CHNA Cycle II Report
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Introduction

Community health assessment is an important component of health planning. Every three years, not-for-profit health care facilities are required to conduct assessments of the communities with the purpose of identifying significant community health needs, prioritizing health needs, and linking persons with unmet health needs to community resources. The WVU Medicine/University Healthcare Community Health Needs Assessment (CHNA) Cycle II was a 12-month process conducted in 2016 under the guidance of a Steering Committee comprised of select members of the WVU Medicine Executive Committee. A CHNA liaison served on the Health and Human Services Collaborative Steering Committee (HHSC) and community survey was conducted to facilitate broad community input about unmet needs and priorities in the Eastern Panhandle and strategy implementation. In April 2017, the Board of Directors (Board) approved the CHNA Cycle II priorities and implementation plan and the creation of CHNA Strategy Implementation Teams (IT) to be chaired by administrative and clinical champions from each hospital. Four teams in the areas of chronic disease, cancer, behavioral health, and maternal/child health were created. Their charge was to develop and implement action plans and strategies that addressed priorities identified CHNA.

CHNA Priorities

Based on the 2016 assessment data he following areas were identified as priorities for University Healthcare community outreach and strategic planning: 1) Primary and secondary prevention of colorectal, lung, and breast cancer and outreachto underserved populations; 2) Reduce barriers to colorectal, breast, and lung cancer screening and treatment; 3) Primary and secondary prevention of metabolic syndrome, diabetes, lung disease, and obesity; 4) Self-management of chronic illness for persons with diabetes, COPD, heart failure, and metabolic syndrome; 5) Access to and the continuity of community-based chronic illness care and supports for persons with complex health challenges and their families; 6) Primary and secondary prevention of substance use disorders and associated aftermath on families; 7) Timely access to comprehensive behavioral health services and community-based recovery programs, family resources, and supports; and, 8) Primary and secondary prevention of perinatal exposure to substances, complications of the neonatal period, and infant mortality.

Overall, the CHNA Cycle II priorities were consistent across both Berkeley County and Jefferson County. There were hospital/county specific priorities based on findings revealing slightly different trends and gaps. For example, both counties have significant gaps in behavioral health services for youth, but Berkeley County has more assets to address those gaps than Jefferson County. Similarly, the 2010-2014 age-adjusted suicide death rate in Berkeley County was 17.5/100,000 population and 9.7/100,000 in Jefferson County. The Berkeley County rate is significantly higher than the Healthy People 2020 goal of 10.2/100,000 and the national rate of 12.5/100,000 and the Jefferson County rate is well below both.

Universal problems to be addressed by the hospital system and CHNA Implementation Teams (IT) were: (1) prevalence of substance abuse and gaps in local residential treatment facilities and community-based treatment and recovery services; (2) incidence of and poor health outcomes among persons with chronic disease such as diabetes, heart disease, and lung disease; (3) late stage cancer diagnosis for breast cancer, colorectal cancer, and lung cancer; and (4) rates of complications of the neonatal period.

CHNA Cycle II Implementation Champions and Teams

The CHNA Cycle II Strategy Implementation Plan built on Cycle I achievements and continued to focus on (1) changes to internal processes that improve the quality of inpatient care; (2) collaboration with community groups to improve the interface between acute and community-based care for persons with complex health challenges; and, (3) communication, coordination, and collaboration among the champions and between BMC and JMC and the counties that they serve.

The CHNA Implementation Team core consisted of the Champions, Health Promotion Coordinator, WVU Medicine/University Healthcare Vice President for Marketing and Development, and the CHNA consultant. The implementation action plan process was influenced by a delay between the assessment and development of action plans, rapid changes in healthcare environments, public health crises, and public investment to address those crises. The group met monthly to report on strategy revisions that were aligned with CHNA priorities, did not duplicate existing system and/or community initiatives, and were consistent with resource availability. Evaluation data were reported at quarterly meetings during 2018, reported to the Board of Directors, and compiled for this report. A summary of the priorities, strategies, and impact of those strategies follows.

Perinatal and Maternal/Infant Health

Clarise Ottley, PhD, RNC, MNN, Manager, Mother and Baby Unit
Helena Brady, PhD(c), NNP-BC, IBCLC, Nursing Manager, Neonatal Intensive Care Unit.
Kellie Rae Minnie, BSN, OB Nurse Manager, Jefferson Medical Center

The Perinatal and Maternal/Infant Health was a newly formed team that focused on primary and secondary prevention of complications of the neonatal period and decreasing infant mortality rates. Maternal smoking *is one of the most prevalent modifiable risk factors for poor birth* outcomes. In 2013, 26.3% of West Virginian women smoked during pregnancy compared to 13% nationally. In 2015, 23.2% of all adults smoked in Berkeley County. With the overall aim of reducing complications of the neonatal period and infant mortality rates, the IT continued their partnership with the West Virginia Perinatal Partnership to implement an evidence-based smoking cessation program. Consistent with the aims of the WV Perinatal Partnership smoking cessation initiative, the plan targeted community OB providers. In addition, the training targeted hospital staff to assure continuity of smoking cessation interventions across care settings.

Strategies:

1. Determine perinatal exposure to smoke during 2017 as a baseline.
2. Conduct needs assessment for smoking cessation initiative among OB/GYN providers, office staff, and hospital staff.
3. Implement *Help2Quit – Tobacco Cessation Training Project* in collaboration with the West Virginia Perinatal Partnership.[i]

Impact:

- Baseline BMC perinatal exposure to smoke established:
  - In 2017, 296 mothers who delivered at BMC smoked
  - 28% of babies born at BMC exposed to smoke in utero
- Conducted community provider and hospital needs assessment
- WV Perinatal Partnership/Help2Quit training

  - Hospital staff smoking cessation training
  - Two trainings May 2019 (JMC and BMC)
- Community outreach education planned for 2019

Cancer

Yvonne Katz, MS, RN, Cancer Navigator, Community Outreach Coordinator, WVU Medicine/University Healthcare, Berkeley Medical Center
Samantha Spearing, BSN, Breast Cancer Navigator, WVU Medicine/University Healthcare, Berkeley Medical Center

The Cancer Implementation Team (IT) consisted of the Champions and the Berkeley Medical Center Cancer Committee (BMCCC). The BMCCC consists of multidisciplinary experts and stakeholders in cancer prevention, treatment and care. The Medical and Nursing Directors of Outpatient Oncology, Navigation, and Community Outreach Development met to review priorities and develop a plan that was implemented by the Oncology Nurse Navigator and Breast Cancer Nurse Navigator. Based on an assessment of existing community initiatives, resources, and additional assessment, the Cancer IT developed a plan to address the following priorities: (1) primary and secondary prevention of lung, breast, and colorectal cancer; (2) reduce barriers to cancer screening and treatment; and, (3) continued outreach to underserved populations.

Strategies:

1. Continue breast cancer screening in collaboration with Bonnie's Bus.
2. Continue reduced fee mammogram clinics.
3. Continue monthly, reduced fee Low Dose CT lung cancer screening for high risk individuals.
4. Create Colorectal Committee Subcommittee to promote colorectal cancer awareness.
5. Continued support of cancer navigators to identify and meet navigation and support needs of patients and families.
6. Continued partnerships to expand outreach to special populations.

Impact:[ii]

Breast Cancer Screening

- Bonnie's Bus made 4 visits across Berkeley and Jefferson County in 2018. (P)
  - 10% increase from 2015 in number of Bonnie's Bus participants (O)
    - 40.6% uninsured; 15.9% Medicare; 8.8% Medicaid.
    - 15.1% required either ultrasound or diagnostic mammogram.
- 27% increase in number of reduced-fee mammogram participants (O)

Reduced Fee Low Dose CT Screening (LDCT)

- 55% increase from 2015 in participants in the LDCT screening program (O)
  - Increased female participation in screening
  - 71% (n=24) had nodules 4 mm or greater (37% in 2015)
    - Fewer individuals with nodules (24.3%) but higher proportion with nodules $\geq$ 4 mm. (71%).

Colorectal Cancer Subcommittee

- Standing Colorectal Cancer subcommittee created, and Cancer Risk Assessment Program developed. (P)

- Pilot FIT testing program with employees implemented (P/O)[iii]
- Colorectal cancer prevention strategies for healthcare settings and community.

Cancer Navigation[iv]

- Cancer Navigation Program expansion
- Four most common navigation needs addressed by Nurse Navigators (O)
  - Care coordination needs, including coordinating appointments, internal and external referrals, genetic testing needs, and symptom management.
  - Educational needs including education related to cancer, staging, diagnosis, treatment and survivorship.
  - Psychosocial barriers to care including difficulty coping with diagnosis, treatment, caring for family members, and sexual/body image disturbances.
  - Healthcare and medication costs, including referral to internal and external resources for financial assistance.

Outreach:[v]

- Ongoing meetings with community partners to identify and address sociocultural barriers to screening among underserved populations.
- Information packets to community partners to increase awareness and access to screening and area resources for underserved populations.
- Translation services and cancer prevention educational materials in English and Spanish to community partners.
- Outreach to senior centers, community health centers, and other community groups to increase awareness and reduce barriers to timely screening.
- Regular community wellness activities and programs coordinated by Health Promotion Coordinator.

Behavioral Health

The Behavioral Health plan built on existing and new community partnerships to address behavioral health needs and gap and bolster assets. The implementation plan was refined in response to the significant rise in overdose deaths in the Eastern Panhandle and subsequent infusion of federal and state financial resources to address the gaps. The Behavioral Health IT worked with community partners to (1) primary and secondary prevention of behavioral health problems; and (2) timely access to behavioral health services, recovery programs, and family supports and resources. The IT based their approach on the assumption that enhanced community collaboration on outreach, education, and dissemination of resource guides would improve access to timely behavioral health and recovery services. The following strategies were developed for action:

Strategies:

1. Continue to collaborate with partners on community/school-based substance abuse/ mental health education.
2. Develop formal mechanisms to increase awareness of behavioral health resources targeting suicide and overdose.
3. Collaborate with area first responders on mental health and crisis intervention.
4. Coordinate with existing substance abuse recovery resources to foster collaboration and outreach to affected populations.

5. Expand training capacity for adult and child/adolescent Mental Health First Aid.
6. Collaborate with the Department of Health and Human Resources as well as Family Services and faith groups to increase awareness of available resources for behavioral health.

Impact:

- *Increased Awareness of Suicide and Overdose Resources*
  - All patients receive universal discharge instructions with HELP4WV and Suicide Hotline information. (P/O)
  - Overdose survivor packet of resources distributed to Emergency Department and first responders. (P/O)
  - Comprehensive resource guide EPIC integration ongoing. (P)

- *First Responders and Mental Health*
  - First responder training on crisis intervention and mental illness
  - First Responder Behavioral Health/Crisis Intervention
    - 8 crisis debriefings with first responder/dispatch personnel (O)
  - Berkeley County Health Department Harm Reduction Program
    - Agreements signed for integrated behavioral health services.

- *Community Education and Outreach*
  - 40 collaborative community partners (O)
  - 4 WVU system collaborative partners (O)
  - 555 community education contacts (O)
    - Topics including youth developmental assets; SBIRT, Medication Assisted Treatment;
  - 4 Mental Health First Aid training with 39 participants; positive evaluations (4.5/5) (O)
    - Qualitative evaluation of benefits: "Being able to recognize mental health disorders and how to address them"; "Not looking at mental illness as a weakness"; "Being able to recognize mental health disorders and how to address them."

- *Leadership in the Community*
  - Health and Human Services Collaborative Steering Committee membership (HHSC)
  - Chair, HHSC Behavioral Health Workgroup
  - Bridging Public Safety and Public Health to Reduce Overdose Steering Committee membership

Chronic Illness

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Alexandria Arvon, MD, WVU Medicine Primary Care, Pendleton; Co-Founder, Healthcare Advocates for Recovery, Inc. (HART)
Dana DeJarnett, MS, Health Promotion Coordinator, Wellness Center at Berkeley Medical Center

The chronic illness plan built on and expanded existing initiatives. Strategies were developed that built on existing initiative to address internal (hospital) and external (community) gaps and strengthened bridges to existing community initiatives. included diabetes management quality initiatives, a transition improvement plan, and reduction of preventable hospitalizations. External initiatives focused on sustaining the Chronic Disease Self-Management Program, continued bridging with community providers to improve care transitions for persons with chronic illness, and continuing community-based wellness

initiative in collaboration with the Wellness Center at Berkeley Medical Center. Specific priorities selected were (1) primary and secondary prevention of metabolic syndrome and diabetes; (2) timely access to and continuity of chronic illness care; and, (3) self-management of chronic illness.

Strategies:

1. Create a group to address our discharge process to try to do a better job of preventing people from "falling through the cracks".
2. Create standardized processes and discharge instructions for patients who decide to leave AMA.
3. Work with the diabetes group to improve care transitions for persons with diabetes.
4. Support Chronic Disease Self-Management Program.

Impact:

Timely access to and continuity of chronic illness care

- Two process improvement groups formed, one "working group" and larger group with community providers. (P)
- System-level approaches for diabetes management (DKA and Hyperglycemia) developed and are being deployed. (P)
- Basal insulin dosing and sliding scales are used as appropriate. (O)
- Diabetes Transition plan approved December 2018. (P)

Self-management of chronic illness

- Chronic Disease and Diabetes Self-Management Programs (CDSMP/DSMP) offered in partnership with Berkeley County Health Department.
- 2 CDSMP courses held in 2018 (O)
    - 29 signed up; completion rate 62% (O)
    - Course evaluations positive - increased self-management skills, motivation to live healthier lifestyle, ability to cope with frustration and develop action plan.
- Berkeley County Health Department CDSMP/DSMP license lapsed and no additional classes planned.
- Pain Self-Management Program to be offered in January 2019 in cooperation with WVU researchers. (P)

Primary and secondary prevention[vi]

- Ongoing collaboration with special population providers, and system providers
- Changes in food options in cafeteria. (P)
    - Carb counts added to menus. (P)
    - Catering staff education on carb counts and to facilitate appropriate food choice selection among patients. (P)
- Prevention outreach:
    - 85 chronic illness prevention and care occurrences (O)
    - 19 physical activity/behavior change occurrences (O)

Strengths and Limitations

One of the major strengths of the CHNA/Implementation Plan was the level of commitment of the champions and long-standing relationships with and furthered collaboration with their community partners. For example, although the Perinatal/Maternal Infant team was new to the CHNA, their plan built on the existing relationship with the WV Perinatal Partnership to implement a smoking cessation educational intervention in acute and community-based care settings. The WVU Medicine/University Healthcare investment included training resources, paid staff time for education, and support for community-based provider and office staff training. Similarly, the Chronic Illness and Behavioral Health

Champions built on long-standing relationships within the community to further develop bridges between the hospitals and community-based providers to improve chronic illness prevention and care and provide much needed behavioral health support for first responders. Perhaps more importantly, the development of new bridge programs that extended out into the community, created new and sustainable partnerships that promise to improve access to health and healthcare resources in the community. All the Champions dedicated both paid and volunteer hours in service to the community and should be commended for their diligence and hard work.

Another strength of the plan was the level of community engagement in the process. By engaging the community in the development of health priorities and strategies to improve community health, the credibility and sustainability of health improvement efforts and the image of WVU Medicine/University Healthcare and its vital role in the health of the community was enhanced. For example, two champions served Health and Human Services Collaborative (HHSC) Steering Committee. The HHSC consists of approximately 90 community agencies, groups, and volunteers from all three Eastern Panhandle counties (Appendix C). Service on the Steering Committee offered a conduit for communication and the development of strategies to address social and economic determinants of health. In addition, one of the Behavioral Health Champions served as Chair of the HHSC Behavioral Health Work Group (BHWG). Although the full impact of the community engagement and leadership is not captured in this report, the community benefit is substantial and will be reported in the Community Benefit Report.

While there were many positive outcomes associated with the CHNA, there are were limitations as well. Some of these changes are emblematic of the nature of the healthcare system, WVU Medicine/University Healthcare responses to the challenges and opportunities inherent in today's healthcare environment, changes in key personnel, and the breadth and depth of the initial strategies and their practical application. For example, a delay between completion of the 2016 assessment and strategy implementation was accompanied by rapid changes in healthcare environment, public health crises, and public investment to address these crises. This resulted in delays in the development and implementation of strategies and implementation plans that were aligned with CHNA priorities, did not duplicate existing system and/or community initiatives, and were consistent with resource availability.

System constraints also served as barriers to strategy implementation, such as the Chronic Disease IT CDSMP/DSMP strategy. Although the collaboration with the Berkeley County Health Department to implement this program continued despite lapse in state funding during the first CHNA, the CDSMP/DSMP license lapsed and training of new trainers was cost prohibitive. This led to a gap in certified trainers to implement the training. This gap was counterbalanced by new outreach and educational programs offered by the Wellness Center, WVU Center for Diabetes and Metabolic Health, and strategies developed by the Diabetes process improvement groups. This illustrates the impact of programs closures but also the benefits of the expansion of resources and investment in and partnerships with community partners to improve the health of local communities.

In summary, the CHNA limitations are emblematic of the nature of the healthcare system, WVU Medicine/University Healthcare responses to the challenges and opportunities inherent in today's healthcare environment, and the breadth and depth of the initial strategies and their practical application. Overall, the CHNA implementation plan strengths far outweigh its limitations.
APPENDIX A: Cancer Navigator Community Partners and Resources

Community Partners and Resources

- HHSC Health Workgroup
- Mountains of Hope
- WVU Cancer Institute
- Wellness Center at Berkeley Medical Center (exercise, diet/nutrition, wellness classes/programs)
- Community Foundations
- "Bridge" Home Health/Hospice Program and hospital palliative care program
- Regional home health agencies
- American Cancer Society
- Wellness Center
- Bonnie's Bus
- Cancer Support Groups
- Reduced-fee screening programs
    - Low Dose CT Lung (monthly)
    - Mammograms (weekly at specified times)
- Department of Health and Human Resources (eligibility for Medicaid/Medicare and other programs and referral)
- Senior Services
- Shenandoah Community Health (Comprehensive FQHC)
- Local pharmacies and pharmaceutical access programs
- MTM, EPTA, Berkeley and Jefferson Senior Services (transportation)
- Social Security
- Diabetes Management
- Coalition to End Homelessness, Catholic Charities
- Telemon Corporation
- HUD
- Therapeutic Referral Resources
- Local and regional cancer service providers, including interventional radiology,
- Translation services
    - Stratus (language translation)
    - Shenandoah Community Health
- Community behavioral health providers
    - Shenandoah Community Health
    - EastRidge Health Systems
    - Private providers
- Mountain Health (WV Medicaid Child Care Support Services)
- WVU Medicine Internal Scheduling Services
- Regional hospice/palliative care programs

APPENDIX B: Behavioral Health IT Community and System Contacts and Collaborations

Community Contacts and Collaborations

- Health and Human Services Collaborative (HHSC)
    - Continued promotion of mental health/substance abuse issues education through advocacy, community education/ community events.
    - HHSC Steering Committee
    - HHSC Behavioral Health Workgroup
    - HHSC Health Workgroup
- HART: Healthcare Advocates for Recovery- Collaboration in providing community education through health fair attendance and educational events.
- Elements Behavioral Health- Collaborating to provide educational events.
- HELP4WV- Providing resources for survivor packets.
- Berkeley County Recovery Resource Center- Agreement to allow Harm Reduction program information to be included in survivor packets and providing resource information.
- Berkeley County Schools- Providing in school education to students on mental health issues, health fairs.
    - Project Aware- Collaborating to offer Adult MHFA trainings, providing class materials.
- RESA 8- Collaborating to provide education on mental health issues within Berkeley County Schools.
- Martinsburg Fire Department
- Berkeley County Emergency Ambulance Authority- Worked together to create a training on effectively caring for psychiatric patients for EMS providers
- United Way of the Eastern Panhandle.
- The Renovo Center
- Telemon Corporation
- Shenandoah Valley Medical Systems
- East Ridge Health Systems
- Potomac Highlands Guild
- Oxford House
- Nurture & Balance
- National Youth Advocacy Program
- Mountaineer Behavioral Health
- Mountain State Natural Care
- Martinsburg Police Department
- Legal Aid of WV
- Family Resource Network
- Christian Psychological Services
- Catholic Charities
- Board of Child Care
- Berkeley County Day Report Center
- Berkeley County Health Department- Agreement to allow Harm Reduction program information to be included in survivor packets
- Bridges Project
- Senior Towers
- Greater Recovery through

- Delphi Behavioral Health
- American Addiction Centers

WVU System Collaborations

- Behavioral Health Unit collaboration with Emergency Departments- Collaborating to create and implement program that would bring Recovery Coaches into the Emergency Departments to support those patients who have substance abuse issues.
- WVU IT/EPIC staff to incorporate universal discharge information on *Help4WV* and suicide hotline into EPIC.
- WVU IT/EPIC staff and WVU Medicine Clinical Research Coordinator to integrate comprehensive behavioral health resource guide into EPIC for hospital and community providers.
- WVU Pendleton Primary Care to assure timely SUD treatment through bridge from hospital-based MAT induction to MAT treatment.
- Chestnut Ridge Center and Dr. James Berry for consultation on inpatient MAT induction for SUD patients.

APPENDIX C: Health and Human Services Organizational Members

ORGANIZATIONS:

1. American Cancer Society (Health)
2. Berkeley County Health Department (Health)
3. Berkeley County Schools (Board of Education)
4. Berkeley County Schools/Nutrition & Wellness Department (Health)
5. Berkeley County Recovery Services (Behavioral Health)
6. Berkeley Day Report Center (Behavioral Health)
7. Berkeley Medical Center Behavioral Health Services (Behavioral Health, Health)
8. Board of Child Care (Behavioral Health and KIT)
9. Boys and Girls Club of the Eastern Panhandle (KIT)
10. Blue Ridge Community & Technical College (Behavioral Health, Housing, Strong and Stable Families)
11. Bridges to Healthy Transitions, WVU School of Nursing (Behavioral Health)
12. Burlington United Methodist Family Service, Inc. (KIT, Strong and Stable Families, Health)
13. CASA of the Eastern Panhandle, Inc. (Strong and Stable Families, KIT, Housing)
14. Catholic Charities West Virginia – Eastern Region (Strong and Stable Families, Housing)
15. Childhelp Alice C. Tyler Village (Behavioral Health)
16. Children's Home Society of WV (KIT)
17. Christian Psychological Services (Behavioral Health)
18. City of Martinsburg Community Development (Housing)
19. Community Alternatives to Violence (Behavioral Health)
20. Community Networks, Inc. (Strong and Stable Families & Housing)
21. Daily Companions, Inc. (Strong and Stable Families)
22. Department of Veterans Affairs – Veterans Experience Office (Health, Behavioral Health, Housing)
23. EPEC (Eastern Panhandle Empowerment Center Inc.) (Strong and Stable Families, Behavioral Health, Housing)
24. EPIC (Eastern Panhandle Instructional Cooperative) Adolescent Health Program (Behavioral Health, KIT, Strong and Stable Families)
25. EPIC (Eastern Panhandle Instructional Cooperative) Adult Education & SPOKES (Strong and Stable Families)
26. EPIC (Eastern Panhandle Instructional Cooperative) Birth to Three (Strong and Stable Families)
27. EPIC (Eastern Panhandle Instructional Cooperative) Head Start (Strong and Stable Families)
28. Eastridge Health Systems (Behavioral Health, Housing, KIT)
29. Eastern Panhandle Transit Authority (Strong and Stable Families)
30. Elmcroft of Martinsburg (Health, Housing)
31. Faith Community Coalition for the Homeless (Housing)
32. Family Preservation Services (Behavioral Health, KIT)
33. Family Resource Network of the Panhandle, Inc. (All)
34. FLOC Outdoor Education Center (Health)
35. Good Samaritan Free Clinic (Housing, Health)
36. Good Shepherd Interfaith Volunteer Caregivers (Health, Strong and Stable Families, Housing)
37. Habitat for Humanity of the Eastern Panhandle (Housing)
38. The Health Plan (Health)
39. Healthy Berkeley (Health)
40. Hospice of the Panhandle (Health)

41. Jefferson County Council on Aging (Health)
42. Jefferson County Health Department (Health)
43. Jefferson County Schools (Behavioral Health, KIT)
44. Jefferson Day Report Center (Behavioral Health)
45. Jefferson County Teen Court (KIT, Behavioral Health)
46. Juvenile Justice Commission – WV Supreme Court (Behavioral Health, KIT)
47. Legal Aid of West Virginia (Behavioral Health, Housing)
48. Martinsburg City Council (Housing)
49. Martinsburg Housing Authority (Housing)
50. Martinsburg Police Department (Housing)
51. Maximus/Mountain Health Trust (Behavioral Health, Health, Strong and Stable Families)
52. MODIFY (Behavioral Health, KIT)
53. Morgan County Partnership (Behavioral Health)
54. Morgan County Starting Points FRC (KIT, Strong and Stable Families)
55. Mountain Heart Community Services, Inc. (Strong and Stable Families)
56. Mountaineer Behavioral Health (Behavioral Health)
57. National Youth Advocate Program (Behavioral Health, KIT, Strong and Stable Families)
58. New Hope Treatment Centers (KIT)
59. Panhandle Home Health (Health)
60. Partnership for Affordable Housing (Housing)
61. Potomac Highlands Guild (Behavioral Health, KIT, Health)
62. Project Aware – Berkeley County Schools (Behavioral Health, KIT)
63. Promise Neighborhood Initiative (Strong and Stable Families)
64. RAPP of the Panhandle (KIT)
65. Recovery West Virginia, Inc. (Behavioral Health, KIT)
66. The Renovo Center (Behavioral Health, Health, KIT, Strong and Stable Families)
67. Retired Senior Volunteer Program (Strong and Stable Families)
68. Safe Haven Child Advocacy Center (KIT)
69. Senior Community Service Employment Program/Region 8 Planning and Development
70. Senior Towers/Millennia Housing (Strong and Stable Families, Behavioral Health)
71. Shenandoah Community Health Center (Strong and Stable Families, Housing, Health, Behavioral Health)
72. Shenandoah Community Health- Ryan White Program (Behavioral Health, Health)
73. Shenandoah Valley Medical Systems, Inc. – Behavioral Health Services (Behavioral Health, KIT)
74. Shenandoah Valley WIC Program (Health)
75. Telamon Corporation (Strong and Stable Families, Behavioral Health, Housing)
76. Timber Ridge School (Behavioral Health, KIT)
77. Unicare Medicaid Health Plan of WV (Strong and Stable Families, Health, BH, KIT)
78. United Way of the Eastern Panhandle (Behavioral Health, Housing, Strong and Stable Families)
79. WV AmeriCorps VISTA (Health, KIT)
80. West Virginia Coalition to End Homelessness (Behavioral Health, Housing, Strong and Stable Families)
81. West Virginia Department of Health & Human Resources – Bureau for Children and Families (Strong and Stable Families & KIT)
82. WVNG Family Programs, Child & Youth (Health, Behavioral Health, KIT, Housing)
83. West Virginia Counseling Advocacy- YAP (Behavioral Health, KIT, Strong and Stable Families)

84. West Virginia University Center for Excellence in Disabilities: Traumatic Brain Injury Services (Behavioral Health, Health, Housing)
85. West Virginia University Extension Service – Berkeley County (Health, Strong and Stable Families)
86. West Virginia University Medicine/ The Wellness Center @ Berkeley Medical Center & Jefferson Medical Center (Health)
87. WVU Medicine – Harpers Ferry Family Medicine (Behavioral Health)
88. West Virginia University Medicine – Jefferson Medical Center (Health, Behavioral Health)
89. West Virginia University School of Social Work- Martinsburg (Behavioral Health, KIT)
90. YoungLives of Jefferson County (Behavioral Health, Self-Sufficiency, Health, Housing)

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[i] WV Perinatal Partnership Help2Quit Initiative: http://www.wvperinatal.org/initiatives/help2quit-tobacco-cessation-training-project/

[ii] (P) = Process indicator; (O) = Outcome indicator; (P/O) indicates both process and outcome indicators.

[iii] This project was spearheaded by Dr. Ryan Livengood, WVU Medicine Pathology and Mr. Joshua Mongold, Laboratory Manager, Jefferson Medical Center.

[iv] List is not all inclusive.

[v] Regular community wellness activities and programs coordinated by Health Promotion Coordinator.

[vi] These activities were coordinated and reported by Regular community wellness activities and programs coordinated by Health Promotion Coordinator. Additional detail of outreach activities will be included in the Community Impact report.