



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

**State Narrative for
West Virginia**

**Application for 2013
Annual Report for 2011**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are located at the following address:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

/2012/ In accordance with Public Law 97-35, the Joint Standing Finance Committee of the WV Senate and House of Delegates holds the Federal Block Grant Public Hearing each year for legislators and the general public. Public Notice is issued and interested citizens, groups and organizations are encouraged to attend. Written and oral comments on allocation and possible uses of the funds are accepted and considered. //2012//

While there has been established federal expectation that public forums be held around the Block Grant, WV has found this to be an expensive and inefficient, less than effective means of having topical discussions about the use of Title V resources. To counter this, OMCFH involves critical stakeholders in all facets of charting a course for the use of multiple funding streams that support maternal, child and family health activities in WV; the use of stakeholder advisories, surveys, task forces to study particular population groups and issues, engagement with established non-Title V

advisories and lastly public forums and specific engagement of parents using parent-to-parent networks. The end result is that there is not one isolated event to seek public input about the use of Office resources but rather have on-going study and action plan development, as evidenced by the following examples:

The establishment of the WV Perinatal Partnership, which includes multiple personnel from the OMCFH and the involvement of the Office Director, has developed an action plan for changes in the perinatal system. The details of the plan and action steps are woven throughout the Block Grant Application and Five-Year Needs Assessment. Successes have included procurement of legislative resources and statutory changes necessary to expand metabolic screening to the 29 tests as recommended by the Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases. ***/2013/ In direct response to physician requests to add critical congenital heart disease (CCHD) screening before infant discharge from the hospital, OMCFH and the Perinatal Partnership supported population based screening. The 2012 legislature mandated screening for CCHD and the OMCFH has been involved in the implementation processes with the physicians and birthing facilities. Also in 2012, because of community requests, severe combined immune deficiency (SCID) will also be added to the screening panel. //2013//***

/2012/ In addition, because of Perinatal Partnership recommendations, legislation passed that allowed the State to establish the expectation that all medical practitioners serving pregnant women use a risk screening instrument regardless of the woman's insurance carrier. Screening information is sent directly to the OMCFH to be used for planning purposes that ultimately affects direct patient care. /2013/ In 2011, the first year of data collection, over 50% of the women who were pregnant had a screening form submitted. Analysis of collected data has been completed. Work is ongoing with the OBGYNs to complete and submit screening forms on all pregnant women as required by law. //2013//

Another example is the Birth to Three/Part C Early Intervention Program which has experienced such extremes in participation that the State had to make changes in eligibility definitions in order to keep the system solvent. Parents of participants were involved in the decision making process. Public forums have been historically held for parents and participants of CSHCN and Birth to Three services.

The OMCFH Maternal Mortality Review Team (MMRT) was established in response to Perinatal Partnership recommendations resulting in a Legislative mandate. The Team has since reviewed cases from ***/2013/ 2007, 2008, 2009 and 2010. //2013//*** The MMRT has made several recommendations to enhance care of the pregnant woman who presents to the ER. As a result, educational materials designed for medical personnel and patient awareness have been developed on cardiac issues during pregnancy and distributed to emergency rooms located throughout WV.

During the 2011 Legislature, legislation was mandated to add infant mortality review to the maternal mortality review as a result of the Perinatal Partnership involvement. ***/2013/ In 2012, Memorandums of Understanding were developed with all birthing facilities to allow review of infant charts as well the infant's mother's prenatal and delivery medical records. Reviews are currently occurring for the 2011 infant deaths. //2013//***

During fiscal year 2010, public forums for Oral Health were held across the state and resulted in development of a State Oral Health Plan using collected feedback. ***/2013/ In response to continued requests for more action, a full-time State Dental Director was hired and housed within OMCFH. The Secretary for the WV DHHR conducted a meeting in June 2011 to discuss the need and barriers for an adult oral health project. This project is still under development.//2013//***

Drug and alcohol abuse among WV pregnant women has been a growing concern among the

medical community. The medical community asked the OMCFH to participate in and fund an initial research project to look at the burden. The OMCFH did fund the initial study and has plans to fund an additional drug and alcohol use during pregnancy study in FY 2012. //2012//

/2012/ The WV Developmental Disabilities Council held public forums around the State with 194 persons participating. Health care issues cited from the forums were: 1) availability and affordability of health care services, including providers who accept Medicaid; 2) availability of knowledgeable health, dental and vision care providers for people with DD, including those who are nonverbal; 3) health insurance policy restrictions and exclusions; and 4) consumer information about available health services and resources.

The DD Council also distributed a "Meeting the Needs of People with Developmental Disabilities" survey through the mail and Survey Monkey on the Council's website. Four hundred sixty surveys were returned. Of the surveys returned the three most important health related issues were: 1) dental services for adults with developmental disabilities receiving Medicaid; 2) coverage for nutritional supplements; and 3) coverage for durable medical and other equipment. //2012//

/2012/ Every five years WV local health departments are required by the Office of Community Health Systems and Health Promotion within the Bureau for Public Health to complete a needs assessment for their assignment area. The expectation is that the local health departments hold public forums and complete surveys from residents in their county assignment areas to determine resident needs. This has been a great tool to receive input from each community. Based on needs, strategies are developed that target improvement. Common health issues that residents across WV felt were important are: affordable prescription drugs, driving while drinking, child abuse, chronic disease conditions (heart, diabetes, cancer), obesity, smoking, health insurance for adults, early detection and treatment of cancer, poverty, unemployment, drug use and lack of public transportation. Focus groups raised the issue of needing more physician specialists, emergent care in small town communities and the concern for the overall decreasing number of physicians due to malpractice costs. In one of the counties, citizens interviewed wanted the community to offer more centrally located hiking trails, more childrens' activities/playgrounds/outdoor facilities. They also expressed concern for lack of physicians and urgent care centers. In another county, residents felt they needed knowledge about what services are available and how to access care/information to improve their health, in addition to the previous common health issues mentioned. And yet another county identified resident priorities as: job quality, with many families working, but still living in poverty; lack of recreation or programs for teens and young children with teen pregnancy and child abuse listed as concerns; and lack of knowledge about resources. In most of the surveys and focus groups the two main sources of information for adults was television and newspapers. The OMCFH partners with local health departments and the Office of Community Health Systems and Health Promotion to deliver services and education on topics of need. //2012//

/2012/ The Adolescent Pregnancy Prevention Initiative (APPI)/Family Planning Program in the Bureau for Public Health, WV Department of Health and Human Resources has been addressing a rising problem among young adults in the state - unplanned pregnancies and high risk sexual activity. This problem is also being addressed at the national level, and, according to a recent national study of 1800 young adults between the ages of 18 and 29, among the 77% who said it is very important to avoid pregnancy right now, 34% said it is likely they will have unprotected sex in the near future. These findings are significant and concerning to health policy planners.

APPI, the Family Planning Program and the contracted media vendor, Arnold Agency, are teaming up to address this issue in West Virginia by first understanding some of the parallels between the national FogZone research report and young adults in WV. In order to explore this and other objectives, R.L. Repass & Partners, Inc. planned and conducted a series of focus groups among the targeted audience throughout West Virginia. Three focus groups were conducted in Logan, Charleston, and Elkins, West Virginia among targeted respondents. Groups were recruited based on the age of the respondents and gender.

Focus group results indicated a need for improved educational programs for adolescents and young adults addressing sexual health. Many young adults discussed that there were few opportunities for them to learn about more than just the biological aspects of sex. A few individuals reported experiences where additional information was given, but that a fear tactic was frequently utilized with teenagers: If you have sex you will get pregnant or get an STD. Therefore there was little knowledge among focus group participants about how young adults can best protect themselves. The respondents all seemed to be in agreement that more opportunities for discussing sexual health and at more frequent intervals would be appreciated. //2012//

/2012/ The Block Grant application, Needs Assessment and Needs Assessment Executive Summary are posted on the OMCFH web site and elicits requests and responses. The Needs Assessment Executive Summary and the application were sent to OMCFH stakeholders and partners for review and comments. //2012//

The preceding narrative is provided as confirmation of how public input and consensus building guides OMCFH strategies, objectives and action planning. Details of efforts are woven throughout this application. The attachment includes OMCFH advisories and members

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The West Virginia Office of Maternal, Child and Family Health is the State maternal and child health agency serving the needs of women, infants, children, families and children with special health care needs. The OMCFH receives the federal MCH Block grant (Title V) which requires the completion of a population based needs assessment every five years. The goal of the WV Title V Needs Assessment is to assure availability of a comprehensive quality, accessible maternal and child health system that will positively affect pregnancy outcomes and promote positive health status (family well-being) for infants, children, adolescents and children with special health care needs by involving multiple stakeholders across WV. The OMCFH identifies health needs based on data/outcomes and partners with community and state stakeholders to develop interventions that will achieve positive results. Other goals of the Needs Assessment are to: collaborate around data collection activities that support the evaluation of care availability, service utilization and the quality of health services for maternal and child health populations; administer population-based health surveillance activities, such as birth defects registry, newborn hearing and metabolic screening which are used to prevent and/or lessen disability and death among children; and collaborate with community resources, government agencies, families and other stakeholders to identify resources essential for healthy families such as childcare services, health care and economic support. The vision of the 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. Allocation of resources is based on need that takes into consideration other available resources, population served and desired outcomes.

//2012/ State priorities have been summarized and listed below:

A. Pregnant women, women of childbearing age, mothers and infants

1. Decrease smoking among pregnant women
2. Reduce the incidence of prematurity and low birth weight
3. Reduce the infant mortality rate, focusing efforts on African American infants and Sudden Unexplained causes

B. Children and Adolescents

1. Assure that children and adolescents access preventive dental services
2. Reduce smoking among adolescents
3. Reduce obesity among WV's population
4. Decrease the incidence of fatal accidents caused by drinking and driving
5. Increase the percentage of adolescents who wear seat belts
6. Reduce accidental deaths among youth 24 years of age or younger

C. Children with Special Health Care Needs

1. Maintain and/or increase the number of specialty providers in health shortage areas //2012//

Please see the attachment for the complete Needs Assessment Summary.

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

West Virginia 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 West Virginia the highest elevation of any state east of the Mississippi River. The second most rural state in the nation, 20 of West Virginia's 55 counties are 100% rural according to the Census Bureau definition, with an additional 14 more than 75% rural. West Virginia is the only state that lies entirely in the Appalachian Region. Even so, West Virginia is located within 500 miles of 60% of the nation's population. The state is traversed by two north/south and one east/west interstates that connect its major population centers. In addition, I-68, which ends at Morgantown, where West Virginia University is located, provides access to Washington, D.C. and Baltimore, MD. Interstate 68 also connects with Interstate 79 providing access to Charleston, WV, our state capitol. 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.

/2012/ According to Wikipedia, WV was only one of ten states in 2009 which grew economically. While per capita income growth fell 2.6% nationally in 2009, WV's grew at 1.8%. Through the first half of 2010, exports from WV topped \$3 billion, growing 39.5% over the same period from the previous year and ahead of the national average by 15.7%. Morgantown, WV was ranked by Forbes as the #10 best small city in the nation to conduct business in 2010. The city is also home to West Virginia University, the 95th best public university according to U.S. News and World Report in 2011. //2012//

As of January 2010, 36 of WV's 55 counties were classified as medically underserved areas with an additional 13 counties classified as partially underserved. Only six counties in the entire State were considered to have adequate medical manpower to meet the population need. ***/2013/ The WV Board of Medicine, as of December 31, 2011, reported that the current number of licensed physicians in WV is 5,962 an increase of 105 from 2010. Of this 5,962, some, while licensed, are not actively practicing. Ultimately, the number of practicing physicians across the entire state is 3,946, an increase of 82 from 2010. The Board of Medicine also reports that there are 671 physician assistants. West Virginia has one School of Osteopathic Medicine and historically their physicians have established practices in our state. The Board of Osteopathy reported June 12, 2012, 1,131 D.O.s and 184 physician assistants were licensed in WV. All have increased since 2010. //2013//***The WV Perinatal Partnership, which includes representatives from the OMCFH, has reported that the availability of OB/Gyns and other practitioners to provide prenatal care and delivery continues to be problematic. Not every county has sufficient births to justify labor and delivery at local hospitals, making it necessary for WV women to be served outside the boundaries of our state. ***/2013/ The Board of Medicine, in 2011, reports that there are 168 M.D.s and another 35 D.O.s delivering infants across the state. This is an increase over the number delivering in 2010.//2013//***

Community health centers have played a critical role in improving access to health care for all populations across WV. The community health center network is supported with state appropriations and there are multiple centers that receive both state and federal resources. In a previous meeting with Senator Jay Rockefeller, the Office was advised that the community health centers would be able to apply for resources under the American Recovery and Reinvestment Act that would allow them to expand their physical plants. The Office is working with community health centers on this issue in hopes that the physical expansion of the facilities will allow them to recruit dental health practitioners. The lack of available oral health services for adult persons in the state is a critical problem. Also, \$1,000,000 was spent on oral health equipment for community health centers during the 2010 fiscal year. This equipment was ready for use July 1,

2010.

The OMCFH has been a strong supporter of the evolving community health center network dating back to the early 1980's. The networks at that point were struggling, and beginning in the '80's to this date the Office has used the community health centers to provide patient care for maternal and child health populations and used resources to offset the cost on a fee-for-service basis. Using this system, the community health centers and OMCFH have a symbiotic relationship that works to the mutual benefit of all: the patient, the health center and the Office.

The community health center network operates more than 106 health care sites across the state which includes school-based health centers and multiple free clinics. The purpose of the School-Based Health Center Program is to provide easy access to preventive and primary health care for school-age children at their local elementary, middle, or high school. These centers are operated and administered by a community-based healthcare clinic in their area. Each center is located within the school building, or on the school campus. When the school is closed, the student may seek care at the healthcare clinic which operates their school's center. Currently, funding is provided through the Division of Primary Care to 49 school-based health centers serving 64 schools in 24 counties, making health services available to over 25,000 students. Also, funding is provided to one more primary care organization which supplies referrals to the students at 3 high schools in their county. Additional school-based health centers are planned.

Each student receiving services at a school-based health center must be enrolled with written parental permission. Follow-up with the parent/guardian is conducted at the time of service, or immediately following. Services which may be provided by a school-based health center include: preventive education, yearly physicals, immunizations, chronic disease management, check-ups, acute and intermediate care, oral health, mental health, counseling, and ancillary and enabling services.

According to 2008 Census data, 15% of the population in the state does not have health insurance. In March 2006, Former West Virginia Governor Joe Manchin III signed legislation to expand SCHIP eligibility up to 300 percent of the federal poverty level, and on January 1, 2007, the state began a phase-in expansion by enrolling children in SCHIP with family incomes up to 220 percent of the federal poverty level. Adoption of this change is estimated to provide comprehensive health care coverage to approximately 400 uninsured children of working families during the first year of implementation. WVCHIP expanded the upper income limit to cover families with incomes at 250% of poverty January 1, 2009. /2012/ The state Children's Health Insurance Board submitted its request March 31 to the federal Centers for Medicare and Medicaid Services to expand eligibility for CHIP coverage to children from families with incomes of up to 300 percent of the federal poverty level. For a family of four, that would increase the income cut-off to \$67,050 a year, making an estimated 720 uninsured children eligible for CHIP coverage. Anticipated implementation is July 2011. //2012// **/2013/ In July 2011, CHIP expanded its income limit for eligibility to 300% FPL. Starting with 220% of the FPL, families are required to make monthly premium payments based on the number of children enrolled in the family. Members in this group receive full medical, drug, dental and vision benefits, but with copayments for some dental services. //2013//**

West Virginia reached its population peak a half century ago with 2,005,552 residents counted in the 1950 Census. The state's population has not exceeded the two million mark since then, but has fluctuated between 1.7 and 1.9 million depending on the state's economy. Four of the state's five largest cities have lost population since 1990. Charleston, the state capitol and largest city, and Huntington are the only places with populations exceeding 50,000. Population estimates from U.S. Census show West Virginia among the most racially homogeneous states in the country. /2012/ The 2010 census reported that 93.9% of WV residents are Caucasian, 3.4% Black or African American, 0.2% American Indian and Alaska Native, 0.7% Asian, 0.3% some other race and 1.5% were more than one race. The Hispanic population was reported as 1.2%. //2012//

/2012/ West Virginia has one of the oldest median age (40.4 years) and percent of people age 60 and older in the nation according to 2010 U.S. Census data. Between 2000 and 2010 people age 85 and older increased by 24.8%; the number of individuals age 90 and older grew by 41.3%. Although the population has fluctuated between 1.8 and 2.0 million over the last 50 years, the rate of births have declined from 50,000 births in 1950 to 21,225 births in 2009 dropping from a rate of 25.4 births per 1,000 to 11.3 births per 1,000. In 1997 West Virginia saw its first natural decrease, having 137 more deaths in that year than births, the first state in the nation to experience such a phenomenon. This trend continued through 2003. Because of its older population, West Virginia ranked first among the states in the percentage of its residents enrolled in Medicare (18.4%, compared to a national average of 13.9%). Older West Virginians value their independence, self-sufficiency and preservation of the family homestead. This lifestyle is demonstrated by the fact that residents maintain one of the highest percent of home ownership in the nation at 74.3% compared to 66.9% nationally. Almost 85% of individuals age 65 and older own their home. //2012//

Over the past 30 years dominant industries in West Virginia have shifted from mining and manufacturing to services and service producing jobs. Traditionally, mining and manufacturing wage scales are much higher than those in service occupations and include benefits such as medical, dental, and vision plans. Service jobs, on the other hand, are often part-time and do not include insurance plans. Low wages earned at such jobs often do not allow individuals to purchase their own health insurance coverage. ***/2013/ Since 2011, there has been an increase in the natural oil and gas business which has boosted the state economy. WV ranks second in the nation in non-agricultural job growth according to a report compiled by Arizona State University's W.P. Carey School of Business. The report provides analysis based on figures from the U.S. Bureau of Labor Statistics. The data shows that WV gained 19,200 jobs between January 2011 and January 2012.//2013//***

/2013/ According to Workforce West Virginia, West Virginia's seasonally adjusted unemployment rate for May 2012 was 6.9% compared with a national rate of 8.2%. State and federal minimum wage remained the same at \$7.25 per hour. This is down from last years rates of 8.8% and 9% respectively. //2013//

/2013/ Work disability is a significant problem in West Virginia. The U.S. Census Bureau states in 2010, 17.2% of the population 18-64 years of age had a disability. //2013//

/2012/ Because of the loss of higher paying jobs over the past thirty years in West Virginia, there has been a concurrent rise in the state's poverty rate. According to figures supplied by the U.S. Census Bureau, 17.8% of the state's residents are living in poverty, compared to the national average of 14.3%. In 2009 the median household income in West Virginia was \$37,423, while nationally it was \$50,221. Of residents age 65 and older, 11.9% are living below the poverty level, while 24.1% of children under age 18 are living in poverty. The percent of high school graduates or higher, of the population 25 years and over, is 81.6%. //2012//

/2012/ There are approximately ***/2013/ 387,418 //2013//*** children under the age of 18 in West Virginia, making up 21% of the total population. While West Virginia remains predominately white (93.9%), racial diversity of the State's children is increasing. According to the 2005-2009 American Community Survey 5 year Estimates, 92.1% of children are white, 3.8% black, 3.0% multi-racial, and 1.1% other. ***/2013/ According to the 2009/2010 National Survey of Children with Special Health Care Needs, 18.5% of West Virginia's children have a special health care need as compared to the United State's rate of 15.1%. //2013//*** Multi-racial children are at higher risk of special needs. //2012//

Former Governor Joe Manchin III developed the West Virginia Kids First Screening Initiative so that children could benefit from a caring health professional working closely with their parents and school. The Kids First Screening Initiative unites parents, health professionals and teachers to give West Virginia's children the positive start in life they deserve by working together to assure

WV children entering kindergarten are healthy and ready to learn. Every child, at first school entry, receives comprehensive screening that includes hearing, speech, language, and growth and development using the EPSDT/HealthCheck protocol. Beginning with the 2008-09 school year, all children entering school received this wellness exam.

According to America's Promise Alliance, children need "Five Promises" to succeed in life. Since his inaugural speech in 2005, Former Governor Manchin asked that the state unite in committing to keep these five promises for WV children. The promises are: 1. Caring adults 2. Safe places 3. A healthy start 4. Effective education 5. Opportunities to help others. The Kids First Screening Initiative is a part of keeping these valuable promises for the children of WV. The former Office Director of OMCFH was intimately involved in the design and development of this project.

In the last ten years the number of cases of autism spectrum disorder has grown from one in 500 to one in 100 children across the nation. This disorder has huge implications for state governments and the health care economy. WV, like state governments across the country, is grappling with policy questions of who is going to pay, how can services be coordinated, and how can OMCFH ensure evidence-based interventions are available to families.

Previous legislative sessions prior to 2011 had autism bills introduced but without success. The bills had provisions requiring insurance coverage for the diagnosis. Advocates for the legislation argued that twelve states already require private health insurers to cover autism treatments. Insurance lobbyists argued that the legislation was an attempt to shift responsibility for services from school systems to the health care systems. Obviously the health and educational challenges of autism are inextricably intertwined. /2012/ In 2011, autism legislation passed, HB 2693, requiring insurance coverage for autism treatments. //2012//

State efforts in regards to this growing concern includes: 1) Part C/IDEA - West Virginia Birth To Three; 2) Medicaid Waivers, not to be confused with a specific Autism Waiver; 3) Marshall University - Autism Training Center; 4) West Virginia University (WVU) Center for Excellence in Disabilities; and 5) Education.

All the above efforts are addressing services for people with autism.

/2013/ WVBTT in collaboration with the WV Department of Education, received a grant from the national Technical Assistance Center on Social Emotional Intervention (TACSEI) to develop professional development infrastructure that will support early childhood professionals gain knowledge and skills needed to promote positive social emotional development and address challenging behaviors in young children. WV is supporting demonstration sites which are infusing TACSEI Pyramid model strategies across their child care centers. WV has been the first state to work with TACSEI to modify the Pyramid strategies for use by early intervention professionals working with families in home based settings. In 2010-2013 this effort will be expanded to include professionals in the State's home visitation programs.

Marshall University Autism Training Center and WVBTT, in coordination with the WV Department of Education are developing an autism initiative specific to early intervention professionals. The initiative will start in the fall of 2013 and expand on TACSEI, adding content specific to supporting children with autism. an early intervention Autism Academy is being planned for the summer of 2013. //2013//

The OMCFH operates in partnership with the federal government and the state's medical community, including private practicing physicians, county health departments, community health centers, hospitals and various community agencies to address WV residents' needs. The OMCFH strives to provide the necessary education and access to treatment needed in order for residents to make informed decisions regarding their own individual health needs. Categorical programs to address specific needs for targeted groups are limited with 80 percent of the Office's

energy being used to develop systems for the provision of population-based and target specific preventive interventions, as well as infrastructure for the support of the maternal, child and family health populations.

Availability of services for WV's MCFH population has increased dramatically, however, there remain areas of the state that continue to lack medical practitioners. In addition, meeting the needs of chronic or disabled populations is impaired by the lack of medical sub-specialty providers, such as occupational therapists, physical therapists, speech pathologists, dentists; and as is typical with most states, pediatric sub-specialties are mostly available at tertiary care sites. To attend to these problems, the Bureau for Public Health, in collaboration with the West Virginia University School of Medicine, sponsors a rural practice rotation for physicians, social workers, dentists and other specialty providers, with the intent of encouraging the establishment of rural practices, as well as expanding immediate service capability, since these practitioners render hands-on care.

The Perinatal Partnership found that many providers, especially at small rural hospitals, complained that pregnant women and/or their newborn infants needing tertiary care were being turned away due to a lack of bed capacity at the three tertiary care centers in the state. Further study demonstrated this to be true finding the Neonatal Intensive Care (NICU) facilities have been functioning at 100 percent capacity. Physicians with the tertiary care facilities reported that they were turning away both high-risk maternal transports and infant transports, primarily due to no availability of NICU beds.

The Partnership's Committee on Adequacy of NICU Beds recognized that the cost to operate NICU beds and the physical capacity of some tertiary facilities to add more beds posed problems. At the same time, it was of utmost importance to care for newborns as close to home as possible and it was recommended that the tertiary care facilities seriously study their capability to increase NICU beds. To assist in accomplishing this, it was recommended that the West Virginia Health Care Authority should immediately evaluate and update the current methodology utilized in determining Certificate of Need approval of NICU beds. The need to upgrade some community hospitals and equip them to handle newborns needing added care but not necessarily needing transfer to a NICU was discussed. Also, community hospitals could be upgraded to handle NICU "back referrals" for infants needing intermediate but not intensive care. Community hospitals that had the capacity or were willing to upgrade their capacity to accommodate infants that needed added care as they transition into health were asked to begin addressing this issue.

Between 2004 to 2007, the state's three tertiary care facilities were at NICU bed capacity with just 89 NICU licensed beds. Between October 2007 and October 2008, 31 infants were turned away from one of the three NICU's due to lack of bed availability. This information was presented to the Legislative Oversight Committee on Health and Human Resources in an effort to increase attention to perinatal system shortcomings in WV and resulted in expansion of the NICU bed capacity to 118 in 2009.

The Perinatal Partnership noted that to avoid unnecessary admissions to NICU, all birthing facilities and maternity providers should curtail elective delivery prior to 39 weeks gestation, following ACOG recommended guidelines for elective delivery.

WV House Bill 2388 established a mandate for the universal testing of newborns for hearing loss. The Newborn Hearing Screening Advisory, as established in statute, has made testing recommendations, developed screening protocols, and assisted the Office of Maternal, Child and Family Health with the development of user friendly education materials for inclusion in hospital birth packets and distribution through the state's perinatal program called Right From The Start (RFTS). The passage of the West Virginia Birth Score, in this same legislation, further strengthened the state's ability to universally screen all newborns for developmental delay, hearing loss, and conditions that may place infants at risk of death in the first year of life. The original Birth Score instrument was modified to accommodate hearing screening, so one

instrument and one tracking system addresses the mandate. All WV birthing facilities began universal newborn hearing screening effective July 1, 2000. The Birth Score Office and the OMCFH Newborn Hearing Screening Project coordinator offer on-going technical assistance related to the operation of the initiative.

In 2002, three additional bills were passed: SB 672 establishing a Birth Defects Surveillance System, HB 216 requiring screening of all children under the age of 72 months for lead poisoning, and HB 3017 requiring the creation of a state oral health program. Although all of these programs existed previously, legislative mandates ensure continuance of these health efforts.

The 78th West Virginia Legislature, passed in the 2007 session, H. B. 2583 mandating the expansion of newborn screening to include 29 disorders. The West Virginia Newborn Screening Program, housed within the Office of Maternal, Child, and Family Health within the Bureau for Public Health, partnered with the State Laboratory to expand newborn screening to include all 29 disorders in order to adhere to national standards recommended by the United States Department of Health and Human Services, Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases. The Bureau for Public Health submitted legislative rules that allowed for financial sustainability by invoicing the hospitals for each live birth receiving a screen. The fee charged is based on cost and is sufficient to cover the cost of the newborn metabolic system. Screening for all 29 newborn disorders became effective February 4, 2009. **//2013/ Addition of Critical Congenital Heart Disease (CCHD) and Severe Combined Immunodeficiency Disease (SCID) to the newborn screening panel will occur in 2012. //2013//**

West Virginia purchased Ages and Stages (ASQ:3) kits in 2009 for use by childcare, medical practitioners, and the IDEA/Part C system to improve early identification efforts of children experiencing delay. ASQ:SE kits were also purchased in April 2010 **//2013/ with 300 distributed to participating HealthCheck providers. An additional 100 kits were purchased in 2012 after a QA initiative revealed that only about 25% of providers were conducting developmental screenings as recommended by Bright Futures. //2013//** There is also discussion about monies being dedicated to quality improvement in early childhood care centers, since three quarters of the nation's children between the ages of 3 and 5 and more than half of the children ages 2 and under spend time in some form of non-parental care. Many of these children are cared for by relatives, but a large proportion - 57% of children aged 3 to 5 and 20% of infants and toddlers are in center-based care. The quality of care in childcare settings varies dramatically, with low income children generally receiving the lowest quality care. Voluntary participation in statewide quality rating and improvement systems are the best way to improve the overall level of quality.

Childhood is a unique and valuable stage in the human life cycle. The most important influence in the life of a young child is the family. Parent education and home visiting programs strengthen the family and support parents. Many early childhood home visiting programs focus on families who are at risk, such as young, first-time mothers, mothers of low birthweight infants and low income families. West Virginia RFTS Program focuses on low income, medically high risk pregnant women; its goal is improving pregnancy outcomes and infant well-being, and is managed by the OMCFH in partnership with licensed nurses and social workers employed by community-based agencies statewide. Birth to Three, the State's Early Intervention/Part C/IDEA Program (BTT) provides developmental services in the child/family's natural environment with 99.9% of children in BTT receiving the majority of services in home and community settings. This Program is considered educational in nature, has no income guidelines, and is for a subset of the population. BTT (Part C/IDEA) is an investment in early childhood, administered with oversight by the U.S. Department of Education/Office of Special Education Programs' guidelines by the OMCFH.

Other home visiting programs in WV support parents and caregivers in preparing children for school entry and lower risks associated with growing up in poverty. The multiple programs serving early childhood populations provide unique opportunities for overall improvement in child

and family well-being.

/2012/ The WV Department of Health and Human Resources (WVDHHR) on behalf of Governor Earl Ray Tomblin, designated the Office of Maternal, Child and Family Health as lead agency to coordinate, develop and implement the WV Home Visitation Program (WVHVP). The primary focus of this Program is to increase the infrastructure within WV to expand home visitation services to clients residing in the identified highest at-risk counties. The WVHVP proposes to meet the requirements and expectations of the assignment to: expand the home visitation infrastructure and training capacity; develop and implement a statewide continuum of evidence-based home visitation from pregnancy to five (5) years of age; establish effective partnerships among WV home visitation programs and identified resource agencies; and develop an integrated surveillance and reporting system to monitor and evaluate selected home visitation performance and outcome measures required to show improvements in federally mandated benchmark areas. //2012//

/2012/ In FY 2009, the West Virginia Children's Health Insurance Program (WVCHIP) reported having 169,387 children enrolled in the Title XIX Medicaid Program, and 24,238 children enrolled in the Title XXI Children's Health Insurance Program. Information reported by the Primary Care Association indicates there are eighteen community-based dental clinics where dental services are provided free or at a reduced cost regardless of the funding source. Six local health departments offer oral health education services only, and four provide preventative oral health services. In the past year there were six mobile dental clinics in West Virginia which provided preventative services, where two clinics were Missions of Mercy (MOM) dental clinics which provided preventative and restorative dental services at no charge on a first come, first serve basis.

The Board of Dental Examiners reported for FY 2010 that there were 1,218 licensed dentists in the State, and 863 of those had physical addresses within West Virginia's borders. Of those 1,218 licensed dentists, 577 had at least one paid Medicaid claim and 610 had at least one paid WV CHIP claim. The Board of Dental Examiners also reported during that same time there are 1,314 licensed dental hygienists in the State, and 848 currently have West Virginia addresses. The State does not allow dental hygienists to bill Medicaid, however those hygienists who have a public health practice permit can bill under a supervising dentist. Medicaid in WV currently only offers emergency services to adults and pregnant women who are eligible for services. WV has six counties with only one dentist, and has twenty counties with less than five dentists.

In September 2010, the Association of State and Territorial Dental Directors released a national analysis of state oral health plans, "The State Oral Health Plan Comparison Tool". Out of 42 states with oral health plans, WV is one of 18 states that scored 19 or better on the Comparison Tool. WV met 19 of the 22 established benchmarks.

West Virginia frequently receives negative national attention for the poor oral health of its residents. In 2010 West Virginia was given an "F" by The Pew Center on the States in their report entitled "The Cost of Delay: State Dental Policies Fail One in Five Children." However, this report was not designed to recognize the significant investments and efforts that West Virginia has made in oral health over the last year. For example, in 2010, the Office of Maternal Child and Family Health (OMCFH) provided funding to Marshall University School of Medicine to develop and conduct a random oral health survey for children in West Virginia which follows Centers for Disease Control and Prevention guidelines and recommendations. In March 2010, West Virginia released its first Oral Health Plan, which was developed through a culmination of statewide efforts of oral health professionals to identify barriers and strategies to improve oral health. This process was a partnership between public and private organizations, legislators and community leaders. The State Plan outlines objectives and identifies responsible stakeholders to achieve goals for improved oral health across West Virginia. In 2011, the Pew Center raised West Virginia's oral health grade to a "C". //2012//

/2012/ An environmental research study completed by Washington State University and West Virginia University found an association between mountaintop mining and an increase in certain birth defects among live births in central Appalachia for the time period 1996-2003. In this study, birth defects are examined in mountaintop coal mining areas compared to other coal mining areas and non-mining areas of central Appalachia. Southern counties in WV were included in the study. The study found that the prevalence rate ratio (PRR) for any birth defect was significantly higher in mountaintop mining areas compared to non-mining areas (PRR=1.26, 95% CI=1.21, 1.31), but was not higher in the non-mountaintop mining areas, after controlling for covariates. Rates were significantly higher in mountaintop mining areas for six of seven types of defects: circulatory/respiratory, central nervous system, musculoskeletal, gastrointestinal, urogenital, and other. There was evidence that mountaintop mining effects became more pronounced in the latter years (2000-2003) versus earlier years (1996-1999). Spatial correlation between mountaintop mining and birth defects was also present, suggesting effects of mountaintop mining in a focal county on birth defects in neighboring counties. Elevated birth defect rates are partly a function of socioeconomic disadvantage, but remain elevated after controlling for those risks. Both socioeconomic and environmental influences in mountaintop mining areas may be contributing factors.

In this exploratory study, the authors stated that they did not have the data to examine biological mechanisms by which mountaintop mining pollution may lead to birth defects. Investigating these potential mechanisms remains an important future research step. Given the multiple forms of mountaintop mining pollution identified in previous research, involving multiple chemicals operating through both water and air transport routes and the fact that elevated rates of birth defects were present across multiple organ systems, they offer as a working hypothesis for future research that mothers residing in different locations within the region may be exposed to different or combined impacts of the industry.

Results extend previous research on low birthweight outcomes and on adult morbidity and mortality in mining areas by demonstrating increased rates of birth defects as an additional public health effect related to coal mining in Appalachia. Results also offer one of the first indications that disparities are concentrated specifically in mountaintop mining areas, and have become more pronounced as this type of mining activity has expanded. Existing regulations to protect air and water quality in mountaintop mining areas may be inadequate (Palmer et al., 2010), and enforcement of those regulations has been lax (Ward, 2008; Burns, 2007), although recent efforts by the Environmental Protection Agency (2010) may be moving in the direction of stricter regulations.

(Ahern, M.M., et al., The association between mountaintop mining and birth defects among live births in central Appalachia, 1996-2003. Environ. Res. (2011), doi:10.1016/j.envres.2011.05.019).

On June, 23, 2011, the OMCFH Office Director participated in an hour long conference call with the study authors, a few Perinatal Partnership physicians representing WV ACOG, WVAAP, legislative and community agency representatives. The group agreed on the following:

- This is a general public health/MCH issue and additional action and research is warranted
- Additional research needed to determine what specific minerals and by-products from explosives, diesel equipment, etc. were causative/associated factors for the birth defects
- There was interest in linking with the OMCFH Birth Defects Registry to evaluate particular location by type of defect (perhaps by zip code)
- There was recognition that any action to mitigate future impact on WV moms and babies must also consider strong political and economic impacts of coal mining industry
- The study authors will present initial findings at the July Legislative Interims, Health Committee

//2012//

//2013/ There has been no further discussion on this research study. //2013//

//2013/ Overview of CSHCN Program:

The Children with Special Health Care Needs (CSHCN) Program receives referrals directly from the Newborn Screening Program, Newborn Hearing Screening Program, and Social Security disability determinations. Last year, efforts to utilize the birth defect registry to target newborns at risk of or diagnosed with a chronic medical condition for referral to the CSHCN Program proved difficult with privacy and confidentiality regulations as well as the data file containing no demographic information necessary for follow up. However, to address early identification and building the medical home, the CSHCN Screener(r) has been implemented in ten pediatric provider offices, with 40 practitioners, as part of the Tri-State Children's Health Improvement Consortium (T-CHIC) which is a five year project funded by a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant. As a foundational piece of the comprehensive pediatric provider care coordination model implemented in this project, and guided by the CHSCN Program care coordination model, the CSHCN Screener(r) is administered via family interview when children are identified for needed referral through their well-child exam. Referrals are received directly from the pediatric provider care coordinator if a child is identified as a child with a special health care need via CSHCN Screener(r) definitional domains. Furthermore, emotion-based public awareness materials and CSHCN program applications continue to be distributed directly to medical providers, early childhood providers, and Medicaid application centers (West Virginia Department of Health and Human Resources county offices) through CSHCN Program staff and Parent Network Specialists.

Through a cooperative agreement with the state's Medicaid program dating back to 1967, the CSHCN Program maximizes Title XIX, Title V as well as state funds to provide for evaluation, diagnostic/assessment, treatment, habilitation, and care coordination of children at risk of or diagnosed with a chronic medical or disabling condition. This partnership includes a centralized system for provider credentialing, medical necessity determination, prior authorization and billing processes for medical foods, durable medical equipment and medical services to children who have health financing by Title V.

The CSHCN Program partners with medical schools and hospitals to maximize and build the system of care in West Virginia. In efforts to ensure children can receive quality care within one hour drive from their home, and facilitate communication with a child's medical home, the CSHCN Program supports providers and practices with care coordination services by partnerships with: 1) West Virginia University to conduct six (6) specialty clinics in eight (8) locations throughout the state in the areas of cardiology, cleft and craniofacial surgery, genetics, myelodysplasia, and neurology; 2) Charleston Area Medical Center to conduct two (2) specialty clinics in Charleston WV in the areas of cystic fibrosis as well as cleft and craniofacial surgery; and 3) Marshall University to conduct two (2) specialty clinics in Huntington WV in the areas of spina bifida and cardiology. The CSHCN Program independently hosts, by individual contracts with providers, an additional 35 specialty clinics in 17 locations throughout the state in areas of cardiology, neurology, orthopedics, nutrition and ear, nose and throat, supported by donated office space and supplies provided by Women's and Children's Hospital, Beckley Health Right, St. Mary's Hospital, St. Joseph's Hospital, WV School for the Deaf and Blind, Ohio Valley Medical Center, Broaddus Hospital, Princeton Community Hospital, Wetzel County Center for Children and Families, Summersville Pediatrics, Associates in OB/GYN, West Virginia University Center for Excellence in Disabilities, University Pediatrics School Solution Center, Dr. John Eckerd, Dr. Monique Gingold, Dr. George Herriott, Dr. Jeffrey McElroy, Dr. John Draper, and Dr. Thomas Scott.

HealthCheck and the CSHCN Program are partnering with the Tri-State Children's Health Improvement Consortium which is a five year project funded by a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant with participating states of Alaska, Oregon and West Virginia. The goal of the project is to establish and evaluate a national quality system for children's health care which

encompasses care provided through the Medicaid program and the Children's Health Insurance Program. HealthCheck and the CSHCN Program, in addition to 10 independent medical practices, will participate in evaluating the use of newly developed evidence-based measures of the quality of children's healthcare, promote the use of health information technology (HIT) in children's healthcare delivery, and contribute to the development of a comprehensive pediatric provider care coordination model. At the beginning of the third year of the project, quality assurance reviews have been completed to gather baseline measurement for the initial core set of Children's Health Care Quality Measures, the reporting system and training of provider practices is in place to begin gathering ongoing data concerning the quality measures, an electronic personal health record has been developed and piloted, and each of the ten practices have been provided a care coordinator utilizing a care coordination model guided by the CSHCN Program services model.

The CSHCN Program continues a partnership with the West Virginia State Implementation Grant working to build a family-centered, culturally competent and community based system of care for Children with Special Health Care Needs. The three year project will develop a model of integrated services supported by health information technologies to create a Virtual Medical Home. Thus far, the CSHCN Program has piloted a care coordination care plan in specialty care practices in two locations with the goal to include the families as part of the care coordination team for their child. The Care Coordination Care Plan also provides documentation to the families, Primary Care Physician (PCP) and the patient's local care coordination team, on what was recommended for the child and who will be responsible for arranging what is needed following a specialty care visit. A copy of the form is given to the patient's family as a guide for what the next step will be for their child. A copy is faxed to the patient's regional care coordination team, to keep them informed of what recommendations the specialist had and what they might be responsible to arrange. Also a copy will be sent to the patient's PCP. The pilot has proven helpful in increasing family involvement, and adherence to the physician recommendations. However, the form is not user-friendly since it is not electronic for upload into electronic medical records. The focus next year will be on ensuring a Care Coordination Care Plan that is compatible with multiple electronic medical records prior to distribution in other specialty care clinics.

The CSHCN Program also sponsors a telehealth clinic at St. Joseph's Hospital in Parkersburg WV initiated through the West Virginia State Implementation Grant. Telehealth clinics provide access to specialty care appointments in the patient's local community by using Mountaineer Doctor Television (MDTV). Using telehealth clinics allows specialty and primary care providers as well as care coordinators to be a part of the clinic and, in essence, become the Virtual Medical Home. In 2011, negotiations began to expand telehealth clinics to a large pediatric practice in Lewisburg WV, and a new pediatric practice in Harper's Ferry, WV.

The Office of Maternal, Child and Family Health/Social Security Administration Task Force resumed partnership in 2011 with the goal of identification and referral of children with special health care needs, and expedited disability determinations as a result of a seamless referral and information sharing system. //2013//

Following is a Vital Statistics summary: /2013/ The 2010 Vital Statistics narrative was not available for this application. //2013//

Population

In 2009, 110 West Virginians were lost to the total population as a result of natural decrease, the excess of deaths over births. Results from the 2009 Census estimate show an overall increase (approximately 0.6%) in the state's population since 2000, from 1,808,344 to 1,819,777. This increase is the result of a slight growth in the excess of in-migration over out-migration during that

span, as well as the natural increase.

Although there was an increase in the overall population from 2000 to 2009, slightly under half (26) of the state's 55 counties have shown an increase. Furthermore, only three of the state's 25 largest cities have shown an increase in population since the 2000 Census.

Live Births

West Virginia's resident live births decreased by 218 or 1.0%, from 21,493 in 2008 to 21,275 in 2009. The 2009 birth rate decreased 0.9% from 11.8 per 1,000 population in 2008 to 11.7. The U.S. 2009 birth rate was 13.5 live births per 1,000 population, decreasing from the 2008 rate of 14.1. West Virginia's birth rate has been below the national rate since 1985. It continued its overall decline until 1996, interrupted by slight upturns in 1989 through 1991. It remained relatively stable from 1996 to 2006 and 2008 with an increase in 2007.

The fertility rate among women aged 15-19 in West Virginia was 26.6% higher than that among young women in the U.S. (49.5 vs. 39.1). The fertility rate among women aged 20-44 was lower by 11.4% in the state than in the nation (63.9 vs. 721.).

The number of births to teen mothers (ages 10-19) increased by 69 (2.5%), from 2,781 in 2008 to 2,850 in 2009. The percentage of total births represented by teen births was higher in 2009 than 2008 (13.4% vs. 12.9%). The lower fertility rate among older women, however, resulted in teen births continuing to constitute a higher proportion of total births than was found nationally (10.0% in 2009).

The percentage of births occurring out of wedlock continued to rise in 2009. More than two of every five (43.6%) West Virginia resident births were to unwed mothers. The percentages of white and black births that occurred out of wedlock in West Virginia in 2009 were 42.3% and 78.0%, respectively, compared to 40.8% and 75.2% in 2008. In the United States in 2009, 29.0% of white births (non-Hispanic) and 72.8% of births to black mothers (non-Hispanic) occurred out of wedlock. The percentage of teen births to unmarried teen mothers in the state increased from 80.5% in 2008 to 81.3% in 2009.

There were a total of 1,957 low birthweight babies (those weighing less than 2,500 grams or five and a half pounds) born to West Virginia residents in 2009, 9.2% of all births. Of the 1,957 low birthweight infants, 1,306 or 66.8% were preterm babies born before 37 weeks of gestation. Of all 2009 resident births with a known gestational age, 10.8% were preterm babies. Of all births with known birthweight, 9.0% of babies born to white mothers and 14.6% of babies born to black mothers were low birthweight. Nationally, 8.2% of all infants weighed less than 2,500 grams at birth in 2009; 7.2% of white infants and 13.6% of black infants were of low birthweight. Also nationally, 12.2% of all infants were preterm births; 10.9% of births to white mothers (non-Hispanic) and 17.5% to black mothers (non-Hispanic).

Eighty-two percent (82.1%) of 2009 West Virginia mothers with known prenatal care began their care during the first trimester of pregnancy, compared with 83.2% of mothers nationwide in 2006. Among those with known prenatal care, 82.5% of white mothers began care during the first trimester; 72.2% of black mothers did so. U.S. figures show that 88.1% of white mothers and 76.1% of black mothers had first trimester care. No prenatal care was received by 0.6% of white mothers and by 1.9% of black mothers.

Over one-fourth (27.2%) of the births in 2009 were to mothers who smoked during their pregnancies, while 0.3% of births were to women who used alcohol. National figures from 2007 show that 10.4% of women giving birth reported smoking during pregnancy; 0.8% used alcohol in 2004 (the latest data available). Among the state mothers who reported smoking during pregnancy, 14.1% of the babies born were low birthweight, compared with 7.4% among non-smoking mothers. Over one-third (36.3%) of 2009 state births were delivered by Cesarean section, compared with a national rate of 32.9%. One or more complications of labor and/or

delivery were reported for 34.2% of deliveries in the state in 2009.

Deaths

The number of West Virginia resident deaths decreased by 166, from 21,551 in 2008 to 21,385 in 2009. The state's crude death rate dropped from 2008 at 11.9 per 1,000 population to 11.8 in 2009. The average age at death for West Virginians was 72.1 (68.7 for men and 75.5 for women), slightly lower than the 2008 average of 72.5 (69.0 for men and 75.9 for women). One hundred and thirty-three West Virginia residents who died in 2009 were age 100 or older. The oldest man was 107 years old while the oldest woman was 108 years old at the time of death.

Heart disease, cancer, and chronic lower respiratory diseases, the three leading causes of death, accounted for 53.3% of West Virginia resident deaths in 2009. Compared with 2008, the number of state deaths due to heart disease decreased by 212 or 4.0% while cancer deaths increased 3.2%. Chronic lower respiratory disease, the third leading cause, decreased 5.2%; stroke mortality, now the fifth leading cause, increased 4.4%. Diabetes mellitus deaths increased 2.0%, while the number of reported deaths due to pneumonia and influenza decreased 1.0%. Dementia, now the seventh leading cause of death in the Mountain State, decreased by 2.3%, while Alzheimer's disease decreased 15.7%. Accidental deaths were the fourth leading cause of death for the third year in a row. The number of accidental deaths dropped by 45 (3.8%), from 1,195 in 2008 to 1,150 in 2009. Motor vehicle accident deaths decreased by 12 or 3.2% from 380 in 2008 to 368 in 2009. Accidental poisoning deaths was on the rise in West Virginia for five of the previous seven years, but decreased by 50 (11.3%) from 444 in 2008 to 394 in 2009. The vast majority of these deaths were due to both legal and illicit ingestion of prescription pharmaceuticals.

Accidents were the leading cause of death for ages one through forty-four years. Motor vehicle accident fatalities remained the single leading cause of death for young adults aged 15 through 24, accounting for 39.3% of all deaths for this age group in 2009. West Virginia's 2009 motor vehicle fatalities included three children under five years of age, two fewer than 2008.

Suicides increased by four, from 280 to 284 between 2008 and 2009. Male suicides increased by 12 or 5.4%, from 223 in 2008 to 235 in 2009; the number of female suicides (53) decreased by eight or 13.1% from 2008. Nearly two-thirds (66.0%) of all suicide deaths were firearm related -- 71.9% of male suicides and 39.6% of female suicides. The average age of death for a suicide victim in 2009 was 46.7 years. While suicide was the 12th leading cause of death overall, it was the second leading cause of death for ages 15-34. The number of suicides among persons aged 19 and under was 12 in 2009, three more than 2008 at nine.

Homicides increased by 22, from 77 in 2008 to 99 in 2009. Seventy-one (71) of the homicide victims were male, 28 were female. The average age at death for a homicide victim in 2009 was 40.7 years. There were two homicide victims under the age of five in 2009, compared with 7 in 2008. Over half (57.6%) of 2009 homicide deaths were due to firearms.

Years of Potential Life Lost (YPLL)

YPLL is a measure of mortality, calculated as the difference between age 75 (an average life span) and the age at death. Using YPLL before age 75, the sum of YPLL across all causes of death represents the total YPLL for all persons dying before the age of 75. A person dying at the age of 39 would therefore contribute 36 years to the total YPLL (75-39=36). YPLL is an important tool in emphasizing and evaluating causes of premature death.

The YPLL from all causes increased 2.7%, from 170,033 YPLL in 2008 to 174,632 in 2009. The four leading causes of YPLL in 2009 were malignant neoplasms (37,441 YPLL), diseases of the heart (24,859 YPLL), non-motor vehicle accidents (17,921 YPLL), and motor vehicle accidents (12,059 YPLL). Combined, these four causes accounted for over half (52.8%) of all years of potential life lost in 2009. In comparison to 2008, YPLL attributable to malignant neoplasms increased from 21.3% to 21.4%. YPLL due to diseases of the heart decreased from 14.3% to

14.2% of the total, and YPLL due to non-motor vehicle accidents decreased from 12.1% to 10.3%. The percentage of total YPLL due to motor vehicle crashes also decreased, from 7.1% to 6.9%.

Infant Deaths

Deaths of infants under one year of age rose by one, from 166 in 2008 to 167 in 2009. West Virginia's infant mortality rate also rose slightly, from 7.7 per 1,000 live births in 2008 to 7.8 in 2009. The preliminary U.S. infant mortality was 6.4 in 2009.

The state's 2009 white infant mortality rate increased slightly from 7.3 in 2008 to 7.4, while the rate for black infants decreased slightly from 20.9 to 20.7.

Approximately one out of five (18.6%) infant deaths in 2009 were due to SIDS (sudden infant death syndrome). Approximately one in six (16.8%) was the result of congenital malformations, while 53.9% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birthweight (17.4%).

Neonatal/Postneonatal Deaths

The number of neonatal deaths rose by 17, from 96 in 2008 to 113 in 2009; the neonatal death rate also increased, from 4.5 deaths among infants under 28 days per 1,000 live births in 2008 to 5.3 in 2009. Neonatal deaths comprised 67.7% of all West Virginia resident infant deaths in 2009, compared with 57.8% in 2008. The rate of postneonatal deaths decreased from 3.3 deaths per 1,000 neonatal survivors in 2008 to 2.6 in 2009. The 2009 preliminary U.S. neonatal death rate was 4.2, while the postneonatal rate was 2.2 deaths per 1,000 neonatal survivors.

Fetal Deaths

The 121 resident fetal deaths occurring after 20 or more weeks of gestation reported in 2009 were 27 more than in 2008 (94). The fetal death ratio also increased, from 4.4 deaths per 1,000 live births in 2008 to 5.7 in 2009. The majority (92.6%) of fetal deaths were due to conditions originating in the perinatal period, including complications of placenta, cord, and membrane (29.8%), maternal conditions (4.1%), maternal complications (8.3%), short gestation and low birthweight (5.8%), and other ill-defined perinatal conditions (32.2%). Congenital malformations accounted for 5.0% of all fetal deaths.

Induced Termination of Pregnancy (ITOP)

The annual reporting of induced termination of pregnancy (ITOP), also properly referred to as "induced abortion," was mandated in the latest revision of the West Virginia Code. An ITOP is a purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant and which does not result in a live birth. The management of prolonged retention of products of conception following fetal death is excluded. The major distinguishing feature of this event is the fact that it is "purposeful" rather than spontaneous. A spontaneous interruption of a pregnancy is also known as a fetal death or a spontaneous abortion or, more commonly, as a miscarriage or a stillbirth.

One of the primary differences between the reporting of ITOP statistics and birth and death statistics is that ITOP statistics reflect events that occurred in West Virginia. Due to exchange agreements with other states, births and deaths to West Virginia residents that occur elsewhere are reported back to West Virginia, making it possible to ascertain the number of births and deaths among West Virginia residents in a given time frame regardless as to where the event occurred. Information on the number of West Virginia residents who obtain an ITOP in another state is infrequently reported back to West Virginia by the state where the procedure took place, normally due to restrictions within the other state's legal code.

The only two free-standing clinics that perform ITOPs on demand in West Virginia are in Charleston, which makes the likelihood of out-of-state ITOPs greater in some regions of the state. It is unlikely that the majority of women living in the northern or eastern panhandle of the state

seek an ITOP in West Virginia. Due to known incomplete reporting, therefore, the procedures performed on West Virginia residents in other states have been excluded from the compiled statistics.

In 2009, there were 1,772 ITOPs performed in West Virginia, 10.6% less than in 2008 (1,982). Nearly eight out of every nine (88.5%) ITOPs involved a West Virginia resident, while 5.0% were Kentucky residents and 4.7% were residents of Ohio, compared with 2008 percentages of 88.2%, 4.8%, and 5.8%, respectively. The median age of women having an ITOP in 2009 was 23, same as 2008. There were 110 procedures in 2009 involving females under the age of 18, of which 105 were to unemancipated minors compared with 117 in 2008, of which 102 were unemancipated minors. Nearly eighty-two percent (82.1%) of the 2009 ITOPs performed in West Virginia were to women who were not married at the time. Over one-third (35.5%) of the 2009 ITOPs involved women who had never had a previous live birth; while 87.9% were to women who had two or fewer children. There were seven ITOPs performed on women who had six or more children. Over sixty percent (63.8%) involved women for whom it was their first ITOP, while nearly all (95.8%) involved women who had two or fewer previous ITOPs. There were two ITOPs performed upon women who previously had six or more ITOPs.

Marriages

For the eighth time in the past nine years, the number of marriages in West Virginia decreased, from 13,025 in 2008 to 12,468 in 2009. The marriage rate in 2009 was 6.9 per 1,000 population; lower than the 2008 rate of 7.2. The 2009 U.S. provisional rate was 6.8.

For all marriages in 2009, the median age was 26 for brides and 29 for grooms. The mode (most frequently reported age) for all marriages was 23 for brides and 25 for grooms. There were 161 brides less than age 18 while there were 29 grooms. There were 166 brides over the age of 65 while there were 312 grooms. Also in 2009, there were 210 marriages where the groom was 20 years or more older than the bride while there were 22 marriages where the bride was at least 20 years older.

For first marriages, the median age for brides was 23; for grooms it was 25. The mode for first marriages in West Virginia was 22 for brides and 25 for grooms. All of the West Virginia grooms while but one of the brides less than age 18 were in their first marriage. There were three brides over the age of 65 while there were eight grooms in their first marriage.

Divorces and Annulments

The number of divorces and annulments increased by 517 or 5.8%, from 8,903 in 2008 to 9,420 in 2009. The 2009 rate of 5.2 per 1,000 population was also higher than the 2008 rate of 4.9.

Of the 9,420 divorces in West Virginia in 2009, the median duration of marriage was six years. Approximately one out of every four (24.0%) West Virginia divorces with a known duration in 2009 involved marriages lasting only two years or less; 7.0% involved marriages of 25 years or longer. There were 17 divorces involving a wife less than age 18 while there were three where the husband was under age 18. During 2009, 107 divorces involved a wife aged 65 or older, and 185 involved a husband in the age group.

Over half (53.8%) of the divorces involved no children under 18 years of age in the family, while one child was involved in 23.2% of all divorces and two children were involved in 16.8%. Five divorces involved six or more children.

B. Agency Capacity

The Office of Maternal, Child and Family Health (OMCFH) has historically purchased and/or arranged for health services for low income persons, including those who have health care

financed under Title XIX. The Medicaid expansion of the 1980's resulted in health financing improvements, but it was Title V energy that developed obstetrical risk scoring instruments and recruited physicians to serve mothers and children, including those with special health care needs. It was also Title V that established standards of care, and developed formalized mechanisms for on-site quality assurance reviews.

Income eligibility coverage for pregnant women is 185% of the Federal Poverty Level in response to patient demand, using Title V monies. Although the OMCFH is less and less involved as a health care financier, the Office continues to provide gap filling services when indicated.

The OMCFH is constituted of three divisions, plus a Quality Assurance/Monitoring Team, Early Intervention IDEA/Part C, Home Visitation Program and the Administrative unit. With the exception of the Children with Special Health Care Needs Program (CSHCN), the OMCFH does not deliver direct services but rather designs, oversees and evaluates preventive and primary service systems for WV women and men of reproductive age, infants, children, adolescents, and children with special health care needs.

Quality Assurance/Monitoring Unit:

The OMCFH Quality Assurance/Monitoring Team has over 30 years proven experience in conducting on-site clinical reviews. These reviews occur with medical and educational providers who contract with the Office - private physicians, primary care centers, local health departments, hospitals, etc. The reviews are conducted on site and include patient interviews, chart reviews, and provider interviews. Formal reports are submitted to each program, as well as the health care provider.

WV Birth to Three/Part C IDEA (BTT):

BTT provides therapeutic and educational services for children ages 0-3 years and their families who have established, diagnosed developmental delays, or are at risk of delay through a network of credentialed practitioners statewide. The goal is to prevent disabilities, lessen effects of existing impairments, and improve developmental outcomes. Services are provided based on individual child/family assessments and delivered by community-based practitioners who are credentialed by Birth to Three. The service system is supported by Title V, federal Part C/Early Intervention, State appropriations and Title XIX funds.

Division of Perinatal and Women's Health (PWH):

The focus of the PWH Division is to promote and develop systems which address availability and accessibility of comprehensive health services for women across the life span and high risk infants in the first year of life. Administrative oversight includes an integrated perinatal care and education system paid for by Title V and Title XIX. PWH programs include the Family Planning Program under which the Adolescent Pregnancy Prevention Initiative is housed; the Breast and Cervical Cancer Screening Program; WISEWOMAN; universal maternal risk screening and the Right From The Start (RFTS) perinatal program that includes the Newborn Hearing Screening Project and the Birth Score Project. Additionally, these programs provide linkage and referral to other women's, infants', and children's services.

Family Planning Program (FPP):

The FPP provides an array of confidential preventive health services for low-income women, men and adolescents through a community-based provider network of locations. Sites include county health departments, primary care centers, hospital outpatient centers, private providers, free clinics and university health sites. FPP services include contraceptives; health histories; gynecological exams; pregnancy testing; screening for cervical and breast cancer; screening for high blood pressure, anemia, and diabetes; screening for STDs, including HIV; basic infertility services; health education and counseling, and referrals for other health and social services. Free or low cost pregnancy testing is offered to enable early identification of pregnancy and timely referral into prenatal care.

Any female or male capable of becoming pregnant or causing pregnancy whose income is at or below 250% FPL is income eligible to receive free or low-cost clinical examinations and free contraceptives through the FPP. These publicly funded clinics help women prevent 13,800 unintended pregnancies each year.

FPP clinics offer counseling and referral for patients regarding future planned pregnancies, management of current pregnancies, or other individual concerns (i.e., nutrition, sexual concerns, substance use and abuse, sexual abuse, domestic violence, or genetic issues). FPP clients seeking pregnancy or planning a pregnancy in the future are offered prenatal multi-vitamins with folic acid as part of their pre-conceptual counseling. Clients in need of enhanced preconception counseling or genetics testing are referred to tertiary care facilities or specialty providers for additional assessment.

Domestic Violence:

Screening for domestic and intimate partner violence continues to be monitored by the FPP. FPP Specialists inquire about screening and availability of resources for victims at annual site visits. Findings are documented in their reports and entered in a data base. All FPP providers (100%) provide resources on site for services to those who are victims of domestic or intimate partner violence.

A Domestic Violence Intervention Guide was developed within the FPP for use by clinicians. A poster was also created to be placed in the restrooms with tear-off safety-plans for victims to take with them. The intervention guides and posters with tear-off safety plans were mailed to all FPP provider sites and are available by request.

/2013/ In 2011, RFTS distributed posters and brochures for the WV Committee Against Domestic Violence entitled "End Domestic Violence". //2013//

Adolescent Pregnancy Prevention Initiative(APPI):

/2012/ The APPI influences and supports teens as they explore and determine responsible sexual and reproductive options for the future through the development, oversight and coordination of evidence-based activities. The goal of APPI is to reduce the number of pregnancies among adolescents using an abstinence based approach which includes: improvement of decision-making skills, development of refusal techniques, and/or access to contraceptive services.

APPI is made up of 5 full-time employees: 1 Director and 4 APPI Prevention Specialists, who conduct education and outreach activities on a regional/local level. The APPI Prevention Specialists work to increase public awareness of problems associated with early sexual activity and childbearing and collaborate with existing community organizations to promote local activities for adolescent pregnancy prevention.

Confidential access to FPP services is crucial in helping sexually active teenagers obtain timely medical advice and appropriate medical care to delay childbearing. Minor clients seeking reproductive health care can only be assured of confidential services by a Title X-funded FPP network provider. *//2012//*

Right From The Start (RFTS):

West Virginia's RFTS began in 1989 as a partnership between OMCFH and WV Medicaid to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal home visitation services to low-income women up to sixty days postpartum and care coordination for Medicaid eligible infants up to one year of age. RFTS also provides direct financial assistance for obstetrical care for WV pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if they are a WV resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive

assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit.

The state is divided into eight regions for management of RFTS. Each region has a Regional Lead Agency (RLA) that provides a Regional Care Coordinator (RCC) to oversee activities of the community based Designated Care Coordinators (DCC). In addition to assigning patient referrals and promoting the project, the RCC coordinates training and education for DCC staff, and recruits obstetrical care providers and designated care coordination agencies.

Currently, there are 188 DCCs dedicated to the core public health function of assisting with access to early and adequate prenatal health care. In addition to RFTS DCCs, there are 85 obstetricians, nurse practitioners, nurse midwives and family practice physicians in WV and bordering states that have Letters of Agreement with the Project to provide quality obstetrical and delivery care to pregnant women.

HAPI:

WV Healthy Start/HAPI (Helping Appalachian Parents and Infants) Project is a federally funded Healthy Start grant which uses DCCs in RFTS Region VII for service provision. The purpose of this project is to work collaboratively with existing systems, most notably RFTS and the WV Birth Score Office, to provide comprehensive services to those women, infants and families at highest risk. In addition to the care coordination and health education offered through RFTS, the HAPI Project also provides prenatally targeted screening and referral for depression, domestic violence, substance use and oral health services. The HAPI Project focuses on helping women to become healthier between pregnancies, encourages spacing of pregnancies, provides assistance with travel and childcare, and focuses on mental health issues.

RFTS SCRIPT:

WV continues to have the highest rate of pregnant smokers in the U.S. To address this issue, RFTS adopted an intense smoking cessation initiative, the WV Right From The Start SCRIPT (Smoking Cessation/Reduction in Pregnancy Treatment). SCRIPT was developed by Dr. Richard Windsor, MS, PhD, MPH, George Washington University Medical Center, Department of Prevention and Community Health. RFTS SCRIPT uses the 5 A's (Ask, Assess, Advise, Assist, Arrange), best practice method for smoking cessation education with pregnant women supported by the Treating Tobacco Use and Dependence: Clinical Practice Guideline, Agency for Healthcare Research and Quality and by the American College of Obstetricians and Gynecologists Bulletins.

The smoking cessation program was implemented statewide in WV in January 2002, through the OMCFH and incorporated as protocol into the RFTS Program in October 2003. The WV RFTS SCRIPT uses the existing home visitation network and protocols established in the RFTS Program. Registered nurses and licensed social workers, provide services to pregnant women and infants throughout WV.

Newborn Hearing Screening:

The Newborn Hearing Screening (NHS) Project ensures that all children born in WV are screened at birth for the detection of hearing loss. Case management services are provided by the RFTS Program for every infant who either fails the hearing screen or is not screened prior to hospital discharge. The NHS Project has adopted goals set forth by Healthy People 2010 and the Centers for Disease Control and Prevention who recommend that all newborns be screened for hearing loss prior to one month of age, have an audiological evaluation by three months of age, and if needed, have appropriate intervention services by six months of age. Children in need of intervention are referred to CSHCN and WV Birth to Three. Referrals are also made to the Ski*Hi Parent/Child Program for home-based family education and support for deaf and hard of hearing children and their families, administered by the WV School for Deaf and Blind.

Access to Rural Transportation (ART):

ART provides payment for transportation of RFTS Maternity Services eligible clients to medical or other predetermined medical care appointments (i.e. childbirth classes). The provision of transportation assistance is important to the goal of improving pregnancy outcomes and to the wellness of women and infants in WV. RFTS Maternity Services clients receive transportation assistance via the ART system while Medicaid eligible clients receive this coverage via the Non-Emergency Medical Transportation (NEMT) system.

Birth Score:

High risk infants are referred to RFTS by the WVU, Birth Score Program. The Birth Score Developmental Risk/Newborn Hearing Screen instrument is a population-based assessment designed to identify infants at birth that may be at risk for developmental delay or death within the first year of life. Infants who are identified as high risk receive an accelerated number of six medical visits in the first six months of life. Other Medicaid-sponsored infants who are considered at risk are referred to RFTS from various sources for care coordination.

In 2007, the Birth Score Developmental Risk/Newborn Hearing Screen instrument was revised and questions added pertaining to the mother's oral health and substance abuse during pregnancy. The numerical Birth Score was changed so that the newborn is considered High Birth Score if the score is 99 or greater. All WV birthing sites implemented the modified Birth Score August 1, 2007. All High Birth Score infants continue to be referred to the RFTS Program for care coordination from birth through age one year.

Breast and Cervical Cancer Screening Program (WVBCCSP):

The WVBCCSP is a comprehensive public health program that assists uninsured/underinsured, low income women (at or below 200% of the Federal Poverty Level) between the ages of 25 and 64 in receiving quality breast and cervical cancer screening services. These services are offered through a statewide network of over 350 screening and referral providers. The WVBCCSP is funded through a federal cooperative agreement with the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). WV was one of the original four states to receive funding to implement this program in 1991. Today, the NBCCEDP spans all fifty states and the District of Columbia, five U.S. territories, and twelve American Indian/Alaska Native organizations.

Since its inception, the WVBCCSP has enrolled over 129,300 women and provided more than 168,600 mammograms, 256,200 clinical breast exams, 251,700 Pap tests and 3,700 hrHPV tests. Annually, the Program screens over 16,000 women. However, the Program does more than simply screen women. There are several core components of the WVBCCSP including: Program Management; Screening, Tracking and Follow-up; Surveillance/Data Management; Quality Assurance and Improvement; Professional Development; Recruitment; Partnerships; and Evaluation.

To assist NBCCEDPs in providing treatment to women diagnosed with breast and/or cervical cancer, the 2000 Congress gave states the option to provide medical assistance for treatment through Medicaid as a part of the passage of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). WV was one of the first states to take advantage of this opportunity. This means that when an uninsured woman under the age of 65 is diagnosed with breast and/or cervical cancer and/or certain precancerous conditions, she is eligible for a Medicaid card. The card will pay for all her health care services that are included in the Medicaid State Plan, not just those to treat the cancer diagnosis.

WISEWOMAN:

WV's WISEWOMAN Program is a public health program that works with the WVBCCSP to provide women access to cardiovascular risk factor screening and lifestyle interventions. WISEWOMAN participants must be enrolled in the WVBCCSP and be between the ages of 40-64 years. As part of a WVBCCSP eligible woman's routine breast and cervical cancer screening exam, she will be provided blood pressure readings, total and HDL cholesterol screening, blood

glucose screening, calculation of body mass index, assessment of smoking status, and evaluation of personal and family medical history. As follow-up to her screening exam, she will be offered risk reduction counseling and lifestyle interventions that will address nutrition, physical activity and tobacco use. The majority of WISEWOMAN provider sites are community health centers, since their federal assignment is assuring health access, and this provides an opportunity to be identified as the woman's health home.

/2012/ The WV WISEWOMAN Program Coordinator is involved with several initiatives that address health-related racial and socio-economic disparities in WV. These initiatives includes participation in the following: 1) quarterly meetings of the Black Medical Society of WV, a nonprofit organization created to bring healthcare professionals together to end health disparities affecting WV's African American communities; 2) discussions with the Advisory Council and staff of the WV Diabetes Control Program regarding the social determinants of health equity; 3) the WV Minority Health Coalition, which addresses education and outreach programs to all minority communities within WV; 4) the WV Nutrition Network which promotes healthy lifestyles through collaborative partnerships and social marketing efforts to improve eating habits and increase physical activity levels; and 4) the Bonnie's Bus workgroup focusing on increasing the numbers of African American and other minority women accessing the screening services available through the mobile mammography unit.

Statistics show an increased incidence of poor perinatal outcomes among minority women, and certain perinatal risk factors appear to be more prevalent among this population. Prenatal care is important in evaluating risk, promoting health, and managing complications in pregnancy, yet disparity of and access to care place these vulnerable women at increased risk. The Perinatal Partnership is interested in studying disparities find a solution that works for West Virginia. The Minority Health Division is currently working with the Black Medical Society. //2012//

Division of Infant, Child and Adolescent Health:

/2012/ The goals of this Division are to recommend and implement standards of child health supervision from infancy to adolescence, implement care coordination for children with special health care needs, identify strategies for the prevention of childhood injuries, and coordinate prevention and education programs to improve child health. Both families and medical professionals are a key component of meeting these goals through their involvement in strategic planning and advisory committees. //2012//

Adolescent Health Initiative (AHI):

The primary goal of the AHI is to improve the health status, health related behavior, and availability/utilization of preventative, acute, and chronic care services among the adolescent population of WV and promote risk resiliency and strengthen youths' personal assets.

Formal work with the AHI began in 1988. Introduction of the developmental asset principles of Search Institute brought about a change in the mission in 1993. Search Institute identified 40 positive experiences and qualities everyone can bring into the lives of youth, called the developmental assets. Organized training opportunities are provided by a workforce hired from the community they serve and offered in the community that the youth live. This workforce, called AHI Coordinators, is located in each of the eight regions of the state. These Coordinators offer young people, parents, and other significant adults in a child's life skill building sessions on conflict resolution, communication, increased awareness of harmful consequences of substance use, and strategies to develop self-reliance and improve responsible decision making.

Since the inception of the federal abstinence education funding, WV has been at the forefront of administering these grant dollars by providing long-term, intensive programs in an asset development framework in public schools and community organizations. Abstinence education is primary health prevention that teaches youth the physical, emotional, social, intellectual, spiritual and financial benefits of abstaining from sexual activity. /2012/ An effective teen pregnancy prevention program integrates well with WV's asset-based approach to reducing risk behavior

and increasing protective factors among youth. The AHI administers the Title V State Abstinence Education Grant Program as one component of the OMCFH's multi-faceted approach to address the problem of teen pregnancy and sexually transmitted diseases/infections (STDs/STIs). Federal funding for abstinence education expired in June, 2009 but was reinstated as part of the Patient Protection and Affordable Care Act in 2010. In Fiscal Year 2011, the AHI contracted with five local programs located throughout the State to offer an evidence-based curriculum program. The program provided in-school and after-school curriculum classes and educational services that included, but not limited to: alcohol, drug and tobacco prevention, violence prevention, life skills and character development. /2012//

EPSDT/HealthCheck:

The OMCFH administers the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for EPSDT members not enrolled in a health maintenance organization (HMO) statewide, for all children receiving Physician Assured Access Services (PAAS) and children receiving SSI. The program is administered under an OMCFH contract with the state's Medicaid agency, Bureau for Medical Services. OMCFH has provided EPSDT administration for 30 years.

/2013/ EPSDT's promise to children eligible for Medicaid is the provision of screening services; diagnosis to determine the nature or cause of physical or mental disease, conditions, or abnormalities identified during screening services; and treatment of all medical conditions discovered during screening services even if the service is not a part of the Medicaid State Plan.

EPSDT screening services include: 1) one or more physical exams each year based upon an age dependent periodicity schedule; 2) dental services; 3) vision services; 4) appropriate immunizations; 5) hearing services; 6) laboratory tests; 7) other necessary health care as described in section 1905(a) of the Social Security Act to correct or ameliorate health problems discovered during the screening services 8) health education and anticipatory guidance; and comprehensive health and developmental history. //2013//

Oral Health Program (OHP):

/2012/ The mission of the Oral Health Program (OHP) is to improve the oral health status of West Virginia by providing a structured approach to meeting the oral health needs of everyone in the State. The primary goals of the Program are to provide preventative education and improve oral health care access. Recent successes of the program are due to the collaborative efforts with other government agencies and community partners. Activities of the OHP continue to be guided by the WV Oral Health Advisory Board consisting of key stakeholders. The Oral Health Advisory Board was established in 2008 and continues to meet on a routine basis to advise the OHP in addressing oral health issues of West Virginia.

/2013/ Over the last year, the OHP has undergone a number of significant changes which includes the development of an Oral Health Plan that follows CDC's guidelines. The OHP provides an overview of the burden of oral health disease, goals, and strategies to improve the oral health status of all West Virginians. The Plan was created from feedback and input received during community and town hall meetings held across the State with final input received from the WVDHHR Oral Health Advisory Board.

The hiring of full-time State Dental Director, Dr. Jason Roush, continues to build upon existing collaborations. New in 2012, the OHP will support regional Oral Health Coordinators to promote and provide oral health education. The OHP continues to support fluoridation efforts in the community in addition to providing oral health supplies and educational materials to community partners. The OHP also provides fluoride water testing for private water systems and if needed, the clinician can prescribe fluoride supplements to ensure optimal fluoride levels are present.

Last year, the OHP and Oral Health Coalition (OHC) submitted and received DentaQuest Oral Health 2014 planning grant titled, "West Virginia-Champions for Oral Health." The OHP and OHC will focus on two priorities: Prevention and Public Health Infrastructure and Medical and Dental Collaboration. This grant will build on existing efforts to establish and enhance the infrastructure and capacity to plan, implement, and evaluate population-based prevention and promotion programs by adding a full-time epidemiologist to the program. Second, the OHP and OHC will partner with West Virginia University School of Dentistry to improve medical and dental collaboration by developing and implementing an educational curriculum for non-dental health care providers in order to expand the number and types of health care professionals providing preventative oral health services.

In recognition of science-based evidence supporting good oral health for adults which contributes to better overall health, this program supports two dental projects for adults throughout the State. The Pre-Employment Services Project provided dental and vision services for approximately 3,500 eligible individuals in 2011 who are receiving Temporary Assistance for Needy Families (TANF) from the WVDHHR with the goal of assisting adult persons to transition from "Welfare to Work." The Donated Denture Program provides dentures and/or partials for a limited number of low-income senior citizens (at or below 133% of the federal poverty level) and adults under 65 with disabilities who are receiving Supplemental Security Income (SSI) benefits. Participating dentists do the work for free, but receive Continuing Education credits, while the Program pays the lab bills. Due to extra funding in 2011, 340 eligible persons throughout West Virginia received dentures and/or partials free of charge. //2013//

Early Childhood Comprehensive Systems (ECCS):

/2012/ The ECCS facilitates collaboration with partners in order to attain a statewide system that builds protective factors within families and communities. This Project ensures that families of young children are resilient, able to assess their children's developmental needs and assure their children are healthy and ready to learn at school entry. //2012// ***//2013/ The ECCS is in the process of integrating/transitioning roles and functions to the Home Visitation Program. //2013//***

Children With Special Health Care Needs (CSHCN):

/2012/ The West Virginia Children with Special Health Care Needs (CSHCN) Program is improving the health of children at risk of or diagnosed with a chronic medical condition by providing family-centered, community-based, coordinated care through multidisciplinary teams. This vision is being strengthened through program redesign which was initiated in September 2010. All state, local and contracted CSHCN staff are serving on one of four redesign teams to develop tools or supports to implement best practices outlined by the American Academy of Pediatrics' policy statement, "Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs," and the Association of Maternal and Child Health Programs', "Meeting the Needs of Families: Critical Elements of Comprehensive Care Coordination in Title V Children with Special Health Care Needs Programs." These efforts build capacity for the CSHCN Program to work towards the Title V mission by offering medical and care coordination services that are accessible, continuous, comprehensive and compassionate; creating the optimal system of care for all children, particularly children with special health care needs. //2012//

/2012/ Through a cooperative agreement with the State's Medicaid program dating back to 1967, the Children with Special Health Care Needs Program maximizes Title XIX, Title V, as well as, state funds to provide for evaluation, diagnostic/assessment, treatment, habilitation, care coordination, and transition to adult services for children at risk of or diagnosed with a chronic medical or disabling condition.

The CSHCN Program provides nursing and social work services for enrolled children and their families throughout WV through development of needs assessments and care plans, as well as,

managing medical clinics, contributing in community clinics, organizing nutrition clinics and supplying medical foods that help children, youth, and families be healthier at home, in school and in the community. This care coordination and clinic system contributes to building the medical home model in WV, improving the system of care and strengthening family voices in health care. //2012//

/2013/ The CSHCN Program direct services continues to increase the number of low income children receiving health assessments, diagnosis and treatment with pediatric specialists in their own community as well as provide rehabilitation services for disabled individuals receiving benefits under Supplemental Security Income. To the extent it is not provided under Medicaid, CSHCN direct services ultimately influences and improves public policy necessary to support community-based systems of services specific to meeting the needs of children with special health care needs. //2013//

Systems Point of Entry (SPE):

SPE serves as the centralized information, patient education distribution and referral center for the Office of Maternal, Child and Family Health. SPE is responsible for intake and eligibility review for the CSHCN Program. SPE also does eligibility review for the Right From The Start (RFTS) Program for WV residents who have been denied services through Medicaid for their pregnancy. SPE is very unique in that whenever any type of contact is made, whether, by phone on one of OMCFH's two toll-free lines, email, or applying for one of the various programs, SPE focuses on the overall needs of the client/family, making community referrals whenever appropriate.

SPE is responsible for two phone numbers and two toll-free lines located in OMCFH. WV callers are responded to Monday through Friday, except holidays, 8:30-5:00, by either a licensed social worker or a registered nurse. The two toll-free responders provide referrals and information to all of WV free of charge. In CY 2011, there were 6,278 calls received on the toll-free lines.

/2013/ In November 2011, in conjunction with the new Home Visitation Program, SPE hired a Social Service Worker II to assist with answering the two toll-free lines as well as to assist families with home visitation services referrals.

SPE receives monthly reports from WVCHIP on clients who are receiving pregnancy related services. SPE reviews to assist the client in receiving either WV Medicaid or Right From the Start services for their pregnancy as WVCHIP does not cover pregnancy related services.

The Data Entry Unit for the OMCFH is housed within SPE and consists of six data entry operators who currently enter 90% of all OMCFH's program data.

SPE, in collaboration with the Bureau for Children and Families, works with the Bureau for Behavioral Health and Health Facilities in reviewing all Benjamin H. Project clients to ensure they are receiving all assistance available while on the Waiver waiting list. //2013//

Violence and Injury Prevention Program (VIP):

/2012/ The VIP is in the beginning stages of building infrastructure and developing a childhood injury component. This Program moved from the Office of Community Health Systems and Health Promotion to the OMCFH in 2010. At this time, the Program is staffed with a full-time program manager and a part-time coordinator. ***/2013/ An epidemiologist was hired in November 2011 and assigned to work with both the Home Visitation and Violence and Injury Prevention Programs. //2013//*** The Violence and Injury Prevention Program's current primary activities include: the facilitation of sexual violence prevention programs throughout the State, and the maintenance and expansion of collaborative projects that will encourage reporting, investigation, arrest, and prosecution of sexual assault and stalking in our state. //2012//

/2013/ The Violence and Injury Prevention Program strives to provide a more coordinated approach to prevention efforts across the State. Several partnerships have emerged as a result of collaborative efforts. Current coordinated efforts include: partnering with WVU's Injury Control Research Center to develop a comprehensive report on the Burden of Injury in WV; providing safety seats to Emergency Medical Services for children to place on every ambulance in the State to ensure safer travel for pediatric patients; along side the WV Council for the Prevention of Suicide, developing educational campaigns to address the problem of adolescent bullying and suicide; partnering with the State's Oral Health Program to encourage young athletes to wear mouth guards; and developing a basic home injury prevention training and curriculum for the State's Home Visitation Program. //2013//

/2012/ Fostering Healthy Kids Project (FHK):

The FHK Project is a collaborative pilot project between the Bureau for Children and Families and the OMCFH to improve healthcare coordination for children placed in relative/kinship care and/or WVDHHR foster family homes. This Project ensures that all children in foster care receive a timely EPSDT screen and assistance with accessing medically necessary treatment. //2012//

Division of Research, Evaluation and Planning (REP):

The REP is responsible for epidemiological and other research activities of the OMCFH, including all programmatic data generation and program/project evaluation endeavors, as well as ensuring that the OMCFH's planning efforts are data-driven. Most of OMCFH's program specific databases are housed in this Division, and are linked with Program leadership. There are currently 8 epidemiologists assigned to different Programs within OMCFH and 5 data programmers.

The Division administers the Pregnancy Risk Assessment Monitoring System (PRAMS) Project, and the Childhood Lead Poisoning Prevention Project (CLPPP), sponsored by the Centers for Disease Control and Prevention (CDC); birth defects surveillance; and in conjunction with the Office of Laboratory Services, the Newborn Screening Project, supported by State funds and revenue generation. This Division is responsible for SSDI data integration activities and grant application as well as the Title V Block Grant application and Needs Assessment. The Division is also responsible for development of data applications and data analysis for OMCFH programs and projects.

Pregnancy Risk Assessment Monitoring System (PRAMS):

This is a population-based surveillance system of maternal behaviors and experiences before, during, and in the early infancy of the child. The Project is an integral component of the Office. Data and information gathered by the Project are used by the West Virginia Bureau for Public Health as a resource for both the development of maternal, child and family health programs and for evaluating the new and existing programs and projects. Some of the data gathered includes smoking during pregnancy, intendedness of pregnancy, entry into prenatal care, etc.

Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID) Project:

This project collects and reports data regarding the occurrence of SIDS/SUID deaths in the State. When a SIDS/SUID death is reported, the local police are contacted who conduct a home visit and complete a home interview. Educational and grief information is sent to the family upon request. Training is provided to emergency room personnel, police, and funeral home personnel to sensitize them and offer strategies for responding to families. The Infant Mortality Review nurse, as well as the OMCFH Director, are members of the Child Fatality Review Team. /2012/ In 2011, Legislation mandated the development of an Infant Mortality Review Team to be incorporated with the Maternal Mortality Review Team. //2012//

Newborn Screening:

Expansion of newborn screening to include the 29 nationally recommended tests was mandated by the 2007 Legislature. Newborn screening rules were passed during the 2008 Legislative session mandating insurance companies pay for system costs. In February 2009, WV began

screening for all 29 of the nationally recommended disorders using the State Laboratory. Follow-up is provided by OMCFH nursing personnel, in collaboration with the child's primary care physician. Children with inborn errors of metabolism receive special consultation through the WVU, Department of Pediatrics-Genetics Program, as part of a contractual agreement with OMCFH. The nurses track all medically prescribed food products/formulas and have responsibility for assuring timely shipment of formulas to families, in addition to coordination of care between the medical community and the family. ***/2013/ CCHD and SCID are being added in 2012. //2013//***

Genetics Project:

This project provides clinical genetic services preconceptually and for children with congenital defects at six satellite locations under the auspices of WVU, Department of Pediatrics. Services include diagnosis, counseling and management of genetically determined disease, prenatal diagnosis and counseling, and evaluation of teratogen exposure. These services are almost solely financed by Title V. The Genetics Program staff provides all technical guidance for the medical community caring for children with metabolic disease. With the expansion of newborn screening for metabolic diseases to meet the national standards, the Genetics Project has had to expand as well. WV only has one Geneticist and the WVU Department of Pediatrics is recruiting for additional physician positions. In order to meet current service demand, WVU has expanded the number of genetic counselors using OMCFH resources to support their salaries.

Childhood Lead Poisoning Prevention Project (CLPPP):

This Project is a collaborative effort between two Offices in the Bureau for Public Health, OMCFH and the Office of Environmental Health Services (OEHP), funded by the CDC. An Advisory guides the operation of the Project, assisting the state with determining the extent of childhood lead poisoning in WV. To this end, extensive data collection and analysis are routinely distributed. The OEHP provides assessment of home and environment for residences of children with elevated blood lead levels. A new database is being planned for the CLPPP.

Birth Defects Surveillance System:

This Project tracks the incidence of specific diagnostic codes using the birth files, death files and monthly hospital reports of infants reported with a birth defect. All infants identified with a birth defect are referred to CSHCN.

C. Organizational Structure

/2013/ 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. The majority of OMCFH resources are allocated to develop systems of care for population-based and target-specific prevention services, as well as build infrastructure for support of maternal, child and family health populations. OMCFH maintains an annual operating budget of approximately \$58 million, with 164 staff in professional, technical and administrative support positions. Experiences gained from administrative oversight of varied grant requirements, program models, funding streams, and data driven decision making, place OMCFH in a unique position to effectively design and deliver evidence-based MCH services. //2013//

West Virginia's Office of Maternal, Child and Family Health is located within the state's Bureau for Public Health, administered by the umbrella organization, the Department of Health and Human Resources. As previously discussed in the agency capacity section, the OMCFH houses the CSHCN Program, Birth to Three/Early Intervention/Part C Program, Title X Family Planning, the State's Perinatal Home Visitation Program called Right From the Start, federal Maternal, Infant and Early Childhood Home Visitation Program, Oral Health Program, EPSDT/HealthCheck Program, Newborn Screening Program, Childhood Lead Poisoning Prevention and Surveillance, Birth Defects Surveillance, Infant and Maternal Mortality Review Team, Breast and Cervical Cancer Screening and other programs that lend support to developing and assuring a system of

quality care across the life span. The Bureau's overall goal is to attain and maintain a healthier West Virginia.

The Office of Maternal, Child and Family Health provides operational guidance and support to providers throughout West Virginia to improve the health of families. In addition to providing funding support for service delivery, the Office of Maternal, Child and Family Health funds projects intended to develop new knowledge that will ultimately improve service delivery within the health community.

It is important to remember that improvement in the health of West Virginia's perinatal population is a result of a carefully crafted, highly-interdependent partnership. Tertiary care centers, primary care centers, local health departments, private practitioners and agencies have worked with the Office of Maternal, Child and Family Health (OMCFH) for 30 years to make a difference in the health and well-being of the state's people. In conjunction with its medical advisory boards, OMCFH has designed a system that offers early and accessible health care to low income, medically indigent and under insured women and children.

Nationally, federal health agencies, insurance providers, health researchers, and policy groups are promoting the need for "Continuum of Care" with patients. It is recognized that continuity of coordinated, quality care is the best model of care for patients and is the most cost effective method for providing and paying for services. Continuum of care is best achieved through consistent access to quality health providers and services. Gaps in consistent care result in increased need for intensive and crisis care, which leads to higher costs for health care services. Research supports greater patient compliance with care plans when a positive relationship with their health care provider is well established. Ensuring access to health care for low-income women and children has been an ongoing concern for state and federal officials. The Bureau for Medical Services (Medicaid), the Bureau for Children and Families and the Office of Maternal, Child and Family Health (OMCFH) have worked collaboratively to develop special initiatives that extend support services to women, infants and children at-risk of adverse health outcomes. This partnership has not only expanded the state's capacity to finance health care for low-income adults and children, but has also strengthened the delivery of care by establishing medical service protocols, recruiting medical providers, expanding care coordination services, and offering nutrition counseling which contribute to improved patient well-being.

West Virginia Medicaid and the OMCFH share a common commitment to the goal of ensuring healthy births, reducing the incidence of low birth weight, and improving the health status of West Virginia's children, particularly those with special health care needs. These agencies also recognize the importance of maximizing scarce fiscal resources and the benefit of collaborative efforts in the development of programs that support shared goals. West Virginia's efforts to improve the health status of pregnant women and children have been successful over time as evidenced by broadened medical coverage, streamlined medical eligibility processes, shared government funding for targeted populations, targeted outreach, risk reduction education, and development of comprehensive programs that address both medical and behavioral issues.

/2012/ Life Course Model:

/2013/ The life course approach, also known as the life course perspective or life course theory, refers to an approach developed in the 1960s for analyzing people's lives within structural, social, and cultural contexts. The life course approach examines an individual's life history and sees for example how early events influence future decisions and events such as marriage and divorce, engagement in crime, or disease incidence. A life course is defined as "a sequence of socially defined events and roles that the individual enacts over time". In particular, the approach focuses on the connection between individuals and the historical and socioeconomic context in which these individuals live. The method encompasses observations including history, sociology, demography, developmental psychology, biology, public health and economics. So far, empirical research from a life course perspective has not resulted in the development of a formal theory. //2013//

"Rethinking MCH: The Life Course Model as an Organizing Framework" concept paper was released in November, 2010 by the U.S. Department of Health and Human Services, Health Resources and Services Administration, under contract with Amy Fine and Milton Kotelchuck. Peter C. van Dyck, M.D., M.P.H., Associate Administrator for Maternal and Child Health states that MCHB has turned its attention to better understanding life course theory and its implications for maternal and child health. Excerpts from the concept paper include the following:

"By combining a focus on health equity and social determinants with an updated understanding of how biology and environment interact, life course theory offers a rich and layered understanding of how health develops over a life time and across generations." Four key concepts were identified: timeline, timing, environment, and equity.

UCLA submitted an abstract on Life Course Research to the Maternal and Child Health Research Division and included the age breakdown for the life course as follows: Maternal, prenatal, infancy (0-12 months), toddlerhood (1-2 years), early childhood (3-5 years), middle childhood (6-11 years), adolescence (12-18 years) and young adulthood (19-21 years). The WV OMCFH has been building this life course model for years, but had not assigned a formal name to the model. Following is the age breakdown and programs the WV OMCFH offers to support the MCH population:

Maternal: Family Planning Program; media campaign targeting young men and women of childbearing age addressing readiness for parenthood; violence and injury prevention; quality assurance monitoring of health care facilities that contract to provide Family Planning services; conference calls that target specific subjects and share the latest techniques in order to continue to attract and develop highly qualified professionals

Prenatal: population based maternal risk screening; Right From The Start (the state's home visitation program); transportation to medical appointments; coordination of the Maternal, Infant and Early Childhood Home Visitation Program that includes partnership with all home visitation programs; Maternity Services Program that funds prenatal care visits for teenagers and mothers without health insurance or awaiting confirmation of insurance coverage; violence and injury prevention; quality assurance monitoring of community agencies that contract to provide Right From The Start services

Infancy: population based high risk infant screening called Birth Score; newborn screening and formula/supplements; newborn hearing screening; birth defects surveillance; Children with Special Health Care Needs (CSHCN) to age 21; coordination of Infant and Maternal Mortality Review Team; SIDS/SUID surveillance; management of the EPSDT/HealthCheck Program; Birth to Three (Early Intervention/Part C); Fostering Healthy Kids, a partnership with the Bureau for Children and Families coordinated through the CSHCN Program that case manages health management for children placed in Foster Care; Right From The Start; Maternal, Infant and Early Childhood Home Visitation Program; quality assurance monitoring of RFTS and BTT providers; violence and injury prevention

Toddlerhood: EPSDT/HealthCheck Program; Birth to Three; Home Visitation Program; Children's Dental Program (CDP); CSHCN; Childhood Lead Poisoning Prevention Program (CLPPP); Fostering Healthy Kids; metabolic formula/supplements; quality assurance monitoring of contracted agencies/service providers; violence and injury prevention

Early Childhood: Kids First screening for children entering school; Childhood Lead Poisoning Prevention Program; Healthcheck; Children's Dental Program; CSHCN; HealthCheck; Fostering Healthy Kids; Early Childhood Health; metabolic formula/supplements; genetic counseling; Maternal, Infant and Early Childhood Home Visitation Program; quality assurance monitoring of agencies/service providers; violence and injury prevention

Middle Childhood: HealthCheck; CSHCN; metabolic formula/supplements; genetic counseling; Home Visitation Program; Fostering Healthy Kids; quality assurance monitoring of agencies/service providers; violence and injury prevention

Adolescence: HealthCheck; CSHCN; genetic counseling; Adolescent Health Initiative (AHI), Adolescent Pregnancy Prevention Initiative (APPI); Family Planning; metabolic formula/supplements; Fostering Healthy Kids; quality assurance monitoring of agencies/service providers; violence and injury prevention

Young Adulthood: HealthCheck; CSHCN; genetic counseling; healthy pregnancy/healthy baby media campaign; Family Planning; domestic violence prevention; metabolic formula/supplements; quality assurance of agencies/service providers; rape and sexual assault prevention; violence and injury prevention

Adulthood: Pre-employment Dental/Vision Program; Donated Denture; Family Planning; domestic violence prevention; Breast and Cervical Cancer Screening Program; WISEWOMAN; metabolic formula/supplements; Infant and Maternal Mortality Review Team; quality assurance monitoring of agencies/service providers; rape and sexual assault prevention; violence and injury prevention

(The above programs and the partnerships involved with each are discussed in-depth throughout the Application).

In applying LCT as a strategic framework, it is important to note that much of the current work of the OMCFH integrates health services and support systems across the lifespan, with particular attention to critical/sensitive periods, to maximize protective factors and minimize risks. WV has built a strong population based risk identification system, beginning with maternal high risk screening, several Programs/Projects for identification of infants at risk, early childhood screening, screening of children entering school for the first time, and early childhood health screening. Other OMCFH programs/projects focus on a healthy pregnancy for identified high risk women. Fostering Healthy Kids focuses on the health of foster children, while the Bureau for Children and Families focuses on social and environmental, building a shared relationship that overlaps to ensure the children's overall needs are being met.

With the Home Visitation Program there is expanded opportunity to work with families in a holistic approach to reduce poor health and social outcomes. A strong referral system exists in all OMCFH Projects, Programs and Initiatives increasing the capacity to improve outcomes across several critical periods in the LCT model. In adolescence, the focus is on building assets, reducing risky behaviors, pregnancy prevention and making wise decisions. In adulthood, the WV OMCFH focuses on breast and cervical cancer screening for low-income women, healthier lifestyles for women, and oral health care for persons actively seeking employment. In-depth information on OMCFH programs is included in the Agency Capacity section and referenced throughout the Application Narrative.

Organizational charts for the WV Department of Health and Human Resources, Bureau for Public Health and the Office of Maternal, Child and Family Health are attached. //2012//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

/2013/ Currently there are 164 staff positions in OMCFH that include 4 senior management, 75 professionals, 28 medical professionals, 52 clerical and 5 technicians. //2013//

Parent Network Specialists System (PNS):

/2012/ In conjunction with the West Virginia University Center for Excellence in Disabilities (WVUCED), Title V supports the PNS system. This statewide system features five parents of children of varying ages who have a disability and are located in geographically strategic areas of WV. These PNSs provide one-on-one information, referral services and follow-up to families who have a child with a disability. PNSs receive on-going training in pertinent areas such as Title XIX MR/DD Waiver and Medicaid processes, the Health Insurance Portability and Accountability Act (HIPAA) regulations, roles of other agencies, and availability of resources.

The PNS project also partners and directly supports the goal of the WV Family to Family Health Information Center to improve health care and health care supports throughout WV for children with developmental delays, chronic illnesses and special needs by empowering families to advocate for their children and youth. //2012//

/2013/ Ultimately, PNSs serve as a member on the CSHCN Program multidisciplinary care teams specializing in assessing and care planning for developmental, educational, vocational and support system needs of the child and family. This parental perspective and expertise is essential in CSHCN Program care teams working with the child's family to ensure that all medical, non-medical, psychosocial and educational needs of the child and family are met in the local community in order to coordinate and facilitate the children's participation in both primary and specialty health care services. //2013//

The PNS Project has produced a Care Notebook for parents and other family members caring for a child with a disability. The Care Notebook is a case management tool and a resource guide, which can be used as a single repository of information (e.g., medical, emergency contacts, and care provider contact information) that parents can have available to take to appointments or to leave at home as a reference for care providers. The annotated resource guide section provides contact information for disability-related agencies and services.

The PNSs offer direct services through the CSHCN Program's multidisciplinary care team by engaging in the needs assessment and care planning process, providing direct, non-medical services, information or support to families, engaging in assisting families with transition through the educational and vocational systems, and helping to empower families to advocate for themselves in regards to educational and vocational needs.
//2012//

/2012/ The Developmental Disabilities Council continues to run ongoing Partners in Policy Making Educational Series. The new sequence will start in September 2011 and run through May 2012. //2012// Also available to WV residents is the Tiger Morton Catastrophic Medical Fund. This fund assists persons with medical expenses who have had a catastrophic medical incident and either are underinsured or uninsured. Referrals to this fund are managed by the Systems Point of Entry staff within OMCFH.

Meeting the health and psychosocial needs of persons with developmental disabilities are reflected in part as: WV Special Olympics sponsor Camp Tommy, a day camp held annually for the developmentally and physically disabled. The camp is held in the Buckhannon-Upshur High School during the third week in July. Approximately 100 campers of all ages participate. A variety of planned programs as well as crafts, sports, games and socialization is provided. The camp received a contribution of \$5,000 from the OMCFH.

The CSHCN Program, through the OMCFH, supports the Mountaineer Spina Bifida Camp held in June for those children up to age 21 with the diagnosis of Spina Bifida or Myelodysplasia. In 2011, the camp celebrated its 26th year of residential camping where children learn independent self care skills while participating in crafts, fishing, swimming, games, talent shows and a "prom" night. The CSHCN Program provides financial support for transporting equipment and supplies to staff who volunteer as counselors.

Data Reporting and Evaluation Capacity:

The WV OMCFH has applied for and received the State Systems Development Initiative (SSDI) Grant from HRSA for many years. This Grant has allowed the OMCFH to increase data collection and analysis capacity over the years. The SSDI Project is housed within the Division of Research, Evaluation and Planning. The Division has developed a Data Mart that has access to data from all of OMCFH's programs as well as birth records, infant death records and Medicaid eligibility files. This enables the OMCFH to examine and analyze data using multiple data sources to report on outcomes. New databases planned for collection and reporting of program data include Home Visitation, Infant Mortality Review and newborn screening case management. The Breast and Cervical Cancer Screening database that connects billing and services is in the process of being replaced.

The Division of Research, Evaluation and Planning has access to multiple data sets to be able to match data to evaluate program activities and results that fall under the OMCFH umbrella. These data bases include: birth and infant death files, newborn hearing screening, newborn metabolic screening, childhood lead screening, birth defects, SIDS/SUID, PRAMS, Birth Score (newborn high risk assessment screening), Medicaid eligibility files, FACTS (Families and Children Tracking System), Family Planning, Right From The Start, Early Intervention/Part C and CSHCN. /2012/ There are four database programmers and a web designer housed within this Division to assist OMCFH with development of data collection and reporting. **/2013/ This Division also houses the Epidemiologist section and has expanded capacity to nine epidemiologists. Areas of assignment for the Epidemiologists include: PRAMS, MCH issues, Birth to Three, Breast and Cervical Cancer Screening, WISEWOMAN and Family Planning, women's health issues including maternal risk screening and RFTS, home visitation and injury prevention, CSHCN, and oral health. //2013//**

Maternal Risk Screening:

Since the 1980s, West Virginia has screened low income, government-sponsored women for adverse outcomes, and although the screening instrument has changed numerous times over the last 25 years, the use of information to prevent or treat conditions associated with poor pregnancy outcomes has remained the same. Low income pregnant women who receive government-sponsored health care were routinely screened using the Prenatal Risk Screening Instrument (PRSI).

A survey of West Virginia medical obstetrical practitioners was completed by OMCFH to determine their current risk screening practices including the instrument used, and the PRSI was most often cited as the tool used. Out of 120 surveys returned, 40% reported regular use of the PRSI, 14% used an ACOG tool, 4% used the POPRAS, 14% used an in-house tool and 28% were not using a risk assessment form. The PRSI includes both medical history and psychosocial information to assess risk. Screening differs from assessment in that screening only identifies those most likely to be at increased risk and should result in further assessment to determine intervention and service need. In short, risk screening is the beginning of the process.

In recognition of the need for population-based maternal risk screening, Senate Bill 307, "Uniform Maternal Screening Act", was signed into law on May 28, 2009 by former WV Governor Joe Manchin III. The bill required the Bureau for Public Health, Office of Maternal, Child and Family Health (OMCFH) to convene a diverse maternal risk advisory council to develop a uniform maternal risk screening tool to help pregnant women for potential at-risk pregnancies and to meet annually to revise the tool as needed. The Advisory Council and OMCFH were required to develop a statistical matrix to measure incidents of high-risk pregnancies.

Preparations started on selecting, appointing and establishing the Maternal Risk Screening Advisory Committee in June 2009. As outlined in the legislation, representatives included at least one private maternity service provider; at least one public maternity provider; representation from each of the State's three medical schools; at least one certified nurse midwife; at least one representative of a tertiary care center; Bureau for Public Health Commissioner (or designee);

and OMCFH Office Director (or designee).

The Committee agreed to adapt the OMCFH, Right From The Start Program's Prenatal Risk Screening Instrument, which had been widely used by numerous OB providers throughout the State for years. Members wanted to keep the form simple, one page, user-friendly and electronically compatible.

After the Committee's suggestions were incorporated and a consensus was reached, the new universal screening tool was finalized in June 2010, and was identified as the West Virginia Prenatal Risk Screening Instrument (PRSI). The new tool contains the 4P's, an opt-in/opt-out for client referral services and an alert to the prenatal provider that the client may need a referral for a maternal fetal medicine consultation. //2012//

//2013/ Universal maternal risk screening was implemented statewide of January 1, 2011. //2013//

//2013/ For CY 2011, 11,082 PRSIs were received, roughly 50% of the state's pregnancies. Although there were gaps identified within the data on the completed forms, a data snapshot was developed by the epidemiologist and presented to the Advisory. Increased provider education is planned to encourage compliance and correct completion of the PRSI.

Drug Free Moms and Babies Project:

In response to the startling 2009 cord tissue drug study revealing that nearly 20% of all WV babies were found to have one or more illicit substances or alcohol present at birth, the WV Perinatal Partnership, in collaboration with the WVDHHR, Office of Maternal, Child and Family Health; the Bureau for Behavioral Health and Health Facilities; and the Benedum Foundation, launched an exciting new initiative called the "Drug Free Moms and Babies Project". Under this jointly funded program, four pilot sites are to establish integrated recovery models for pregnant women who are using illicit substances and alcohol. The goal is to identify programs that can be successful in supporting healthy baby outcomes by providing prevention, early intervention, addiction treatment and recovery support services. The pilots will follow mothers from pregnancy through the infant's 2nd birthday to support the women in their recovery from addiction and to prevent future drug exposed pregnancies. Basic requirements for participation include: Integration of the Screening, Brief Intervention, Referral and Treatment (SBIRT) model; program evaluation; provider outreach education; long term follow-up; and recovery coach services.

ASTHO/MOD Partnership:

In mid-April 2012, OMCFH joined the Association of State and Territorial Health Officials (ASTHO)/March of Dimes partnership to work towards reducing premature births and ensuring more healthy births in West Virginia. Dr. Marion Swinker, MD, MPH, signed the pledge to reduce prematurity by 8% in the State by 2014. Planning meetings have been scheduled with representatives from the March of Dimes, WV Chapter, and the WV Perinatal Partnership. Tentative intervention opportunities include co-branding March of Dimes print patient education materials and "Healthy Babies are Worth the Wait" public service announcements to increase consumer awareness and knowledge of the benefits of assuring full term deliveries.

Autism Spectrum Disorder/Developmental Disabilities (ASD/DD):

The rising number of individuals identified and diagnosed with autism spectrum disorder and other major disabilities poses a challenge to OMCFH. In 2011, the WV Legislature passed a bill requiring insurers to cover screening, diagnostic and treatment services for children with ASD. In response to this legislation, the WV Children's Health Insurance Program (WV CHIP) released an Autism Policy in February 2012, with OMCFH requested to review and provide input on the draft policy content.

In early 2012, OMCFH convened an internal workgroup to determine appropriate roles and approaches to pursue in building, improving and maintaining a State level system of care for children and youth with Autism Spectrum Disorder/ Developmental Disabilities (ASD/DD) and their families. The group was charged with conducting an environmental scan to review current OMCFH policies, procedures, activities and initiatives related to ASD/DD, then to brainstorm about expected or potential OMCFH roles, responsibilities and approaches in addressing ASD/DD.

In the assessment of current roles, staff discussed and identified challenges and pressing needs in the service delivery system (provider availability, diagnostic services), data sources, financing, family participation and outreach/awareness.

For the environmental scan and self-assessment, the Title V Index was used to address leadership related to ASD/DD in 6 core areas of involvement: Overall Leadership; Partnerships across Public and Private Sectors; Quality Improvement; Use of Available Resources; Coordination of Service Delivery; and Data Infrastructure. Each of the identified existing OMCFH roles and activities related to ASD/DD were grouped under one of these leadership areas to aid in better understanding of capacity, system-building and sustainability.

OMCFH staff continue to identify and refine an action plan to better address ASD/DD, with linkage to the MCHB Six Critical Indicators of Quality for a System of Care for CYSHCN to meet the diverse and complex needs of children with ASD/DD: Medical Home; Insurance and Financing; Early and Continuous Screening; Easy-to-Use Services; Family-Professional Partnerships; and Transition to Adulthood. For example, one critical role will be the development and launch of a Learn the Signs, Act Early public informing and provider education campaign to promote earlier identification of young children from birth to age five at risk of developmental delays. //2013//

Brief biographical sketches of the Office Director and Division Leaders:

Anne Amick Williams, RN, BSN, MS-HCA - OMCFH Director

EDUCATION:

Marshall University Graduate College, Master of Science in Management/Healthcare Administration, 1999

West Virginia University School of Nursing, Bachelor of Science in Nursing, 1986, Graduated Magna Cum Laude

PROFESSIONAL EXPERIENCE:

Director, OMCFH (2010 to Present)

Director, Division of Perinatal and Women's Health, OMCFH/BPH (2006 to 2010)

Director, Family Planning Program, OMCFH/BPH (1991 to 2006)

Clinical Nurse I -- NICU (1988 to 1991) Charleston Area Medical Center -- Women's and Children's Hospital

Clinical Nurse I -- Pediatrics Unit (1986 to 1988) Charleston Area Medical Center -- Women's and Children's Hospital

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

EDUCATION:

Master's of Social Work, West Virginia University, 1988

Bachelor's of Social Work, West Virginia University, 1974

Minors in Psychology and Speech

PROFESSIONAL EXPERIENCE:

Director, Research, Evaluation, and Planning, OMCFH/BPH (9/2000 - Present)

Clinical Social Worker, Comprehensive Psychological Services (12/99 - 9/2000)

Clinical Social Worker, Charleston Area Medical Center (9/89 - 7/90) and (5/98 - 12/99)

Director of Social Work Services and Discharge Planning, Charleston Area Medical Center (8/90 - 5/98)
Administrator, Northern Tier Youth Services (7/84 - 5/89)
Supervisor, Lutheran Youth and Family Services (6/81 - 7/84)

Christina Mullins, M.A. Director, Division of Infant, Child and Adolescent Health (including CSHCN)

EDUCATION:

Psychology, MA, Marshall University, 1997
Psychology, BA, Marshall University, 1995

PROFESSIONAL:

Director, Division of Infant Child and Adolescent Health, Bureau for Public Health (2/09 - Present)
Director, Breast and Cervical Cancer Screening Program, Bureau for Public Health (2004 - 2009)
Associate Director, Division of Tobacco Prevention, Bureau for Public Health (2002 - 2004)
Associate Director, Tobacco Prevention Program, Bureau for Public Health (2000 - 2002)
Coordinator, Tobacco Prevention Program, Bureau for Public Health (2000)
Supervised Psychologist, Allied Behavioral Services (1997 - 2000)
Teaching Assistant, Psychology Department, Marshall University (1996 - 1997)

Alta Denise Smith, MS, MCHES--Director, Division of Perinatal and Women's Health

EDUCATION:

Master's Degree in Community Health Education, West Virginia University, 1998
Bachelor's Degree/Board of Regents, West Virginia State College, 1996
Associates of Science/Radiologic Technology, Morris Harvey College, Charleston, WV, 1977

PROFESSIONAL EXPERIENCE:

Director, Division of Perinatal and Women's Health, OMCFH/BPH (3/11 - Present)
Director, Family Planning Program, OMCFH/BPH (2/06 - 3/11)
Coordinator, Adolescent Pregnancy Prevention Initiative, OMCFH/BPH (4/99 - 2/06)
Resources Specialist, Family Planning Program, OMCFH/BPH, (2/98 - 4/99)
Radiologic Technologist, St. Francis Hospital, Charleston, WV (97 - 2/98)
Radiologic Technologist, CAMC, Charleston, WV (11/91 - 97)
Radiologic Technologist, C-Radiation Therapy Consultants (11/85 - 91)

E. State Agency Coordination

The Office of Maternal, Child and Family Health has historically contracted with the Title XIX agency for the administration of EPSDT. In addition, there have also been formalized agreements with community agencies for services offered through the Perinatal Program/Right From The Start, Family Planning Program, Breast and Cervical Cancer Screening Program and the Children with Special Health Care Needs Program. The Office of Maternal, Child and Family Health administers and participates in the coordination of programmatic services funded under Title XIX to prevent duplication of effort, as required by federal regulation 42 CFR sub-section 431.615 (C)(4). The Office of Maternal, Child and Family Health has administrative responsibility for dental and vision care for persons moving from Welfare to Work called the Pre-Employment Services Project. These efforts are financed by TANF resources; a copy of the grant agreement may be obtained from the OMCFH. As a component of the Birth to Three/Part C system change initiative, an additional interagency agreement has been finalized with the Bureau for Medical Services, utilizing the unique statutory relationship between Title XIX and Title V, the agreement established the Office of Maternal, Child and Family Health as the sole provider of Part C early intervention services for Medicaid eligible children. The Department of Health and Human Resources developed a central finance structure for early intervention services in order to facilitate timely payment to practitioners and maximize available fund sources.

The Office of Maternal, Child and Family Health has in place many systems that contribute to the early identification of persons potentially eligible for services. These population based systems include Birth Score (administered by WVU), birth defect registry, newborn metabolic screening, childhood blood lead level screening, and newborn hearing screening. In addition, because OMCFH administers the EPSDT Program, children who have conditions that may be debilitating and/or chronic diseases, are referred to the CSHCN Program for further evaluation. This connection with EPSDT, which targets some 200,000 eligible children yearly, provides public health with a vehicle for identifying youngsters with problems, knowing that economically disadvantaged children are at increased risk. OMCFH, in an effort to increase public awareness, routinely participates in health fairs and community events. The toll free lines, established in 1980, average over 800 calls per month. Each caller receives individualized follow-up from Systems Point of Entry staff to assure referrals and pertinent information related to the request met their need. OMCFH toll free lines always receive accolades. Evaluation materials are on file and available if desired.

One of the strategies the Office of Maternal, Child, and Family Health has applied to ensure the quality of EPSDT services, is to partner with others. Partnerships bring additional experience, expertise and resources to bear on improving EPSDT. HealthCheck and WV Birth to Three routinely work in partnership for early identification of developmental delays in children. Recently, ECCS, HealthCheck and WV Birth to Three purchased more than four hundred (400) Ages & Stages Questionnaires, Third Edition (ASQ-3™) starter kits after consulting with the WV Chapter of the American Academy of Pediatrics (AAP). HealthCheck Regional Program Specialists distribute the ASQ-3™ starter kits and provide training to primary care providers (medical homes) throughout the state. WV Birth to Three sponsored a training by Brookes Publishing on the ASQ-3™. Participants included child care providers, early intervention and Head Start personnel. WV Birth to Three is piloting the ASQ-3™ in their initial intake process. Furthermore, HealthCheck and the WV Immunization Program have agreed on a collaborative effort to diminish unnecessary barriers to achieving better immunization rates among the WV population by promoting the Vaccines for Children (VFC) Program with primary care physicians (medical homes).

/2012/ The "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents" facilitates collaboration between the HealthCheck Program, the Title XIX state agency, and the Children's Health Insurance Program, and continues to be the foundation of all HealthCheck Program initiatives. Particularly, HealthCheck purchased and distributed 300 ASQ-3™ kits to primary care providers throughout the State in support of the developmental surveillance and screening. HealthCheck purchased and distributed 550 Body Mass Index (BMI) kits to primary care providers throughout the State in support of the Bright Futures health promotion theme, healthy weight. HealthCheck partnered with the West Virginia Department of Education, Children's Health Insurance Program, West Virginia University, West Virginia Birth to Three, and the West Virginia Autism Training Center to apply for a U.S. Department of Health and Human Services -- Maternal and Child Health Bureau State Planning Grant for improving access to comprehensive, coordinated health care and related services for children and youth with autism spectrum disorder (ASD) and other developmental disabilities. ***/2013/ The WV Autism Training Center at Marshall University did not receive the grant. //2013//***

HealthCheck has a strong collaborative effort with the West Virginia Department of Education-Office of Healthy Schools to support the Bright Futures standard for pediatric preventive healthcare as well as the medical home approach to providing comprehensive primary care. Recognizing that the Bright Futures standard is best carried out by a personal physician or primary care provider (PCP) that coordinates care across conditions and settings, HealthCheck and the West Virginia Department of Education - Office of Healthy Schools have created and nurtured a true partnership through which children, families, education, and health professionals all work together to ensure each West Virginia public school enterer receives a comprehensive wellness screening, per the Governor's Kids First Screening Initiative and WV Code SS18-5-17.

With the statewide implementation of Medicaid managed care, services for most Early and Periodic Screening, Diagnosis, and Treatment eligible individuals are integrated into qualified health plans (QHPs). The HealthCheck Program continues to work with the Title XIX state agency to ensure quality of the qualified health plans (QHPs) via technical consultation with primary care providers in keeping with the American Academy of Pediatrics "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents". //2012//

//2013/ HealthCheck and the Children with Special Health Care Needs (CSHCN) Program convened their medical advisory boards on January 12, 2012 to obtain provider input regarding healthcare coordination for children in foster care (all of which meet the federal definition of "children with special health care needs").

In coordination with the Bureau for Medical Services and the Pediatric Medical Advisory Board, HealthCheck established a standardized procedure for medical practitioners to document recommendations for treatment to correct or ameliorate conditions discovered by screening (initial, periodic, and/or interperiodic) services afforded to Medicaid-eligible children and youth up to 21 years of age. Accordingly, HealthCheck's age-appropriate preventive health screen forms were revised to include additional documentation/medical necessity certification. Moreover, the form is available via the HealthCheck website in a fillable PDF format for providers to save and import to their electronic medical records.
//2013//

Helping Appalachian Parents and Infants(HAPI):

The OMCFH and West Virginia University maintain an agreement for joint implementation of the Risk Reduction Through Focus on Family Well-Being/Helping Appalachian Parents and Infants (HAPI) Project, a Healthy Start grant, in RFTS Region VII. The OMCFH and WVU continue to collaborate to provide services to high-risk pregnant women and infants through the Healthy Start, HAPI Project. Mental health providers and dentists continue agreements to participate in the program to provide patient services. HAPI Project services encompass care coordination provided to pregnant women and infants, including a preconception phase, as per the existing RFTS Program. The HAPI Project focuses on helping women become healthier before becoming pregnant, encourages spacing of pregnancies, provides child care services, oral health care reimbursement, transportation assistance to doctor appointments and payment for mental health services. Curriculum for patient education was developed by WVU. OMCFH, as the subcontractor, acts as the fiscal agent for HAPI. Billing procedures have been developed by OMCFH and patient service invoices are processed by the state on behalf of the grantee, WVU.

//2013/ OMCFH no longer processes patient service invoices on behalf of the grantee.
//2013//

Initially started in four West Virginia counties, the HAPI Project has expanded to include eight counties, with service components in areas of: oral health services; substance abuse screening and referral; and outreach services utilizing former consumers. The long-term goal of the Project is to decrease the incidence of low birth weight infants born in West Virginia by reducing recurrent low birth weight. It is hoped that resulting data may also show that there is a significant benefit of cost savings through the risk reduction plan for at risk families. Hopefully from this data, RFTS can justify the benefit in expanding the current case management program to include the risk reduction plan for families and allow implementation of a longer period of eligibility for case management to assist at-risk families.

West Virginia's Office of Maternal, Child and Family Health is known for its positive partnerships with the medical community, the University Affiliated Programs, the State Department of Education, and the March of Dimes, among others. These partnerships have resulted in shared initiatives. One initiative is the folic acid campaign, a national March of Dimes assignment, used in West Virginia to advocate for the distribution of this supplement preconceptually to reduce the incidence of neural tube defects. Another initiative made possible was the Smoking Cessation or Reduction in Pregnancy Treatment (SCRIPT) initiative developed in partnership with Richard

Windsor and the Office of Epidemiology and Health Promotion, who contributed tobacco funds for the purchase of CO monitors for 174 RFTS care coordinators for use with pregnant women statewide. Another recent initiative, called Kids First, targets health screening for children entering school for the first time using the EPSDT (HealthCheck) protocol. Objectives of the initiative include: to establish a medical home for the child, to allow school systems to focus on providing needed services for children with identified deficits, to assist families in finding treatment resources, and to promote healthy lifestyle activities. The screening focuses on oral health, vision, hearing, speech and language, and behavior/development. Kids First is an example of high-level collaboration in government. Three Cabinet level agencies, the Department of Education, the Department of Health and Human Resources and the Department of Administration, are working closely together to bring this project to the families of West Virginia. All insurers agreed to pay for the services. Another initiative is the West Virginia Perinatal Partnership that includes stakeholders from across the state. Stakeholders include obstetrical and neonatal physicians, Medicaid, private insurance providers, OMCFH, Vital Statistics staff, the Hospital Association and the March of Dimes, among others. A 2011 Work Plan has been developed.

//2012/ OMCFH provides two representatives, one from the Early Intervention/Part C Program and the other from the Early Childhood Health Project on the newly appointed Governor's Early Childhood Advisory Council (ECAC), established under Head Start reauthorization. //2012//

The Birth to Three/Part C Program partners with a multitude of agencies to assist with child find efforts and to ensure needed services are arranged. WV Birth to Three has institutionalized a variety of strategies for the early identification of infants and toddlers with developmental delay or significant risk factors. WV Birth to Three's interagency agreements with Title V, CHIP, Bureau for Children and Families, Head Start, and Medicaid assist in the early identification and referral of potentially eligible children. West Virginia finds that coordination with primary health care providers and other community partners is important to assure that children potentially in need of early intervention services are identified as early as possible.

WV Birth to Three continues coordination with Title V/CSHCN, Newborn Hearing, and Right From The Start programs to assure that infants failing the newborn hearing screen receive diagnostics, and referral to Part C and Ski *Hi when hearing loss is confirmed. The Birth Score universal newborn screening, conducted on all children born in West Virginia, identifies infants who are born with conditions that may make them at risk for developmental delay. Referrals are made directly to the appropriate Birth to Three Regional Administrative Unit (RAU). Public awareness and child find activities are conducted collaboratively with interagency partners, including Part B preschool, Child Care and Head Start. Examples of this collaboration include the publication and distribution of a quarterly magazine, annual calendars, and developmental wheels to county schools, physicians, Family Resource Networks, medical clinics, early childhood providers, and higher education faculty. The publications include information about how to make a referral to Part C, Part B, Head Start and/or Child Care. The WV Birth to Three Public Information Coordinator has worked closely with WV CHIP to develop parent educational and child find materials, to be distributed collaboratively. The WV Birth to Three Public Information Coordinator has participated in faith based planning initiatives coordinated through WV CHIP to provide information about WV Birth to Three as a resource for families.

Child find strategies have also included coordination with the Right From The Start and HealthCheck Programs coordinated through the Office of Maternal, Child and Family Health. Local Right From The Start personnel who work directly with high risk mothers and infants are able to identify those children who may be in need of early intervention services. Program Specialists within the HealthCheck Program, in their work with physicians, are able to provide information about the criteria and requirements, and importance of identifying children who may be in need of early intervention services. Recent policy direction by the AAP to its members encouraging early screening for developmental delays and subsequent referral to Part C have also contributed to increases in the number of children served by the Program.

WV Birth to Three staff have coordinated with the Bureau for Children and Families, Child Protective Services, in the development of procedures to assure the referral of children who have experienced substantiated abuse and/or neglect. Training is provided to WV Birth to Three service coordinators and practitioners related to the requirements and coordination with Child Protective Services and Foster Care, as required by the Federal Child Abuse and Protection Act (CAPTA).

The prevalence of Autism Spectrum Disorder (ASD) is approximately 1 in every 100 American children. In an effort to secure more commitment to expanding access to services such as early identification, diagnosis, early intervention, family support, etc. in West Virginia, the Autism Training Center at Marshall University received a funding increase of 1 million dollars for FY 09, making a total appropriation of \$2,075,739 per year from the West Virginia Legislature.

The WV University School of Medicine has been recognized as one of the top ten schools of medicine in the country for rural medicine. WVU made the top ten list for the first time in U.S. News & World Report's 2009 edition of "America's Best Graduate Schools." Rankings are based on ratings by medical school deans and senior faculty in the nation's 125 accredited medical schools and 20 accredited schools of osteopathic medicine. School of Medicine students learn and care for patients in rural areas of WV as part of the requirements for graduation. They work in partnership with rural communities and other health care providers in rural clinics across the state. Rural health training at WVU is about education and community service. Forty-eight percent of WVU School of Medicine graduates choose to practice in primary care areas, such as family medicine, internal medicine, emergency medicine, and pediatrics.

/2012/ The West Virginia Department of Health and Human Resources (WVDHHR) on behalf of Governor Earl Ray Tomblin, designated the Office of Maternal, Child and Family Health (OMCFH) as lead agency to coordinate and implement the West Virginia Home Visitation Program (WVHVP).

The goals and objectives include: Collective efforts between state and local stakeholders will expand infrastructure and training capacity; develop and implement a statewide continuum of evidence based home visitation from pregnancy to five years of age; and identify resource agencies. The following is the State Plan framework:

1. Partner with state and local stakeholders to establish an innovative administration providing oversight of operational plans required for implementation with fidelity;
2. Encourage active collaboration and shared learning between multiple models through quarterly state and local continuous quality improvement activities;
3. Conduct focus groups to evaluate awareness of home visitation services and determine both barriers and motivators in home visiting;
4. Design a web based data collection system utilizing uploads from selected models, capacity to collect staffing and training details, and track referral processes;
5. Implement a rigorous evaluation of the Maternal Infant Health Outreach Worker (MIHOW) model as a promising approach;
6. Coordinate cross model trainings for depression screening, injury prevention, preconception counseling, child abuse prevention, domestic violence and SIDS/SUID;
7. Develop a Central Intake System providing single point of entry to appropriate agencies ensuring reduced model competition, decreased duplicative services and ensure continuum of care for clients served.

Community-based home visitation models involved in the WVHVP include: Right From The Start (RFTS); Healthy Families America (HFA); Parents as Teachers (PAT); Head Start; Early Head Start; and Helping Appalachian Parents Initiative (HAPI). //2012//

//2013/ As the lead State agency, the West Virginia Home Visitation Program is charged

with coordinating, developing and implementing evidence based home visiting services. The primary focus is to increase infrastructure to expand services to clients residing in identified high risk counties. Included in the activities to build strong organizational and management capacity for implementation are:

- 1) Establish a Continuous Quality Improvement (CQI) team to identify initial areas to target, incorporate CQI activities in evaluation design, data collection system and collectively review CQI activities with stakeholders.**
- 2) Assure implementation of home visitation service delivery with fidelity by selected models (Parents as Teachers, Healthy Families America, and Maternal Infant and Health Outreach Worker) through ongoing monitoring based upon individual national accreditation standards and collectively review progress of service delivery.**
- 3) Utilize the WVHVP website to provide up to date information on programs, activities, trainings, community resources and data collection processes.**

The WVHVP will develop cross model programs standards, core competencies and a Help Me Grow model while integrating home visiting with other social and medical services.

New sites in Boone, McDowell and Mason counties, and expansion in Wayne and Cabell counties occurred during the first year based upon the Home Visitation Statewide Needs Assessment. Expansion or implementation in Nicholas, Lincoln and Raleigh counties will occur in year 2 along with efforts to strengthen 16 existing Parents as Teachers sites throughout some of West Virginia's highest risk counties. These efforts should provide outcomes in over 1000 families served by year 3 of the WVHVP. //2013//

/2013/ The Oral Health Program was influential in the formation of a statewide Oral Health Coalition (OHC) which was recommended in the State Oral Health Plan. The Coalition is comprised of any individual or group with an interest in oral health. The creation of the statewide OHC allows non-traditional oral health stakeholders such as faith-based organizations, primary medical care providers, social service organizations, community programs, consumer advocacy groups, and others with an interest in oral health to have a voice in implementing policy change. The OHP will continue to provide the OHC with support in the form of logistical planning and clerical needs, as well as representation on the Executive Committee.

The West Virginia Department of Health and Human Resources OHP and Bureau for Medical Services worked with the West Virginia University School of Dentistry and their partners to develop a training program for medical personnel and their ancillaries to apply fluoride varnish as a preventative oral health measure. Once properly trained, primary care physicians and their ancillaries will complete oral health evaluations for children three years old and under using the caries risk assessment tool. In addition, the providers will give anticipatory guidance, provide fluoride varnish application twice annually and make dental referrals at age one or within six months of eruption of the first tooth as recommended by the American Dental Association. The program is designed to be completed in two sequential phases by the medical professional. Phase One consists of an on-line training and Phase Two consists of a live face-to-face training led by a professional that has completed the "Train the Trainer" course. //2013//

APPI:

APPI has created a text message line for adolescents to use when they have questions about biology, sex and contraception. The adolescent sends a text message which is converted to email. The email is answered by a specialist within 48 hours of receipt. The response is then converted back to text and sent to the teen. The text message line number is available on the APPI website and at APPI presentations and exhibits.

APPI administers the federal Personal Responsibility Education Program (PREP) grant. PREP

has 6 grantees who will implement evidence-based comprehensive sexuality education in 7 locations. The curricula selected were: Reducing the Risk, Making Proud Choices!, and SIHLE. Each was chosen to meet the needs of the populations served. Grantees were selected through a Request for Application process and scored by an independent committee, these seven projects were the most promising. In order to avoid duplication of services, APPI has partnered with grantees of the federal Teen Pregnancy Prevention (TPP) grant to ensure that services are provided to teens around the state.

F. Health Systems Capacity Indicators

Medicaid serves a large portion of the population within the state, including women, infants and children. Approximately 62% of all deliveries of infants are paid for by Medicaid. Within the capacity indicators there is definite variation in the Medicaid versus non-Medicaid population. The family income eligibility for CHIP was expanded and now covers additional children in the state who are otherwise uninsured.

The OMCFH Division of Research, Evaluation and Planning has had a grant from HRSA for State Systems Development Initiatives since 1996. The Research Division has used these funds to increase capacity and access data files throughout the Bureau and beyond. The OMCFH Research Division has access to both birth and death files on a regular basis from Vital Statistics, birth defects data, childhood lead screening data, Medicaid eligibility files, newborn screening from the State Laboratory, high risk and hearing screening data collected on the Birth Score card through West Virginia University, CSHCN data, and the states's perinatal program data. It is important to build data collection capacity to monitor progress of patient access, health improvement and program performance.

#01 Rate of children hospitalized for asthma: Approximately 12% or 42,000 WV residents under the age of 18 have at some point been diagnosed with asthma by a health care professional.

WV has one of the highest smoking rates nationally and second hand smoke is a known irritant for asthma. Appropriately so, tobacco monies are also being used to address environmental factors that increase the risk of developing asthma or exacerbate the disease. Although the OMCFH is not the home of the Asthma Initiative, since it is a disease that affects both children and adults, the OMCFH has a role in prevention via education of parents and children, plus a direct clinical care role which includes: 1) addressing maternal smoking during pregnancy and/or early infancy, and 2) provision of asthma therapy for children to include maintaining pulmonary function, normal activity levels, minimizing emergency room visits and hospitalization, and making available medication to control persistent asthma and "quick relief" medication to treat acute symptoms.

The WV Asthma Coalition consists of members from public health offices as well as community physicians and other interested agencies. The Coalition's role is one of prevention through education, establishing disease reporting parameters and mechanisms enabling tracking of incidence levels, advocacy for inclusion of benefit coverage across all payors for those affected by the disease, and payment for screening and prevention activities. There also remains the responsibility to assure screening and treatment is available and accessible to all, an assignment which exceeds the scope of health care financing available to OMCFH.

The WV Department of Education, in collaboration with the WV Asthma Coalition, developed a survey for school administration to determine the educational needs of staff. Responses to the survey identified the need for school personnel education directed at emergency care of the child, asthma inhaler legislation affecting in-school use, exercise and asthma, and managing students with asthma.

The WV Bureau for Public Health's Asthma Education and Prevention Program (WV-AEPP), funded by CDC since 2001, maintains an asthma surveillance system, promotes statewide partnerships, and implements interventions to reduce the burden of asthma in WV. As a member of the Centers for Disease Control and Prevention's National Asthma Control Program, WV-AEPP has a priority goal of decreasing hospitalizations due to asthma complications.

The Asthma Education and Prevention Program distributes quarterly newsletters to individuals, community organizations, and medical practice sites, discussing management, treatment methods, and the harmful effects of smoking.

#02 The percent Medicaid enrollees who are less than one year who received at least one initial or periodic screening.

The OMCFH administers the mandated Medicaid EPSDT Program (known in WV as HealthCheck). The HealthCheck Program educates families who receive Medicaid about preventive health care for their children and encourages their participation in the HealthCheck Program while ensuring the following: 1) children are screened/re-screened according to periodicity tables established by the American Academy of Pediatrics "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition"; 2) medical problems identified by examination are treated/referred; and 3) children/families receive transportation assistance and help with appointment scheduling. Per the 2010 CMS-416, 13,574 of the 13,799 or 98.36% of children, less than one year of age who are eligible for EPSDT through Medicaid, received at least one initial or periodic screening, an increase of 1% from 2009. The HealthCheck Program focuses on equipping Medicaid providers with the necessary tools and knowledge to carry out EPSDT screening services. As part of the Governor's Kids First Initiative all school enterers are required to receive a health screen using EPSDT protocol, regardless of insurance carrier.

Using a combination of written and oral methods, community-based Outreach Workers effectively inform Early and Periodic Screening, Diagnosis and Treatment eligible individuals (or their families) of the importance of well-child care visits based on the Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, which sets out a series of examinations at specific developmental stages. HealthCheck also supports Bright Futures recommended preventive health care encounters for children ages 0-1 by making available to all health professionals (without charge) the following six (6) age-appropriate Preventive Health Screen forms to medical providers.

- 1 Day-4 Weeks
- 2 Month
- 4 Month
- 6 Month
- 9 Month
- 12 Month

Per 2011 CMS-416 -- 9,586 total individuals <1 that were eligible for EPSDT 90 continuous days. 9,155 received at least one initial or periodic screen, or 95.50%.

On March 27, 2012, the Centers for Medicare and Medicaid Services (CMS) flagged the 2010 CMS 416 data reported last year for this indicator. Consequently, the accuracy of the 2010 CMS 416 data specific to this indicator is in question. The WV CMS 416 annual report does not distinguish between children in fee-for-service and those in managed care delivery models. Hence, potential access problems unique to a particular delivery model cannot be assessed.

Since 2007, WVCHIP has continued their partnership with the OMCFH's Division of Infant, Child and Adolescent Health, to promote full periodic and comprehensive well child visits recommended by AAP. Health messages focusing on vision, dental, development, and hearing

screenings appeared in Child Care Provider Quarterly Magazine. Through this partnership, WVCHIP identified the "HealthCheck" form as the standard form providers are to use in all well-child exam visits, and this occurred prior to the implementation of Kids First.

RFTS, the State's perinatal program serving Medicaid eligible pregnant women and infants up to age one counsels women on birth and newborn care preparedness and the importance of postnatal visits for enhanced referrals of sick newborns as well as healthy newborns for preventive care.

RFTS enrollees in 2010 with completed outcomes reported that 67% kept 5 well-child visits with providers, 70% had current immunizations and 74% had primary care provider at case closure.

#03 The percent SCHIP enrollees who are less than one year who received at least one periodic screen.

The bipartisan Rockefeller-Kennedy-Snowe CHIP Reauthorization Act of 2007 (S.1224) provided significant new federal resources for children's health coverage that enables states to substantially expand the number of children in this country who have health care. The legislation assures states a stable and sufficient source of financing to cover uninsured children. Because of this, WV's previous Governor Joe Manchin III, signed into legislation, during the 2007 session, CHIP eligibility expansion up to 300 percent of the FPL. A phase-in eligibility of up to 220 percent of the FPL began July 1, 2007. In July of 2008, the eligibility raised to 250% of the FPL. In 2011, eligibility was requested to be raised to 300% of the FPL and was implemented July 1, 2012.

Not many infants, under the age of one in WV, are eligible for CHIP. Most infants under age one are insured by Medicaid (eligible at or below 150% FPL) or private insurance.

In WV, the delivery systems for children include managed care, fee-for-service (FFS) and provider service networks. Generally, health care providers that accept CHIP also accept Medicaid. HealthCheck has championed the "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents" and the medical home approach to providing comprehensive primary health care with all health professionals.

The reauthorization of the CHIP program requires that CHIP change its methodology used to pay Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). FQHCs and RHCs have been reimbursed under a fee-for-service methodology. CHIP is required to change to a prospective payment (PPS) methodology and adjust claims for this methodology back to October 1, 2009 once the rates are determined. Also, the program continued its monitoring and analysis of eligibility and enrollment information transfers among its various partners. This work will culminate with changes to the WVCHIP Premium group that allow families to enroll in the program back to the month of application and also provide them with an option to make payments online. CHIP partnered with Oregon and Alaska CHIP programs for a five year multi-state grant that focuses on increasing the quality of healthcare provided to children. This is the Agency's second year of participation in the multi-state pediatric demonstration quality grant project. Also as called for in statute, CHIP actively participates with other state agencies to prepare the state for healthcare reform, mainly through meetings coordinated by the Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP).

#04 The percent of women with a live birth whose prenatal visits are greater than or equal to 80% on the Kotelchuck Index.

According to 2009 WV Vital Statistics, 5.4% of women had 1-5 prenatal care visits, 27.3% of women had 6-10 prenatal care visits, 54.5% had 11-15 prenatal care visits and 11.3% had 16 or greater prenatal care visits. Of women with known prenatal care, 80.5% of women began prenatal care in the first trimester, 14.3% began in the second trimester and 2.6% began prenatal care in the third trimester while 0.6% of women received no prenatal care.

Availability of prenatal care providers continues to be problematic. Also, the only board-certified perinatal specialists in WV are located in Charleston, Huntington, and Morgantown, where the tertiary care hospitals are located. Women and babies needing the services of high-risk specialists often have to travel long distances for an appointment. Many do not keep their appointment because of the long distances on difficult WV roads. Telemedicine is being expanded to bring expertise to patients and community-based physicians in rural areas, saving transportation cost and time. In addition, community-based physicians would receive valued support. Telemedicine also gives health care providers access to continuing education lectures that are given at medical schools. Please see information on the Connect to Care Project under Other Program Activities.

#05A Percent of low birth weight (<2,500 gms).

WV has struggled with the incidence of low birth weight infants. Birth weight is the single most important predictor of survival. Low birth weight is defined as a weight of less than 2,500 grams at birth and may result from preterm birth (before thirty-seven weeks) or poor fetal growth for a given duration of pregnancy (intrauterine growth retardation) or both. In the United States, most infant deaths are associated with low birth weight. Risk factors for preterm birth and low birth weight include: previous preterm and/or low birth weight birth, multiple births, smoking, unplanned pregnancy, infections, poor nutrition, lack of access to adequate and early prenatal care, harmful substance abuse, and domestic violence.

Although the RFTS Program provides in-home care coordination to a high risk population of pregnant women and infants, 2011 data show the average birth weight for an infant born to Program participants was 6.97 pounds.

Refer to State Priorities for additional discussion.

#05B Infant deaths per 1,000 live births.

Prematurity/low birth weight is the leading cause of death in the first month of life. In addition to mortality, prematurity is a major determinant of illness and disability among infants, including developmental delays, chronic respiratory problems and vision and hearing impairment. Through enhanced education and intervention, birth outcomes can be improved. Tracking the proportion of births that are preterm and identifying other risk factors such as low-income levels and education affirms that focusing attention on government sponsored patients (i.e., Medicaid, Title V, Title XIX) remains important.

In the last several years, WV's infant mortality rate and percent of low birth weight babies have increased rating WV well below other states and below the national average for these two indicators of child well-being.

According to 2009 WV Vital Statistics, approximately one out of five infant deaths (18.6%) was due to SIDS. Approximately one in six (16.8%) were the result of congenital malformations, while 53.9% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birth weight (17.4%). The number of neonatal deaths increased by seventeen, from 96 in 2008 to 113 in 2009; the neonatal death rate also rose, from 4.5 deaths among infants under 28 days per 1,000 live births in 2008 to 5.3 in 2009. Neonatal deaths comprised 67.7% of all WV resident infant deaths in 2009 compared with 57.8% in 2008. The overall infant mortality rate for WV in 2009 was 7.9 and 7.7 in 2008 deaths per 1,000 live births whereas the overall infant mortality rate for the United States in 2009 (latest data available) was 6.4 per 1,000 live births.

In 2011, The Period of PURPLE Crying was initiated as a pilot project in four WV hospitals. The Period of PURPLE Crying is an evidence-based program that teaches parents about the normal

patterns of crying in babies (traditionally referred to as colic), and the dangers of shaking.

#05C and #05D Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester and percent of pregnant women with adequate prenatal care.

Fifteen rural healthcare sites have access to specialized medical consultation via live telemedicine with the three WV tertiary hospitals providing high risk prenatal and newborn care. Approximately 255,534 women of child bearing age in fifteen rural WV communities have easier access to specialized maternity and newborn care, eliminating the need to travel far distances. 353,250 rural county residents realize additional benefits from this project through access to medical videoconferencing equipment provided in their local areas.

The WV Perinatal Partnership Maternity Care Provider Shortages Committee is continuing its work to improve access to maternity care and appointed this committee to study the issues.

Refer to State Priorities for additional information.

#06 The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants, children and pregnant women.

The percent of poverty level for eligibility in the State's Medicaid programs is 150% for infants (0-1) 133% for children ages 1-5, 100% for children ages 6-18 and 150% for pregnant women. The poverty level for eligibility in the State's SCHIP programs is 300% for infants and children ages 0-19. There is no SCHIP coverage for pregnant women. OMCFH offers maternity coverage for pregnant women up to 188% of the poverty level, coverage for pregnant teens and coverage for the first visit and labs for women who have applied for Medicaid but have not yet received approval.

#7A Percent of potential Medicaid-eligible children who have received a service paid by Medicaid.

HealthCheck is WV's name for the mandated pediatric Medicaid program, Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Over 200,000 Medicaid-approved children in WV have been eligible to participate in the HealthCheck Program for the past three years. EPSDT's promise to children eligible for Medicaid is the provision of screening services and treatment of all medical conditions discovered during the exams.

HealthCheck Program Specialists are assigned to geographical regions to educate, orient and provide ongoing technical assistance to EPSDT providers and have been especially active in recruiting additional primary care providers for underserved areas. This workforce has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides EPSDT orientation for HMO providers serving Medicaid enrolled children. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community is presently at capacity. The Program provides ongoing staff development to enhance skills needed to better market the EPSDT Program to both providers and families. Program Specialists, who recruit, train, and provide technical assistance to participating medical providers, have also been active in working with local school systems to increase the number of school-based clinics and on site EPSDT evaluations. The number of students using school-based health centers (SBHC) has steadily increased over the past few years. The School-Based Health Center Initiative's goal is to develop a coordinated system of health care for children that increases access to primary and preventive care, especially for students who are uninsured, who lack a medical home, or who are at risk for health problems.

HealthCheck monitors the utilization of the program to ensure that Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible individuals receive health screens per the American Academy of Pediatrics' Bright Futures: Guidelines for Health Supervision of Infants, Children, and

Adolescents periodicity schedule and provides follow up to ensure that EPSDT eligible individuals receive the medically necessary services to assess/treat conditions that are discovered by personal physicians or primary care providers (PCPs) during initial or periodic HealthCheck screens.

HealthCheck ensures that no less than 95% of EPSDT eligible individuals who are not enrolled in a managed care organization and 90% of children in foster care have a clearly identifiable personal physician or primary care provider (PCP), the foundation of the medical home model, by the end of each month. HealthCheck community-based Program Specialists encourage medical/dental providers to accept and serve Medicaid eligibles and to streamline referral systems to improve client access to services.

#7B The percent of EPSDT eligible children aged 6 through 9 who have received any dental services.

The Children's Dentistry Project (CDP) is a component of the Oral Health Program within the Division of Infant, Child and Adolescent Health housed within the OMCFH. In WV, Medicaid child beneficiaries have financial access to dental services, yet 41% do not routinely seek care.

The Oral Health Program (OHP), in partnership with the county schools systems, Head Start agencies, and other community groups work closely together to offer a sealant and fluoride rinse program within schools, to increase utilization of the Medicaid eligible child less than 18 years of age. In addition, the OHP provides loan equipment to the Appalachian Regional Commission/Benedum's School Community Partnership Sealant Program. The OHP staff serves on the oversight committee and grant review team for the project managed out of Marshall University's School of Medicine. This program targets third graders without an established dental home and those lacking sealants. The WV Head Start program began the dental home initiative for all Head Start participants, with the goal of increasing preventative and restorative visits for that population. The OHP staff work alongside Head Start to educate parents and staff on the importance of preventative routine dental visits and the coverage provided by Medicaid and Children's Health Insurance Program. Also, the OHP worked in conjunction with the WV Perinatal Partnership's Oral Health Committee to increase dental utilization rates of Medicaid eligible pregnant women in WV. These efforts included working with Right from the Start and other home visiting programs, and education of perinatal providers on the relation of good overall health and good oral health.

In FY 2010 WV reported having 170,432 children enrolled in the Title XIX Medicaid, and 24,397 children enrolled in the Title XX1 Children's Health Insurance Program. The Board of Dental Examiners reporting having 1241 licensed dentists. Of those, 587 had at least one Medicaid patient and 587 had at least one paid CHIP claim.

WV Dental Census (new in 2012): The WV Board of Dental Examiners in cooperation with WV University School of Dentistry and the WV Department of Health and Human Resources - Oral Health Program, requested information be completed and returned with provider's licensure application. The purpose of this census is to match new graduates with dental practitioners that are actively seeking an associate or dental hygienist and to gather information on clinically active dentists by county. The OHP is currently evaluating and analyzing the data.

The great majority of dental care in WV and across the country is delivered by private practicing dentists, so participation is key to improving access for publicly-sponsored patients. Private dentists in WV, like dentists across the country, cite three primary reasons for their low participation in state Medicaid program: low reimbursement rate, burdensome administrative requirements and problematic patient behaviors.

In 2009, OMCFH convened an Oral Health Advisory to study policy and procedures necessary to improve oral health access and utilization. In March 2010, this advisory completed its first

strategic plan to address oral health in the context of public health issue.

"Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents" recommends oral health screening at every preventive health care encounter, with a referral to a dental home at age 12 months. Health professionals perform a screening of the lips, tongue, teeth, gums, inside of the cheeks, and roof of the mouth to identify oral disease, especially tooth decay, or other oral conditions (e.g. delayed tooth eruption or premature tooth loss, abscesses, trauma) and to provide anticipatory guidance for management. HealthCheck's community-based Program Specialists conduct regular site visits to familiarize Medicaid providers with the Bright Futures standard.

As part of its effective informing of EPSDT eligible individuals, HealthCheck conducts targeted outreach. Particularly, HealthCheck mailed individual letters to the parent(s) of HealthCheck clients on the 2nd, 3rd, and 4th birthdays to raise awareness among beneficiaries of the importance of oral health, a dental home, and the dental benefits under Medicaid.

#8 The percent of State SSI beneficiaries less than aged 16 receiving rehab services from the State CSHCN Program.

The CSHCN) Program improves the health and well-being of children and youth, birth to age 21, at risk of or diagnosed with chronic medical or disabling conditions, including cardiac, cystic fibrosis, craniofacial anomalies, digestive, ear, nose and throat, hearing loss, endocrinology, genetic, myelodysplasia, neurological, orthopedic, pulmonary, and urological. The CSHCN Program works with the child's family to ensure that all medical, non-medical, psychosocial and education needs of the child and family are met in the local community.

It should be considered that the statistical information shared for this indicator is best described as an estimate because the CSHCN Program data is from calendar 2011, but the WV Supplemental Security Income (SSI) data is from calendar year 2010, which is the most recent data available. Also when comparing historical data, 2010 is the first year in which age 17 and 18 year olds are not included in the numerator for calculation of the annual objective and performance data.

A more accurate snapshot may be offered when considering a specific rehabilitative service currently provided from the CSHCN Program to SSI beneficiaries. For example, Title V funds are utilized for coverage of medical foods. At the end of 2011, there were 236 children less than 16 years old receiving medical foods from the CSHCN Program; 192 of those children are SSI recipients. This offers the conclusion that 81% of the children receiving the rehabilitative service of medical food coverage from the CSHCN Program are SSI beneficiaries.

Nevertheless, at the end of 2011, there were 1,330 children enrolled in CSHCN Program services and 74 children awaiting eligibility determination or diagnostic assessment. Of the enrolled clients, 800 receive SSI; 625 of those children are less than 16 years old. Hence, 60% of the CSHCN enrolled children are SSI recipients with 47% of the SSI recipients enrolled in CSHCN being under the age of 16. It should be noted, 103 children enrolled in CSHCN Program Services are not eligible for rehabilitative services because of being over-income, but are offered care coordination services. Hence, if these children are not factored into the eligible enrollees for rehabilitative services, then 65% of the children eligible for rehabilitative services in the CSHCN Program are SSI recipients with 51% of these recipients being under the age of 16.

It is of importance to note there are disparities within the geographic areas of WV in regards to SSI recipients. For example, 81% of the CSHCN enrolled children residing in McDowell County, the county with the highest poverty level according to WV Kids Count, receive SSI. Ultimately, CSHCN care teams in the southern region of the state serve a higher percentage of SSI recipients than CSHCN care teams in the eastern panhandle or northern panhandle. This creates disparity in access and outreach techniques necessary to identify and enroll eligible

children.

The CSHCN program received a total of 949 referrals directly from the Social Security Administration Disability Determination Unit during the 2011 calendar year; a 69% increase from 2010 when there were 651 referrals. However, only twenty-six percent of the 949 referrals met CSHCN Program medical eligibility criteria needed to apply for CSHCN services, and were mailed program applications; a significant decline from 72% of referrals meeting medical eligibility criteria in 2010. Unfortunately, there is no ability to gather data to assess the application return rate specific to this population. In July 2011, the CSHCN Program revised the application to begin gathering this data, but reporting is not yet consistent in the database. In addition, an emotion-based mailer application, utilizing a 6th grade literacy level, offers more public awareness and information within applications distributed via mail.

There are 9,193 children in WV under the age of 18 receiving SSI benefits indicating that the CSHCN Program served 7.7% of West Virginia children under the age of 18 who received SSI benefits. This is a 0.2% increase over 2010. Even so, there may be several factors that could be contributing to the impression that the CSHCN Program does not serve a large portion of the children. First, the CSHCN Program does not provide medical or care coordination services for all conditions that qualify children for SSI. For example, at this time the CSHCN Program does not have capacity to provide rehabilitative services for autism, emotional disorders or behavioral disorders. Secondly, the CSHCN Program has been undergoing program changes that have created a focus on care coordination versus direct services. In WV, the culture tends to focus on tangible or entitlement services versus support services that yield long-term health benefits. The Program transition has created a decrease in enrollment and parental understanding of the benefits of enrollment. A specific public awareness and physicians' relations campaign is being developed to address this as an objective of program redesign.

#09A and #09B (General MCH data capacity) The ability of the State to assure MCH program relevant information and (data capacity-adolescent tobacco use) the percent of adolescents in grade 9 -12 who reported using tobacco products in the past month.

The OMCFH has had an SSDI grant for many years which has helped build data collection and reporting capabilities. All population based programs, including PRAMS, data management and epidemiologists are housed within the Research Division. Epidemiologist capacity has grown from a staff of six since June of 2011 to nine in July 2012. The YRBS is housed within the Health Statistics Center (Vital Statistics) and is located within the Bureau for Public Health as well. There is full cooperation between Vital Statistics and the Research Division for data sharing.

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2012/ According to the 2010 Needs Assessment, West Virginia continues to have many health care issues such as: smoking, smoking among pregnant women, infants born prematurely, infants born with low birth weight, high rate of sudden unexplained infant deaths, obesity, injuries, adolescent suicide, fatal car accidents involving youth, and asthma that contribute to poor outcomes.

Geographic and socio-economic issues that influence the ability to achieve desired health outcomes include:

- According to the 2008 Census data, 15% of the population in WV does not have health insurance.
- Six percent (6%) of children do not have health insurance.
- There are still parts of WV where health care is not easily accessible. Winding secondary roads connect the majority of WV's population with little to no public transportation available between many of the small isolated towns.
- The WV Perinatal Partnership has reported that the availability of OB/GYNs and other practitioners to provide prenatal care and delivery continues to be problematic. Not every county has sufficient births to justify labor and delivery at local hospitals, making it necessary for some WV women to be served outside WV's boundaries or several miles from home. Only six counties in WV were considered to have adequate medical manpower to meet the population need.
- Because of the loss of higher paying jobs over the past thirty years in West Virginia, there has been a concurrent rise in WV's poverty rate. WV continues to rank fifth in the nation of the state's population living in poverty.
- West Virginia's unemployment rate reached a 15-year high at 10.5 in January 2010. The number of unemployed people grew from 29,000 in September 2008 to 64,200 in September 2009, an increase of 121 percent.
- According to the U.S. Census 2005-2009, 81.6% of persons age 25+ are high school graduates compared to 84.6% nationally. This is a six percent increase from the 2000 U.S. Census. However, according to the same data source only 17.1% of persons age 25+ have a bachelor's degree or higher compared to 27.5% nationally.
- Work disability is also a significant problem in West Virginia. The 2000 U.S. Census Bureau states that 22.5% of the population 16-64 years of age had a disability and 13.2% had a work disability.

It is evident when data/statistics are analyzed for health care outcomes, the higher the education and income level, the better the outcomes. If West Virginia is going to experience better outcomes, education and higher paying jobs must be a top priority. Evidence of this is in Monongalia County, where West Virginia University is located. Because of the availability of a higher educated work force, the city of Morgantown has been one of the fastest growing cities in the U.S. and experiences some of the best health outcomes in WV. It has also been ranked as one of the best small cities in the U.S. to live and raise a family. West Virginia has capacity to address most health related issues as shared throughout the Needs Assessment; however, there remain areas that need improvement to have an impact on outcomes.

Former West Virginia Governor Joe Manchin III signed legislation to expand SCHIP eligibility up to 300 percent of the federal poverty level, and on January 1, 2007, WV began a phase-in expansion by enrolling children in SCHIP with family incomes up to 220% of the federal poverty level. Adoption of this change is estimated to provide comprehensive health care coverage to approximately 400 uninsured children of working families during the first year of implementation. WVCHIP expanded the upper income limit to cover families with incomes at 250% of poverty January 1, 2009 **/2013/ and on July 1, 2012 CHIP expanded to 300% FPL. //2013//**

Community health centers have played a critical role in improving access to health care for all populations across WV. The community health center network is supported with state appropriations and there are multiple centers that receive both state and federal resources. Rural areas are in need of additional community health centers. Former Governor Joe Manchin III placed emphasis on education and introduced several bills to address the issue. Using American Recovery and Reinvestment Act funds several schools have added "coaches" to assist students at risk of not graduating. Several other schools have introduced initiatives to also facilitate keeping kids in school.

WV has systems in place to address access to care, identification of health issues at birth and health care coverage for pregnant women, infants, children and children with special health care needs. There still exist areas that need improvement such as increased reimbursement for home visiting for high risk pregnant women and oral health. These are two identified areas where health care providers have limited the number of patients they treat due to low reimbursement rates.

Mothers surveyed by PRAMS report that one of the reasons they do not see a physician in their first month of pregnancy is that they have not yet received a medical card. A process to expedite the issuance of a Medicaid card for the pregnant woman needs to be reviewed.

Historically, many West Virginians have to survive with fewer of life's essentials than many others in the United States. This lack of resources makes working together essential. Because this lesson has not been lost on those in public service and advocacy organizations at the state and community level, WV has learned the value of collaboration. The OMCFH knows that WV cannot afford to duplicate systems that exist and are working well, and knows that it is imperative to join with other stakeholders to create partnerships to achieve goals.

Eight state performance measures were chosen from the list of concerns/priorities discussed throughout the Needs Assessment that were not already national performance measures. These priorities and state performance measures were chosen based on data and help from OMCFH advisories and parents and are listed below in order of priority as they were chosen from the various groups. Priorities were chosen based on slower improvement in those specific areas and the need to increase efforts within these areas.

State priorities have been summarized and listed below:

A. Pregnant women, women of childbearing age, mothers and infants

1. Decrease smoking among pregnant women
2. Reduce the incidence of prematurity and low birth weight
3. Reduce the infant mortality rate, focusing efforts on African American infants and Sudden Unexplained causes

B. Children and Adolescents

1. Assure that children and adolescents access preventive dental services
2. Reduce smoking among adolescents
3. Reduce obesity among WV's population
4. Decrease the incidence of fatal accidents caused by drinking and driving
5. Increase the percentage of adolescents who wear seat belts
6. Reduce accidental deaths among youth 24 years of age or younger

C. Children with Special Health Care Needs

1. Maintain and/or increase the number of specialty providers in health shortage areas//2012//

B. State Priorities

/2012/ Each current state performance measure was selected because of the health status of the respective population and based on information derived from the Needs Assessment completed in 2010. The new state performance measures are once again based upon the Needs

Assessment and have changed only marginally from the 2005 measures.

Although West Virginia has financial stressors and many health care issues such as smoking among pregnant women, infants born prematurely, infants born with low birth weight, obesity and asthma, the WV OMCFH has woven together multiple funding streams to develop a system of care for women, infants, and children, including adolescents and those with special health care needs as well as some services for adults such as dental care and breast and cervical cancer screening that support a life course model. The WV OMCFH has developed strong partnerships across the state with the medical community, private sector, as well as community health centers and local health departments, all in an effort to assure access. Medicaid has purchased services for their beneficiaries at the request of Title V but they, too, are facing financial stressors.

It is clear that the OMCFH cannot support all programs and services that are needed to meet the needs. In response to shrinking resources, the WV OMCFH has advocated for the purchase of those services most critical to the health of maternal and child populations--family planning, prenatal care, support of EPSDT, population based surveillance programs, CSHCN services, etc. all in an effort to support the life course and prevent catastrophic illness. Another strategy that the WV OMCFH has undertaken is reduction of cost wherever possible. ***//2013/ The Family Planning Program has seen a significant increase in the use of Long-Acting-Reversible Contraceptives (LARCs). These more effective forms of birth control are purchased in mass and stored at a government operated warehouse that is supported by multiple programs. //2013//*** West Virginia is also efficient with resources, often administering programs and services that are used by multiple payor sources such as Title XIX and XXI. To assure that federal resources are maximized, all uninsured children and pregnant women seeking services must apply for Title XIX. If the patient is ineligible for Title XXI or Title XIX, Title V resources may be used to pay for their care.

The West Virginia five year needs assessment is a work in progress throughout the year, every year. In order to ensure that adequate health care is available OMCFH must continually ask customers, clients and providers if their needs are being met and use data to support outcomes. With limited resources, it is essential to target areas that will have the greatest impact in improving overall health outcomes.

Through the participation of OMCFH medical advisory boards, population targeted focus groups, workgroups and other agencies who conducted surveys of shared constituencies throughout the State and use of qualitative and quantitative data, the following priorities were established for the MCH population as follows:

A. Pregnant women, women of childbearing age, mothers and infants

1. Decrease smoking among pregnant women

West Virginia has the highest smoking rate for pregnant women in the U.S. 2008 data from the WV Health Statistics Center show that the rate of smoking during pregnancy in WV was 27.0% compared to the national rate of 10.7% in 2005 (last available national information). Alarming rates of these were that 40.7% of Medicaid insured mothers reported smoking while only 11.7% of the non-Medicaid insured women reported smoking during pregnancy.

The state's home visiting perinatal program, Right From The Start (RFTS), provides services to Medicaid insured pregnant women and infants. To address the smoking during pregnancy concern, RFTS continues to implement the evidence-based intense smoking cessation initiative, called SCRIPT, in partnership with George Washington University Medical Center, Department of Prevention and Community Health. Education tools such as videos, carbon monoxide breathalyzers and smoking cessation guides are funded through the WV Division of Tobacco Prevention and are available for use during home visits. A DVD player has been assigned to each home visiting nurse or social worker to use during home visiting sessions for education purposes.

RFTS provides services to approximately one-fourth of the pregnant Medicaid population.

RFTS collaborates with the WV Tobacco Quitline. The Quitline offers nicotine replacement therapy (NRT) options, free of charge, to pregnant women, with a physician's order. NRT products are also available to family members living in the home of the pregnant woman. ***//2013/ During 2011 and continuing in 2012 the Division of Tobacco Prevention and OMCFH co-funded smoking during pregnancy public service announcements as public education and awareness events. //2013//***

2. Reduce the incidence of prematurity and low birth weight

An examination of West Virginia birth certificate data showed a marked increase since 1993 in the rate of births occurring at 34 through 36 weeks of gestation. The rate of Cesarean delivery among late-preterm births increased at a faster pace than that among other births over the study period. The birth certificate data confirm a growing problem of late-preterm births in West Virginia, pointing to a need for a more comprehensive examination of these births. The Perinatal Partnership has made recommendations to practicing obstetricians and birthing facilities that elective c-sections should not occur before 39 weeks if not medically indicated. In 2009, there was a 50% improvement in the rate of elective c-sections.

3. Reduce the infant mortality rate, focusing efforts on black infants and Sudden Unexplained causes

A significant cause of infant death in WV is Sudden Unexplained Infant Death Syndrome (SUID). In 2006, there were 46 SUIDs that accounted for 29.7 percent of the infant deaths. In 2007, there were 29 SUIDs that accounted for 17.8 percent of the infant deaths and in 2008 there were 35 SUIDs accounting for 21 percent of the infant deaths. OMCFH has joined forces with a community collaborative group "Our Babies-Safe and Sound" to increase public awareness of the need to provide safe sleeping arrangements for infants. ***//2013/ OMCFH has assisted financially with public awareness activities such as placement of public service announcements and printing and distribution of patient education materials. //2013//*** During the 2011 Legislature, legislation was enacted that added review of infant deaths to the existing Maternal Mortality Review Team. Staff are being hired and processes are currently being developed. Findings from a formal review of infant mortality will serve as the basis for future activities. ***//2013/ Case abstraction and review of infant deaths that occurred in 2011 is underway. A database is currently being purchased and should be installed in 2012. An Advisory meeting will be scheduled in late fall to discuss the chart reviews and first year findings. //2013//***

B. Children and Adolescents

1. Assure that children and adolescents access preventive dental services

The West Virginia Department of Health and Human Resources Oral Health Advisory, spearheaded by the OMCFH, worked cohesively to develop the West Virginia Oral Health Plan 2010-2015 which was released in March 2010. The Oral Health Advisory will be involved in shaping oral health goals, identifying process improvements and legislative awareness.

The Children's Dentistry Program, (CDP) housed within the OMCFH, in partnership with county school systems, Marshall University, Head Start Agencies, WIC, 4-H, school-based health centers and other community children's programs, are working together to offer a sealant and fluoride rinse program within schools. Payments from existing insurance sources are sufficient to cover operational costs and ultimately improve oral health access. This project was initially offered only to students in one targeted county, but the CDP continues to work with partners to expand this service to students in three additional counties. The CDP provides portable dental equipment to ten primary care facilities for the purpose of offering school-based dental services,

including sealant applications, in eight counties.

The Oral Health Program is working with Marshall University to establish a surveillance system for school based oral health activities. Currently, school based oral health centers serve 61 schools in 24 West Virginia counties.

2. Reduce smoking among adolescents

The 2009 YRBS shows that the percentage of students who ever smoked cigarettes daily, which is, at least one cigarette every day for 30 days has decreased slightly to 17.7%, however, the 2009 YRBS also shows that smoking within the last 30 days has decreased from 38.5% in 2000 to 21.8% in 2009. The percentage who reported they have never smoked cigarettes rose from 25.7% to 44.8% from 2000 to 2009.

The Adolescent Health Initiative (AHI) and the Abstinence Education Project (AEP), housed within the OMCFH Division of Infant, Child and Adolescent Health, educate youth about the consequences of tobacco use and encourage responsible behavior. Both programs partner with RAZE, the statewide teen-led, teen-implemented anti-tobacco movement, and other prevention programs to facilitate community-based activities and events promoting awareness.

RAZE is coordinated by the Youth Empowerment Team (YET). YET members include representatives from the Division of Tobacco Prevention, the West Virginia Department of Education's Office of Student Services and Health Promotion, the American Lung Association of West Virginia and the West Virginia Youth Tobacco Prevention Campaign. There are currently 187 RAZE crews in WV's schools.

West Virginia's youth-led tobacco prevention initiative is moving beyond the school system to reach more teens. Initially, the program revolved around the WV Department of Education and funding was routed through schools, where crews were organized. Now, annual \$1,000 grants to form crews are available for community groups as well.

West Virginia is aggressively addressing this problem by implementing evidence-based comprehensive tobacco control programs. The comprehensive plan focuses on four goals: 1) Prevent the initiation of tobacco products among young people; 2) Eliminate exposure to secondhand smoke; 3) Promote quitting among adults and young people; and 4) Eliminate tobacco-related disparities among different population groups. As of January 2009, all 55 counties have clean indoor air regulations.

3. Reduce obesity among the state's children less than age 18

The increasing rates of childhood obesity nation-wide and the prevalence of adult risk factors for cardiovascular disease at earlier ages, reflect a public health crisis that schools, agencies, and allied health professionals in West Virginia are attempting to address with intervention programs and information campaigns. West Virginia has one of the highest obesity rates in the nation for children and adults.

There are a multitude of programs in WV trying to combat obesity as described in the Five-Year Needs Assessment and discussion in the performance measures. ***//2013/ Refer to State Performance Measures 4 and 5 for activities occurring to combat children's obesity within the State. //2013//***

4. Decrease the incidence of fatal accidents caused by drinking and driving among high school students

West Virginia continues to develop traffic safety materials targeted at young people. Through collaboration, the Department of Education's school-based health education is being improved to

incorporate information on health-related decision making. The WV Division of Highways will implement plans for the Strategic Highway Safety Plan that includes several programs targeting underage drinking and drinking and driving.

Both the Adolescent Health Initiative and Adolescent Pregnancy Prevention Initiative target risk behaviors and stress making wise decisions.

5. Increase the percentage of adolescents who wear seat belts

In WV, the Governor's Highway Safety Program (GHSP) encourages the development of local traffic safety initiatives. Approximately 60% of the Section 402 funds received by the GHSP in 2010 were forwarded to Safe Community Programs formed by local government and civic and business groups in eight different areas of the state. Using this approach, the entire state's population is covered by a Safe Community Program. In 2009, WV's seat belt usage rate was 87%. In 2010 it dropped 5% to 82.15%. The GHSP attributes the decrease in usage rate to a lack of stronger legislation. WV's current seat belt law is a secondary enforcement law. ***//2013/ During the 2012 Legislative session, the seat belt law was introduced as a primary enforcement law, but did not pass. //2013//*** GHSP also continued the sustained DUI enforcement, and reported more participation in 2010 in the Child Passenger Safety Program. Student trainee attendance for the Motorcycle Safety program was up in 2010 as well.

The Adolescent Health Initiative participated in several health and safety events across West Virginia and distributed information regarding seatbelt usage to adolescents, parents and other community members. The Adolescent Health Initiative Director collaborated with the Governor's Highway Safety Program to launch a statewide campaign that included billboards and electronic seatbelt usage signs. The Adolescent Health Initiative Director also worked with Kanawha Coalition for Health Improvement and the Charleston Police Department to sponsor seatbelt and child safety seat checkpoints throughout the City of Charleston.

6. Reduce accidental deaths among youth 24 years of age or younger

The Injury Prevention Program participates in events throughout the State specifically addressing childhood injuries relating to motor vehicle crashes. Program staff continue to meet with partners and stakeholders to develop and maintain prevention activities throughout the State. The Program works closely with Emergency Medical Services for children to distribute educational materials and provide skill building for parents and children regarding the risk of injuries from motor vehicle crashes. A full-time coordinator was hired to manage the project. ***//2013/ In 2012 the WV Legislature passed secondary enforcement laws pertaining to texting and talking on cell phones while driving. These will become primary enforcement laws in 2013. //2013//***

C. Children with Special Health Care Needs

1. Maintain and/or increase the number of specialty providers in health shortage areas

The CSHCN Program is working with the Medical Advisory Board to: identify and recruit physicians; to ensure that CSHCN clinics are established and/or maintained in areas of need; establish a provider recruitment plan that includes utilization of Family to Family partnership and presentations at medical schools; minimize out of state referrals so that WV infrastructure can be maintained.

CSHCN will continue to work with the WV Chapter of the American Academy of Pediatrics to encourage the medical community to refer children with chronic, debilitating conditions to the CSHCN Program.

CSHCN will continue to collaborate with another office within the Bureau for Public Health, Office

of Nutrition Services' Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to assure children who are age eligible to receive WIC services are identified.

State priorities are not necessarily the state performance measures since national performance measures already exist and cover some of the priorities. //2012//

/2012/ Health Disparities:

Although WV is primarily homogenous in population with 93.9% white and 3.4% black, there remains a great disparity in health and economic outcomes. //2012//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	27	26	43	61	43
Denominator	27	26	43	61	43
Data Source		Newborn Metabolic Screening	Newborn Metabolic Screening	Newborn Metabolic Screening	Newborn Metabolic Screening
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

2011 Occurrence births

Notes - 2010

2010 Occurrence births

Notes - 2009

2009 Occurrence births

a. Last Year's Accomplishments

Newborn metabolic screening is a critical public health function by which all newborns are screened shortly after birth for selected disorders with potentially adverse consequences that can be identified and treated before the illness becomes apparent. For many years, even before mandatory legislation, the Office of Laboratory Services (OLS) worked in tandem with the OMCFH to develop capacity to expand the newborn screening panel. Prior to 2005, WV screened for only five disorders, while in 2007 had the ability to screen for ten disorders and in February, 2009 began screening for all 29 nationally recommended disorders. It is the partnership between the OLS and the OMCFH that has allowed this expansion to occur while also being able to provide follow-up and genetic health services to all infants that are born within WV borders. The WV Newborn Screening Program (NBSP) boasts coordination of services between birthing facilities, insurance companies, West Virginia University (WVU) who provides genetic and cystic fibrosis expertise, as well as with the endocrine, metabolic/genetic and hematology specialists across the state.

In 2011, 96.9% of infants born in the state of WV received newborn screening. Of the 43 infants with a definitive diagnosed condition in 2011, all received timely follow-up and clinical management. In conjunction with the OLS, the NBSP ensures infants are screened before hospital discharge. All abnormal test results are followed by OMCFH staff and confirmed abnormalities receive case management, with assistance from the Genetics Program at WVU. The OMCFH provides, free of charge, regardless of family income, formula for those with confirmed PKU and other nutritional supplements and vitamins indicated for other diagnoses. The OMCFH, using Title V dollars, in the past reimbursed the OLS for all newborn screening specimens. With the passage of Newborn Screening Rules during the 2008 Legislative session, the Bureau for Public Health is now able to bill hospitals for every infant who receives a screen. The cost of the newborn screening system is included in this charge.

With the addition of the 29 disorders, improvements in the data system, laboratory equipment, reagents, and personnel, costs have increased from \$47 per screen to \$94 per screen starting July 1, 2011. Charges are based on actual costs of screening, follow-up by case managers, genetics staff and nutritional supplements.

The Genetics Program at WVU provides genetic clinics at 6 strategic locations throughout the state, offering diagnosis, treatment and counseling and was historically funded using Title V dollars. The Genetics Program costs associated with newborn screening are now included in system charges, since they provide medical support for primary practitioners serving affected newborns. WVU Genetics, with NBSP financial support, was able to add an additional geneticist to work with the State because of the expanded panel.

Educational information on the expanded panel of disorders has been developed for use by physicians and families. The NBSP website is continually updated to include progress on expansion efforts and information on disorders as well as establishing links to supportive information.

Expanding newborn screening incrementally has afforded OMCFH the opportunity to build State laboratory capacity as well as bill hospitals to recoup system costs between expansion phases.

WV will be adding SCID to the list of newborn disorders screened when equipment arrives and the validation process has been completed. Also to be added is CCHD/Pulse Oximetry Testing for Newborns that was passed by the Legislature during the 2012 legislative session. Testing is to be implemented July, 2012 and collected on the Birth Score form.

Between April 30 to June 2, 2012, the NBSP underwent a technical review by the National Newborn Screening and Genetics Resource Center. The review encompassed both the State

Lab and OMCFH case management processes. A written report has not yet been received.

In April 2012, WV sent 100 blood spot specimens to Delaware for processing and in May 2012, Delaware sent 100 specimens to WV for processing in an exercise for emergency planning. Several meetings were held between the main parties including E-MAC representatives of both states. A formal agreement was developed and agreed upon. HIPAA precautions were observed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All abnormal test results are followed by OMCFH case management.		X		
2. The Pediatric Genetics Program at WVU provides six subspecialty clinics throughout the State of West Virginia.				X
3. An active advisory committee assists with policy and program development.				X
4. The NBS Program staff work collaboratively with the State Lab to ensure screening before hospital discharge.				X
5. Formula for PKU patients is provided free of charge, regardless of income, by OMCFH.		X		
6. Linkage of data between OMCFH and the State Lab creates efficiency.				X
7. Formal relationships have been developed with Schools of Medicine to assure availability of medical experts.				X
8. WV currently screens for 29 disorders (includes hearing). SCID and CCHD to be added in 2012.			X	
9. The Bureau for Public Health generates cost-based revenue by billing the birthing hospital for each live birth for newborn screening.				X
10. WV is adding a data collection case management module to the existing contract with Neometrics to enhance efficiency. The module should be installed in Sept. 2012.				X

b. Current Activities

It is the goal of the NBSP to screen every newborn in WV for disorders to ensure diagnosis and treatment before the consequences of the disease become apparent ensuring the greatest opportunity to live a normal, productive life. Long-term benefits include a better quality of life for the child and his/her family and considerable cost savings for the insuring payers and the taxpayers of WV.

The NBSP staff and the infant's physician are immediately notified by the OLS of all abnormal screening results. In turn, the NBSP staff discusses with the infant's parents/legal guardian and the primary care physician the need for a repeat screening or a confirmatory test. The NBSP staff tracks each newborn with an abnormal test result to be certain that the newborn receives prompt and appropriate care. Since initial screening tests give only preliminary information, more precise testing must follow. Thus, an abnormal screening result indicates that further testing is necessary to confirm or eliminate the diagnosis suggested by the screened disorder. Infants with an abnormal screening result are also referred to an endocrinologist, a hematologist, a pediatric pulmonologist and/or to the state's pediatric geneticists. All referred newborns undergo confirmatory testing and receive treatment if indicated. Newborn screening tests are only performed by the OLS.

Continued education and planning for implementation of SCID and CCHD is ongoing.

c. Plan for the Coming Year

The Office of Maternal, Child and Family Health will maintain its relationships with the State Laboratory, the Newborn Screening Advisory, WVU Genetics Program, birthing facilities, Medicaid, insurance companies and the March of Dimes. The follow-up component of the Newborn Screening Program is housed within OMCFH and currently two fulltime nurses hold these positions.

Processes were developed and will be refined as necessary to purchase supplements needed for those infants diagnosed with a disorder. Partnership with WIC and CSHCN will continue to enable infants to receive nutritional products that he/she may be eligible for beyond that provided for by the Newborn Screening Program.

WV continues its plans on adding the case management follow-up module to the existing data package contracted with Neometrics. This will enable nurse case managers more timely access to the data system for follow-up activities and for surveillance activities by the epidemiologist. Implementation is tentatively planned for early Fall of 2012.

Screening for SCID and CCHD will occur in 2012.

The Program will revise and develop policies and procedures and complete a provider manual in 2012-2013.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	20759					
Reporting Year:	2011					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	19851	95.6	1	1	1	100.0
Congenital Hypothyroidism (Classical)	19851	95.6	427	15	15	100.0
Galactosemia (Classical)	19851	95.6	72	4	4	100.0
Sickle Cell Disease	19851	95.6	101	1	1	100.0
Biotinidase Deficiency	19851	95.6	241	4	4	100.0
Cystic Fibrosis	19851	95.6	110	8	8	100.0
Homocystinuria	19851	95.6	1	0	0	

Maple Syrup Urine Disease	19851	95.6	6	0	0	
beta-ketothiolase deficiency	19851	95.6	3	0	0	
Tyrosinemia Type I	19851	95.6	18	3	3	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	19851	95.6	1	0	0	
Argininosuccinic Acidemia	19851	95.6	0	0	0	
Citrullinemia	19851	95.6	8	0	0	
Isovaleric Acidemia	19851	95.6	2	0	0	
Propionic Acidemia	19851	95.6	11	0	0	
Carnitine Uptake Defect	19851	95.6	51	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	19851	95.6	4	1	1	100.0
Multiple Carboxylase Deficiency	19851	95.6	4	0	0	
Trifunctional Protein Deficiency	19851	95.6	0	0	0	
Glutaric Acidemia Type I	19851	95.6	113	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	19851	95.6	56	1	1	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	19851	95.6	11	4	4	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	19851	95.6	1	0	0	
3-Hydroxy 3-Methyl Glutaric Aciduria	19851	95.6	4	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	19851	95.6	0	0	0	
S-Beta Thalassemia	19851	95.6	0	0	0	
Mitochondrial Acetoacetyl-	19851	95.6	3	0	0	

CoAthiolase deficiency (3-ketothiolase)						
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Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	56.1	65	60	60	60
Annual Indicator	56.1	59.2	59.2	59.2	72.0
Numerator	39060	41150	41150	41150	50850
Denominator	69567	69567	69567	69567	70609
Data Source		2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2009-2010 CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	73	73	75	75	75

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

The 2009-2010 National Survey-Children with Special Health Care Needs (NS-CSHCN) is a telephone survey conducted by the National Center of Health Statistics at the Centers for Disease

Control under the direction and sponsorship of the federal Maternal and Child Health Bureau intended to represent the population of non-institutionalized children ages 0-17 who are classified as having one or more special health care needs (CSHCN). In each state, telephone interviewers screened at least 3,000 households with children to identify CSHCN. In-depth interviews were conducted with the parents of 750 -- 850 CSHCN in West Virginia in 2001, 2005-2006 and again in 2009-2010.

According to the 2009-2010 NS-CSHCN, 72% of West Virginia children with special health care needs age 0 to 18 years have families partner in decision making at all levels, and are satisfied with the services they receive. This is 1.7% above the 2009-2010 national average, and an increase of 12.8% since the 2005-2006 NS-CSHCN performance measure data.

The West Virginia Children with Special Health Care Needs (CSHCN) Program ensures a key element of comprehensive care coordination is that families are at the center of the process, and there are mechanisms to include family involvement in systems improvement. Parents or legal guardians of children enrolled in the CSHCN Program are involved in the Level of Need Assessment (LONA) by a face-to-face, in-home interview to determine what services the family needs and wants. The Care Plan then explicitly organizes the family's needs and wants to help the family play a part in health care services.

During calendar year 2011, 925 LONA and 824 care plans were developed and/or updated with family involvement. The initial LONA assesses eleven functional areas which include: 1) medical, adherence and insurance; 2) nutrition; 3) housing; 4) financial; 5) transportation; 6) legal; 7) daily living and other basic needs; 8) safety of self and others; 9) coping strategies; 10) development, education and vocation; 11) support systems and relationships. Holistic and analytical scoring methods are utilized to define top priorities that will be addressed on the care plan. Care plans, combined with a medical summary, are outlined for six-month service periods.

To assure continuum of comprehensive care coordination and building the medical home, copies of care plans are shared with all members of the medical care team including the family, PCP, other providers, agencies and organizations involved in the care of the child. A central record containing all pertinent medical information is maintained; the record is accessible to families, but confidentiality is preserved.

The CSHCN Care Coordinator shares information among the child, family and specialist while making referrals as needed. Families are linked to family support groups, parent-to-parent groups and other family resources. When a child is referred for a consultation or specialty care, the CSHCN Nurse Case Manager assists the child and family in understanding clinical issues. The CSHCN Nurse Case Manager evaluates and interprets the specialists' recommendations for the child and family and, in consultation with them and subspecialists, implements recommendations that are indicated and appropriate. The plan of care is coordinated with educational and other community organizations to ensure that special health needs of the individual child are addressed. Families of children with special health care needs have the opportunity to lead the care coordination team and are encouraged to be proactive participants. To do so, the CSHCN care team provides information about the condition and access to necessary resources.

Lastly, the CSHCN Program has implemented strategies identified by staff to support a culturally competent system of care by training on the topic of "The Culture of Poverty" to assist in addressing individual beliefs that could interfere with implementing an in-home care coordination model, and revising CSHCN Program form letters, applications, and public awareness materials to ensure a reading level no higher than the 6th grade.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with Marshall University in Parent Partners in Education (PPIE) funding results in parent advocates placed in Cabell-Huntington Hospital PICU and Pediatric Clinic.		X		
2. Culture competency training of staff "The Culture of Poverty" and "Home Visit Safety."				X
3. Parent/Professional Collaboration Conference sponsored by OMCFH and Marshall University Pediatrics.				X
4. Parents participate as part of the care coordination team for development of individual care plans in Part C and CSHCN Programs.		X		X
5. Copies of Care Plans and updates are given to the child's parent.		X		X
6. Care Notebook and Resource Manual were revised with the assistance of the PNS and families and distributed to families and applicants.		X		X
7. On-going training of Birth To Three practitioners beyond their professional licensure is required.				X
8. Paid Parent Coordinators, one in each of the 8 Birth to Three Regions are available to families, and 5 Parent Network Specialists.		X		X
9. All BTT participants self select practitioner offering services.		X		
10. The WV CSHCN Program in 2013 will fund expansion of residency training in delivery of chronic care to those with special health care needs to WVU/CAMC campus.				X

b. Current Activities

The West Virginia Children with Special Health Care Needs (CSHCN) Program continues to ensure a key element of comprehensive care coordination is that families are at the center of the process, and there are mechanisms to include family involvement in systems improvement. Parents or legal guardians of children enrolled in the CSHCN Program are involved in the Level of Need Assessment (LONA) by a face-to-face, in-home interview to determine what services the family needs and wants. The Care Plan then explicitly organizes the family's needs and wants to help the family play a part in health care services.

The CSHCN Program policy and procedure as well as staff expectations have been revised to reflect that all newly enrolled children will have the initial LONA and care plan completed in their home. The goal of utilizing the new LONA, medical summary and care plan for previously enrolled children, to create consistency in service delivery and fully implement the redesigned CSHCN Program care coordination model, is that each care coordination team will conduct a minimum of six (6) home visits per month upon annual anniversary review.

As a result of the need to address intricate dynamics, including multiple parental and caregiver involvement in the decision making and service provision, of children placed in foster care, the CSHCN Program created an addendum to the Level of Need Assessment specifically targeting the foster care population.

c. Plan for the Coming Year

The LONA foster care addendum assesses functional areas of placement and permanency as well as emotional and behavioral coping strategies of the child and caregiver. Furthermore, the Child Protective Service agency serving as the child's guardian is invited to the in-home interview to assist in developing the child's care plan, but the foster parent or kinship/relative placement implements the care plan objectives and goals.

Partnering with families and ensuring the family perspective in decision making at all levels of the CSHCN Program is demonstrated through the participation of Parent Network Specialists (PNS) and families in: 1) developing individualized, family-centered care plans; 2) the CSHCN Program Medical Advisory Board; 3) quarterly staff meetings with work sessions dedicated specifically to program tools, policies and procedures; and 4) surveys.

To ensure resource and referral information is responsive to family needs, the Parent Network Specialist project, in cooperation with the CSHCN Program, continues to update the Care Notebook. CSHCN Program Care Coordinators continue to develop and update an electronic resource library accessible to all CSHCN Program staff members including regional, state and national resources addressing topics of medical, social and educational services available to families.

The 2012 CSHCN Program work plan includes goals of developing up to four (4) family education tools specifically defined by families to help them care for their child. A parent survey has been developed, and will be administered to families via phone or face-to-face contact (i.e. home visit or clinic appointment), to prioritize what parents define as needs in attaining the best care possible for their child. The survey seeks a yes, no, I don't know or not applicable response to topics including: tracking medications; emergency planning; approval process and obtaining durable medical equipment; arranging and reimbursement for non-emergency medical transportation; legal guardianship; transition options; teaching children self-advocacy skills; and education plans. The survey also offers a comment section for parents to identify other needs.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	60	58	58	55	55
Annual Indicator	50.5	50.5	50.5	50.5	46.7
Numerator	35100	35100	35100	35100	33000
Denominator	69567	69567	69567	69567	70609
Data Source		2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2009-2010 CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	50	50	50	50	50

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and

the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

According to the 2009-2010 NS-CSHCN, 46.7% of West Virginia children with special health care needs age 0 to 18 years receive coordinated, ongoing, comprehensive care within a medical home. This is 3.7% above the 2009-2010 national average. Even so, West Virginia has experienced a decline of 3.8% since the 2005-2006 NS-CSHCN performance measure data which also is consistent with national average decline of 4.1%. It is significant to note that receiving effective care coordination when needed is the weakest component of CSHCN receiving care in the medical home. Considering the CSHCN Program redesigned its care coordination services model throughout 2011, it is premature in the redesigned model's ability to specifically address this performance measure. However, with exploration of the CSHCN Program providing care coordination services directly in offices of primary care physicians, CSHCN Program care coordination focus on supporting the medical home via methods such as submitting all medical records to the Primary Care Provider, CSHCN Program staff becoming more skilled and competent in implementing the redesigned care coordination model as well as creating consistent care coordination models between care coordinators stationed in primary and specialty providers via the Tri-State Children's Health Improvement Consortium project, the State of West Virginia can make strides in improving the quality of this measure.

Information about a child's primary care provider is collected by the Systems Point of Entry (SPE) during initial intake. During calendar year 2011, 885 children who enrolled in CSHCN Program services had an identified medical home defined as a usual source for sick and well care with a personal provider. This represents 72% of the enrolled children identifying having a medical home when seeking CSHCN Program services. Furthermore, the 2009-2010 NS-CSHCN indicates, 92.1% of West Virginia children with special health care needs age 0 to 18 years have a usual source for sick or well care with a personal provider.

SPE service coordinators link children without an identified medical home to the state's expansive network of community health centers and to primary practice clinicians for medical care. All children receiving benefits through the WV Medicaid Program, including those participating in the CSHCN Program, choose a primary care physician. This lends to the impression that assessability is not a barrier, but instead individual components of the medical home may affect the performance data, and hence are targeted areas of the CSHCN Program redesigned care coordination model. These individual components are: having no difficulty with receiving needed referrals; receiving family-centered care; and receiving effective care coordination when needed.

Marshall University has a medical program focusing on the needs of children who are homeless. The program provides care coordination for children staying at the Huntington City Mission and its

Project Hope transitional living apartments. The effort is funded by a 5 year, \$250,000 Healthy Tomorrows Partnership for Children Program grant from the American Academy of Pediatrics in cooperation with HRSA, Bureau for Maternal and Child Health. Marshall's program is the first in the state to be awarded one of these grants. The goal of the project is to provide a medical home for this unique group of children with special health care needs. The coordination of services to these families will improve children's health by decreasing hospitalizations, emergency room visits and school absences. In addition to meeting children's acute care needs, the program hopes that early identification and treatment of developmental or school problems will enable these children to become healthy, productive West Virginians. In FY 2011, OMCFH augmented the Marshall University grant by contributing \$36,000.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 95% of WV children have insurance coverage (Medicaid, CHIP, private carrier)		X		X
2. State CSHCN Program provides extensive care coordination		X		
3. Medicaid, CHIP, PEIA and commercial carriers are requiring use of a medical home				X
4. The U.S. Scorecard ranked WV number 8 for percent of children who have a medical home			X	
5. The U.S. Scorecard ranked WV number 1 for percent of children whose personal doctor or nurse follows up after receipt of specialty care services		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Informational materials, including a CSHCN Program Brochure, Provider List, and Poster, have been developed and distributed in primary care and specialty provider offices to explain and promote the advantages of the CSHCN Program providing care coordination services in the medical home to the children, families and physicians.

A pilot project has been initiated with Summersville Pediatrics for the CSHCN Program to provide care coordination services during well-child exams of children enrolled in the CSHCN Program, and receiving rehabilitative services of medical foods. Aside from direct assistance to the family, and supporting the medical home, this pilot project hopes to improve the system of care for CSHCN through education of the physician, multidisciplinary-concurrent service provision, and improved efficiency (i.e. dietary assessment conducted by a Registered Dietitian concurrently with the well-child exam; utilizing Inter-Qual criteria for durable medical equipment identified through the well-child exam; completion of certificate of medical necessity during the well-child exam, etc).

The heightened emphasis on patient-centered medical homes also promotes a team approach for optimal care of patients. Such an approach assures whole patient orientation, follows evidence-based guidelines, and implements continuous quality improvement.

c. Plan for the Coming Year

The possibility of CSHCN Program nurses and social workers providing care coordination services in offices of primary care physicians will continue to be explored, especially in rural areas. To increase the number of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home, scheduling CSHCN Program enrolled children for well-child exams with completion of their care plan and specific directives from the child's Primary Care Provider regarding needed referrals and care coordination, can support medical home without increased cost while maintaining workload capacity for CSHCN Program staff.

The CSHCN Program will also prudently explore the options of combining the benefits of the telehealth pilot (specialty care via Mountaineer Doctor Television), and CSHCN Program care coordination services during well-child exams, to create a system of care that is multi-disciplinary and collaborative in nature while minimizing the burden of travel and multiple appointments for families.

The CSHCN Program has strengthened the relationship with the West Virginia Chapter of the American Academy of Pediatrics, and will be conducting a presentation at their 2013 spring meeting. Objectives of the presentation include: 1) an overview of the prevalence of children with special health care needs in West Virginia and adequacy of insurance coverage for this population; 2) highlighting the history of success within the CSHCN Program; 3) increasing understanding of the CSHCN Program eligibility determination process; 4) educating providers on the CSHCN Program care coordination model; and 5) stressing all components of a CSHCN medical home.

Marshall University has expressed interest in including a rotation with the CSHCN Program into their community pediatrics residency training options. The CSHCN Program will continue to support development of this curriculum, and remain accessible to accommodating residency training programs. As a matter of fact, Marshall University has Parent Partners in Education and Project DOCC (Delivery of Chronic Care) curriculum that has been in place for 14 years. Parent Partners in Education (PPIE) is a lecture to third year medical school students by a parent of a child with special health care needs. Project DOCC is a rotation for pediatric and general practice residents that includes a home visit to a family with children with special health care needs in which a family can share their experience in the medical system of care. OMCFH has made a commitment for 2013 to fund expansion of these curricula into the residency program of West Virginia University at the Charleston Area Medical Center campus. In addition, the PPIE lecture will be revised to include the CSHCN Program to educate medical school students about the components of a medical home for CSHCN as well as the concept of care coordination.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	65	65	65	65	65
Annual Indicator	64.2	64.2	64.2	64.2	62.0
Numerator	44650	44650	44650	44650	43800
Denominator	69567	69567	69567	69567	70609
Data Source		2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2009-2010 CSHCN Survey
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	65	65	65	65	65

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

According to the 2009-2010 NS-CSHCN, 62% of West Virginia children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. This is 1.4% above the 2009-2010 national average. Even so, West Virginia has experienced a decline of 2.2% since the 2005-2006 NS-CSHCN performance measure data which is slightly higher than the national average decline of 1.4%.

The Systems Point of Entry (SPE) Project, housed within OMCFH, is a telephone hot-line and referral service that identifies families that do not have Medicaid, CHIP or private insurance coverage at the time an application to participate in the CSHCN Program is made. Families without resources to pay for medical services must apply for Title XIX and Title XXI, and must be denied by these sources, prior to Title V payment initiation.

During calendar year 2011, 92% of the children enrolled in the WV CSHCN Program have public insurance; 86% Medicaid and 6% CHIP. Eleven percent of the children enrolled in the CSHCN Program report having 'other insurance.' (It should be noted some children may be eligible for more than one insurance plan so totals do not add up to 100%). There are three managed care organizations (MCO) that administer benefits through the WV Medicaid Managed Care system. However, recipients of Supplement Security Income and children placed in foster care have public insurance benefits administered by the WV Medicaid state agency. As a result of this structure, benefit packages vary even though a family is entitled to public insurance. The CSHCN Program Nurse Case Manager assures families are informed about insurance coverage and benefit eligibility, including benefit packages of each WV Medicaid MCO, so the family is educated about their options when making choices to best care for their child.

To assure that families have the best available coverage for their child's medical care, the

CSHCN Program requires all applicants to first apply for Medicaid and CHIP at their local Department of Health and Human Resources (DHHR) Office. Verification of their application is done through receipt of written notice given to the family and/or by accessing RAPIDS, the Medicaid eligibility data system. Information submitted to the DHHR office during this process is also used as the determinant of a child's financial eligibility for the CSHCN Program.

In addition to Title V coverage for treatment, testing and services for children that do not qualify for public health insurance and with a family income at or below 200% of the federal poverty level, the CSHCN Program provides coverage of medical foods for children enrolled in the program without adequate private and/or public insurance coverage. The CSHCN Program currently has 16 children with Title V insurance coverage, and 268 children receiving medical food coverage. This is 1.2% and 20%, respectively, of the enrolled CSHCN Program caseload.

The CSHCN Program continues to administer the Kids First Hearing Project via funds donated by Mountain State Blue Cross/Blue Shield (private insurer) to provide hearing aid services and supplies for children 3, 4, 5 or 6 years of age who lack insurance coverage for this benefit. During calendar year 2011, 77 children were served in the Kids First Hearing Project.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 95% of WV children have insurance coverage (Medicaid, CHIP, Private carrier)		X		
2. CSHCN requires Medicaid and CHIP applications, to ensure Title V resources are used as last resort		X		X
3. Coordination between CSHCN and Social Security Administration facilitates access to SSI		X		
4. CHIP approved expansion of eligibility to 300% FPL				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Patients receiving medical treatment and/or care coordination through the CSHCN Program have their health care financed by Medicaid, CHIP, private insurance or Title V funds. Families with income of 200% of the Federal Poverty Level or below may be eligible for Title V sponsored services if they have an eligible/covered diagnosis. The Program does not have sufficient resources to act as an insurer for every chronic debilitating condition. For example, Title V does not provide payment for treatment of asthma or diabetes. Continued financial eligibility is determined on a yearly basis using a computer generated letter asking families to reapply for Medicaid and CHIP to assure Title V funds are used as payor of last resort. The care coordinator reviews financial information as well as determines continued medical eligibility.

Regardless of insurance coverage, the CSHCN Program will provide health assessments and diagnostic evaluations with a pediatric specialist in a CSHCN Program Clinic at the request of a parent or physician to assist in early identification and treatment of a chronic, debilitating condition; the CSHCN Program will schedule up to two free medical exams, including testing in a CSHCN Program clinic.

c. Plan for the Coming Year

Building on outreach efforts for the past year, CSHCN will continue efforts to make potential recipients aware of services available through CSHCN. To expand CSHCN outreach efforts, the DHHR Division of Management Information Systems will identify approved or denied Medicaid beneficiary children (age 0-20) who have a disability. The system will generate a monthly report to use in CSHCN outreach efforts by the Systems Point of Entry unit. The SPE unit will mail identified families information about available CSHCN Program services and care coordination. This will augment population based surveillance efforts and children identified as a consequence of an EPSDT screen.

Additional informational materials, including a CSHCN Annual Report and CSHCN Fact Sheet, will be developed for a physician awareness campaign. The CSHCN Fact Sheet will highlight the current income guidelines and specifically highlight the eligibility process. The CSHCN Annual Report focuses on how the CSHCN direct services supports the medical system of care, encourages best practice standards to influence pediatric practice for all children, and builds state infrastructure.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	75	90	90	90	90
Annual Indicator	89.7	89.7	89.7	89.7	66.5
Numerator	62420	62420	62420	62420	46950
Denominator	69567	69567	69567	69567	70609
Data Source		2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2009-2010 CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	67	67	67	67	67

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

According to the 2009-2010 NS-CSHCN, 66.5% of West Virginia children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. This is 1.4% above the 2009-2010 national average. Unfortunately, this MCHB core outcome indicator is not comparable over NS-CSHCN survey years.

In CY 2011 an informational pamphlet was given to each family at the time of enrollment. The pamphlet provided information about the CSHCN Program, eligibility criteria for continued service, services offered including aspects of care coordination and a listing of the patient/family rights and responsibilities.

To improve the system of care, expand population-based MCH services and build the medical home model, the CSHCN Program partners with specialty, multi-disciplinary clinics or private practices throughout WV to provide care coordination services for any children, adolescents and adults with special health care needs. The CSHCN Program nurse case manager and social worker care coordinator are members of the multi-disciplinary team to implement care coordination in the clinic or practice.

In efforts to ensure children can receive quality care within one hour drive from their home, facilitate communication with a child's medical home, and expand care coordination services to a broader population of children with special health care needs, the CSHCN Program supports providers and practices with care coordination services by partnerships with: 1) West Virginia University to conduct six (6) specialty clinics in eight (8) locations throughout the state in the areas of cardiology, cleft and craniofacial surgery, genetics, myelodysplasia, and neurology; 2) Charleston Area Medical Center to conduct two (2) specialty clinics in Charleston WV in the areas of cystic fibrosis as well as cleft and craniofacial surgery; and 3) Marshall University to conduct two (2) specialty clinics in Huntington WV in the areas of spina bifida and cardiology. Ultimately, the CSHCN Program provides a Nurse Case Manager and Social Worker Care Coordinator for care coordination services in each of these clinics; services are available to any child scheduled in the clinic on the designated date the CSHCN team attends.

In calendar year 2011, the CSHCN Program provided care coordination services in 203 partnership clinics. In these clinics, the CSHCN Program Nurse Case Managers and Care Coordinators provided services to 469 children enrolled in the CSHCN Program and 994 patients of the clinics that are not enrolled in the CSHCN Program. Likewise, during calendar year 2011, 791 children enrolled in the CSHCN Program received services in a CSHCN-sponsored clinic. This indicates the CSHCN Program is providing care coordination services to 95% of the enrolled children in their specialty care provider office; 1,260 enrolled children (out of 1,330) were seen by a CSHCN care coordinator in at least one of their specialty care provider offices.

In addition to contact in clinic settings, CSHCN care coordination teams made 573 face-to-face visits in homes or other sites excluding clinics. In calendar year 2011, 2,690 resources and/or referrals, by a CSHCN nurse or social worker, were provided to or for CSHCN Program clients and families.

WV BTT received from the U.S. Department of Education the highest ranking possible for its administration of Part C which includes evaluation of timely service delivery, parent knowledge of rights and responsibilities, parent satisfaction and measured child performance milestones.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Parents participate in policy and procedures development for WV Birth to Three, Hearing Screening and CSHCN.		X		
2. Collaboration with WV Medicaid to optimize resources and plan efficient use of funds.				X
3. CSHCN collaborates with other OMCFH programs to coordinate needed services efficiently.				X
4. CSHCN Nursing Director participates on Medicaid policy committee sharing input from families.				X
5. CSHCN Program Advisory includes medical providers, service providers, and parents.		X		X
6. Survey of BTT parents reflect satisfaction and child performance improvement.				X
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN quality assurance component was strengthened by continuation of an internal process designed to monitor staff documentation in enrolled patient records. Each month the CSHCN Director of Nursing and the Director of Social Services review a portion of each of their assigned staff's work using an Internal Chart Review form, which identifies important elements in care management and case recording. This process identifies areas that need improvement and serves as a basis to identify staff training needs and evaluation. The system serves to augment the periodic clinic/field office site visits completed by the CSHCN Director of Nursing and the Director of Social Services. An electronic data system was developed by OMCFH's Division of Research, Evaluation and Planning for recording and tracking of completed reviews. This allowed the CSHCN nurses and social workers to track response times from the time of inquiry, to the time of authorization and then to the delivery of patient equipment or services.

c. Plan for the Coming Year

The CSHCN Program differentiates itself from other programs/payers by continuing to emphasize the importance of care coordination services. Nurses and social workers are trained to view the family as a whole and assess their needs, both medical and social, and link them with available resources and community services.

The Parent Network Specialists (PNS) will continue to provide resource information, support families in dealing with educational issues, and plan regional workshops to include information on transition services. The PNS will continue to develop parent support groups in their assigned areas.

The ability to serve more children with special health care needs and support the medical system of care will require continued partnerships with hospitals, clinics and private providers with the CSHCN Program offering the care coordination services while the medical management of the clinic patients remain with the provider.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	6	41.3	42	43	43
Annual Indicator	41.3	41.3	41.3	41.3	41.6
Numerator	28700	28700	28700	28700	29400
Denominator	69567	69567	69567	69567	70609
Data Source		2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2005-2006 CSHCN Survey	2009-2010 CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	43	43	43	43	43

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

According to the 2009-2010 NS-CSHCN, 41.6% of West Virginia youth with special health care received the services necessary to make transition to all aspects of adult life, including adult health care, work and independence. This is 1.6% above the 2009-2010 national average, and an increase of 0.3% since the 2005-2006 NS-CSHCN performance measure data.

Transition services are provided to all children, age 14-21 enrolled in the CSHCN Program, in collaboration with parents, education specialists and other interested parties. Transition screening tools for middle adolescents and young adults are completed by the client and/or family to develop a transition care plan focused on the effective and efficient organization and utilization of resources as well as seek to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural and social needs. During calendar year 2011, 204 transition tools were completed with 849 transition services provided to clients and families enrolled in the CSHCN Program.

The CSHCN Program continued to seek and allow training of CSHCN staff and contracted employees to build skill and competence in the area of transition services. Topics included: 1) alternatives to guardianship, 2) wills and special needs trusts, 3) "Help Yourself -- Chronic Disease Self-Management Programs", 4) pre-existing condition insurance plan program, 5) overview of Social Security Administration Disability Determination Services and understanding the benefits, and 6) keeping Social Security benefits on track with community work incentive. The Level of Need Assessment (LONA) completed in the home to help families define their needs and wants assesses readiness and reaction to transition in the healthcare section, education section, and coping strategies section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN offers transition services to all Program participants beginning at age 14.		X		
2. WVU Center for Excellence in Disabilities has a transition advisory.		X		
3. Marshall University School of Medicine is collaborating with Title V on transition programming.		X		
4. Participants are encouraged to access Vocational Rehabilitation counseling in schools.		X		
5. WV established required certification for interpreters.				X
6. Division of Rehabilitation Services has Cooperative Agreements with all 55 county school systems.				X
7. Throughout WV, rehabilitation counselors are assigned to work with public and private schools.				X
8. Rehabilitation counselors assist students with disabilities in developing individualized plans for employment.		X		
9.				
10.				

b. Current Activities

The CSHCN electronic data system produces reports identifying adolescents 14 through 21 years of age as a tracking system for social workers and nurses. These reports are produced on a monthly basis and used by CSHCN staff when determining need for frequency of contact with

clients in providing transition services.

School transition is an area where progress is actively occurring including: statewide and district level workshops and forums; transition targeted teleconferencing; transition assessment resource development; focus on improving achievement; attention to differences in graduation and dropout rates for students with disabilities and all students; efforts to increase collaboration and coordination with WV Division of Rehabilitative Services (DRS), Office of Maternal, Child and Family Health/Children with Special Health Care Needs (OMCFH/CSHCN) and the Department of Education (DOE); development of inclusive educational models and strategies to improve access; and the opportunity to progress in the general education curriculum.

The CSHCN Program continues work with Dr. Shannon Browning from the Marshall University Joan C. Edwards School of Medicine, Pediatrics Department to provide care coordination services in a transition clinic. Transition planning and care coordination is provided by the CSHCN staff to patients 14 through 20. This clinic is highlighted in a newly developed provider listing brochure to promote services statewide.

c. Plan for the Coming Year

The OMCFH has representation on the State Developmental Disabilities Council and shares data and programmatic information that can be used to pursue system change, increase service or support availability or otherwise promote positive and meaningful outcomes. Several examples include coordinated advocacy for the passage of an expanded newborn metabolic legislation, coordination with Vocational Rehabilitation on policy and practice to promote self-determination and transition planning for youth, and CSHCN Program staff participation in advocacy training and public policy.

A greater emphasis will be placed on transition services by collaboration between state and local school systems, Division of Rehabilitation, medical care providers, social service agencies and the CSHCN Program. Transition screening forms will be revised and updated to better determine the needs of the adolescent and their family.

While there are a number of services and programs that are designated to assist people with disabilities in various facets of training and employment assistance, central easy access to these services across agencies and providers is lacking. A forum where stakeholders can work together to bring about change is needed.

A team of stakeholders continues to assist with the core design of the strategic planning process. This team consists of representatives from: The Bureau for Medical Services, Goodwill Industries of KYOWVA, WV Developmental Disabilities Council, Workforce WV, People's Advocacy Information and Resource Services Center, Bluefield State College, Office of Special Education Assistance, WV Mental Health Planning Council, Job Accommodation Network, the Center for Excellence in Disabilities (CED) and Division of Rehabilitative Services (DRS). Technical assistance is provided by the program staff of CED.

Varieties of assessments across different groups continue to be completed. The voices heard within the state from a wide audience (education, business, advocates and people with disabilities and their families) provides positive feedback, challenges and ideas for improvement.

Support for initiating and collaborating for the establishment of a Family Voices organization was presented by Dr. James Lewis, committee chair of the WV Chapter American Academy of Pediatrics CSHCN/Foster Care Committee, at their April 2012 meeting. He proposes hosting a session at the March 2013 spring meeting to organize Family Voices and begin coordination of the Parent Partners in Education at all medical residency sites in WV. He would also like to secure a visiting professor with interest in parent involvement in community pediatrics to provide a two to three day educational component in pediatric residency lecture series.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	95	95	95	96	71
Annual Indicator	93.3	77.0	65.0	70.3	74.6
Numerator	57850	21420	18380	20500	19800
Denominator	62000	27811	28270	29181	26553
Data Source		2008 Immunization Data	2009 Immunization Data	2010 Immunization Data	2011 Immunization Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	75	75	75	75	75

Notes - 2011

National Immunization Survey

2011 State Division of Immunization Services - individual immunizations: (DTaP-4: 84%, IPV-3: 92%, MMR-1: 90%, Hib-3: 92%, Hep B-3: 89%, and VAR-1 (chickenpox): 89%)

Notes - 2010

2010 National Immunization Survey

2010 State Division of Immunization Services - individual immunizations: (DTaP-4: 78.8%, IPV-3: 88.6%, MMR-1: 89.2%, Hib-3: 82.3%, Hep B-3: 88.3%, VAR-1: 86.9%)

Notes - 2009

National Immunization Survey

2009 State Division of Immunization Services - individual immunizations:(DTaP-4: 85%, IPV-3: 94.5%, MMR-1: 88%, Hib-3: 94%, Hep B-3: 96%)

a. Last Year's Accomplishments

The State's Division of Immunization Services is housed in the Office of Epidemiology and Prevention Services, Bureau for Public Health. This division works closely with local health departments, WIC, hospitals, the private practicing medical community, and other early childhood programs in an effort to get children fully immunized. The current immunization coverage rates from the National Immunization Survey (NIS) for children 19 through 35 months of age in West Virginia: 84% had been immunized for DTaP-4, 92% for IPV-3, 90% for MMR-1, 92% for Hib-3 and 89% for Hep B-3, and 89% for VAR-1 (chickenpox). The Division of Immunization Services worked with the WV Higher Education Policy Commission from 2006-2008 to develop a list of recommended immunizations for college enterers. WVCHIP enrollment materials and information were included in the State's Newborn Immunization Program packets to new mothers through the Right From The Start Coordinators.

In 2011, WV remained 36th among the states in overall immunization coverage of 2 year-old children at 74.6%.

In accordance with federal regulations and the Bright Futures standard, appropriate immunizations must be provided.

HealthCheck mailed individual letters to the parent(s) of HealthCheck clients on the clients' 11th birthday to raise awareness among beneficiaries of the importance of adolescent immunizations.

HealthCheck makes available to all health professionals (without charge) Vaccine Administration Records.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In 2011, WV remained 36th in the nation for completion of regularly scheduled immunizations coverage rates for 2 year old children.		X		
2. The EPSDT/HealthCheck Program encourages providers to offer immunizations as part of health care.				X
3. The RFTS Program collects data on whether or not infant participants (who are up to 12 months) are up to date on immunizations.				X
4. All women giving birth in WV receive an information packet including an immunization schedule before leaving the birthing facility.		X	X	
5. WV does not allow non-medical exemptions for immunizations.			X	
6. Partnered with West Virginia's Immunization Network (WIN) to promote adolescent immunizations.		X		
7. Need for immunizations is promoted by RFTS, WIC and other public health programs.		X		
8.				
9.				
10.				

b. Current Activities

The Division of Immunization Services is working to increase the number of providers who regularly report to the immunization registry, the West Virginia Statewide Immunization Information System (WVSIIS). Of the 405 providers of immunizations enrolled in the Vaccines for Children (VFC) Program, all are enrolled and have reported at least once to WVSIIS, but only 80-

85% report regularly to the Registry. A Certificate of Immunization has been developed. The Certificate of Immunization has helped to improve preschool and school-age immunization levels by establishing a standard process by which children are given documents certifying receipt of age-appropriate immunizations. A uniform Certificate of Immunization will enable the consolidation of all valid immunization dates on one document that can be utilized by schools, child care centers and in other settings. The certificate is a tool used by the Division of Immunization Services as an ongoing effort to increase preschool and school immunization levels in West Virginia. VFC Providers in WV may now order vaccines online via the WVSIS. Additionally, providers may manage inventory and generate vaccine usage reports, coverage rates, and reminder/recall messages from the registry.

c. Plan for the Coming Year

All women giving birth in WV receive an information packet including an immunizations schedule before leaving the birthing facility. WV does not allow either religious or philosophical exemptions to immunization requirements.

The Division of Immunization Services and the West Virginia Immunization Network (WIN), a statewide coalition of more than 200 public and private sector members who work to protect West Virginia's residents from vaccine-preventable diseases, have collaborated to implement the "Take Your Best Shot" campaign targeting adolescents for HPV, MCV, Tdap, chickenpox and Hep B vaccinations in 38 counties, up from 32 counties in 2011.

During the 2012 Legislative Session, the WV Legislature passed a resolution to study nonmedical exemptions to school immunization requirements. A public hearing as part of this study was held on Monday, June 25, 2012 at 5pm in the House Chamber.

States, where nonmedical exemptions are allowed, have seen reductions in their immunization rates and outbreaks of vaccine-preventable diseases as a result of these exemptions. Thus, the West Virginia Immunization Network (WIN) strongly opposes allowing nonmedical exemptions to school immunization requirements.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	19	19	19	20	22
Annual Indicator	20.7	23.2	24.7	21.1	21.1
Numerator	733	779	814	693	693
Denominator	35411	33640	32984	32903	32903
Data Source		2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	based upon 2010 Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be					

applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	21	21	21	21	21

Notes - 2011

based upon 2010 Vital Statistics

Notes - 2010

2010 Vital Statistics

Notes - 2009

2009 Vital Statistics

a. Last Year's Accomplishments

The Adolescent Pregnancy Prevention Initiative (APPI) influences and supports teens as they explore and determine responsible sexual and reproductive options for the future. Through the development, oversight and coordination of evidence-based activities, APPI is able to influence WV's youth to make healthier choices. These activities include conducting evidence-based curricula within a variety of settings, presenting information in public school classrooms that meets the State Health Content Standards and Objectives, providing resources for public school educators and others with regard to pregnancy and disease prevention, and exhibit in a variety of venues in order to increase awareness of the detrimental effects of teen pregnancy. The goal of the program is to reduce the number of pregnancies among adolescents using an abstinence-based approach which includes: improvement of decision-making skills, development of refusal techniques, orientation to and/or access to contraceptive services.

APPI received the Adolescent Health Star Award given by WV FREE and Planned Parenthood for outstanding service to the adolescents of the state.

During the month of April (Get Yourself Tested Month) APPI distributed informational pamphlets regarding the necessity for sexually active teens to have sexually transmitted infection testing. APPI presentations in addition to information about abstinence and contraception contain an educational component about sexually transmitted infections which includes testing location within the students' area.

During the month of October (Let's Talk Month), APPI conducted parent-teen communication sessions in multiple counties.

APPI is the primary contact for state agencies and community groups regarding teen pregnancy prevention. As a result, APPI participates in at least 75 health related fairs and conferences annually. APPI staff is often requested to conduct presentations during these same events.

APPI distributes a minimum of 100,000 pieces of literature regarding the prevention of sexually transmitted infections, abstinence and contraception throughout the school year to public schools, community organizations and partnering state agencies.

APPI Specialists assist public school educators in the delivery of State mandated, medically accurate comprehensive sexuality education as required by the Health Content Standards and Objectives of the West Virginia Department of Education.

The Adolescent Health Initiative led and/or coordinated the following activities:

- Participated in statewide meetings for the Leadership to Prevent Teen Pregnancy Task Force;
- Partnered with the Adolescent Pregnancy Prevention Initiative to host four regional youth focus groups across the state;
- Participated in the Live Out Loud girl's conference in Fairmont, WV;

- Facilitated a statewide training in the evidence based teen pregnancy prevention curriculum Promoting Health Among Teens;
- Initiated curriculum classes in ten West Virginia schools;
- Sponsored a "night at the ballpark" in Bluefield, WV and provided attendees with information about abstinence, parental communication, etc;
- Developed posters and banners to provide health information to the community and raise awareness about available health resources;
- Sponsored a Life Skills Camp in Mercer County, WV;
- Sponsored a five day Teen Institute camp in Romance, WV. The camp is designed to teach middle school youth how to make positive life decisions and avoid risk behaviors;
- Sponsored a two day Teen Institute in Mason County, WV;
- Provided education seminars to over 200 parents;
- Developed a Public Service Announcement (PSA) encouraging parents to talk to their teens about sex. The PSA aired in up to 67,850 homes with 175,732 potential viewers in southern West Virginia;
- Facilitated community-based teen pregnancy prevention meetings in several WV counties;
- Provided trainings for teens and parents on "sexting" and it's social, emotional and legal impacts.

The Leadership to Prevent Teen Pregnancy Taskforce is a statewide initiative lead and sponsored by APPI. The Taskforce is comprised of more than 50 individuals and organizations that focus on encouraging medically accurate, age appropriate sexuality education and promoting healthy informed reproductive life planning for teens. The goal of this taskforce is to reduce the number of unplanned, unwanted teen pregnancies through education and outreach.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Adolescent Pregnancy Prevention Specialists conducted numerous community education and outreach activities on a regional/local level.		X		
2. Conducted school presentations at WV schools distributing over 100,000 pieces of literature and participated in 75 health related community events, fairs and conferences.		X		
3. Recognized and promoted "National Teen Pregnancy Prevention Month".			X	
4. Recognized and promoted "Let's Talk Month".			X	
5. Free family planning services are available at 163 locations.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

APPI is made up of 5 full-time employees: 1 Director and 4 Adolescent Pregnancy Prevention Specialists, who conduct education and outreach activities within the public school system, social service groups, criminal justice and community service organizations. The Specialists increase public awareness of problems associated with early sexual activity, pregnancy, child-bearing and

sexually transmitted infections. The Specialists teach skills related to the development of strong relationships and positive self-image and collaborate with existing community networks to promote responsible choices with regard to sexual activity and reproduction.

APPI initiated and maintains a text line designed for teens to ask confidential questions.

The Adolescent Health Initiative facilitates educational opportunities for adolescents and other community members on preventing pregnancy, delaying sexual activity and other risk behaviors. Trainings promote positive decision making and support asset-building targeting both traditional and non-traditional partners. Traditional partners include youth 10-19, parents of youth 10-19, schools and public health/local health departments. Non-traditional partners include local business/industry, health care, and the faith community.

The Adolescent Health Initiative continues to partner with the Teen Pregnancy Prevention grantees and the Adolescent Pregnancy Prevention Initiative in the provision of evidence-based curriculum services across the State.

c. Plan for the Coming Year

APPI encourages the use of Family Planning service providers, available at 163 locations, for those teens who are sexually active or considering becoming sexually active. Specialists provide information regarding location and services provided by Family Planning clinics during their presentations, exhibits and school visits. Confidential access to Family Planning Program services is crucial in helping sexually active teenagers obtain timely medical advice and appropriate medical care in order to delay childbearing which will result in improved maternal and child outcomes. Minor clients seeking reproductive health care can only be assured confidential services by a Title X funded Family Planning Program network provider.

APPI will continue to provide education and outreach activities within the public school system, social service groups, criminal justice and community service organizations.

APPI will maintain a text line designed for teens to ask confidential questions regarding sex and sexuality. Specialists take turns answering messages with medically accurate, age appropriate information.

The Adolescent Health Initiative will continue to serve as a statewide resource for schools and communities seeking to increase protective factors and reduce adolescent risk behavior. The Adolescent Health Initiative will continue to educate parents, youth and communities about the importance of teen pregnancy prevention. The Adolescent Health Initiative will expand evidence-based curriculum classes within the public school system in the coming year.

APPI is a planning member in Teen Institutes for Kanawha Mason, Putnam, Boone, Clay, Logan, Wirt and Cabell counties. APPI sponsors these events and in addition provides Specialists who conduct presentations and assist with activities. Teen Institutes are leadership camps for teens that encourage respect and responsibility for self and others. Workshops are held daily and include discussions about risky behaviors, consequences and refusal skills. The goal of Teen Institute is to develop leaders in the field of prevention. Many of the youth who attend Teen Institute as young teens return to camp as peer leaders while in high school and as adult counselors when they enter college. The teens who are invited to attend are encouraged to take the lessons learned from camp back to their home communities and schools and spread a message of self-confidence and prevention.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	38	30	57	57	30
Annual Indicator	55.9	56.1	56.6	29.0	29.0
Numerator	11461	11500	11600	8250	8250
Denominator	20485	20485	20485	28416	28416
Data Source		Health Care Authority	CMS 416	ASTDD	ASTDD
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	30	30	30	30	30

Notes - 2011

based upon 2010 Oral Health random sample
denominator is estimated number of third graders in state

Notes - 2010

2010 Oral Health random sample
denominator is estimated number of third graders in state

Notes - 2009

Estimate based upon CMS 416 Fiscal Year 2009
(receiving preventive dental services)

a. Last Year's Accomplishments

Statewide surveillance - FY 2011 marked the first time WV submitted Institutional Review Board approved, reportable baseline data to the Centers for Disease Control and Prevention (CDC). The submission of this data was a result of collaborative efforts of the Oral Health Program and its partners.

This project represents the first statewide oral health surveillance data collection of its kind in West Virginia's history. Oral health surveillance provides a representative snapshot of children's oral health in West Virginia. The data collected will bring West Virginia in line with national protocol, and will strengthen the state's ability to monitor progress in addressing the oral health needs of West Virginia.

Information was collected on third grade and kindergarten children in WV, stratified by economic indicators. A random sampling of schools was generated by Bureau for Public Health epidemiologists. Twenty-four schools from 15 counties across WV participated in the screening. The screenings were conducted by a brief visual assessment, where licensed dental professionals looked into a child's mouth using a penlight and, if necessary, a tongue depressor or mirror. Screeners looked for existing restorations, sealants and obvious decay. Twenty-nine

percent of third grade children had received protective sealants on at least one permanent molar tooth.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Children's Dentistry Project (CDP) subgrants preventive health block funds for application of sealants.		X		
2. CDP collaborated with a CHC and a county school system on a pilot project for sealant application.		X		
3. CDP provides oral health education which includes information on sealants.			X	
4. 18 community-based dental clinics where dental services are provided free or at reduced cost.		X		
5. Six local health departments offer dental education and four provide preventative oral services.		X		
6. Six mobile dental clinics were held providing preventive services and two clinics were Missions of Mercy providing preventative and restorative dental services at no charge.		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Oral Health Program works with 26 communities in West Virginia that received grant funding through a partnership between Appalachian Regional Commission (ARC) and the Claude Worthington Benedum Foundation. The goals of the program are to increase the number of children receiving preventive services, such as sealants and fluoride treatments, and to increase the number of children with a dental home. In the 2010-11 school year, a total of 4174 children in 15 counties from 104 schools received an initial dental screening. Of all the children screened- 75% were covered by Medicaid and 6% by WV CHIP. 649 sealants were applied to 420 children.

c. Plan for the Coming Year

The WV Oral Health Program is funding Marshall University to support the transition of the existing Community Oral Health Coordinator into the role of State Dental Sealant Coordinator. The Dental Sealant Coordinator will work with WVDHHR staff to develop and implement a statewide dental sealant plan. The plan will build upon the WV School-Community Partnership Program with the goal of increasing the number of third grade children receiving protective sealants.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	3.3	3.9	4.5	3	1.5
Annual Indicator	5.4	3.5	1.9	3.8	3.8
Numerator	17	11	6	12	12

Denominator	316809	316986	318634	319121	319121
Data Source		2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	based upon 2010 Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	3.5	3.5	3	3	3

Notes - 2011

Based upon 2010 Vital Statistics

Notes - 2010

2010 Vital Statistics

Notes - 2009

2009 Vital Statistics

a. Last Year's Accomplishments

The Violence and Injury Prevention Program was able to hire a Secretary and Epidemiologist that is shared with the State's Home Visitation Program. These two additional positions have helped the Violence and Injury Prevention Program to continue to develop the necessary infrastructure in order to build a successful, comprehensive prevention program. In addition, the Program contracted with the West Virginia University Injury Research Center to compile a data report that outlines the burden of injuries in the State, including associated costs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Department of Education/Health Education Assessment Project to calculate student health knowledge of seat belts and other safety issues.		X		
2. The EPSDT Program provides anticipatory guidance to parents regarding childhood injuries.		X		
3. Adolescent Health Coordinators and others provide classroom injury prevention instruction.		X		
4. Home Visitation Program and RFTS Program promote infant/toddler car seat and seat belt usage with children.		X		
5.				
6.				
7.				
8.				
9.				

10.				
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b. Current Activities

The Violence and Injury Prevention Program participates in events throughout the State specifically addressing childhood injuries relating to motor vehicle crashes. The Program continues to distribute educational materials to children and parents regarding the risk of injuries from motor vehicle crashes. The Program partners with other entities whenever possible, to provide resources and skill building to parents, educating them on the necessary preventive measures related to injuries from motor vehicle crashes. In addition, the Program has signed an agreement with a qualified facilitator to begin working on a state plan for violence and injury prevention. It is anticipated that this plan will be completed in 2013.

c. Plan for the Coming Year

The Violence and Injury Prevention Program will continue to partner with other agencies whenever possible in or to develop and implement additional prevention activities. The Program will work closely with Governor's Highway Safety and Emergency Medical Services for Children to distribute materials and provide awareness and education to the public. The Program will also finalize a Violence and Injury Prevention state plan that will be used to prioritize injury prevention programming, and will assist the Program in meeting eligibility requirements for CDC funding under the core injury program.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	35	60	35	35	35
Annual Indicator	32.5	34.0	25.9	26.2	28.1
Numerator	7155	7310	5500	5350	5730
Denominator	22017	21492	21225	20391	20391
Data Source		2008 PRAMS	2010 NIS Breastfeeding Report Card	2011 NIS Breastfeeding Report Card	2012 NIS Breastfeeding Report Card
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	29	29	29	29	29

Notes - 2011

2012 NIS Breastfeeding Report Card

Notes - 2010

2011 NIS Breastfeeding Report Card

Notes - 2009

2010 NIS Breastfeeding Report Card

previously used PRAMS data - mom breastfeeding at 12 weeks

a. Last Year's Accomplishments

The West Virginia Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is dedicated to informing families about the importance of breastfeeding - both as the optimal source of nutrition and for a child's improved growth and development. WIC provides breastfeeding promotion and encouragement for pregnant women who are considering how best to care for their babies. WIC also provides on-going breastfeeding information and support for new mothers after baby has arrived.

WIC is dedicated to building support for the practice of breastfeeding among entire communities - health care providers, employers, neighbors, churches. WIC publishes Breastfeeding Update, a newsletter for health care professionals with clinically useful breastfeeding information. Social marketing research for the WIC Program has shown that support from those in their communities gives women the confidence and pride to begin and continue to breastfeed their children.

While the latest data on breastfeeding indicates that a low percentage of women choose to breastfeed their infants, this should not be taken as an indication of little effort on the part of the State's Bureau for Public Health or, in particular, the Office of Maternal, Child and Family Health (OMCFH). All pregnant women participating in the RFTS Program receive information about the benefits of breastfeeding their infants. RFTS Program DCCs provide comprehensive in-home breastfeeding education and support to prenatal participants through sixty days postpartum and to breastfeeding mothers of eligible infants until their infant reaches age one year.

Educational tools such as videos, DVDs, brochures, The Pregnancy Workshop and medical models were available to RFTS DCCs for use on home visits to promote breastfeeding. A DVD player was used by each RFTS DCC in order to more effectively provide client education in their homes.

RFTS DCCs have had access to the use of standardized step-by-step prenatal curriculum which includes education on breastfeeding. The curriculum is entitled "The Pregnancy Workshop" and "Planning A Healthy Pregnancy" has been available to each DCC at no cost. In 2010, it was decided that the RFTS Program would benefit from more standardized, evidence-based curriculum. Therefore, the OMCFH purchased the evidence-based "Partners for a Healthy Baby" curriculum developed by Florida State University. All RFTS providers were trained on how to use the curriculum in 2011 and it has been implemented statewide.

RFTS Program participants have experienced a fairly steady increase in the number of moms who choose to breastfeed their infants at hospital discharge and those who continue to breastfeed at case closure.

OMCFH is a member of the WV Breastfeeding Alliance (WVBA) which strives to improve the health of West Virginians by working collaboratively to protect, promote, and educate our community about breastfeeding. A one day conference was held in Charleston on May 18, 2012, titled "Connecting the Pieces: Obesity, Diabetes and Breastfeeding". Over 150 healthcare professionals attended the meeting and learned about the link between breastfeeding and the prevention of disease in later life.

The WVBA also recognizes employers annually with the Breastfeeding Employer Recognition Awards. The two (2) categories are Breastfeeding Supportive Worksite and Outstanding Breastfeeding Supportive Worksite. Businesses that qualified as being Breastfeeding Supportive met the basic criteria as outlined in new federal guidelines from the Department of Labor. Businesses that qualified as Outstanding met that minimum criteria, plus offered additional benefits to moms like a place for milk storage, access to an electric breast-pump, etc., and had a policy in place to inform mothers of this option.

RFTS recently purchased laminated handouts that are recommended for used with the evidence-based "Partnering for a Healthy Pregnancy" curriculum currently implemented within the Program. These handouts provide visual clues for the mother to help access the hunger of the infant and feeding adequacy. One of the handouts shows the number of diapers a new breastfeed infant normally has within 24 hours. These will help ease the anxiety of new mother's breastfeeding for the first time and hopefully assure them to continue.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WIC Program strongly supports and promotes breastfeeding.		X		
2. WIC goals include providing additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physicians' practices in order to keep mothers breastfeeding longer.				X
3. WIC increased income guidelines to allow more women, infants and children to qualify.				X
4. RFTS collects data on prenatals who are breastfeeding at hospital discharge, and how many continue to breastfeed at case closure.				X
5. All women participants in RFTS receive benefits of breastfeeding information.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Pregnant RFTS Program participants are encouraged to breastfeed and are educated on health and socioeconomic benefits such as how human milk meets the specific needs of human babies and changes with growth to offer the best combination of nutrients.

Women are educated about the health benefits for themselves associated with breastfeeding including reduction of postpartum blood loss, increased postpartum weight loss with no return of weight once weaning occurs, possible delay of fertility, need for reduced insulin in diabetic mothers, psychological benefits of increased self-confidence and enhanced mother/infant bonding, reduced risk of breast, ovarian and endometrial cancers, reduced risk of osteoporosis and bone fracture.

The social and economic benefits of breastfeeding for families are emphasized by RFTS Program DCCs such as saving several hundred dollars when the cost of breastfeeding is compared to the cost of using formula. Breastfeeding is convenient and safer because breast milk is always available at the correct temperature, is sterile, and requires no mixing.

The RFTS Program encourages collaboration with WIC offices statewide to ensure participants continue to receive breastfeeding education and support after case closure. In 2011, the Program revised the WIC Memorandum of Understanding and continued active involvement with WV WIC in a collaborative strategic planning effort to develop a cross-referral system for service integration and coordination.

c. Plan for the Coming Year

Because children are healthier when they are fed breast milk exclusively for the first six months, WIC continues to encourage fully breastfeeding for that time period. The WIC Program provides for an increased food package to breastfeeding women who use no commercial formulas from WIC.

Trained WIC nutritionists, board-certified lactation consultants and breastfeeding peer counselors are available at all local WIC clinics to help mothers, and entire families, learn how to have a satisfying and healthy breastfeeding experience.

The WIC Program has board-certified lactation consultants on staff to act as breastfeeding information resources in their communities.

The RFTS Program will continue to provide educational materials on breastfeeding such as videos, pamphlets, and literature for DCCs to use during home visits. RFTS DCCs promote breastfeeding with each prenatal participant and provide support and referrals as needed. RFTS will continue to train DCCs on the benefits of breastfeeding and how to encourage participants to try breastfeeding as their choice for infant feeding.

RFTS is committed to increasing breastfeeding rates throughout WV and promoting optimal breastfeeding practices. This goal can be achieved through the existing RFTS Program network by supporting breastfeeding mothers, their families, communities, employers, and health care providers by providing education, training, funding, technical assistance, and research.

Women can be encouraged to breastfeed longer into the postpartum period by being educated to seek assistance from local support groups, other mothers who have successfully breastfed and from their local WIC lactation consultants.

The Director of Perinatal Programs and the RFTS RCCs will continue collaborative efforts with staff of the WV Office of Nutrition Services to ensure that local WIC offices refer clients to the RFTS Program and work effectively with DCCs.

Since each RFTS Program DCC is assigned a DVD player to use for client/family education during home visits, the Program recently purchased educational DVDs that effectively promote breastfeeding. Copies of the DVD entitled "The Baby Care Home Video" in English and Spanish were purchased by the OMCFH in 2009 and assigned to each DCC for use during in home education. The DVD includes information on how to successfully breastfeed and will continue to be used for client education.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	99	99	99	99.1	99.2
Annual Indicator	94.7	99.0	96.1	96.5	97.2
Numerator	20843	21233	20461	20051	20416
Denominator	22017	21443	21299	20781	21001
Data Source		Birth Score Office	Birth Score Office	Birth Score Office	Birth Score Office
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	99.2	99.3	99.3	99.3	99.3

Notes - 2011

2011 WVU Birth Score Data - occurrence births screened before hospital discharge

Notes - 2010

2010 WVU Birth Score Data - occurrence births screened before hospital discharge

Notes - 2009

numerator: 2009 WVU Birth Score Data - occurrence births screened before hospital discharge

a. Last Year's Accomplishments

The OMCFH contracts with the WVU Birth Score Office (BSO) to administer, collect and analyze information/data submitted by delivering facilities. Newborn hearing screening results at WV birthing facilities are collected on the Birth Score Card (BSC), an instrument designed to capture information on infants who may be at risk of developmental delay or death within the first year of life. The BSO has the capability to compare WV Vital Statistics birth records to determine those infants missed for a birth score assessment and hearing screening as well as determining, from data submitted, which infants failed the hearing screen. The BSO provides the initial follow-up for those infants who are not screened or failed a screen at birth. The BSO contacts the parents/guardians of the infant and/or the primary medical provider to facilitate the screening or re-screening of the infant's hearing. If the infant fails the second screening, the BSO sends referrals to the State's Perinatal Program, RFTS, for follow-up.

Comprehensive services for infants and families referred following screening failure are coordinated between the infant's family, medical team, the NHS Coordinator, RFTS and professionals with expertise in hearing loss to assure diagnostic evaluation occurs in a timely manner. Infants identified as having a potential hearing loss begin audiological and medical evaluations before 3 months of age or 3 months after discharge for NICU infants. Infants with hearing loss upon audiological evaluation receive otologic evaluations. The family and child are referred to Ski*Hi, Birth To Three Program (BTT) and Children with Special Health Care Needs (CSHCN) by RFTS DCCs or the primary medical provider. Ski*Hi is funded through the WV Schools for the Deaf and Blind - Ski*Hi Preschool Program. Children ages birth to five who have a documented hearing loss are eligible for Ski*Hi home visits at no cost to the parents. The goal is to identify and provide care to 100% of WV infants needing services.

Since the NHS Project returned to the Division of Perinatal and Women's Health in 2010, the eight region RFTS workforce continued to follow-up with the families of those infants who initially missed or failed screens, through direct referral from the BSO. Each region's registered nurse continued to oversee targeted case management of enrolled clients as well as determine gaps in services. The BSO continued to send monthly prompts to birthing facilities for completion of Birth Score Cards. DCCs mailed introductory letters and brochures discussing hearing follow-up services and other health/social service offerings, when initial contacts could not be made. Each birthing facility validated contact personnel and identified the issues and concerns with screening and referral procedures. NHS Project staff, RFTS and the BSO conducted site visits to offer technical support to address issues and concerns for Project enhancement.

The Newborn Hearing Screening Advisory Committee members selected in 2010 continued to serve and provide valuable input into ways to strengthen the program. Most notably, they provided information to the NHS Coordinator regarding hearing aid loaner banks and the potential benefits/downfalls of creating one in WV. They offered expertise and support to the new NHS Coordinator, hired in November of 2011. The NHS Advisory Committee, NHS Project Coordinator and RFTS discussed options for an initiative which would enable clients to receive screening at a facility close to their residences. It was suggested this would minimize lost to follow-up for those infants who have not been rescreened because of the inability to return to a convenient testing site.

There are 31 birthing facilities in WV. Data from WV Vital Statistics indicate there were 19,752 occurrence births in the State in 2010. Data from the BSO showed a total of 19,187 (97%) of infants screened for hearing loss before discharge from the hospital. A total of 1,364 or 3% of infants were referred to RFTS for follow-up services. Of the RFTS referrals made, 958 or 75% known to have received services from RFTS, reported that tracking was complete.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All WV birthing facilities are required to screen infants for hearing loss before discharge.			X	
2. Infants identified with a hearing loss are referred to the CSHCN Program for assistive devices.		X		
3. OMCFH purchased and maintains diagnostic equipment to assure access/availability as loaner equipment and shared hospital equipment.				X
4. Redesigned and updated NHS website.				X
5. Educational literature is created and distributed to providers and parents.		X		
6. Maintain Advisory Board members per WV state code.				X
7. RFTS DCCS contact families of infants who missed/failed initial screens.	X			
8.				
9.				
10.				

b. Current Activities

The NHS Project is focusing on assuring that 100% of infants born in WV are screened for hearing loss prior to discharge from a birthing facility or within the first month of age. This minimizes the number of infants not screened and decreases the number of cases referred to the BSO and RFTS for follow-up as well as those infants and families lost to follow-up. All thirty-one birthing facilities have a minimum of two trained staff with competence in screening and referral protocols. Border hospitals continue to refer WV newborns to the BSO where all infants not

screened/failed screening are being tracked and referred for follow-up services.

WV resident infants born at home receive a follow-up for screening and referral for audiological services if indicated. The NHS Project created and maintains formal relationships with organizations that support newborn hearing screening activities, such as the WV Speech & Language Association.

The NHS Project is dedicated to ensuring that all infants requiring audiological follow-up and/or intervention receive diagnostic evaluation by 3 months of age and receive intervention services by six months of age when necessary. The NHS Project collaborates with the WV Chapter of the American Academy of Pediatrics, WV Academy of Family Physicians, WV Chapter of the American Medical Association, WVU and Marshall University Schools of Medicine, WV School of Osteopathic Medicine and others to assure that NHS training and education is continuous.

c. Plan for the Coming Year

At minimum, it is anticipated that 90% of early intervention practitioners and RFTS DCCs will receive training in addressing intervention for children with hearing loss. Parent information, letters, brochures and resource guides will be available in 2 languages. The Audiology Service Availability Guide will be updated quarterly and a web-based resource directory will be maintained. All children with hearing loss and their families will be connected with local or regional family-to-family support networks. The OMCFH will collaborate with the Commission for the Deaf & Hard of Hearing to increase capacity of trained interpreters serving in the State. The NHS Project will continue to research and implement specific strategies aimed at reducing the number of WV infants and families who are lost to identification and follow-up care through coordination and collaboration with the NHS Advisory Committee, RFTS, birthing facility personnel, audiologists, Early Intervention/Part C, Children with Special Health Care Needs (CSHCN) and primary care providers. Some strategies that will be considered are, improving the timeliness in the receipt of birth records from Vital Statistics sent to the BSO; discussion of how to improve follow-up in remote areas; scripting a culturally competent message for RFTS to use when contacting the family; and evaluating referral processes to increase the availability of family contact information. The success of these strategies will determine the next steps aimed at reducing the number of infants who are either not screened or lost to follow-up.

Again in 2012, NHS staff, RFTS and the BSO will conduct annual or as needed site visits to the hospitals to discuss compliance issues and review reporting/referral protocols. Through the BSO, NHS will continue to monitor changes in procedure to direct hospital staff to verify contact information and the identity of the primary care provider or clinic for those infants who fail or do not receive an initial hearing screen before discharge from their facility.

The West Virginia NHS Project was one of six state EHDI Programs selected to participate in a Community of Learners (COL) through the National Center for Hearing Assessment and Management (NCHAM) and the National Center for Cultural Competence (NCCC). This COL will focus on Leadership to Advance and Sustain Cultural and Linguistic Competence in EHDI Programs. The NHS Coordinator, staff from the BSO, and a parent of a child who is deaf or hard of hearing will participate in workshops, teleconferences, and webinars throughout the year to learn about implementing cultural and linguistic competence as it relates to the newborn hearing screening project. The COL program is designed to allow participants to learn from each other's experiences as well as from the information provided by the NCCC.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2007	2008	2009	2010	2011
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Performance Data					
Annual Performance Objective	5.7	4.3	4.2	4.5	4.5
Annual Indicator	4.5	4.5	5.0	5.0	4.7
Numerator	19057	19057	21300	21300	20000
Denominator	427879	427879	427879	427879	427879
Data Source		2008 CHIP Annual Report	2009 CHIP Annual Report	2010 CHIP Annual Report	2011 CHIP Annual Report
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	4.5	4.5	4.5	4.5	4.5

Notes - 2011

2011CHIP Annual Report: The 4.65% uninsured total number for children in lower income (=250% FPL) households is an estimate from the most current (2009) US Census Current Population Survey. This data is based on two year rolling averages.

Notes - 2010

CHIP 2010 Annual Report

Note 1: The most recent estimate for all uninsured children statewide from the U.S. Census Current Population Survey is from 6.3% to 5%. Even a five percent extrapolation at the county level may vary significantly from county to county depending on the availability of employee sponsored insurance. However, it remains our best gross estimate of the remaining uninsured children.

Note 2: It has been estimated that 7 of 10 uninsured children qualify or may have qualified for CHIP or Medicaid in the past, WVCHIP uses the lower estimated limit of 5% as a target number for outreach due to the way census sampling is likely to overstate this rate.

Notes - 2009

Note 1: The most recent estimate for all uninsured children statewide from the U.S. Census Current Population Survey is from 6.3% to 5%. Even a five percent extrapolation at the county level may vary significantly from county to county depending on the availability of employee sponsored insurance. However, it remains our best gross estimate of the remaining uninsured children.

Note 2: It has been estimated that 7 of 10 uninsured children qualify or may have qualified for CHIP or Medicaid in the past, WVCHIP uses the lower estimated limit of 5% as a target number for outreach due to the way census sampling is likely to overstate this rate.

a. Last Year's Accomplishments

WVCHIP submitted a state plan amendment to increase program eligibility to 300% of the Federal Poverty Level (FPL). The program continued its monitoring and analysis of eligibility and enrollment information transfers among its various partners. This work culminated with changes to the WVCHIP Premium group that allow premium paying families to enroll in the program back to the month of application and also provided them with an option to make payments online.

WVCHIP changed its eligibility re-determination process from requiring a full-application every other year to a passive renewal process every year. This change took place in partnership with the state's Medicaid program.

This year at WVCHIP was a very active one involving implementation of some significant program changes. The reauthorization of the CHIP program, passed in February 2009, mandates that WVCHIP change its methodology used to pay Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Historically, WVCHIP reimbursed FQHCs and RHCs for services using the same fee-for-service methodology as for other providers. CHIPRA requires States to include dental coverage in their CHIP benefit packages. States must offer a dental benefit that is equivalent to one of the following: the children's coverage that is provided in the Federal Employees Health Benefits Program ("FEHBP"), state employee dependent dental coverage, or dental coverage that is offered through the commercial dental plan in the State with the highest non-Medicaid enrollment. WVCHIP is required to cover Orthodontic, Prosthodontic, and Periodontic services under CHIPRA.

CHIPRA allows States for the first time to offer dental coverage to children who are enrolled in private or job-based plans that do not include dental coverage. As long as these children are otherwise eligible for CHIP, States can enroll them in CHIP exclusively for dental coverage.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State leaders promote SCHIP and increasing enrollment.				X
2. WVCHIP approved expansion of eligibility to 300% FPL.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In compliance with CHIPRA's requirements, the benefit design for coverages over 200% FPL changed effective July 1, 2009. Dental services for this group were limited to preventative services and subject to a maximum of \$150 per year. The new dental benefit includes both preventative and restoration services. Services including all restoration, space maintainers, endodontics, prosthodontics, implants, dental surgeries and periodontics are subject to a co-payment of \$25 per service and are capped at \$100 per year.

c. Plan for the Coming Year

West Virginia has become one of the most successful states in enrolling children in CHIP and Medicaid. More than 95% of the state's children now have health coverage. The increase in enrollment of children in both CHIP and Medicaid has been the result, in part, of the efforts of a public/private partnership between the WV Healthy Kids Coalition, primary care centers, Family Resource Networks, state government, and private and public funds. For the last four years, the WV Healthy Kids Coalition has conducted community-based outreach for CHIP and Medicaid through the placement of outreach coordinators who serve each of the state's 55 counties from 49 locations. Since the inception of this program, more than 40,000 children have been enrolled in CHIP and more than 5,000 children have been enrolled in Medicaid via the CHIP application. To maintain and even improve upon this high level of enrollment the State must continue this

effective outreach and enrollment effort and explore the recommendations from advocate groups for affordable health coverage.

Given the above, the primary issues are assuring that the state has sufficient medical capacity to meet the demand and secondly, creating a demand for care by educating would-be consumers on the importance of receiving basic primary, preventive health care. In order to determine why patients aren't using the health services now that they have health care financing, OMCFH plans to survey families and providers about issues of accessing care.

The Office of Maternal Child and Family Health will continue to support West Virginia CHIP and Medicaid in enrollment of children and assuring access to health care.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	24	23	25	28	28
Annual Indicator	24.0	27.4	28.1	29.9	30.3
Numerator	4938	5169	5407	4943	4883
Denominator	20556	18835	19266	16559	16124
Data Source		2008 WIC Data	2009 WIC Data	2010 WIC Data	2011 WIC Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	30	30	30	30	30

Notes - 2011

2011 WIC data

Notes - 2010

2010 WIC data

Notes - 2009

2009 WIC data

a. Last Year's Accomplishments

Budgeting for families, Sesame Street's Healthy Habits for Life multimedia outreach kits, are distributed to WIC families. The kit consists of an original DVD and storybook starring the Sesame Street Muppets, featuring "The Get Healthy Now Show" that encourages parents with the help of their friends, to explore ways to eat and drink so they can play, learn, and grow up healthy. It also includes a guide for parents and caregivers that contain strategies and hands-on activities for everyday and on the go using their food dollar wisely.

The WV WIC program has developed and implemented online nutrition education. The purpose of the website is to help WIC participants learn more about feeding their child such as providing

regular meals and snacks, working with picky eaters, creating a positive eating environment, and the roles of the parent and the child in the feeding relationship.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC supports healthy nutrition and breastfeeding.	X			
2. WIC increased income guidelines to allow more women, infants and children to qualify.		X		
3. Since 1974, WIC has combated childhood hunger, low birth weight, under-nutrition, and iron deficiency anemia so that WIC participants have better health outcomes.		X		
4. New WIC food choices encourage breastfeeding and support infant feeding practices recommended by the American Academy of Pediatrics.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

WIC participants receive individual and group nutrition education, breastfeeding support, referrals to health care providers, assistance with making healthy lifestyle choices, and help with immunizations. The Special Supplemental Nutrition Program for Women, Infants and Children provides participants with certain healthy foods for free, and offers assistance in planning low-cost healthy meals that include foods high in essential nutrients and vitamins.

State staff have started training local agency vendor liaisons, community outreach liaisons, nutritionists and outreach coordinators through face-to-face visits to authorized vendors. The training and technical assistance have the goal of developing a store specific product list that serves as a reference for cashiers and a participant education tool. In addition, shelf tagging while simultaneously correcting the store computer system offers the ability to facilitate change quickly. This method also allows a direct, hands-on teaching approach for vendors as well as WIC staff in gaining understanding in how the shopping experience can be overwhelming to WIC participants.

c. Plan for the Coming Year

WV WIC continues to partner with the WV Nutrition Network and the Pick A Better Snack promotion. Implementation of the expanded WIC Food Packages will continue to present opportunities to reinforce nutrition messages. Partnership with the National Dairy Council to promote Low Fat Dairy by distribution of Dairy Council Nutrition Education Information and Materials. WV WIC State Office developed a handout about low fat milk-why low fat milk is offered, tips on gradually weaning to lower fat milk and then to skim milk and will continue to use this handout.

Bulletin boards and displays for the clinic and in the community will promote trying a new food. The State Agency will develop nutrition topic tool open discussion questions as an additional resource for promoting trying a new food. Operational assistance funds will be requested to support cooking demonstrations and taste testing during these sessions.

WIC will promote the nutrition message of building a healthy plate.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	27	26	26	28	27
Annual Indicator	30.0	28.7	28.9	30.5	30.5
Numerator	6595	6165	6140	6220	6220
Denominator	22017	21492	21225	20391	20391
Data Source		2008 PRAMS	2009 PRAMS	2010 PRAMS	based upon 2010 PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	30	30	30	30	30

Notes - 2011

based upon 2010 PRAMS

Notes - 2010

2010 PRAMS data

Notes - 2009

2009 PRAMS data

a. Last Year's Accomplishments

WV has the highest smoking rate for pregnant women in the United States. Data from the WV Health Statistics Center show that the rate of smoking during pregnancy in WV for 2009 was 27.3% and WV PRAMS data show 28.9% of maternal smoking during pregnancy. Preliminary 2010 Health Statistics data show the rate may have decreased to 26.2% however WV PRAMS data reveal an increase in maternal smoking at 30.5%.

Data collected by the RFTS Program in 2011 show 38% of pregnant participants had Carbon Monoxide (CO) confirmed rates consistent with that of a smoker. In response WV continued to provide Smoking Cessation Reduction In Pregnancy Treatment services, the intensive smoking cessation initiative. Educational tools such as videos, CO Breathalyzers, smoking cessation guides and smoking cessation literature were available for use during home visits. Additional CO Breathalyzers and supplies along with smoking cessation DVDs, guides and literature were purchased using WV Division of Tobacco Prevention funding in 2011. A portable DVD player is assigned to each DCC to use to provide more effective client education during home visits.

SCRIPT in-service/updates were provided at least one time to each of the eight regions during 2011 by the SCRIPT Coordinator or Regional Care Coordinator.

RFTS utilizes three forms to collect client smoking information; the Tobacco Screening, SCRIPT Intervention and Follow-Up Forms. Data from these forms are entered into the RFTS Electronic Data System (EDS). An additional data quality assurance review began in July 2009 and continued through 2011. The WV SCRIPT Coordinator and George Washington University (GWU) Research Assistant completed quarterly SCRIPT data resolution to assure accurate SCRIPT data collection in both the RFTS EDS and the GWU Teleform System.

During 2011 the RFTS SCRIPT Project continued to collaborate with the WV Division of Tobacco Prevention and the WV Tobacco Quitline to increase Quitline referral, utilization and ultimately, cessation outcomes. In 2010 the WV Tobacco Quitline enrolled 7,976 participants; 233 of these participants were pregnant women. Of the enrolled pregnant women, 89 were Medicaid insured (38.1%). During 2011 the WV Tobacco Quitline enrolled 8,074 participants and 269 of these participants were pregnant women. Of the 269 pregnant women enrolled, 91 were Medicaid insured (33.8%). In 2010, 13 pregnant women enrolled in the Quitline were referred from RFTS and in 2011 the number increased to 22.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented the Smoking Cessation Program (SCRIPT) in January, 2002 and is ongoing.				X
2. WV SCRIPT uses the existing home visitation network and protocols in the RFTS Program.				X
3. Information about negative effects of smoking during pregnancy is distributed to all women.			X	
4. SCRIPT is provided to all willing RFTS/HAPI participants.		X		
5. Smoking information is collected in on all RFTS participants				X
6. All RFTS smokers/former smokers are offered CO Testing		X		
7. State government maintains Tobacco Quit Line.				X
8.				
9.				
10.				

b. Current Activities

Ongoing SCRIPT education continues statewide for Designated Care Coordinator providers during 2011-2012. All RFTS Regional Care Coordinators receive monthly training and updates and provide quarterly mandatory group and/or individual training sessions to DCCs. The RFTS Project Coordinator continues to attend regional DCC trainings to provide SCRIPT updates.

The virtual training CD, "Smoking Cessation for Pregnancy and Beyond-Learn Proven Strategies to Help Your Patients Quit", continues to be used as part of the training curriculum, for both new and existing DCCs. A new, revised version of the virtual training has been purchased. All DCCs will have a license and the training will be available through the RFTS website as part of the training curriculum.

The RFTS Program continues to work closely with the WV Division of Tobacco Prevention and WV Tobacco Quitline. All pregnant women who are smoking are provided with information regarding services through the Quitline. Referrals are completed by the DCCs for any RFTS client requesting Quitline services. The Quitline may be used in conjunction with RFTS services if

the pregnant woman chooses both interventions.

c. Plan for the Coming Year

The foundation has been laid in WV for an effective statewide initiative to continue reductions in the number of pregnant smokers. Although RFTS SCRIPT provides smoking cessation education to numerous low income pregnant women and their families, more than half of WV pregnant women are eligible for this support and for public assistance.

The RFTS Program will continue to provide smoking cessation education and support to pregnant women and their families on the dangers of smoking during pregnancy and the importance of maintaining a smoke free environment. Designated Care Coordinators will continue to use the 5 A's best practice method and a CO monitor to provide a visual message of the dangers of smoking during pregnancy.

In 2011 funding for the SCRIPT Project provided by George Washington University through the National Cancer Institute, 2007-2011, ended. Institutionalization of SCRIPT into the RFTS Program has been achieved. The study results provide valid, empirical evidence that an additional proportion of women, even very late in pregnancy, can be helped by trained nurses and social workers to change their smoking behavior.

RFTS DCCs will continue to receive education on the proper use of SCRIPT resources and service delivery methods to enhance, support and facilitate therapeutic relationships between providers and RFTS mothers desiring to quit or reduce smoking.

Ongoing research continues for new smoking cessation and environmental tobacco smoke exposure educational materials and resources for use in the Program. Resources in the newly purchased "Partners for a Healthy Baby" Curriculum will be utilized. New CO Breathalyzers and accessories will be purchased in the upcoming year to replace older CO units.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	7	7.5	6.5	8	8
Annual Indicator	7.7	9.4	9.3	8.3	8.3
Numerator	9	11	11	10	10
Denominator	117478	116745	117968	120092	120092
Data Source		2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	based upon 2010 Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	8	8	8	8	8

Notes - 2011

Based upon 2010 Vital Statistics

Notes - 2010

2010 Vital Statistics

Notes - 2009

2009 Vital Statistics

a. Last Year's Accomplishments

Along with the West Virginia Council for the Prevention of Suicide and the Adolescent Suicide Prevention Education and Intervention Program (ASPEN), the Violence and Injury Prevention Program developed an educational campaign on suicide prevention. A 60-second Public Service Announcement was played all over the State and increased the awareness of the warning signs of depression and suicide and where individuals can seek help.

The Violence and Injury Prevention Program, the WV Council for the Prevention of Suicide, and the ASPEN Program sponsored a Statewide Suicide Prevention Conference. National experts spoke on the issues of substance abuse, suicide, bullying, and mental health. Over 200 participants attended from across the State.

The Adolescent Health Initiative partnered with several county Family Resource Networks to develop and offer workshops on the topic of teen depression and suicide. The AHI also received training for confronting people who are exhibiting signs of depression, particularly those in military families.

The topic of teen suicide, bullying and cyber bullying received national media attention this past year. The Adolescent Health Initiative provided several workshops across the state on bullying, relational aggression and cyber bullying, including information on the legal impacts of "sexting" and distributing teen pornographic material.

The AHI participated in over sixty activities to include;

- Sponsored a Teen Depression/Teen Suicide forum in Wood County, WV;
- Helped coordinate the Building Bridges of Respect Conference in Beckley, WV;
- Partnered with the Contemporary Youth Arts Company to provide plays with cyber bullying prevention themes;
- Coordinated a Bullying Prevention Workshop featuring best-selling author and international speaker Jodee Blanco;
- Sponsored the social networking workshop, "The Good, The Bad and the Ugly", featuring retired police chief, Jim Holler;
- Provided a workshop at the WV National Social Workers Conference entitled, "Helping Parents Deal with the New Sexualized World";
- Provided a presentation at the National Conference on Girl Bullying and Relational Aggression in Las Vegas, NV;
- Hosted the 22nd Annual Region VIII Adolescent Health Spring Conference featuring Dr. David Walsh presenting "How to Thrive in a YouTube World";

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. The OMCFH's Adolescent Health Initiative provides community based skill building opportunities regarding adolescent at-risk behaviors.		X		
2. The EPSDT screen contains a behavior assessment instrument used for age 10 and above.				X
3. The WV Council for the Prevention of Suicide is offering workshops across the state on how to recognize the early signs of depression.				X
4. The Council has completed a five year strategic plan for suicide prevention in WV.				X
5. The Council has had 4 suicide assessment instruments published in the book "Innovations in Clinical Practice".				X
6. Adolescent Health Initiative offers workshops on parent-child communication.		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Violence and Injury Prevention Program continues to distribute educational materials and resources in order to raise awareness on the growing problem of adolescent bullying as it relates to suicide. The WV Council for the Prevention of Suicide continues to provide support to suicide survivors, promote support for suicide prevention, and improve public awareness and understanding of suicide. In addition, the Program is working on a new media campaign that will specifically address bullying and its consequences. The AHI continues to seek educational opportunities to provide awareness to the issue of teen depression and suicide. The AHI continues to promote the developmental assets model which encourages parent and community involvement and increases self-esteem in youth.

In March, 2012, Gov. Tomblin signed a suicide prevention bill into law and WV became the seventh state to enact a law aimed at preventing suicides among young people, known as the Jason Flatt Act of 2012. The Act aims to make sure that principals, teachers and other educators are trained to recognize the warning signs of suicide and reach out to students in crisis.

c. Plan for the Coming Year

The Violence and Injury Prevention Program plans to partner with the WV Council for the Prevention of Suicide and the ASPEN program in the development of suicide crisis teams that will be available throughout the State to respond to individuals displaying signs of depression and/or thoughts of suicide. The Violence and Injury Prevention Program will also be working with the Bureau for Behavioral Health and Health Facilities to continue funding the ASPEN program, as its funds will expire in September, 2012.

The Adolescent Health Initiative will continue to educate schools, parents, youth and communities on bullying, cyber bullying, teen dating violence, youth depression and correlating risk behaviors such as substance abuse and sexual promiscuity. The AHI will also provide trainings to help adults recognize signs that a teen is contemplating suicide and provide resources for assistance.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	98	98	90	92	65
Annual Indicator	82.9	65.6	62.1	64.8	64.8
Numerator	248	200	195	175	175
Denominator	299	305	314	270	270
Data Source		2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	based upon 2010 Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	65	65	65	65	65

Notes - 2011

based upon 2010 Vital Statistics - calculated on resident births in WV facilities (WVU, CAMC, Cabell-Huntington)

Notes - 2010

2010 Vital Statistics - calculated on resident births in WV facilities (WVU, CAMC, Cabell-Huntington)

Notes - 2009

2009 Vital Statistics - calculated on resident births in WV facilities (WVU, CAMC, Cabell-Huntington)

a. Last Year's Accomplishments

In WV, three hospitals, Cabell-Huntington Hospital, Charleston Area Medical Center, and WVU, provide NICU care. As a result of collaborative efforts among WV providers, bed increases were gained at both WVU and Cabell-Huntington Hospitals. WVU Children's Hospital now houses 39 NICU beds, which is an increase of nine beds and Cabell-Huntington provides 36 NICU beds.

At the Perinatal Transport Summit, nurse managers from around WV requested a consistent set of transport guidelines from the three tertiary care centers. The WV Perinatal Partnership collaborated with the WV State Trauma and Emergency Medical System in an attempt to establish a single hotline that would be available for perinatal providers to call to get current information, thereby saving precious time if the provider's usual referral center is not accepting transports. Although there was not a central hotline established, hotlines were established at each of the three WV tertiary care centers for the transport of a sick mother or a high-risk newborn. Guidelines for maternal and infant transport were developed by the Perinatal Partnership Transport Guidelines Committee and are available on the Perinatal Partnership website. The Perinatal Partnership developed these guidelines in response to a need expressed by nurse managers from around the state and they were last updated 03/16/2010. Collaborative

efforts are ongoing to establish a single statewide hotline.

C-sections and labor inductions have increased dramatically in the United States. West Virginia has higher rates than the rest of the nation. Concerned that many of these inductions and C-sections are not medically necessary and may be resulting in avoidable negative birth outcomes, the West Virginia Health Care Authority, in partnership with the West Virginia Perinatal Partnership and the West Virginia March of Dimes, developed and implemented a collaborative to study and address the issue. The six month project engaged 14 of the state's 30 hospitals that deliver babies. The participating hospitals represented 70% of the total deliveries in the state. Six months after the implementation of the Collaborative, the rate of elective deliveries prior to 39 weeks without a medical indication had decreased by more than 50%. One year after the completion of the Collaborative, the reduction has been maintained. A report summarizing the collaborative is available on the Perinatal Partnership website.

Universal Maternal Risk Screening is conducted at the first prenatal appointment on all West Virginia women. This screening provides a picture for the maternity care provider on the risks associated with this pregnancy. The instrument used, Pregnancy Risk Screening Instrument, is then sent to the Office of Maternal, Child and Family Health where the data is stored, analyzed and reported to the Maternal Risk Screening Advisory Committee. Implemented in January 2011, one full year of maternal risk data has now been received. The data is being used to form public policy and practice changes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OMCFH advocates that all pregnant women be screened for medical risk conditions so that high risk patient care can be planned.				X
2. OMCFH fiscally supports training teams to encourage early screening and referral.				X
3. Legislation mandating high-risk screening of pregnant women.				X
4. Screening tool developed by Advisory and implemented in January 2011.				X
5. RFTS protocols support high risk patient deliveries at tertiary care.				X
6. Perinatal Partnership advocated for additional NICU beds at tertiary care hospitals. Additional beds were added.				X
7.				
8.				
9.				
10.				

b. Current Activities

Eight RFTS RCCs make regular visits to OB and pediatric providers in each region to recruit providers to assure WV high risk pregnant women and infants have access to early and adequate health care.

The WV Perinatal Partnership is collaborating with the WV State Trauma and Emergency Medical System to make a hotline available that perinatal providers can call to get current information, thereby saving precious time if the provider's usual referral center is not accepting transports. Callers to the hotline can not only find a bed but also be connected immediately with a specialist at the referral center for immediate consultation. The target date for activating the hotline is July

31, 2011.

In 2011, WV OBs were mandated by the legislature to complete a Prenatal Risk Screening Instrument (PRSI) on all pregnant women at the first prenatal visit.

c. Plan for the Coming Year

Early recognition and transfer of high-risk pregnant women and sick newborns to facilities with adequate diagnosis and treatment expertise is essential to reduce neonatal mortality rates. When West Virginia perinatal providers were surveyed, they called for a more coordinated, statewide approach to ensuring that appropriate maternal and infant transport is available around the clock. A transport committee was created within the WV Perinatal Partnership to assess needs and to develop transport guidelines and implementing the emergency transport system. Key findings of the committee revealed that West Virginia needed to improve the emergency transport system for high risk mothers and babies. Surveys of small hospitals showed that they were not always able to get these mothers and babies to one of the state's three Neonatal Intensive Care Units (NICUs). The contents of the guidelines include preparation for maternal-fetal transport, maternal transport checklist, maternal transport equipment, specific stabilization requirements and maternal transport notes. The guidelines may be downloaded from the Perinatal Partnership website.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	89	90	90	83	82
Annual Indicator	82.0	79.1	80.0	83.1	83.1
Numerator	18060	17001	16938	15963	15963
Denominator	22017	21492	21162	19199	19199
Data Source		2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	based upon 2010 Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	84	84	84	84	84

Notes - 2011

Based upon 2010 Vital Statistics
denominator excludes unknown prenatal care

Notes - 2010

2010 Vital Statistics
denominator excludes unknown prenatal care

Notes - 2009

2009 Vital Statistics

a. Last Year's Accomplishments

Since the RFTS Program was first initiated in 1989 and has built a strong network, West Virginia's access to first trimester prenatal care rate has improved from 60-70% in the 1980s to 82.1% in 2009. WV Vital Statistics data show a preliminary rate of 83.1% for women who began prenatal care in the first trimester in 2010.

In 2006, the RFTS Program initiated an automated system of sending out invitation letters to all Medicaid eligible pregnant women and infants and this continued in 2011. The reason for this process is to assure that all eligible pregnant women and infants receive an invitation letter and have the opportunity to access early health care through the support of the RFTS Program provider network that has existed in WV since 1989.

In 2009, HB 2837 established an advisory council within the WV DHHR, Office of Maternal, Child and Family Health to provide assistance in the development of a uniform maternal risk screening tool. The WV Maternal Risk Screening Advisory Committee agreed to adapt the OMCFH, RFTS Program's Prenatal Risk Screening Instrument, which had been widely used by numerous OB providers throughout the State for years. Members wanted to keep the form simple, one page, user-friendly and electronically compatible.

Implementation of this new process was effective on January 1, 2011 and is fully operational statewide with OMCFH receiving forms daily from providers. Prenatal care providers are required to complete a PRSI on all WV women on their initial obstetrical visit regardless of payment source. Providers must notify the woman of any identified high-risk condition and provide referrals as necessary. All information submitted is confidential and will not be released or disclosed for any reason other than data analysis of at-risk/high-risk pregnancies and planning purposes by public health officials.

In 2011 providers submitted 3,403 completed PRSIs to the RFTS Program as referrals for pregnant women who were potentially eligible to receive in-home targeted case management services. Preliminary data collected from 75% of the PRSIs reveal 76% of the women accessed first trimester prenatal care, an increase from 72% in 2010. The WV PRSI will continue to serve as a referral source to the RFTS Program for low income, government-sponsored pregnant women.

Once the PRSI is received by the RFTS Regional Care Coordinator, the client is referred to a DCC in the local community immediately for the initiation of care coordination services which includes assistance with access to early and adequate prenatal care.

In 2009, the OMCFH Division of Research, Evaluation and Planning provided a comprehensive report "WV Resident Births: Trimester Prenatal Care Began Study" using data obtained from WV Vital Statistics 1998-2008. Upon review of the data, it is of concern that the overall percent of access to 1st trimester care in WV decreased from 86.0% in 2002 to 80.8% in 2008, however, WV Vital Statistics data show a preliminary rate of 83.1% of women began prenatal care in the first trimester in 2010.

During the visits to maternity care providers, the RCCs also promote the availability of Maternity Services, Presumptive Eligibility. Many clients have stated the waiting on a Medicaid card is their barrier to early prenatal care. OMCFH provides Presumptive Eligibility for the first prenatal visit while the client is waiting for a Medicaid card.

As of July 1, 2012, WV Bureau for Medical Services, Medicaid Program no longer requires proof of pregnancy to be eligible to apply for pregnancy Medicaid. This removes a visit to a healthcare facility to receive documentation of pregnancy and then applying for Medicaid. Removing the required documentation should allow earlier access to prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Free pregnancy testing is available at sites statewide.			X	
2. Women who have a positive pregnancy test are assisted with securing health care coverage.		X		
3. Adolescents age 19 years and under are automatically eligible for OMCFH financial assistance under RFTS.		X		X
4. Early prenatal care is strongly encouraged and supported through all family planning efforts.				X
5. OMCFH partners with the March of Dimes to provide education targeting early prenatal care.			X	
6. OMCFH partners with the local DHHRs to encourage referral of pregnant women who are denied Medicaid coverage for obstetrical care services.		X		
7. RFTS receives a monthly print out sent electronically from Medicaid of those women who were denied Medicaid coverage during pregnancy. RFTS notifies the person by phone and/or letter of OMCFH available services.		X		
8.				
9.				
10.				

b. Current Activities

In 2011 providers submitted 11,082 PRSIs and of these 3,403 were referred to RFTS as potentially eligible to receive in-home targeted case management services. Preliminary data collected from 75% of the PRSIs reveal 76% of the women accessed first trimester prenatal care, an increase from 72% in 2010. The WV PRSI will continue to serve as a referral source to the RFTS Program for low income, government-sponsored pregnant women as well as to other home visitation programs across the State.

The Family Planning Program (FPP) is encouraging all providers to discuss a reproductive health plan with their clients of childbearing age. Starting the discussion before a pregnancy encourages the client to obtain optimal health before conception and to think about pregnancy spacing. FPP offers free or low cost pregnancy testing and provides referrals into prenatal care as needed.

c. Plan for the Coming Year

In 2012 the OMCFH plans to implement the use of Teleform technology for the new WV PRSI process which scans data from forms into a file which is then copied to the PRSI web-based data system. This technology minimizes data entry errors and possibilities for infractions with Personally Identifiable Information.

The OMCFH recently hired a full time epidemiologist who provided a preliminary statewide statistical report for the Advisory Committee to review and discuss.

As a result of combined efforts of the OMCFH and the Maternal Risk Advisory Committee members, WV now has the capacity to quickly and effectively risk screen pregnant women and

will have strong data to drive future practice decisions.

ASTHO/March of Dimes Partnership - OMCFH is working with West Virginia March of Dimes as part of the ASTHO partnership with the March of Dimes to address the President's challenge of reducing premature births by 8% by 2014. Plans are underway to co-brand March of Dimes public service announcements in a statewide public health education campaign.

OMCFH is part of the workgroup within Bureau for Medical Services, Medicaid Program to prepare an application for the Strong Start for Mothers and Newborns funding opportunity. The WV BMS application is focusing on the Maternity Care Homes approach to improve perinatal outcomes for women enrolled in Medicaid who are at high-risk for adverse pregnancy outcomes. Intervention to address the behavioral and socio-economic dimensions of women's lives may successfully prevent preterm births. Non-medical prenatal interventions are believed to reduce the rates of preterm births for these women.

A Healthy Moms, Healthy Baby media campaign has been implemented by OMCFH to address health in preconception, pregnancy, postpartum and infant stages. The campaign is being implemented in three stages and the first two have been released. Development of the last phase will begin in the near future. All three phase will be used together to address the needs of the client depending on where they may be along the cycle. This is a population based educational media campaign to reach all persons of childbearing age.

D. State Performance Measures

State Performance Measure 1: *Decrease the percentage of pregnant women who smoke in the last three months of their pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	23	22	21	20	25
Annual Indicator	30.0	28.7	28.9	30.5	30.5
Numerator	6595	6165	6140	6220	6220
Denominator	22017	21492	21225	20391	20391
Data Source		2008 PRAMS	2009 PRAMS	2010 PRAMS	based upon 2010 PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	30	30	30	30	30

Notes - 2011

based upon 2010 PRAMS data - mom smoked last 3 months of pregnancy

Notes - 2010

2010 PRAMS data - mom smoked last 3 months of pregnancy

Notes - 2009

2009 PRAMS data - mom smoked last 3 months of pregnancy

a. Last Year's Accomplishments

WV has one of the highest smoking rate for pregnant women in the United States. WV PRAMS data show that the overall rate of smoking during pregnancy for 2010 was 30%. Alarming rates of 42.7% for the Medicaid insured mothers smoked during pregnancy while 9.7% of the Non-Medicaid insured women reported smoking during pregnancy.

Preliminary data from the WV Health Statistics Center show that the rate of smoking during pregnancy in WV for 2009 was 27.3%. Preliminary 2010 data show the rate may have decreased to 26.2%. Data collected by the Program in 2011 show 38% of pregnant participants had Carbon Monoxide confirmed rates consistent with that of a smoker. In response WV continued to provide SCRIPT services, the intensive smoking cessation initiative.

According to the WV Birth Score, among the 20,833 mothers who provided data for CY 2011, 5,520 (26%) reported using tobacco. Of the 1,739 women enrolled in RFTS in 2011 who had a tobacco screen completed, 707 (40%) were CO confirmed tobacco users. This creates an enormous health problem for the State of WV which affects not only the developing infant but the pregnant woman, her children, and other exposed family and friends, as well as the health care community. To address this issue, RFTS continued to implement the intense smoking cessation initiative, SCRIPT, developed by Dr. Richard Windsor, MS, PhD, MPH, with George Washington University Medical Center, Department of Prevention and Community Health, who successfully implemented SCRIPT in Alabama.

Educational tools such as videos, CO Breathalyzers and smoking cessation guides were available for use during home visits. Additional CO Breathalyzers and supplies along with smoking cessation DVDs, guides and literature were purchased using WV Division of Tobacco Prevention funding in 2011. A DVD player has been assigned to each DCC to use during home visiting sessions to educate pregnant smokers on the risks of tobacco use, secondhand smoke exposure and smoking cessation.

The RFTS Coordinator is an active participant on the WV DTP's Tobacco Free Pregnancy Advisory Council. The Coordinator participated in four meetings during 2011. The TFPAC consists of partners, both private and public stakeholders, dedicated in identifying strategies to reduce the incidence of smoking during pregnancy in WV.

RFTS Regional Care Coordinators (RCCs) provided SCRIPT education to obstetrical care service providers in each region and encouraged them to refer their pregnant smokers for SCRIPT services available through RFTS.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Smoking Cessation Program (SCRIPT) implemented in January 2002 and is ongoing.				X
2. The WV SCRIPT uses the existing home visitation network and protocols in the RFTS Project.				X
3. All pregnant RFTS smokers/former smokers are offered CO Testing and Smoking Cessation.		X		
4. SCRIPT mandated to be offered to all RFTS/HAPI participants.				X
5. Information collected on smoking in RFTS participants.				X
6. PRAMS data is used to report smoking in last three months of				X

pregnancy.				
7. The negative effects of smoking during pregnancy are distributed universally.			X	
8. State government maintains Tobacco Quit Line.				X
9.				
10.				

b. Current Activities

Collaborative efforts continue with Dr. Richard Windsor, MS, PhD, MPH, SCRIPT Principal Investigator, and WV agencies that have interest in smoking cessation among pregnant women. The SCRIPT grant received in 2007 ended July 31, 2011. The study results provide valid, empirical evidence that an additional proportion of women, even very late in pregnancy, can be helped by trained nurses and social workers to change their smoking behavior. Institutionalization of SCRIPT into the RFTS Program has been achieved.

The RFTS Program continues to collaborate with the WV Tobacco Quitline. All pregnant women who smoking are provided information regarding services through the Quitline. Referrals are completed by the DCCs for any RFTS client requesting Quitline services. The Quitline may be used in conjunction with RFTS services if the pregnant woman chooses both interventions.

A new virtual CD training has been purchased "Smoking Cessation for Pregnancy and Beyond". Each DCC will have a license for the training and it will be available through the RFTS website. The virtual training will be a part of the training curriculum, for both new and existing DCCs.

An excellent online program for provider training on smoking cessation during pregnancy developed by Marshall University continues to be promoted. This program is consistent with the US PHS 2008 Guidelines: "Treating Tobacco Use and Dependence".

c. Plan for the Coming Year

The foundation has been laid in WV for an effective statewide initiative to promote the reduction in the number of pregnant smokers. Although the WV RFTS SCRIPT Project provides smoking cessation education to numerous low income pregnant women and their families, more than half of WV pregnant women are eligible for this support and for public assistance. RFTS expects to be effective to additional WV populations as education filters into other socioeconomic subsets due to the interdependent nature of rural Appalachian families.

The RFTS Program will continue to collaborate with the WV Tobacco Quitline. The Quitline offers nicotine replacement therapy (NRT) options, free of charge, to pregnant women with a physician's order. NRT products are also available to family members living in the home of the pregnant woman. RFTS DCCs will continue to provide pregnant RFTS clients with information regarding services available through the Quitline. DCCs will also make referrals for any RFTS client requesting Quitline services.

The RFTS Program will continue to educate pregnant women and their families on the dangers of smoking during pregnancy and the importance of maintaining a smoke free environment as the DCCs continue to make home visits and use the 5 A's best practice method for smoking cessation during pregnancy. The DCCs will continue using a carbon monoxide monitor to provide a visual message of the dangers of smoking during pregnancy.

The RFTS SCRIPT Project will continue to collaborate with the WV DTP. The RFTS State Program Coordinator will continue to participate on the Tobacco Free Pregnancy Advisory Council (TFPAC). In 2011 RFTS partnered with DTP on the development of a DVD that addresses the risks of smoking during pregnancy. The DVD titled "Mommy Quit for Me" has been completed and a specific website for the distribution of the "Mommy Quit for Me" video and collateral materials is now available.

Utilizing funding provided by the WV DTP, educational tools such as videos, CO Breathalyzers/accessories, smoking cessation guides and smoking cessation incentives will be purchased for DCCs to use during home visits.

State Performance Measure 2: *Increase the percentage of the state's children <18 who are Medicaid beneficiaries who have at least one preventive dental service in a 12-month period.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	90	90	92	92	42
Annual Indicator	89.6	38.1	40.4	38.6	37.1
Numerator	233427	74326	81199	84742	82009
Denominator	260614	194998	201013	219576	221328
Data Source		CMS-416 Fiscal Year 2008 Annual Report	CMS 416 Fiscal Year 2009	CMS 416 Fiscal Year 2010	CMS 416 Fiscal Year 2011
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	38	38	38	38	38

Notes - 2011

CMS-416 Fiscal Year 2011 Annual Report, 12b Preventive Dental Services

This measure was changed from "Increase the percentage of the state's children <18 who are Medicaid beneficiaries who have at least one primary care visit in a 12-month period" to "have at least one preventive dental service in a 12-month period". Data for 06 and 07 reflect the percentage of those children who were Medicaid beneficiaries who received at least one primary care visit in a 12-month period.

Notes - 2010

CMS-416 Fiscal Year 2010 Annual Report, 12b Preventive Dental Services

This measure was changed from "Increase the percentage of the state's children <18 who are Medicaid beneficiaries who have at least one primary care visit in a 12-month period" to "have at least one preventive dental service in a 12-month period". Data for 06 and 07 reflect the percentage of those children who were Medicaid beneficiaries who received at least one primary care visit in a 12-month period.

Notes - 2009

CMS-416 Fiscal Year 2009 Annual Report, 12b Preventive Dental Services

This measure was changed from "Increase the percentage of the state's children <18 who are Medicaid beneficiaries who have at least one primary care visit in a 12-month period" to "have at least one preventive dental service in a 12-month period". Data for 06 and 07 reflect the percentage of those children who were Medicaid beneficiaries who received at least one primary care visit in a 12-month period.

a. Last Year's Accomplishments

Challenges to ensuring Medicaid eligible children receive oral health services they are eligible for are various. Sufficient numbers of dental providers, administrative issues, and low reimbursement

rates have been known barriers. In addition to the aforesaid barriers, Medicaid eligible children sometimes lack transportation. Moreover, anecdotal evidence suggests that many families may not understand the importance of taking their children to a dentist for a check-up or of obtaining preventive care when there are no apparent problems. Some parents may not be aware that their children are eligible to receive dental services.

Although oral health screening by a physician or other provider is encouraged and expected during the provision of preventive pediatric health care, oral health screening does not substitute for a definitive dental examination by a dentist provided in accordance with the State's periodicity schedule.

Given that there is no single solution to improving access to dental services in West Virginia, multiple activities have been employed -- including collaboration and an increase in fees.

- As part of its effective informing of EPSDT eligible individuals, the HealthCheck Program uses a combination of written and oral methods to effectively inform EPSDT eligible individuals that support services, specifically transportation and appointment scheduling assistance, are available on request.

- HealthCheck mails individual letters to the parent(s) of EPSDT eligible individuals on their 2nd, 3rd, and 4th birthdays to raise awareness among beneficiaries of the importance of oral health, a dental home, and the dental benefits under Medicaid.

- Working in conjunction with the WV Dental Association and representatives of Oral and Maxillofacial Surgeons, Medicaid increased dental rates for services that targeted increased program participation for pediatric dentists. The last comprehensive rate increase occurred previously in 2001.

The Oral Health Program, in partnership with county school systems, Marshall University School of Medicine, Head Start, Women, Infants and Children (WIC), 4-H, school based health centers and other community programs, work together to provide a sealant and a fluoride rinse program within the schools.

HealthCheck outreach workers consistently make dental referrals for Medicaid enrolled children. The percentage of Medicaid beneficiaries under the age of 18 who had at least one preventive dental service increased during 2010 which incentivizes providers to accept Medicaid patients into their practice.

Fluoride Water Testing - The Children's Dentistry Project provides water test kits to families to test the fluoride levels of private water systems. This component of the Oral Health Program helped 488 families test for elevated fluoride levels during the 2011 Fiscal Year.

Fluoride Rinse Project - The Project provides a fluoride rinse program in schools. A permission form is provided to the schools for parental consent. This mouth rinsing project is restricted to first through sixth grades. Kindergarten classrooms may participate, if there is adequate supervision allows to make sure the rinse is not swallowed. All materials and supplies are provided to the schools free of charge. Fluoride is the most cost effective means of prevention in oral health care. During the 2011 Fiscal Year, 11,168 children participated.

Oral Health Educators - Oral Health Educators provide oral health education to children and families in all 55 counties through schools, early childhood programs, and community health fairs. The curriculum teaches prevention through proper oral hygiene, including instruction on brushing, flossing; choosing healthy foods; tobacco and drug prevention; and the importance of establishing of a dental home. During the 2011 Fiscal Year, 95,152 children received these educational services.

At the CMS' National Quality Conference in Baltimore in June 2012, WV was one of four states recognized for completeness and data accuracy of the two dental measures for both programs (CHIP and Medicaid).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oral Health State Plan developed.				X
2. New full time State Dental director hired.				X
3. Children's Dentistry Program (CDP) is partnering with Medicaid to encourage increase in use of dental services.				X
4. The Kids First Initiative screens school enterers using HealthCheck protocols.		X		X
5. The CDP partners with Head Start, TANF, WIC and EPSDT to distribute dental awareness information.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oral Health Program in conjunction with several community partners continues to provide fluoride water testing for families, fluoride rinse for kindergarten students, and oral health education throughout the state.

The Oral Health Program in conjunction with the WVU School of Dentistry is currently educating and certifying medical personnel and their ancillaries to participate in the "West Virginia Medical Infant and Child Oral Health Training Program." The goals of the program are to 1) improve the oral health of children less than three years old covered by Medicaid or Chip; 2) ensure these children establish a dental home; and 3) engage the medical community in improving oral health. Once properly trained, primary care physicians and their ancillaries will complete oral health evaluations for children three years old and under using caries risk assessment tool. In addition, the providers will give anticipatory guidance, provide fluoride varnish application twice annually and make dental referrals at age one or within six months of eruption of the first tooth.

c. Plan for the Coming Year

The Oral Health Program plans to collaborate with Bureau for Medical Services (BMS) to develop an oral health action plan. Plans also include the State Dental Director, Children's Health Insurance Program Director, and Medicaid Director working together with Centers for Medicare and Medicaid Services (CMS) to receive technical assistance and share best practices/innovations. The Oral Health Program will work with the dental school and dental hygiene programs to encourage community involvement. The Program is also working to create a standard oral health educational module with a common set of messages and build upon partnerships already established such as Head Start, Temporary Assistance for Needy Families (TANF) and Women, Infant and Children (WIC) to disseminate the materials.

The Oral Program will continue to educate and build upon the existing network of non-dental providers participating in the "West Virginia Medical Infant and Child Oral Health Training

Program." Additionally, the Program is taking a new approach to providing education this year by hiring regional Oral Health Coordinators. The full-time Oral Health Coordinators will be replacing the part-time network of Oral Health Educators. By hiring Oral Health Coordinators, it will increase program infrastructure to work more closely with schools, public water systems, and other community partners across the State. The objectives of the Oral Health Coordinators will be to 1) increase access to early and adequate dental care; 2) increase establishment of a dental home; 3) reduce dental caries in WV; 4) build upon existing sealant programs; 5) and advance all oral health preventative measures within WV.

State Performance Measure 3: *Decrease the number of infant deaths due to SIDS/SUID.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					18
Annual Indicator		20,481.9	150.8	166.7	166.7
Numerator		34	32	34	34
Denominator		166	21225	20391	20391
Data Source		2008 Vital Statistics	2009 Vital Statistics	2010 Vital Statistics	based upon 2010 Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	160	160	160	160	160

Notes - 2011

based upon 2010 Vital Statistics - rate per 100,000 births
includes ICD codes R95 only

Notes - 2010

2010 Vital Statistics - rate per 100,000 births
includes ICD codes R95 only

Notes - 2009

2009 Vital Statistics - rate per 100,000 births
includes ICD codes R95 only
previously calculated as percent of total deaths

a. Last Year's Accomplishments

In 2011, the WV passed legislation adding infant mortality review to already existing legislation for maternal mortality review that is housed within OMCFH. SIDS/SUID continues to be a significant risk to infants in WV. Determined risk factors include co-sleeping and household smoking.

OMCFH staff persons serve on Our Babies: Safe and Sound Advisory Committee and work groups and also provided funding support in 2011. Our Babies: Safe and Sound is an educational campaign, sponsored by the WV Children's Trust Fund, that provides parents and other caregivers of infants under the age of one, as well as expectant parents and professionals, with information and tips on ways to keep babies safe while sleeping, and how to keep your cool when babies cry. The overall goal of the campaign is to help prevent infant injury and death. Our Babies: Safe and Sound is a project of TEAM for West Virginia Children. Campaign materials are based upon the latest state and national research findings, and are intended to be used by parents and other caregivers, community partners, and the general public. The themes of the

campaign are Say YES to Safe Sleep and Keep Your Cool.

OMCFH staff persons also serve on the Child Fatality Review Team which reviewed infant deaths due to SUID/SIDS among other causes.

In 2011 the RFTS Program conducted 25 quarterly training meetings for their home visiting nurses and social workers and 10 training meetings for Regional Lead Agency staff. Training topics included domestic violence, shaken baby syndrome, safe sleep practices for baby, a safe crib and providing a smoke-free environment for the infant.

The OMCFH mails "Back To Sleep" post cards monthly to families of each live newborn in WV as a reminder of the importance of placing the baby on its back to sleep, putting the baby in a safe crib, not allowing the baby to sleep in the bed with others, avoiding fluffy blankets in the crib, and not exposing the newborn to 2nd hand smoke.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Legislation to include infant mortality review within the existing maternal mortality review process.				X
2. Participation and funding support for "Our Babies Safe and Sound" committee to reduce infant mortality and morbidity.				X
3. Educational media campaign to reduce SUID and infant mortality by targeting women and men of childbearing age.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A nurse coordinator was hired to oversee the collection of data to present to the Infant and Maternal Mortality Review Team. A data system is being purchased called Bassinett that will allow easy entry, data reports and surveillance activity. Memorandums of Understanding were modified with the birthing facilities to include the review of infant death records and mother's prenatal and delivery medical records in addition to review of maternal death medical records. The nurse coordinator is in currently reviewing 2011 infant death records and maternal prenatal and delivery records of the infants who died, including SIDS/SUID. An Advisory Committee will be held in late fall 2012 to review the information and make recommendation as appropriate. A database is currently being purchased that allows surveillance and reporting of the collected data.

OMCFH staff persons continue to serve on Our Babies: Safe and Sound Committee.

The RFTS Program continues monthly trainings of home visiting staff to encourage families to provide a safe sleep environment for their baby.

The OMCFH continues to mail "Back To Sleep" post cards monthly to families of each live newborn in WV as a reminder of the importance of placing the baby on its back to sleep, putting

the baby in a safe crib, not allowing the baby to sleep in the bed with others, avoiding fluffy blankets in the crib, and not exposing the newborn to 2nd hand smoke.

c. Plan for the Coming Year

The RFTS Program will continue monthly trainings of home visiting staff to encourage families to provide a safe sleep environment for their baby.

The Right From The Start Program, the State's perinatal home visiting program is planning an educational campaign with their enrollees on safe sleep practices and providing infant sleep sacks in conjunction with the Injury Prevention Program.

OMCFH will continue to mail "Back To Sleep" post cards monthly to families of each live newborn in WV as a reminder of the importance of placing the baby on its back to sleep, putting the baby in a safe crib, not allowing the baby to sleep in the bed with others, avoiding fluffy blankets in the crib, and not exposing the newborn to 2nd hand smoke.

The Infant and Maternal Mortality Review Team will review infant deaths for 2011 and formulate ideas for activities to reduce infant mortality including SIDS/SUID based on collected data.

OMCFH staff will continue to serve on Our Babies: Safe and Sound Committee.

The OMCFH will continue collection and data analysis on infant mortality medical information reviews including those that died from SUID/SIDS.

State Performance Measure 4: *Decrease the percentage of high school students in grades 9-12 who are overweight or obese.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	12	12	12	11	26
Annual Indicator	14.7	14.5	28.6	28.6	30.6
Numerator	18400	18200	35900	35900	37400
Denominator	125578	125578	125578	125578	122115
Data Source		2007 YRBS	2009 YRBS	based upon 2009 YRBS	2011 YRBS
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	30	30	30	30	30

Notes - 2011

2011 YRBS 16.3% overweight 14.3% obese
denominator total enrolled school year 2010-2011

Notes - 2010

based upon 2009 YRBS

14.4% overweight and 14.2% obese

Notes - 2009

2009 YRBS

14.4% overweight and 14.2% obese

a. Last Year's Accomplishments

The Office of Maternal, Child and Family Health joined together with the Office of Community Health Systems and Health Promotion to plan and write an application to the Centers for Disease Control and Prevention for the Community Transformation Grant. This application was funded and strengthens the relationship between the Department of Education, local health departments and the Bureau for Public Health to address overweight and obese students. The Office of Maternal, Child and Family Health has specifically undertaken activities to address children in foster care and children with special health care needs.

Working with the WV Department of Education, Office of Healthy Schools, the Office of Maternal Child and Family Health used state funds to facilitate the construction of eleven playgrounds in high need areas. These playgrounds will also be available to children and their families after school and on weekends.

The Adolescent Health Initiative developed several initiatives to address the issue of adolescent obesity and poor nutrition. These include:

- A weekly community garden project formed in Mount Hope, WV. The Adolescent Health Initiative obtained grant funding for the project and recruited middle and high school students to plan, grow and harvest the gardens. Families who participate not only keep the fresh vegetables, but receive developmental asset training, recipes, healthy cooking tips, and share vegetables and gardening tips with other participating families.
- Received a Five Promises for Children Foundation grant to offer nutrition education to youth in Marshall County;
- Participated in the Strong Families Eat Together workshop to provide ideas to encourage family communication during meal times;
- Provided 8 workshops during Camp Healthy Choices in Hardy County, WV;
- Partnered with various Wellness Teams, Children's Health Councils and schools to provide nutrition information and healthy activities.

The AHI worked with schools and communities to encourage youth to become more physically active. In addition to the active participation on local coalitions and task forces, the AHI provided the following activities:

- The establishment of a "Girls on the Run" program in Southern WV. Girls on the Run is an empirically supported curriculum that teaches life skills, character education and promotes physical activity;
 - Partnered with the local YMCA's Get Up and Get Active Youth Movement;
 - Provided a certified Zumba instructor to teach classes in several WV schools;
 - Initiated efforts for construction of a new skate park in southern WV;
 - PEDAL (Physical Enrichment Daily And for Life) Power program in Calhoun, Pleasants, Ritchie, Roane, Tyler, Wirt, Wood and Jackson Counties. The program promotes a healthy lifestyle and encourages youth and adults to engage in daily physical activity. The program also promotes bicycle safety and helmet usage to prevent childhood traumatic brain injuries.
 - Created and implemented a YBFIT program in the Northern Panhandle of WV. YBFIT is a winter wellness opportunity providing nutrition education, physical activity, parenting and relationship education;
 - Partnered with Wood County Wellness to provide a bike rodeo for youth in the region.
- The AHI disseminated information on healthy lifestyles, nutrition and exercise at numerous health

fairs, "Family Fun Days", Teen Expos, Student Resource Days all across the state. The AHI also coordinated Energy Express programs in various communities across the state. Energy Express provides free and nutritious lunches to school aged children during the summer.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The DHHR Office of Healthy Lifestyles promotes physical activity.			X	
2. Adolescent Health Initiative promotes healthy eating and physical activity.			X	
3. Cardiac Project provides free school-based BMI, BP, etc. for elementary and middle school students.			X	
4. The Kids First Screening Initiative and EPSDT assessments capture BMI.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OMCFH is currently working with the WVDE and other partners to assess and make recommendations for health policy statements regarding physical activity and nutrition. In addition, the Office has modified its Fostering Healthy Kids data system to collect body mass index along with other key health data to establish base line data for the project.

The Adolescent Health Initiative is in the process of formally establishing physical activity, nutrition and injury as its top three priorities for the upcoming year. As a result, staff are participating in literature reviews of Best Practices, assessing community needs, and developing plans for the new year.

WVDE provides leadership, training and support for schools and their communities to improve collaboration and ensure the health and educational achievement of children in a safe, nurturing, and disciplined environment. The Office of Healthy Schools and Office of Child Nutrition partner with BPH programs to connect public health resources with school health resources and improve coordination and integration of both public health and school health outreach. The BPH and WVDE have established a formal working coalition, the Coordinated School and Public Health Partnership, to facilitate this goal. Regional school wellness teams have been formed in each of the State's eight RESAs that serve to coordinate various health promotion activities, resources and professional development opportunities to meet the identified needs.

c. Plan for the Coming Year

The Office will work with the Bureau for Children and Families to draft and implement health policies for children living in foster care. In addition, staff hope to begin family education programs for foster families.

The Adolescent Health Initiative will continue to maintain and expand existing initiatives, while working to develop new ones. The AHI hopes to obtain two Americorps VISTA volunteers to assist in the development of hiking and biking trails in southern West Virginia. The AHI also plans

to seek funds to improve school and community playgrounds, equipment in community centers and develop community basketball courts.

In 2011 WVU was awarded 4.7 million dollars from the USDA's National Institute of Food and Agriculture and is part of a national campaign to combat obesity. Over the course of the five-year project, community stakeholders, parents, educators, healthcare professionals, and researchers will collaborate to develop these strategies. Efforts will begin with an assessment of behavioral and environmental contributors to obesity in early childhood, followed by analysis of this extensive assessment to inform the design and implementation of community, school, and home-level interventions.

The Cardiac WV Project offers several interventions for children and families to take steps toward a healthy lifestyle. Through school-based interventions the Project offers: health screening and education, Healthy Hearts 4 Kids, Take Charge: Be Healthy!, Nursing Education Initiative (Caring), Games for Health/DDR, After School Clubs, West Virginia on the Move-School Grants, Active Academics and Kinder Dental.

Community-based interventions include: WV Resources Directory, WVU Extension - 4-H Clubs and Camp Programs, CARDIAC Bootcamp, CARDIAC Hotline, and Body Works. Interventions specific to at-risk population includes: Camp NEW You, NEW You Program, WV Familial Hypercholesterolemia Project and The Preventative Cardiology Clinic for Children and Adolescents.

OMCFH will continue to contribute funds to the Coordinated School and Public Health Partnership as well as continuing partnerships with DOE and CTG.

State Performance Measure 5: *Increase the percentage of high school students who participate in physical activity for at least 60 minutes a day, 3 days a week.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	69	50	50	55	64
Annual Indicator	42.8	43.0	62.2	62.2	71.4
Numerator	53700	54000	78100	78100	87200
Denominator	125578	125578	125578	125578	122115
Data Source		2007 WV YRBS	2009 WV YRBS	based upon 2009 WV YRBS	2011 YRBS
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	72	72	72	72	72

Notes - 2011

2011 YRBS students who were physically active for at least 60 minutes per day for at least 3 of the last 7 days
denominator total enrolled school year 2010-2011

Notes - 2010

based upon 2009 YRBS students who were physically active for at least 60 minutes per day for at least 3 of the last 7 days

Notes - 2009

2009 YRBS students who were physically active for at least 60 minutes per day for at least 3 of the last 7 days

a. Last Year's Accomplishments

The Adolescent Health Initiative developed several initiatives to address the issue of adolescent obesity and poor nutrition. These include:

- A weekly community garden project formed in Mount Hope, WV. The Adolescent Health Initiative obtained grant funding for the project and recruited middle and high school students to plan, grow and harvest the gardens. Families who participate not only keep the fresh vegetables, but receive developmental asset training, recipes, healthy cooking tips, and share vegetables and gardening tips with other participating families.
- Received a Five Promises for Children Foundation grant to offer nutrition education to youth in Marshall County;
- Participated in the Strong Families Eat Together workshop to provide ideas to encourage family communication during meal times;
- Provided 8 workshops during Camp Healthy Choices in Hardy County, WV;
- Partnered with various Wellness Teams, Children's Health Councils and schools to provide nutrition information and healthy activities.

The AHI worked with schools and communities to encourage youth to become more physically active. In addition to the active participation on local coalitions and task forces, the AHI provided the following activities:

- The Office of Maternal Child and Family Health used state funds to facilitate the construction of eleven playgrounds in high need areas. These playgrounds will also be available to children and their families after school and on weekends.
- *The establishment of a "Girls on the Run" program in Southern WV. Girls on the Run is an empirically supported curriculum that teaches life skills, character education and promotes physical activity;
- Partnered with the local YMCA's Get Up and Get Active Youth Movement;
- Provided a certified Zumba instructor to teach classes in several WV schools;
- Initiated efforts for construction of a new skate park in southern WV;
- PEDAL (Physical Enrichment Daily And for Life) Power program in Calhoun, Pleasants, Ritchie, Roane, Tyler, Wirt, Wood and Jackson Counties. The program promotes a healthy lifestyle and encourages youth and adults to engage in daily physical activity. The program also promotes bicycle safety and helmet usage to prevent childhood traumatic brain injuries.
- Created and implemented a YBFIT program in the Northern Panhandle of WV. YBFIT is a winter wellness opportunity providing nutrition education, physical activity, parenting and relationship education;
- Partnered with Wood County Wellness to provide a bike rodeo for youth in the region.

The AHI disseminated information on healthy lifestyles, nutrition and exercise at numerous health fairs, "Family Fun Days", Teen Expos, Student Resource Days all across the state. The AHI also coordinated Energy Express programs in various communities across the state. Energy Express provides free and nutritious lunches to school aged children during the summer.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Legislation requires three periods of physical activity each week (30 minutes in length) during the school year for grade school.				X
2. Legislation requires one semester each year for middle school.				X

3. Legislation requires one class of physical education during high school.				X
4. The WV DHHR Office of Healthy Lifestyles promotes physical activity.				X
5. Home visitation services promote good nutrition and physical activity for all members in the family.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Adolescent Health Initiative is in the process of formally establishing physical activity, nutrition and injury as its top three priorities for the upcoming year. As a result, staff are participating in literature reviews of Best Practices, assessing community needs, and developing plans for the new year.

The OMCFH will continue to invest in DOE programs targeting healthy lifestyles including physical activity.

c. Plan for the Coming Year

The Adolescent Health Initiative will continue to maintain and expand existing initiatives, while working to develop new ones. The AHI hopes to obtain two Americorps VISTA volunteers to assist in the development of hiking and biking trails in southern West Virginia. The AHI also plans to seek funds to improve school and community playgrounds, equipment in community centers and develop community basketball courts.

State Performance Measure 6: *Decrease the percentage of high school students who smoke cigarettes daily.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	18.5	18	17.5	17	9
Annual Indicator	19.5	19.4	17.7	17.7	12.0
Numerator	24500	24300	22200	22200	14700
Denominator	125578	125578	125578	125578	122115
Data Source		2007 WV YRBS	2009 WV YRBS	based upon 2009 WV YRBS	2011 YRBS
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	10	10	10	10	10

Notes - 2011

2011 YRBS students who ever smoked cigarettes daily, at least one every day for 30 days denominator total enrolled school year 2010-2011

Notes - 2010

based upon 2009 YRBS students who ever smoked cigarettes daily, at least one every day for 30 days

Notes - 2009

2009 YRBS students who ever smoked cigarettes daily, at least one every day for 30 days

a. Last Year's Accomplishments

The 2011 YRBS shows that the percentage of students who ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days has decreased slightly to 12% from the 2009 YRBS, however the 2009 YRBS also shows that smoking within the last 30 days has decreased from 38.5% in 2000 to 19.1% in 2011. The percentage of students who reported they have never tried smoking cigarettes rose from 44.8% in 2009 to 52.9% in 2011.

RAZE, the statewide teen-led, teen-implemented anti-tobacco movement, is coordinated by the Youth Empowerment Team (YET). YET members include representatives of the Division of Tobacco Prevention, the West Virginia Department of Education's Office of Student Services and Health Promotion, the American Lung Association of West Virginia and the West Virginia Youth Tobacco Prevention Campaign. The goal of RAZE is to create a statewide youth anti-tobacco movement that initiates concern and activism, with peer-to-peer influence ultimately reducing tobacco use among teens. Their vision statement is: "We are RAZE: West Virginia teens, tearing down the lies of Big Tobacco and fighting them with all we've got: our passion, our power and our minds. Join up, if you think you can handle it."

RAZE Crews, groups of teens making a difference, are in over 140 schools and communities in West Virginia.

TAC (Teen Advisory Council) members get a chance to be in charge of a number of important duties for RAZE. TAC members meet once a month either in person or by conference call. TAC plans, organizes and implements a number of various trainings and commotions. They also provide feedback on RAZE issues such as ads, gear, etc.

The Adolescent Health Initiative partnered with several county boards of education to develop Title IV Safe and Drug Free Schools plans to address the problem of tobacco, alcohol and substance use within the public schools. All AHI staff participate in community-based substance abuse prevention coalitions, which also address the issue of tobacco use among teens. The AHI facilitated several town hall meetings and community forums on tobacco, alcohol and substance use including meth, inhalants, synthetic drugs and the growing abuse of energy drinks among youth. The AHI also disseminated information on tobacco, alcohol and substance use at numerous health fairs, "Family Fun Days", Teen Expos, Student Resource Days all across the state. Other accomplishments include:

- Partnered with Regional "Wellness" Specialist to develop a workshop for teachers on how to help families stop smoking;
- Partnered with the American Cancer Society to develop prevention efforts;
- Coordinated "Red Ribbon Week" activities across the state;
- Partnered with Westbrook Health Services and the Office of Healthy Schools to develop storyboards to display in 14 middle and 11 high schools. The topics displayed include alcohol, tobacco and drug use, bullying, depression, suicide prevention, peer pressure and eating disorders;
- Attended trainings on the brain chemistry of addiction, particularly in young people.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WV DHHR and Department of Education have strong		X		X

anti-tobacco programs which include a brand and promotional campaign designed with advice from youth in this age group.				
2. RAZE is West Virginia's teen led anti-tobacco movement.		X		X
3. Smoking bans in all public and government buildings and state vehicles throughout WV.				X
4. As of January 2009, all 55 counties have clean indoor air regulations.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

West Virginia is aggressively addressing this problem by implementing evidence-based comprehensive tobacco control programs. The comprehensive plan focuses on four goals: (1) Prevent the initiation of tobacco products among young people; (2) Eliminate exposure to secondhand smoke; (3) Promote quitting among adults and young people; (4) Eliminate tobacco-related disparities among different population groups.

The AHI continues to provide information at various outreach opportunities to educate families on the problem of tobacco, alcohol and drug use among teens. The AHI is continually working with schools and communities to address these issues.

c. Plan for the Coming Year

West Virginia's Youth Tobacco Prevention Program's goal is to prevent WV's youth from using tobacco products, even trying them, and to assist the youth who are using tobacco products in reducing the amount they use or quitting. The Youth Program works closely with the WV Department of Education (WVDE) on tobacco related issues including policy and enforcement. The Regional Tobacco Prevention Specialist (RTPS) Network is facilitated and managed through the Office of Healthy Schools, WVDE and the Division of Tobacco Prevention, WVDHHR. The Youth Program also collaborates with the American Lung Association of WV (ALA) to address the community needs of the state and provide facilitation for both schools and communities. The WVDE and the ALA work with the Youth Program and the Arnold Agency to support RAZE. RAZE is West Virginia's teen led anti-tobacco movement. Additional information is available on the Raze website.

The AHI will continue to work with local substance abuse coalitions, schools and communities to provide information, technical assistance and resources to address the problem of substance use, including tobacco and alcohol.

State Performance Measure 7: *Decrease the percentage of high school students who drink alcohol and drive.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	10	9.5	9	8.5	7
Annual Indicator	10.0	9.8	7.5	7.5	6.7
Numerator	12500	12300	9400	9400	8200

Denominator	125578	125578	125578	125578	122115
Data Source		2007 WV YRBS	2009 WV YRBS	based upon 2009 WV YRBS	2011 YRBS
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	6	6	6	6	6

Notes - 2011

2011 YRBS students who drove a car or other vehicle one or more times during the past 30 days when they had been drinking alcohol
denominator total enrolled school year 2010-2011

Notes - 2010

based upon 2009 YRBS

Notes - 2009

2009 YRBS

a. Last Year's Accomplishments

The Violence and Injury Prevention Program was invited to present at the annual conference held by the WV Chapter of Students Against Destructive Decisions (WVSADD). In addition, the Program contracted with the West Virginia University Injury Research Center to compile a data report that outlines the burden of injuries in the State, including associated costs.

The Adolescent Health Initiative participated in 78 activities to address the problem of underage drinking and driving including:

- Sticker Shock campaigns were held in Kanawha and Marshall Counties. The campaigns involved youth and adult volunteers placing stickers on alcoholic beverages in area retail stores. The stickers warn the purchaser of the risks of the providing alcohol to minors;
- Teen Institutes were held in Jackson and Mingo counties to develop leadership skills and self-esteem in middle school students to enable them to avoid peer pressure to engage in drinking alcohol or using drugs;
- Partnered with local law enforcement and the Governor's Highway Safety Program to provide sobriety checkpoints;
- Developed 2 new SADD (Students Against Destructive Decisions) Chapters;
- Partnered with local law enforcement to provide SOBER's simulated DUI course in several high schools across the state;
- Implemented a "Communities Mobilizing for Change on Alcohol" program in Kanawha County;
- Partnered with community substance abuse prevention coalitions and law enforcement to conduct "Beer Sting", "Shoulder-Tap" and "Cops in the Shop" operations to identify area merchants who sell alcohol to underage adolescents. Merchants caught selling alcohol to minors were given the opportunity for staff to receive free training in lieu of paying a fine;
- Assisted several high schools with providing Project Graduation and After Prom events. These events provide a safe and fun alternative to youth going to parties after prom and graduation;
- Partnered with community coalitions and law enforcement to offer Public Service Announcements aired on the CW Network;
- Disseminated information on tobacco, alcohol and substance use at numerous health fairs, "Family Fun Days", community festivals, Teen Expos, and student resource days all across the state.

The Commission On Drunk Driving Prevention (CDDP) was created by the WV Legislature in 1983. Funding is derived from a 3% tax on liquor sold in WV. They sponsor many activities targeting underage drinkers and young adults. During high school prom activities officers assist by monitoring for alcohol use which includes pre-Prom visits by law enforcement to deter the use

of alcohol. Officers are involved in alcohol free graduation parties by assisting school personnel in the education of students concerning alcohol abuse. Officers visit Drivers Education Classes to educate students against driving while impaired. In its seventh year of operation, officers work with campus teams at all 23 colleges and universities in WV to reduce underage drinking on college campuses. Safety coordinators responsible for statewide education, work with area bars, distributors, and community agencies to establish an on going project to assist the 21-34 age group in avoiding driving under the influence by finding alternative transportation (i.e. designated drivers, public transportation, and Training for Intervention Procedures (TIP) training).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Students Against Destructive Decisions (SADD) works with communities to establish local chapters.		X		
2. Adolescent Health Initiative promotes healthy decision making.			X	
3. State alcohol distribution policy protects youth.				X
4. Governor's Highway Safety Program initiatives.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Violence and Injury Prevention Program continues to distribute educational materials and resources to provide skill building to parents and teens on the risks associated with teen drinking. In addition, the Program has signed an agreement with a qualified facilitator to begin working on a state plan for violence and injury prevention. It is anticipated that this plan will be completed in 2013.

The Adolescent Health Initiative maintains the ongoing initiatives that discourage drinking and driving among youth. The AHI continues to provide information at various outreach opportunities to educate families on the problem of tobacco, alcohol and drug use among teens. The AHI is continually working with schools and communities to address these issues.

c. Plan for the Coming Year

The Violence and Injury Prevention Program will continue to develop and expand existing efforts to reduce adolescent drinking and driving. The Program will work with other agencies to seek opportunities for collaboration to raise awareness of the risks associated with teen drinking and driving and help to reduce teenage alcohol use in the State. The Program will also finalize a Violence and Injury Prevention state plan that will be used to prioritize injury prevention programming, and will assist the Program in meeting eligibility requirements for CDC funding under the core injury program.

The Adolescent Health Initiative will continue to work with the Violence and Injury Prevention Program to develop and expand existing efforts to reduce adolescent drinking and driving. The AHI will continue to work with local substance abuse coalitions, schools and communities to

provide information, technical assistance and resources to address the problem of substance use, including tobacco and alcohol.

State Performance Measure 8: *Decrease the number of high school students who never or rarely wear a seatbelt when riding in a car driven by someone else.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	14.5	14	13.5	13	13
Annual Indicator	16.6	16.4	14.0	14.0	13.8
Numerator	20800	20600	17600	17600	16800
Denominator	125578	125578	125578	125578	122115
Data Source		2007 WV YRBS	2009 WV YRBS	based upon 2009 WV YRBS	2011 YRBS
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	13	13	13	13	13

Notes - 2011

2011 YRBS students who never or rarely wore a seat belt when riding in a car driven by someone else
denominator total enrolled school year 2010-2011

Notes - 2010

based upon 2009 YRBS
never 5.4% and rarely 8.6%

Notes - 2009

2009 YRBS
never 5.4% and rarely 8.6%

a. Last Year's Accomplishments

In 2010, West Virginia's seatbelt usage rate was 82.15%, down from 87% in 2009. WV's usage rate for 2011 is 85%, and the Governor's Highway Safety Program (GHSP) attributes the increase to more citizens getting the Click It or Ticket message through a strong media campaign and law enforcement actively enforcing the seatbelt law. Additionally, the unbelted fatality rate is down for WV in 2011, which is another accomplishment in the GHSP's efforts to reduce fatalities and injuries.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WV Department of Transportation promotes seat belt use.				X
2. WV Department of Public Safety sponsors the "Click It or Ticket" campaign and has put an emphasis on enforcement of seat belt usage laws.				X
3. WV state law requires seat belt use.				X

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Adolescent Health Initiative collaborates with other regional network partners to provide a minimum of 64 (8 per region) presentations to educate youth and parents, and distribute informational literature about unintentional injury, drinking and driving, use of seatbelts.

c. Plan for the Coming Year

The Adolescent Health Initiative collaborates with other regional network partners to provide a minimum of 64 (8 per region) presentations to educate youth and parents, and distribute informational literature about unintentional injury, drinking and driving, use of seatbelts.

E. Health Status Indicators

01A and 01B: The percent of live births weighing less than 2,500 grams and the percent of live singleton births weighing less than 2,500 grams.

There was a total of 1,941 low birth weight babies (those weighing less than 2,500 grams or 51/2 pounds) born to West Virginia residents in 2009, 9.2% of all births. Of the 1,941 low birth weight infants, 1,291 or 66.5% were preterm babies born before 37 weeks of gestation. (Of all 2009 resident births with a known gestational age, 10.8% were preterm babies.) Of the births with known birth weight, 9.0% of babies born to white mothers and 14.6% of babies born to black mothers were low birth weight. Nationally, 8.2% of all infants weighed less than 2,500 grams at birth in 2009; 7.2% of white infants and 13.6% of black infants were of low birth weight.

West Virginia has higher rates than the rest of the nation for c-sections and labor inductions. Concerned that many of these inductions and C-sections are not medically necessary and may be resulting in avoidable negative birth outcomes, the WV Health Care Authority, in partnership with the WV Perinatal Partnership and the WV March of Dimes, developed and implemented a collaborative to study and address the issue. The six month project engaged 14 of the state's 30 hospitals that deliver babies. The participating hospitals represented 70% of the total deliveries in the state. Six months after the implementation of the Collaborative, the rate of elective deliveries prior to 39 weeks without a medical indication had decreased by more than 50%. One year after the completion of the Collaborative, the reduction has been maintained.

02A and 02B: The percent of live births weighing less than 1,500 grams and the percent of live singleton births weighing less than 1,500 grams.

The percent of WV live singleton births weighing less than 1,500 grams was 1.1% for 2009. HB 2837, the Uniform Maternal Screening Act, passed during the 2009 WV legislative session, established an advisory council within the WV DHHR, Office of Maternal, Child and Family Health to assist in developing a uniform maternal risk screening tool. Now developed, all health care

providers offering maternity services are required to utilize the tool in their examinations of any pregnant woman, maintain confidentiality and notify the woman of any high-risk condition which they identify along with any necessary referral.

This uniform approach simplifies the process, standardizes procedures and identifies pregnancies that need more in-depth care and monitoring. Additionally, uniform application provides measurable data regarding at-risk and high-risk pregnancies. This allows public health officials to analyze conditions that are most frequently observed and develop methodology to address concerns. In 2011, about 50% of the pregnant women received a maternal risk screen. Information was analyzed and presented to the Advisory.

03A: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

The Violence and Injury Prevention Program partnered with West Virginia University's Injury Control Research Center to develop a comprehensive report on the burden of injury in West Virginia. It is the hope of the Program that the release of this report will assist the Program in developing a strategic plan in partnership with a broad variety of stakeholders. Unintentional Injuries among children under the age of fourteen remain the leading cause of death in West Virginia, and much more needs to be done to address this continuing problem. In addition, West Virginia's Governor led efforts to pass a law during the 2012 Legislative session that will ban texting and driving effective in June 2012 and will restrict cell phone usage in July 2013.

03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

In 2010, West Virginia's seatbelt usage rate was 82.15%, down from 87% in 2009. WV's usage rate for 2011 is 85%, and the Governor's highway safety program attributes the increase to more citizens getting the Click it or Ticket message through a strong media campaign and law enforcement actively enforcing the seatbelt law.

03C: The death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes.

West Virginia has several programs in place to address the safety of drivers and occupants aged 15 to 24. With Graduated Driver's Licensing Programs, High Visibility Law Enforcement activities, and public awareness education and events, West Virginia's rates of deaths due to motor vehicle crashes should continue to decrease.

APPI is a strong partner with the West Virginia Department of Education. The Initiative supports the belief that improving health-related decision making and reducing risk behaviors can only occur as a result of educating teens with refusal and delay tools. APPI presentations are structured to include development of refusal skills and delay tactics which could be used to avoid unsafe circumstances such as not using a seat belt, driving while impaired and cell phone use during driving. Specialists have adapted techniques from Reducing the Risk, an evidence-based curriculum as the basis for this skill development.

04A: Narrative: The West Virginia Violence and Injury Prevention Program provides coordination of prevention activities throughout the State. By serving on the Violence and Injury Prevention Advisory Board, several OMCFH staff are able to coordinate each other's Program activities so that injuries in every age group may be properly addressed. Much more work is needed to be done, but positive partnerships have developed and Programs are coordinating their efforts now more than ever in order to work toward preventing injuries among children under the age of fourteen.

04B: Narrative: The Governor's Highway Safety Program saw more participation in the Child

Passenger Safety Program (CPS), and held numerous events promoting the importance of keeping all children properly restrained.

04C: Narrative: In 2010, West Virginia's seatbelt usage rate was 82.15%, down from 87% in 2009. WV's usage rate for 2011 is 85%, and the Governor's highway safety program attributes the increase to more citizens getting the Click it or Ticket message through a strong media campaign and law enforcement actively enforcing the seatbelt law.

05A and 05B: Chlamydia infections in West Virginia disproportionately affect women in the early reproductive stage of life. In FH 2011, 55.7 percent (1,150 cases) of all reported infections occurred in women ages 15 -- 24 years, compared to 58.7 percent (1,051 cases) in FH 2010. In FH 2011, 30.0 percent (618 cases) of all reported infections occurred in women ages 20 -- 24 years, closely followed by women ages 15 -- 19 years, which accounted for 25.8 percent (532 cases) of all reported infections. Men ages 20 -- 24 years ranked third with 13.5 percent (278 cases), followed by women ages 25 -- 29 years with 8.1 percent (168 cases).

Chlamydia infections have occurred in all races and in all ethnic groups in West Virginia; however, African Americans have consistently been disproportionately affected. African Americans, despite accounting for approximately 3.5 percent of the state's population, represented 17.5 percent (362 cases) of the infections reported in FH 2011 compared to 18.3 percent (327 cases) in FH 2010. There has been a 10.7 percent increase in cases reported for African Americans during FH 2011 (362 cases) compared to FH 2010 (327 cases), while there was a 4.4 percent increase in cases reported for Caucasians during the same time periods (1,182 cases and 1,132 cases respectively).

In September 2010, after consultation with West Virginia's CDC Project Officer the program implemented changes in chlamydia and gonorrhea case assignments effective January 1, 2011. The following changes were made to case assignments initiated to the field for DIS investigation and partner services: all pregnant females and all females age 14 and under who test positive for chlamydia regardless of testing source and all gonorrhea cases. By reducing the number of chlamydia cases assigned to DIS this will allow the DIS to more effectively target gonorrhea partner services and hopefully reverse the increase in gonorrhea morbidity.

DIS will still be available to assist local health departments with patients who test positive for chlamydia after the local health department has made a good faith effort to bring the patient back for treatment. The DIS will continue to receive notification of all patients who test positive for chlamydia. This will ensure that DIS maintain awareness of what is occurring within their region and respond to any possible outbreaks or problems.

Since the majority of chlamydia and gonorrhea infections in the state are reported in the 15 -- 24 age group, the Division has become a more active partner with the West Virginia Department of Education (WVDE). Although there have been no WVDE conference partnerships in FH 2011, the Division will continue to seek such opportunities during the remainder of CY 2011. Division staff conducted 18 educational presentations to middle and high school students during FH 2011, providing information on disease prevention, testing, and treatment. Literature was also distributed during these presentations. The Division supports educational, testing, and treatment services in student health programs in many universities/colleges in the state, including the Job Corps Program, and supports the "I Want the Kit" program through advertisement and reporting services. The Division collaborates with county health departments, county health officers, colleges/universities, correctional facilities, community clinics, and private providers to provide interventions upon request and education at county health departments' outreach activities. DIS staff provided displays/exhibits for four activities during FH 2011.

Outreach activities were conducted in February and April of 2011 at a college campus. Students were offered the opportunity to be tested for HIV and syphilis as well as the chlamydia/gonorrhea test. A total of 37 students were tested for CT/GC with 4 Positive for chlamydia (10.8 percent

positivity). All 25 students tested for HIV or syphilis were negative. These activities have generated awareness regarding the need for continuing education, testing, and disease prevention in this college community.

The WV Perinatal Partnership Maternity Care Provider Shortages Committee is continuing its work to improve access to maternity care and appointed this committee to study the issues. The 52 page report contains the following work, key findings, and recommendations. The OMCFH Office Director and the Perinatal and Women's Health Division Director serve in leadership roles on the Central Advisory Council and committees. The OMCFH helps to finance the Perinatal Partnership activities. The OMCFH Research Division provides requested data to assess the need for multiple Quality Improvement initiatives.

Committee work outlined in report:

- Key Findings of West Virginia Birth Attendant and Prenatal Provider Studies of 2010 and 2011
- History of birth facility closings since 1976
- Locations and Concentration of Birth Attendants
- Locations of WV Birth Facilities, and Availability of Certified Nurse-Midwives (CNMs)
- Current listing of WV counties with no birth facilities
- Current WV counties with no prenatal care services and no birth facilities
- Maternity Care Professional Shortage Areas:
 - Number of women age 15-44 in counties with no prenatal care or birth services
 - Birth flow patterns in counties with no prenatal or birth services
 - Location of WV based Federally Qualified Health Centers in counties with no prenatal care or birth services
- Recommendations for establishing sites for prenatal care service and areas of future studies needed
- A description of a proposed collaborative practice model for prenatal care

Key Findings:

Birth facilities and prenatal care in WV:

- Thirty-six West Virginia licensed birth facilities have closed since 1976
- Twenty three WV counties currently have licensed birth facilities
- Thirty-two WV counties currently have no birth facilities
- Fifteen WV counties with no birth facilities currently have prenatal care providers
- Seventeen WV counties have no prenatal care and no birth facilities.
- A large portion of WV is not within a 30-minute drive time of any birth facility.
- A smaller but significant portion of WV is not within a 30-minute drive time of any prenatal facility.

Practicing licensed maternity providers who attend births:

- The total number of providers who attend births showed a modest decrease in 2010 after a substantial rise in the years between 1992 and 2006.
- The number of obstetricians who attend births has shown a slow but steady increase since 1992.
- The number of family practice physicians who attend births has steadily dropped since 1991 .
- No family practice physicians in private practice are currently attending births in rural (non-metropolitan), licensed birth facilities that are not teaching hospitals. One family practice physician is currently attending home births in a very rural area of West Virginia.
- The number of certified nurse-midwives who attend births showed a slight decrease in 2010 after a sharp rise between 1992 and 2006.

Residents in Training in WV:

- The total number of resident physicians who provide maternity care has risen since 1991
- Ob/gyn resident positions have shown a modest increase since 1991
- Family practice resident positions have shown almost a three-fold increase since 1991
- All residents must be supervised by faculty who are required to be physically present during all

births attended by residents. Therefore although residents take on a substantial amount of work in teaching hospitals, they do not change the numbers of licensed professionals available to attend births in rural areas.

Committee recommendations for establishing priorities for perinatal care:

1. The State of West Virginia should adopt a long-term focus on reducing poor birth outcomes by placing the recruitment and retention of rural maternity professionals at the forefront of its concerns.
2. Since non-maternity health care professionals are included in the formulas, the current federal system for designating Health Professional Shortage Areas may not adequately identify the rural areas most underserved by maternity services, the state should: Consider designating maternity care health professional shortage areas; identify rural areas that have the lowest ratios of maternity professionals to women of childbearing age; and focus on them when recruiting professionals.
3. Increase support for health science schools that have distinct programs and proven track records for training professionals to practice maternity care in rural areas in West Virginia.
4. The State should find funding for Postgraduate Fellowship Training in Obstetrics for Family Medicine Physicians. This would encourage family practice residents to provide a full spectrum of maternity care, including deliveries, when they begin practicing.
5. The State should closely review and replicate programs that have previously increased the number of nurse midwives practicing in West Virginia.
6. Additional incentives for new maternity care providers are also needed and should be explored. Examples of incentives include scholarships, loan forgiveness, tax credits, and signing bonuses.
7. Future studies needed.
8. The committee outlined a description of a model collaborative practice model for prenatal care as a guide for the future development of comprehensive maternity care services.

Partnership Workplan 2011-12 - Scope of Work

Based on on-going data analysis and other studies, and key informant surveys, the Partnership identifies problems associated with poor birth outcomes in West Virginia. Each year the Central Advisory Council reviews findings of major committee work and recommends an action plan called the Partnership Workplan. The 2011-12 workplan addresses the following key issues.

1. Establish a Statewide Perinatal System
2. Identify and Address Maternity Care Provider Shortage Areas
3. Address the Lack of Oral Health Care during Pregnancy
4. Identify Costly Medical Procedures Associated With Poor Birth Outcomes
5. Develop an Approach to Identify and Treat Drug Use During Pregnancy
6. Promote and Support Breastfeeding
7. Report the Expanded Testing of Newborns Findings
8. Report and review the findings of the WV Maternal Mortality Review Team
9. Study the incidence of pregnancy among WV teens and young adults and developed policy recommendations to reduce the incidence.
10. Collaborate with the State Tobacco Control project and Right from the Start
11. Provide WV Perinatal Outreach Education
12. Create a committee to study the incidence of congenital anomalies among infants born to women living in Mountain top removal areas.

13. Create a study of existing research demonstrating any relationship between autism and the use of drugs/alcohol during pregnancy.

F. Other Program Activities

/2012/ The WV OMCFH has been expanding programs due to the influx of federal funds and reorganization and has outgrown the capacity portion of the application. Additional programs and activities of interest are listed within this section.

Home Visitation:

The West Virginia Department of Health and Human Resources (WVDHHR) on behalf of Governor Earl Ray Tomblin, designated the Office of Maternal, Child and Family Health (OMCFH) as lead agency to coordinate and implement the West Virginia Home Visitation Program (WVHVP). Collective efforts between state and local stakeholders will expand infrastructure and training capacity; develop and implement a statewide continuum of evidence based home visitation from pregnancy to five years of age; and identify resource agencies. Based upon risk factors, current capacity and allocated funding, a data driven decision was made with the WV Home Visitation Stakeholders workgroup to target Boone, Cabell, Mason, McDowell and Wayne Counties from identified twenty-two highest risk counties in the state Needs Assessment.

The Home Visitation Program is a partner with multiple programs within the Office of Maternal, Child and Family Health and Department of Health and Human Resources to implement a Help Me Grow system specifically to detect developmental and behavioral problems early, and share resources with families.

OMCFH is dedicated to implementing evidence-based approaches to address major public health challenges and reduce health disparities. Such efforts can promote health across the life span, from youth to old age, and advance life-saving prevention measures in community as well as in clinical settings.

Connect to Care Project:

Connect to Care is a telecommunications project linking rural health facilities with tertiary care centers housing perinatal specialists. Live telecommunications allows high risk pregnant women and infants and their local health care providers to obtain important medical advice without leaving their own communities and traveling far distances. Connect to Care also allows for medical and nursing education at the rural sites and access for obstetrical referrals. Connect to Care is currently a pilot program. Fifteen rural health care sites are participating with the three West Virginia hospitals providing high risk prenatal and newborn care. The project is funded by a Rural Utilities Service Grant from the U.S. Department of Agriculture and matching funds from eighteen partnering West Virginia hospitals and community health centers. Technical assistance and training for this project is being provided by Charleston Area Medical Center Health Education and Research Institute, a partner organization of the West Virginia Perinatal Partnership. Dr. Luis Bracero, maternal fetal medicine specialist and member of WVPP's Central Advisory Council serves as Principle Investigator for the Project. //2012// **/2013/ A series of live webcasts were provided for healthcare professionals and stored on the Perinatal Partnership website. //2013//**

/2013/ Birth To Three/ Early Intervention/Part C:

In 2012, the ECAC (with Title V, WVBTT and HV as Governor appointed members) will be co-sponsoring with the WV Center on Civic Life, Community Dialogues across the state to encourage communities to engage in conversations about the importance of positive experiences during a child's first three years of life -- and the life-long health and other impacts of negative experiences.

WVBTT uses a rigorous survey to gather input from all families of children as they exit the BTT, regarding impact of early intervention services. The information is used to report on three national Family Outcomes for Part C and guides program improvement strategies.

WVBTT in collaboration with the WV Dept of Ed, sponsors annual Camp Gizmo, a week-long camp for families and professionals to problem solve how assistive technology can support children with significant developmental delays. WVU and Wheeling Jesuit also send students from the Speech Pathology and Physical Therapy programs to participate in the camp for academic credit. This experience encourages many of the students to pursue careers working with young children.

WV CHIP is now partnering with OMCFH and WVBTT to provide reimbursement for Part C early intervention services. //2013//

/2013/ Focus Groups, APPI/FPP, November 2010

Purpose: To understand the health behaviors of young adults 29-29 years of age in regard to unplanned pregnancies. Discussion included accessing the knowledge of various sexual health issues, motivation factors that encourage or deter the use of contraception and to determine if there was a preferred format for learning about these topics.

In November 2010, six (6) groups were conducted consisting of women and men between the ages of 19-29. Increased sex education was the most discussed topic of all the groups. Many of the adults stated they had few opportunities to learn about more than just the biological aspects of sex. Most remembered only have a classroom discussion about sexuality once or twice from 7th to 12th grade. STD prevention was a higher priority than pregnancy prevention for both groups. It was difficult for the groups to talk about pregnancy in a negative way and more stated pregnancy was a blessing.

Focus Groups, APPI, November 2011

Purpose: These focus groups were developed to address the recent increase in births to 15-17 year olds in WV. Discussion included decision making regarding contraception, needs teens have to obtain contraception, why some teens are choosing to have unprotected sex and messaging that could resonate with teens to use protection.

In November 2011, six (6) groups were conducted consisting of women and men that became parents between the ages of 15-17 or were to become parents between the ages of 15-17. Again, education was the most discussed issue. Participants stated the need for more inclusive and frequent sex education. Teens perceived contraception to not be easily accessible whether due to its cost, lack of transportation or embarrassment. Some of the participants planned their pregnancy to escape abuse (physical, sexual or emotional) in their home. Alcohol and other substances were contributors to careless decision making with many participants. The majority felt invincible "it won't happen to me". Although all participants stated they loved their children, they wished they had delayed sexual activity and parenting. //2013//

G. Technical Assistance

West Virginia needs technical assistance to improve capacity to address racial, ethnic, economic and health disparities as well as cultural competence.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	6432506	6422232	6371254		6377020	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	13300796	7026620	9401284		9053003	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	0	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	14000000	11015200	14500000		14500000	
7. Subtotal	33733302	24464052	30272538		29930023	
8. Other Federal Funds <i>(Line10, Form 2)</i>	16691340	20368075	16202177		19384764	
9. Total <i>(Line11, Form 2)</i>	50424642	44832127	46474715		49314787	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	1636704	2166009	1574996		215762	
b. Infants < 1 year old	2540936	2917302	1996409		2117463	
c. Children 1 to 22 years old	2246378	2284771	2922797		3523572	
d. Children with	22306320	11686958	18690072		20306274	

Special Healthcare Needs						
e. Others	4156951	4549171	4329757		2937030	
f. Administration	846013	859841	758507		829922	
g. SUBTOTAL	33733302	24464052	30272538		29930023	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		97260		113470	
c. CISS	0		0		0	
d. Abstinence Education	0		589861		360236	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	4376056		5174915		5741190	
j. Education	4533609		2152956		2151649	
k. Home Visiting	0		0		2242401	
k. Other						
ARREST	0		949966		452000	
Community Based Sys	0		105000		150000	
Family Planning	0		2430093		2382499	
PREP (APPI)	0		0		278827	
Preventative Health	0		0		287248	
TANF	0		1666640		2000000	
TITLE XIX	0		0		3225244	
Early Home Visit	0		883550		0	
Title XIX	0		2151936		0	
Other	6935675		0		0	
WiseWoman	746000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	1948752	1457173	1942176		2091034	
II. Enabling Services	22469349	13147916	18985147		19331002	
III. Population-Based Services	6096037	7084304	6522132		5520445	
IV. Infrastructure Building Services	3219164	2774659	2823083		2987542	
V. Federal-State Title V Block Grant Partnership Total	33733302	24464052	30272538		29930023	

A. Expenditures

Please reference notes contained with forms 3, 4 and 5 for a discussion of budgeted estimates and actual expenditures.

B. Budget

The Office of Maternal, Child and Family Health has done a good job of leveraging resources. The Block Grant Title V, serves as the foundation but the Office also administers Family Planning funded by Title X, TANF, Title V, State funds; Title XV Breast and Cervical Cancer Screening Program; Part C/IDEA, funded by the Department of Education; Childhood Lead Prevention Program, CDC and Title V funded; EPSDT, funded by Title XIX; Children with Special Health Care Needs, funded by Title XIX and Title V; Right From the Start funded by Title XIX and Title V; Adolescent Pregnancy Prevention Initiative funded by TANF; Injury Prevention funded by CDC and PRAMS, funded by CDC and Title V. All of these funding streams augment what is purchased with Title V monies. Like many states across the country, Title V has moved away from the sole focus of purchasing or providing individual health services and has placed attention and fiscal resources on developing a system of care. For example, because the state had high incidences of neural tube defect and other congenital anomalies, the OMCFH approached the WVU School of Medicine to develop satellite clinics providing genetics counseling and screening. Although the medical expertise came from the WVU School of Medicine, the funding to make these services more accessible throughout the state came from Title V. These clinics serve everyone, not just persons who have government sponsored health care.

Because of the low median income for a family, the need for services has been great but resources have been limited. The State Legislature routinely supports Maternal, Child and Family Health, but over the years this commitment has not kept pace with the demand for services and escalating cost. This is largely attributable to the fact that as Medicaid expansions occurred and the CHIP program was introduced, there was an assumption by members of the State Legislature that Maternal, Child and Family Health would not need as many resources. OMCFH has attempted to educate the Legislature, explaining to them that while these alternate health financing strategies have come into being, the MCH monies are needed to improve the quality of services rendered and improve the availability of care. Like states across the country, WV does not have enough money to fund all the many things that our citizens need. For example, several years ago newborn hearing screening legislation was passed but there was no accompanying state appropriation. What was obvious was that, while there was a commitment to identify children who needed intervention, there was no consideration given to the fact that there has to be a mechanism for identifying the children, tracking the children, and making sure the intervention occurred, all of which costs money. OMCFH staff argued this to no avail, OMCFH was very pleased to be a recipient of the Title V monies to support this project. It is true that Medicaid and some insurers would offset the cost of the newborn hearing screening services, but there was no way to individually bill and recover monies necessary for the population-based tracking and surveillance that was necessary; no insurances or Medicaid pay for this activity.

In order to be good stewards of the system, the OMCFH provides leadership for much of the health care services provided in the state. Medicaid, CHIP and others are purchasers, but the OMCFH and its staff recruit clinicians, establish care protocols, monitor provider behavior, and offer skill building opportunities, all using the resources identified above to improve WV's health care system.

The WV OMCFH administers EPSDT on behalf of Medicaid, for children not enrolled in an HMO, and has done so for approximately 30 years. The Medicaid Bureau supports the Program by paying for individual health services that the children access and administrative support for salaries of the MCFH team administering EPSDT. The OMCFH develops, distributes, and purchases anticipatory guidance which is used by the participating providers. OMCFH also is responsible for bringing together members of the medical community to provide guidance as it relates to child health, not just EPSDT, but Newborn Hearing, Children with Special Health Care Needs, Birth Defects, Lead, etc. OMCFH uses many of the programs cited to identify children

who are ultimately referred to CSHCN. The CSHCN Program, financed under Medicaid and Title V, not only serves children who have diagnosed chronic and debilitating conditions but arranges assessment for children referred by their primary care/medical home. All of these efforts are commitments to primary and preventive care of the state's children and ultimately have a tie-in to CSHCN when indicated.

Using the statutory authority under Title V that allowed for cost based reimbursement for Medicaid beneficiaries and the authority invested in Title V to be responsible for all populations, OMCFH embarked upon an ambitious redesign plan for the Birth to Three/Part C system. This redesign has allowed the State of WV to implement a system change that is more in keeping with tenets of Part C and to obtain financing necessary to support the system. This system is designed to serve children who are developmentally delayed or at risk of developmental delay, but the many programs administered by the Office serve as a referral conduit. Referral sources include the Birth Score screening that is completed on every baby born in WV to screen for developmental delay or identify those at risk of post neonatal death, the Birth Defects Surveillance System, Newborn Metabolic and Newborn Hearing Screening programs, and of course EPSDT. This system change has been in the process for about four years and has resulted in families having an opportunity to select a provider of service, improved financing for the system, and assurance that families are served by appropriately credentialed personnel. OMCFH has used Title V connections and fiscal resources to secure support from the medical community including developing physician training programs, offering skill building around the early detection of developmental delay, and to champion messages to their colleagues that the early identification of children who are at risk are important to all.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.