury Surveillance through Emergency Rooms	$ 149,968	$ 850
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Emergency Department Surveillance of Non	$ 146,985	$ 32,296
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > American Rescue Plan Act		$ 1,123,760
US Department of Education > Office of Special Education Programs > Infants & Toddlers COVID		$ 321,633
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > EPIDEMILOGY & LAB CAPACITY FOR PREVENTION & CONTROL		$ 11,561

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health Workforce Activities- Supplemental		$ 30,235
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > MIECHV Innovation Grant		$ 888,474

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Due to COVID, our enrollment was done which caused the expenses to be down	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Due to COVID, our enrollment was done which caused the expenses to be down	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Due to COVID, our enrollment was done which caused the expenses to be down	
4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Due to COVID, our enrollment was done which caused the expenses to be down	
5.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Paid with other state funds cash account	
6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Due to COVID, our enrollment was done which caused the expenses to be down	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: West Virginia

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 156,293	$ 153,844
2. Infants < 1 year	$ 208,080	$ 410,325
3. Children 1 through 21 Years	$ 2,431,618	$ 1,982,618
4. CSHCN	$ 2,251,989	$ 2,195,068
5. All Others	$ 558,672	$ 215,438
Federal Total of Individuals Served	$ 5,606,652	$ 4,957,293

IB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 368,857	$ 40,976
2. Infants < 1 year	$ 428,152	$ 418,803
3. Children 1 through 21 Years	$ 2,502,636	$ 699,159
4. CSHCN	$ 10,408,878	$ 10,373,204
5. All Others	$ 330,189	$ 233,021
Non-Federal Total of Individuals Served	$ 14,038,712	$ 11,765,163
Federal State MCH Block Grant Partnership Total	$ 19,645,364	$ 16,722,456

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 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 1,439,368	$ 962,690
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 156,293	$ 153,844
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 1,283,075	$ 808,846
2. Enabling Services	$ 195,000	$ 708,084
3. Public Health Services and Systems	$ 4,592,819	$ 3,775,913
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		$ 107,495
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Payroll, subrecipients, travel, etc		$ 855,195
Direct Services Line 4 Expended Total		$ 962,690
Federal Total	$ 6,227,187	$ 5,446,687

IIB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 561,844	$ 163,630
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 368,857	$ 40,946
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 192,987	$ 122,684
2. Enabling Services	$ 46,950,872	$ 28,136,750
3. Public Health Services and Systems	$ 7,562,866	$ 4,395,129
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		$ 13,100
Physician/Office Services		$ 76,187
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Payroll, travel, etc		$ 74,343
Direct Services Line 4 Expended Total		$ 163,630
Non-Federal Total	$ 55,075,582	$ 32,695,509

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: 17,550 **Data Source Year: 2023**

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	17,550 (100.0%)	345	73	73 (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	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	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 I (MPS I)	Mucopolysaccharidosis Type II (MPS II)	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	16,280 (92.8%)	24	0	0 (0%)
Newborn Hearing Screening	17,133 (97.6%)	671	9	7 (77.8%)

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. Children who screen positive on the newborn screening panel are eligible for CSHCN Program care coordination services through age 21.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Newborn Hearing Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2023**
	Column Name:	**Other Newborn**

Field Note:
The referral for service status for 2 confirmed cases is unknown.

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 2023

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	8,830	48.0	0.0	50.0	2.0	0.0
2. Infants < 1 Year of Age	11,118	48.0	0.0	50.0	2.0	0.0
3. Children 1 through 21 Years of Age	258,720	44.0	0.0	51.0	5.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	12,306	65.0	0.0	30.0	5.0	0.0
4. Others	17,882	21.0	0.0	71.0	8.0	0.0
Total	296,550					

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	16,929	Yes	16,929	82.4	13,949	8,830
2. Infants < 1 Year of Age	17,923	Yes	17,923	97.9	17,547	11,118
3. Children 1 through 21 Years of Age	425,442	Yes	425,442	75.0	319,082	258,720
3a. Children with Special Health Care Needs 0 through 21 years of age^	108,048	Yes	108,048	53.2	57,482	12,306
4. Others	1,332,338	Yes	1,332,338	35.6	474,312	17,882

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2023**
	Field Note: MCH Maternity Services - referrals from Medicaid for determination of eligibility for prenatal services provided by OMCFH = 309 Maternal Risk Screening - screening completed on first prenatal care visit of resident women for identification of possible high risk pregnancy = 8,521	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2023**
	Field Note: Infants with abnormal/unacceptable newborn metabolic screens = 1,319 (Lysosomal storage disorders were added to the Newborn Metabolic Screening Panel in March 2023) Infants who failed/not screened newborn hearing = 959 Infants who failed/not screened CCHD = 846 Childhood Lead Poisoning Program elevated blood lead level follow-ups (infants <1 year old) = 15 Birth Score - 64% of all births referred for follow-up services EPSDT/HealthCheck expected infants CMS 416 table = 7,979	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: EPSDT/HealthCheck CMS 416 table eligibles who should receive at least 1 initial or periodic screen = 227,109 Childhood Lead Poisoning Program elevated blood level follow-ups (children 1 through 21 years of age) = 478 (CLPPP services children to age 72 months; cutoff for elevated blood lead level lowered to 3.5 µg/dl in mid-August 2023) Adolescent Health Initiative participants <21 years of age = 26,228 Family Planning clients <21 years of age = 4,905	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: CSHCN infants = 309 CSHCN clients > 1 year of age = 3,720 BTT clients = 8,277	
5.	**Field Name:**	**Others**

	Fiscal Year:	**2023**

Field Note:
Family Planning clients > 21 years of age = 10,553
BCCSP clients = 1,644
WISEWOMAN clients = 30
Adolescent Health Initiative participants >21 years of age = 5,655

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2023**

Field Note:
MCH Maternity Services - referrals from Medicaid for determination of eligibility for prenatal services provided by OMCFH = 309
Maternal Risk Screening - screening completed on first prenatal care visit of resident women for identification of possible high risk pregnancy = 8,521
RFTS - positive pregnancy test referrals from Medicaid = 3,698
Home Visitation pregnant participants = 1,437

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2023**

Field Note:
Infants with abnormal/unacceptable newborn metabolic screens = 1,319 (Lysosomal storage disorders were added to the Newborn Metabolic Screening Panel in March 2023)
Infants who failed/not screened newborn hearing = 959
Infants who failed/not screened CCHD = 846
Childhood Lead Poisoning Program elevated blood lead level follow-ups (infants <1 year old) = 15
Birth Score - 64% of all births referred for follow-up services
EPSDT/HealthCheck expected infants CMS 416 table = 7,979
Home Visitation infants <1 year of age = 1,866
Newborn screens completed on 100% of all births

3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**

Field Note:
EPSDT/HealthCheck CMS 416 table eligibles who should receive at least 1 initial or periodic screen = 227,109
Childhood Lead Poisoning Program elevated blood level follow-ups (children 1 through 21 years of age) = 478 (CLPPP services children to age 72 months; cutoff for elevated blood lead level lowered to 3.5 µg/dl in mid-August 2023)
Adolescent Health Initiative participants <21 years of age = 26,228
Family Planning clients <21 years of age = 4,905
Home Visitation participants = 2,356
Students enrolled in state school system = 245,047

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**
	Field Note: CSHCN infants = 309 CSHCN clients > 1 year of age = 3,720 BTT clients = 8,277 Children enrolled in special education with the state school system = 45,114	
5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2023**
	Field Note: Family Planning clients > 21 years of age = 10,553 BCCSP clients = 1,644 WISEWOMAN clients = 30 Adolescent Health Initiative participants >21 years of age = 5,655 Home Visitation participation >21 years of age = 1,882 Education outreach from all programs housed in OMCFH to population >21 years of age estimated 1/3 of the population (total >21 population = 1,352,011)	

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 2023

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	16,476	14,941	565	265	14	160	5	428	98
Title V Served	15,653	14,194	537	252	13	152	5	407	93
Eligible for Title XIX	10,709	9,712	367	172	9	104	3	278	64
2. Total Infants in State	17,135	14,954	549	502	13	127	1	989	0
Title V Served	16,279	14,206	522	477	12	121	1	940	0
Eligible for Title XIX	11,138	9,720	357	326	8	83	1	643	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: 2023 Cumulative Resident Births by Race in WV	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: calculated at 95%	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Calculated at 65%	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: 2023 Census for infants <1 in WV by race	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Calculated at 95%	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Calculated at 65%	

Form 7
Title V Program Workforce

State: West Virginia

Reporting on Form 7 in the 2025 Application/2023 Annual Report is optional. The state has opted-out of providing Form 7 data. Reporting on Form 7 is mandatory for 2026 Application/2024 Annual Report.

Form Notes for Form 7:

West Virginia will report this information as mandatory for the 2026 Application/2024 Annual Report.

Field Level 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	Teresa Marks
Title	Interim WV Title V Director
Address 1	350 Capitol Street
Address 2	Room 427
City/State/Zip	Charleston / WV / 25301
Telephone	(304) 558-5388
Extension	
Email	teresa.d.marks@wv.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Teresa Marks
Title	WV Title V CYSHCN Director/Associate Office Director
Address 1	350 Capitol Street
Address 2	Room 427
City/State/Zip	Charleston / WV / 25301
Telephone	(304) 558-5388
Extension	
Email	Teresa.D.Marks@wv.gov

3. State Family 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

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Sharon Hill
Title	Division of Epidemiology, Evaluation and Population Based Surveillance/SSDI Project Director
Address 1	350 Capitol Street
Address 2	Room 427
City/State/Zip	Charleston / WV / 25301
Telephone	(304) 558-5388
Extension	
Email	Sharon.K.Hill@wv.gov

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(800) 642-8522

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: West Virginia

Application Year 2025

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 - Percent of pregnant women who receive prenatal care beginning in the first trimester (Early Prenatal Care, Formerly NOM 1) - PNC

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	81.2 %	0.3 %	13,622	16,774
2021	79.8 %	0.3 %	13,547	16,986
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 PNC - Notes:

None

Data Alerts: None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	95.3	7.6	157	16,470
2020	98.8	7.8	163	16,491
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 SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2022	23.9	5.2	21	87,834
2017_2021	22.3	5.0	20	89,580
2016_2020	17.5 ϟ	4.4 ϟ	16 ϟ	91,461 ϟ
2015_2019	16.0 ϟ	4.1 ϟ	15 ϟ	93,943 ϟ
2014_2018	15.6 ϟ	4.0 ϟ	15 ϟ	96,108 ϟ

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM MM - Notes:

None

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	10.0 %	0.2 %	1,684	16,922
2021	9.8 %	0.2 %	1,678	17,187
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 LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	13.0 %	0.3 %	2,196	16,923
2021	12.8 %	0.3 %	2,202	17,191
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 PTB - Notes:

None

Data Alerts: None

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	33.9 %	0.4 %	5,744	16,923
2021	31.9 %	0.4 %	5,486	17,191
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 ETB - Notes:

None

Data Alerts: None

NOM - Percent of non-medically indicated early elective deliveries (Early Elective Delivery, Formerly NOM 7) - EED

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022/Q1-2022/Q4	1.0 %			
2021/Q4-2022/Q3	1.0 %			
2021/Q3-2022/Q2	1.0 %			
2021/Q2-2022/Q1	1.0 %			
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	1.0 %			
2020/Q3-2021/Q1	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 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 EED - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	6.7	0.6	116	17,259
2020	6.3	0.6	109	17,370
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 PNM - Notes:

None

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	6.8	0.6	117	17,198
2020	7.3	0.7	127	17,323
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 IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.3	0.5	74	17,198
2020	4.7	0.5	82	17,323
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 IM-Neonatal - Notes:

None

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	2.6	0.4	44	17,198
2020	2.6	0.4	45	17,323
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 IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	203.5	34.4	35	17,198
2020	225.1	36.1	39	17,323
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 IM-Preterm Related - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	145.4	29.1	25	17,198
2020	155.9	30.0	27	17,323
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 IM-SUID - Notes:

None

Data Alerts: None

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

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 DP - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	38.4	1.6	582	15,153
2020	42.4	1.7	664	15,656
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 NAS - Notes:

None

Data Alerts: None

NOM - 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) (Newborn Screening Timely Follow-Up, Formerly NOM 12) - NBS

Federally available Data (FAD) for this measure is not available/reportable.

NOM NBS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR

Federally available Data (FAD) for this measure is not available/reportable.

NOM SR - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	13.9 %	1.2 %	47,230	339,615
2020_2021	13.8 %	1.4 %	46,292	334,947
2019_2020	16.3 %	1.5 %	55,638	340,391
2018_2019	15.5 %	1.5 %	53,374	344,423
2017_2018	13.3 %	1.6 %	46,679	350,706
2016_2017	10.4 %	1.4 %	36,799	353,378

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 TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	22.1	3.6	37	167,160
2021	20.4	3.5	35	171,534
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 CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	34.6	4.1	73	210,945
2021	44.5	4.6	95	213,252
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 AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	13.4	2.1	43	320,640
2019_2021	13.8	2.1	44	318,631
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 AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	6.3	1.0	40	631,757
2019_2021	7.6	1.1	48	629,980
2018_2020	8.6	1.2	54	628,343
2017_2019	8.5	1.2	54	633,612
2016_2018	7.4	1.1	47	639,183
2015_2017	5.6	0.9	36	644,319
2014_2016	6.9	1.0	45	650,009
2013_2015	7.2	1.1	47	655,619
2012_2014	7.4	1.1	49	660,798
2011_2013	6.3	1.0	42	668,100
2010_2012	5.6	0.9	38	676,888
2009_2011	5.1	0.9	35	685,091

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17 (CSHCN, Formerly NOM 17.1) - CSHCN

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	24.4 %	1.4 %	87,498	357,934
2020_2021	21.3 %	1.4 %	75,953	356,218
2019_2020	23.2 %	1.5 %	83,059	358,356
2018_2019	25.2 %	1.6 %	92,240	365,919
2017_2018	23.5 %	1.7 %	87,786	373,656
2016_2017	21.5 %	1.5 %	80,880	376,457

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 CSHCN - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	14.5 %	2.3 %	12,674	87,498
2020_2021	14.7 %	2.4 %	11,188	75,953
2019_2020	18.1 %	2.8 %	15,056	83,059
2018_2019	17.4 %	2.9 %	16,067	92,240
2017_2018	19.5 %	3.6 %	17,086	87,786
2016_2017	21.8 %	3.4 %	17,631	80,880

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 SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder (Autism, Formerly NOM 17.3) - ASD

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	3.8 %	0.7 %	11,711	308,193
2020_2021	3.5 %	0.6 %	10,768	305,272
2019_2020	2.4 %	0.5 %	7,415	308,637
2018_2019	2.4 %	0.6 %	7,330	309,060
2017_2018	2.8 %	0.7 %	8,816	314,673
2016_2017	2.7 %	0.6 %	8,638	317,152

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 ASD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) (ADD or ADHD, Formerly NOM 17.4) - ADHD

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	14.0 %	1.2 %	42,994	307,736
2020_2021	12.7 %	1.3 %	38,560	304,577
2019_2020	13.0 %	1.4 %	39,969	307,123
2018_2019	15.0 %	1.6 %	45,701	304,048
2017_2018	13.6 %	1.6 %	42,312	310,304
2016_2017	10.9 %	1.3 %	34,437	316,335

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 ADHD - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	47.0 %	3.8 %	30,757	65,487
2020_2021	44.2 %	4.0 %	24,493	55,459
2019_2020	51.0 %	4.3 %	30,085	58,962
2018_2019	53.9 %	4.6 %	33,709	62,573
2017_2018	48.9 %	5.6 %	26,174	53,488
2016_2017	44.9 %	5.2 %	20,792	46,315

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 MHTX - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	89.2 %	1.1 %	317,766	356,227
2020_2021	88.7 %	1.2 %	314,800	355,067
2019_2020	90.4 %	1.1 %	323,646	358,081
2018_2019	90.3 %	1.2 %	329,883	365,259
2017_2018	90.1 %	1.3 %	336,098	373,037
2016_2017	91.3 %	1.1 %	341,340	373,695

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 CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	16.5 %	0.4 %	1,253	7,598
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 <20 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**
2021	26.9 %	2.3 %	19,234	71,373
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**
2021_2022	24.1 %	1.8 %	56,999	236,234
2020_2021	24.8 %	2.0 %	57,717	232,262
2019_2020	22.8 %	1.9 %	53,555	235,160
2018_2019	19.8 %	1.7 %	46,797	236,006
2017_2018	20.3 %	2.0 %	48,198	237,237
2016_2017	22.4 %	2.1 %	52,957	236,126

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 OBS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, without health insurance (Uninsured, Formerly NOM 21) - UI

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022	2.6 %	0.4 %	9,159	351,300
2021	3.3 %	0.5 %	11,908	359,731
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 UI - Notes:

None

Data Alerts: None

NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	63.3 %	3.6 %	12,000	18,000
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 VAX-Child - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	50.3 %	2.0 %	170,643	339,250
2021_2022	46.6 %	1.8 %	157,242	337,498
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 VAX-Flu - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	69.9 %	3.4 %	75,210	107,580
2021	70.5 %	3.3 %	72,840	103,334
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 VAX-HPV - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	92.7 %	1.7 %	99,727	107,580
2021	88.4 %	2.1 %	91,379	103,334
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 VAX-TDAP - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	94.2 %	1.6 %	101,360	107,580
2021	90.7 %	2.1 %	93,683	103,334
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 VAX-MEN - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022	19.8	0.6	1,024	51,810
2021	20.9	0.6	1,080	51,690
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 TB - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	11.5 %	1.6 %	1,689	14,665
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

State Provided Data	
	2023
Annual Indicator	15.0
Numerator	2,156
Denominator	14,341
Data Source	PRAMS
Data Source Year	2022

NOM PPD - Notes:

Standard Error for 2022 data is 1.9%

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	2.8 %	0.5 %	10,015	355,202
2020_2021	2.8 %	0.5 %	9,745	354,233
2019_2020	2.7 %	0.7 %	9,561	357,334
2018_2019	3.2 %	0.8 %	11,725	364,904
2017_2018	2.7 %	0.7 %	10,017	371,431
2016_2017	2.6 %	0.6 %	9,640	372,221

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 FHC - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: West Virginia

NPM - Percent of cesarean deliveries among low-risk first births (Low-Risk Cesarean Delivery, Formerly NPM 2) - LRC

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	25	25	24	24	23
Annual Indicator	27.3	26.3	26.9	26.6	28.3
Numerator	1,598	1,528	1,498	1,475	1,560
Denominator	5,845	5,811	5,571	5,554	5,509
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	23.0	22.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	69	70	70	72	72
Annual Indicator	68.2	69.9	63.0	59.8	73.6
Numerator	12,736	12,372	10,871	9,602	11,171
Denominator	18,666	17,711	17,259	16,051	15,185
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2023
Annual Objective	72
Annual Indicator	70.9
Numerator	11,332
Denominator	15,974
Data Source	NVSS
Data Source Year	2022

Annual Objectives		
	2024	**2025**
Annual Objective	74.0	74.0

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	22	18	22	22	24
Annual Indicator	15.2	20.9	15.8	13.8	23.4
Numerator	2,790	3,678	2,678	2,168	3,453
Denominator	18,401	17,602	16,920	15,656	14,743
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2023
Annual Objective	24
Annual Indicator	15.6
Numerator	6,316
Denominator	40,563
Data Source	NSCH
Data Source Year	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	24.0	25.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	87	84	86	86	88
Annual Indicator	82.0	82.0	89.2	84.5	84.5
Numerator	12,495	12,495	12,842	12,086	12,086
Denominator	15,245	15,245	14,394	14,309	14,309
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2018	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	87	84	86	86	88
Annual Indicator					83.3
Numerator					11,489
Denominator					13,794
Data Source					PRAMS
Data Source Year					2022
Provisional or Final ?					Final

Annual Objectives		
	2024	**2025**
Annual Objective	88.0	90.0

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	40	40	40	42	42
Annual Indicator	36.1	36.1	37.1	35.4	35.4
Numerator	5,401	5,401	5,222	4,937	4,937
Denominator	14,977	14,977	14,085	13,963	13,963
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2018	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	40	40	40	42	42
Annual Indicator					31.3
Numerator					4,191
Denominator					13,406
Data Source					PRAMS
Data Source Year					2022
Provisional or Final ?					Final

Annual Objectives		
	2024	**2025**
Annual Objective	44.0	44.0

Field Level Notes for Form 10 NPMs:

None

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	40	44	46	46	48
Annual Indicator	43.1	43.1	36.5	42.1	42.1
Numerator	6,470	6,470	5,106	5,891	5,891
Denominator	15,017	15,017	13,992	13,983	13,983
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2018	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	40	44	46	46	48
Annual Indicator					52
Numerator					6,970
Denominator					13,395
Data Source					PRAMS
Data Source Year					2022
Provisional or Final ?					Final

Annual Objectives		
	2024	**2025**
Annual Objective	48.0	50.0

Field Level Notes for Form 10 NPMs:

None

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Federally available Data (FAD) for this measure is not available/reportable.

Field Level Notes for Form 10 NPMs:

None

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 - Adolescent Health

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	28	26	26	24	24
Annual Indicator	29.1	28.7	28.7	30.0	30.0
Numerator	22,608	22,112	22,112	22,801	22,801
Denominator	77,715	77,035	77,035	75,901	75,901
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2019	2019	2021	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration - All Adolescents					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	28	26	26	24	24
Annual Indicator	13.6	15.2	14.1	13.7	15.0
Numerator	16,987	18,340	16,805	17,034	19,207
Denominator	124,901	120,396	119,261	123,920	128,357
Data Source	NSCHP	NSCHP	NSCHP	NSCHP	NSCHP-All Adolescents
Data Source Year	2018	2018_2019	2019_2020	2020_2021	2021_2022

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Victimization					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	28	26	26	24	24
Annual Indicator	49.1	48.0	39.8	34.2	38.3
Numerator	61,001	57,581	47,541	42,536	49,222
Denominator	124,257	120,074	119,576	124,235	128,357
Data Source	NSCHV	NSCHV	NSCHV	NSCHV	NSCHV-All Adolescents
Data Source Year	2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	22.0	22.0

Field Level Notes for Form 10 NPMs:

None

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 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	48	48	44	48	50
Annual Indicator	45.2	41.8	41.9	43.3	41.9
Numerator	40,169	36,658	34,916	33,839	36,683
Denominator	88,838	87,648	83,316	78,078	87,498
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	52.0	52.0

Field Level Notes for Form 10 NPMs:

None

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 - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	48.7
Numerator	174,190
Denominator	357,508
Data Source	NSCH-All Children
Data Source Year	2021_2022

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	36	38	40	42	44
Annual Indicator	36.0	36.0	28.0	32.7	32.7
Numerator	5,633	5,633	4,157	4,827	4,827
Denominator	15,656	15,656	14,835	14,750	14,750
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2018	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	36	38	40	42	44
Annual Indicator					37.1
Numerator					5,323
Denominator					14,367
Data Source					PRAMS
Data Source Year					2022
Provisional or Final ?					Final

Annual Objectives		
	2024	**2025**
Annual Objective	46.0	48.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	23	22	22	20	20
Annual Indicator	23.9	23.0	21.4	18.2	15.3
Numerator	4,337	4,161	3,697	3,134	2,589
Denominator	18,138	18,106	17,312	17,190	16,913
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	18.0	18.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 0 through 17, who live in households where someone smokes (Smoking - Household, Formerly NPM 14.2) - SMK-Household - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	22	22	28	27	26
Annual Indicator	24.1	29.5	26.7	25.1	26.8
Numerator	88,702	105,832	93,477	87,237	93,934
Denominator	368,117	358,760	350,414	347,889	350,556
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	24.0	22.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	93.8
Numerator	13,792
Denominator	14,711
Data Source	PRAMS
Data Source Year	2021

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	77.7
Numerator	10,607
Denominator	13,659
Data Source	PRAMS
Data Source Year	2021

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					
	2019	2020	2021	2022	2023
Annual Objective	20	22	29	33	29
Annual Indicator	19.9	25	29.6	27.4	22.8
Numerator	25,058	30,365	35,854	34,333	29,223
Denominator	125,615	121,321	121,234	125,369	128,421
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	30.0	31.0

Field Level Notes for Form 10 SPMs:

1.	**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	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2018 - 2019 NSCH CSHCN 25.6 and non CSHCN 24.7	
3.	**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**	**2022**	**2023**
Annual Objective			8	6	6
Annual Indicator	6.9	8.1	6.6	7	5.2
Numerator	776	737	585	605	440
Denominator	11,203	9,059	8,848	8,651	8,521
Data Source	PRSI	PRSI	PRSI	PRSI	PRSI
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	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	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 2022 PRSI data - based upon the number of completed PRSI forms and the number of women reporting substance use during pregnancy	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 2023 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	2022	2023
Annual Objective			0	200	250
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP	PDMP/VIPP
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	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.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: WV has been unable to provide academic detailing to prescribers thus far. However, the SOPs have been developed with a tentative start date of July 2023. Our goal is to reach about 800 providers by the end of 2023. 10 actual academic detailer encounters X 4 academic detailers X 20 weeks.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The tracking database for Academic Detailing was not available until February 2024. Therefore, contacts prior to January 2024 were not entered. The SOPs have been developed and are currently in use.	

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**	**2022**	**2023**
Annual Objective			16	15.8	15.5
Annual Indicator	16.6	16.5	16.5	16.5	16.5
Numerator					
Denominator					
Data Source	WIC	WIC	WIC	WIC	WIC
Data Source Year	2016	2018	2018	2020	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	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	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: WIC PC 2020 data Because of missing and unreliable data in March and April of 2020 as a result of the COVID-19 pandemic, anthropometric data are reported only for participants certified through February 2020.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: WIC PC 2020 data Because of missing and unreliable data in March and April of 2020 as a result of the COVID-19 pandemic, anthropometric data are reported only for participants certified through February 2020.	

SPM 5 - Percent of CSHCN who pay more than $500 for their medical, health, dental, and vision care during the last 12 months.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	26.8	26.2
Numerator	20,925	22,886
Denominator	78,078	87,331
Data Source	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2020/2021	2021/2022
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	27.0	27.0

Field Level Notes for Form 10 SPMs:

None

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

State: West Virginia

ESM LRC.2 - Percentage of birthing facilities that have received Evidence-based Labor Support Training through the Perinatal Partnership.

Measure Status:	Active

State Provided Data			
	2021	2022	2023
Annual Objective			40
Annual Indicator	38.1	33.3	38.1
Numerator	8	7	8
Denominator	21	21	21
Data Source	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership
Data Source Year	2021	2022	2023
Provisional or Final ?	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	50.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM BF.1 - Number of birthing facilities designated Baby-Friendly under the EMPower initiative

Measure Status:	Active				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	5	6	6	8	8
Annual Indicator	5	5	4	4	4
Numerator					
Denominator					
Data Source	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA	Baby Friendly USA
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	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
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note:	According to Baby Friendly website 7.5.23
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note:	According to Baby Friendly website 5/13/24

ESM BF.2 - Percent of infants who are breastfeeding at time of discharge from a birthing facility

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	65	66	68	70	70
Annual Indicator	66.2	66.8	66.7	70.5	68.4
Numerator	11,515	11,069	10,853	11,168	11,270
Denominator	17,405	16,579	16,275	15,840	16,476
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	72.0	72.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: WV resident births only - denominator does not include unknown breastfeeding at discharge	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: WV resident births only - denominator does not include unknown breastfeeding at discharge	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: WV resident births only - denominator does not include unknown breastfeeding at discharge	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: WV resident births only - denominator does not include unknown breastfeeding at discharge	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: WV resident births only - denominator does not include unknown breastfeeding at discharge	

ESM BF.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					
	2019	2020	2021	2022	2023
Annual Objective	13	12	14	16	18
Annual Indicator	11.7	11.9	17.3	17.1	18.4
Numerator	160	149	127	148	164
Denominator	1,367	1,256	735	867	889
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	20.0	22.0

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 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.	
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 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.	
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 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.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The indicator reflects data collected from 1/1/22-12/31/22. The denominator includes only those infants who reached 6 months of age by December 31, 2022. 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:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The indicator reflects data collected from 1/1/23-12/31/23. The denominator includes only those infants who reached 6 months of age by December 31, 2023. 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 SS.1 - Percent of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	100	100	100	100	100
Annual Indicator	100	100	100	100	100
Numerator	25	21	21	21	21
Denominator	25	21	21	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	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives		
	2024	2025
Annual Objective	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**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	
2.	**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.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 21 of 21 in state birthing hospitals trained	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 21 of 21 in state birthing hospitals trained	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 21 of 21 in state birthing hospitals trained	

ESM SS.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					
	2019	2020	2021	2022	2023
Annual Objective	86	80	82	84	86
Annual Indicator	75	77.5	77.1	80.9	83.1
Numerator	804	816	628	796	876
Denominator	1,072	1,053	815	984	1,054
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	88.0	90.0

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 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.	
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 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.	
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 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.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The indicator reflects data collected from 1/1/22-12/31/22. The denominator includes families with a child less than 1 year of age during the reporting period (CY 2022) who received their first postpartum home visit on or after 1/1/2022. 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:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The indicator reflects data collected from 1/1/23-12/31/23. The denominator includes families with a child less than 1 year of age during the reporting period (CY 2023) who received their first postpartum home visit on or after 1/1/2023. 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 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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	80	80	82	84	86
Annual Indicator	74.8	82.8	87.3	88.3	89
Numerator	1,554	1,689	1,554	1,641	1,722
Denominator	2,077	2,039	1,781	1,859	1,934
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	88.0	90.0

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 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.	
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 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:**	**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.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The indicator reflects data collected from 1/1/2022-12/31/2022. 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.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The indicator reflects data collected from 1/1/2023-12/31/2023. 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 BLY.1 - Number of positive youth development (PYD) focused trainings provided to youth, parents, professionals and community members

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	112	100	110	115	105
Annual Indicator	144	71	82	106	111
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	108.0	110.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	32	38	39	39	35
Annual Indicator	38	30	31	33	48
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	37.0	38.0

Field Level Notes for Form 10 ESMs:

None

ESM BLY.3 - Number of messages disseminated via social media

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	135	125	140	150	310
Annual Indicator	122	111	88	307	110
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	312.0	314.0

Field Level Notes for Form 10 ESMs:

None

ESM BLY.4 - Number of trainings provided to youth, parents, professionals and community members

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	100	110	112	115	72
Annual Indicator	102	59	55	70	77
Numerator					
Denominator					
Data Source	AHCS	AHCS	AHCS	AHCS	AHCS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	74.0	76.0

Field Level Notes for Form 10 ESMs:

None

ESM MH.3 - Number of children who receive Title V funded medically necessary medical foods.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			290	310	330
Annual Indicator	270	284	327	280	314
Numerator					
Denominator					
Data Source	CSHCN	CSHCN	CSHCN and NBS	CSHCN and NBS	CSHCN and NBS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	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	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: CSHCN and NBS clients	

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.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	16.3	8.6
Numerator	597	347
Denominator	3,657	4,029
Data Source	CSHCN Program Comprehensive Tracking System	CSHCN Program Comprehensive Tracking System
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	17.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM PDV-Pregnancy.2 - Expectant and recently postpartum mothers who receive oral health education.

Measure Status:	Active

State Provided Data			
	2021	2022	2023
Annual Objective			10
Annual Indicator	0.6	1	3.5
Numerator	100	165	606
Denominator	17,327	16,595	17,550
Data Source	Oral Health Progam/Vital Statistics	Oral Health Program/Vital Statistics	Oral Health Program/Family Resource Network
Data Source Year	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Final

Annual Objectives		
	2024	2025
Annual Objective	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 regarding pregnant women population and oral health education Data collection will begin in the Fall of 2022.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data collection began Fall 2022	
3.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The denominator was changed this year to reflect the actual number of expectant or new mothers who have the opportunity to receive Oral Health Education at Community Baby Showers sponsored by the Family Resource Network. The denominator represents the number who registered for the events. In the past, the denominator included every expectant or new mother but that was not reflective of the number who attend the events.	

ESM SMK-Pregnancy.1 - Number of health care workers who have had Help2Quit maternity care provider training

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	350	300	300	320	320
Annual Indicator	217	245	137	413	304
Numerator					
Denominator					
Data Source	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership	Perinatal Partnership
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Final

Annual Objectives		
	2024	2025
Annual Objective	340.0	340.0

Field Level Notes for Form 10 ESMs:

None

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.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	60	50	55	60	65
Annual Indicator	41.5	52.7	73	68.3	62.5
Numerator	85	178	197	211	272
Denominator	205	338	270	309	435
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)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)	WV Home Visitation Program (HFA, EHS, PAT, RFTS)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	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.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The indicator reflects data collected from 1/1/2022-12/31/2022. 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.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The indicator reflects data collected from 1/1/2023-12/31/2023. 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 SMK-Household.1 - Percent of children in households where someone smokes.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	25	28	27	25	25
Annual Indicator	28.6	28.3	26.7	25.1	26.8
Numerator	100,750	99,750	93,560	87,237	93,949
Denominator	352,397	352,397	350,414	347,889	350,556
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	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	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 2020-2021 NSCH NPM 14.2	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 2021-2022 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) – Cross-Cutting/Systems Building

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

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

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Decrease obesity rates in children, ages two to four, from 16.6% (WIC data 2016) to 14.4% by 2022.</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 children ages two to four participating in WIC who are obese as defined as BMI at or above the 95th percentile on the CDC growth charts for age and sex.</td></tr>
<tr><td>Denominator:</td><td>Total number of children ages two to four participating in WIC.</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Reduce the proportion of children and adolescents with obesity — NWS-04</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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 and a 2020 data limitation is noted that because of missing and unreliable data in March and April 2020 as a result of the COVID-19 pandemic, anthropometric data are reported only for participants certified through February 2020.</td></tr>
<tr><td>Significance:</td><td>West Virginia 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 before increasing again to 14.4% in 2020. During 2010–2014, obesity in this age group 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). Since 2014, obesity rates in WV for this age group have remained consistent between 16.4% and 16.5%.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 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.</td></tr>
</table>

SPM 5 - Percent of CSHCN who pay more than $500 for their medical, health, dental, and vision care during the last 12 months.
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To decrease the finance burden of out-of-pocket costs for CSHCN and their families.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CSHCN in West Virginia who report paying more than $500 annual for the CSHCN's medical, health, dental, and vision care in the last 12 months. **Denominator:** Number of CSHCN in West Virginia
Healthy People 2030 Objective:	Reduce household food insecurity and hunger — NWS-01 Eliminate very low food security in children — NWS-02 Reduce the proportion of people who can't get prescription medicines when they need them — AHS-06
Data Sources and Data Issues:	National Survey of Children's Health (Indicator 3.6)
Significance:	CSHCN require care and related services beyond what is general required for their peers. This places an undue financial burden on CSHCN and their families. According to the National Survey of Children's Health, 94% of CSHCN in West Virginia report having health insurance coverage, but nearly 23% report their current insurance is not usually or always adequate to meet their needs. This creates gaps in services that can be detrimental to the CSHCN's health outcomes if not filled.

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 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

Measure Status:	Active
Goal:	To increase the percentage of birthing facilities that are using the most up-to-date labor support strategies.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of birthing facilities that completed evidence-based labor support training during the reporting period **Denominator:** Total Number of birthing facilities in the state
Data Sources and Data Issues:	Perinatal Partnership Training records and Vital Statistics
Evidence-based/informed strategy:	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.
Significance:	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.

ESM BF.1 - Number of birthing facilities designated Baby-Friendly under the EMPower initiative
NPM – A) Percent of infants who are ever breastfed B) Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months (Breastfeeding, Formerly NPM 4) - BF

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 BF.2 - Percent of infants who are breastfeeding at time of discharge from a birthing facility
NPM – A) Percent of infants who are ever breastfed B) Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months (Breastfeeding, Formerly NPM 4) - BF

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 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 B) Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months (Breastfeeding, Formerly NPM 4) - BF

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 SS.1 - Percent of birthing hospitals that are trained using the evidence-based curriculum for safe sleep education
NPM – 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 D) Percent of infants room-sharing with an adult during sleep (Safe Sleep, Formerly NPM 5) - SS

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 SS.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 – 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 D) Percent of infants room-sharing with an adult during sleep (Safe Sleep, Formerly NPM 5) - SS

<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 of age who received their first postpartum home visit 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 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
NPM – 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 D) Percent of infants room-sharing with an adult during sleep (Safe Sleep, Formerly NPM 5) - SS

Measure Status:	Active
Goal:	Increase the percentage of infants enrolled in a home visitation program that are always placed to sleep on their backs, without bed-sharing or soft bedding to 93% by 2024
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants (aged less than 1 year) enrolled in a home visitation program whose primary caregiver reports that they are always placed to sleep on their backs, without bed-sharing or soft bedding **Denominator:** Number of infants enrolled in a home visitation program who were aged less than 1 year during the reporting period
Data Sources and Data Issues:	Data will be collected from OMCFH Home Visitation Programs.
Evidence-based/informed strategy:	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
Significance:	By asking primary caregivers to report sleep practices regularly, home visitors will have additional opportunities to provide safe sleep education and reinforce the risks of unsafe sleep.

ESM BLY.1 - Number of positive youth development (PYD) focused 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Foster positive and nurturing relationships between young people and caring adults within their communities.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of PYD trainings provided to youth, parents, professionals and community members</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be provided by Adolescent Health grantees</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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
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

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 BLY.3 - Number of messages disseminated via social media
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

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 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

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 MH.3 - Number of children who receive Title V funded medically necessary medical foods.
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

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 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.
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

Measure Status:	Active
Goal:	To increase the percentage of CSHCN with a comprehensive care plan.
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>CSHCN who received care coordination services from the West Virginia CSHCN Program and who had a shared plan of care completed or updated within the last 180 days</td></tr><tr><td>**Denominator:**</td><td>CSHCN who received care coordination services from the West Virginia CSHCN Program</td></tr></table>
Data Sources and Data Issues:	West Virginia CSHCN Program Central Tracking System database.
Evidence-based/informed strategy:	Numerous entities, including the National Standards for Systems of Care for Children and Youth with Special Health Care Needs promote a shared plan of care as a primary component to improve the health care services received by CSHCN and to support care coordination efforts.
Significance:	According to the 2020-2021 National Survey of Children's Health, 37.5% of CSHCN did not receive all needed care coordination services. A comprehensive care plan is a key component to ensuring effective care coordination efforts across the CSHCN's medical home.

ESM PDV-Pregnancy.2 - Expectant and recently postpartum mothers who receive oral health education.
NPM – Percent of women who had a preventive dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-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 SMK-Pregnancy.1 - Number of health care workers who have had Help2Quit maternity care provider training NPM – Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-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 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

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:	<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 women enrolled in home visitation who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment.</td></tr><tr><td>**Denominator:**</td><td>Number of women enrolled in home visitation who reported using tobacco or cigarettes at enrollment and were enrolled for at least 3 months.</td></tr></table>
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 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

Measure Status:	Active
Goal:	Decrease the number of households where someone smokes.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children ages 0-17 who live in households where there is household member who smokes. **Denominator:** Number of children ages 0 through 17
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
Part 1 – MCH Data Access and Linkages

State: West Virginia

Annual Report Year 2023

	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	Yes	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	

Other Data Source(s) (Optional)

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) WV Health Information Network (HIE)	Yes	Yes	Daily	1	Yes	
10) Healthy Homes Lead Poisoning Prevention Surveillance System	Yes	Yes	Daily	0	No	
11) National Syndromic Surveillance Program (NSSP)	Yes	Yes	Daily	1	No	
12) Birth Score (Project Watch)	Yes	Yes	Monthly	0	No	
13) MIECHV-Including RFTS-WV's Perinatal Medicaid Home Visitatio	Yes	Yes	Daily	1	No	
14) Infant Mortality Review	Yes	Yes	Quarterly	0	Yes	
15) Maternal Mortality Review	Yes	Yes	Quarterly	0	Yes	
16) Maternal Risk Screening	Yes	Yes	Monthly	0	No	
17) Fostering Healthy Kids	Yes	Yes	Daily	0	No	
18) Health Check (EPSDT)	Yes	Yes	Monthly	0	No	
19) Children's Oral Health	Yes	Yes	Daily	0	No	
20) CSHCN	Yes	Yes	More often than monthly	0	No	
21) BTT (Part C IDEA)	Yes	Yes	More often than monthly	0	No	
22) Family Planning Program	Yes	Yes	More often than monthly	0	No	
23) WV Breast and Cervical Cancer Screening Program	Yes	Yes	More often than monthly	0	No	
24) Wisewoman	Yes	Yes	More often than monthly	0	No	

	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
25) WV Birth Defects	Yes	Yes	Monthly	1	No	
26) WVSIID	Yes	Yes	Daily	0	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: West Virginia

Annual Report Year 2023

Products and Publications information has not been provided by the State.