PRIORITIZING
PREVENTION
in West Virginia 2020

WEST VIRGINIA
Prevention Strategic Plan

2021–2023

WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR
BEHAVIORAL HEALTH

ACKNOWLEDGEMENTS

It takes a village to create a positive environment in which people can thrive, and so is true with the diverse stakeholders who came together to draft West Virginia's Three-Year Prevention Strategic Plan. The development of this plan is a result of a collaborative process among various bureaus within the West Virginia Department of Health and Human Resources (DHHR), West Virginia Department of Education, and local, public, and private prevention organizations throughout the state. Through the implementation of this Strategic Prevention Plan, West Virginia can continue to build the prevention infrastructure and the health and wellness of individuals, families, schools, and communities within our great state.

We would like to thank all the planning team members without whom the development of this plan would not be possible. Each team member brought valuable knowledge, expertise, and passion to the table. Your commitment to achieving our shared goals is greatly appreciated.

A special thank-you is extended to the following individuals for their assistance in facilitating, moderating, or presenting during the planning sessions: Becky King Facilitator; Jenny Lancaster. Terzetto Creative; Martha Minter, Community Access, Inc.; Jessica Smith, Program Manager, DHHR's Office of Drug Control Policy; and Dr. Tammy Collins, Marshall University's Center for Excellence for Recovery. A complete list of participants can be found in *Appendix 3: Strategic Planning Team Members.*

Additionally, we are grateful to Christina Mullins, Commissioner of DHHR's Bureau for Behavioral Health, and Robert Hansen, formally of DHHR's Office of Drug Control Policy, for their leadership and support in this endeavor. Their recognition of the importance and need for increased collaborative and unified prevention efforts provided continual encouragement throughout this process.

Finally, we would like to thank all the individuals who reviewed this plan and provided valuable input and comments during the draft period. Your contributions are appreciated.

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PRIORITIZING PREVENTION in West Virginia 2020

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INTRODUCTION

In April 2020, DHHR's Bureau for Behavioral Health (BBH) launched a strategic planning process to develop a unified, comprehensive, statewide prevention plan that will help strengthen and sustain West Virginia's current prevention infrastructure. Due to the COVID-19 pandemic, in-person meetings were replaced with a series of facilitated, virtual planning sessions with prevention allies and partners to develop a shared vision, core values, and three-year strategic priorities, objectives, and outcomes.

The West Virginia Strategic Prevention Plan builds upon and aligns with existing prevention plans currently being implemented by our partners. These plans include the *West Virginia 2020-2022 Substance Use Response Plan* through DHHR's Office of Drug Control Policy (ODCP) and the *State Rural Health Plan 2018-2022* through DHHR's State Office of Rural Health. The Governor's Council on Substance Abuse Prevention and Treatment (Council) will act as the main oversight entity for the plan. A subcommittee of the Governor's Council, the Prevention Committee, will work in tandem with the current Prevention Steering Team to implement and evaluate this plan.

The intended audience for this plan includes legislators and other policy makers, governmental agencies, community-based prevention organizations/coalitions, primary and secondary schools, higher education institutions, media, businesses, law enforcement, civic and volunteer groups, youth-serving organizations, and funding partners. The West Virginia Strategic Prevention Plan will be launched December 1, 2020 and overseen by the Governor's Council Prevention committee and the currently in place Prevention Steering Team through BBH.

Throughout the planning process, the importance of building, understanding, and using common language and terminology was noted. A list of various prevention terminologies can be found in *Appendix 1: Acronyms and Abbreviations.*

The Strategic Prevention Framework (SPF) provided by the Substance Abuse Mental Health Services Administration (SAMHSA) was the overall planning framework utilized for the development of this plan. SAMHSA is the agency within the U.S. Department of Health and Human Services designated to lead public efforts to advance the behavioral health of the nation. Congress established SAMHSA in 1992 to make substance use and mental disorder information, services, and research more accessible.

The following key elements comprise the SPF and contribute to more meaningful strategic plans:

- ***Getting Started:*** Initiate the process;
- ***Capacity:*** Mobilizing our state system and building capacity;
- ***Assessment:*** Assess our state's needs, resources, readiness, and gaps;
- ***Planning:*** Develop a strategic prevention plan;
- ***Implementation:*** Implement evidence-based prevention strategies;
- ***Reporting and Evaluation:*** Evaluate and monitor results, change as necessary;
- ***Cultural Competence:*** Ensure that we operate in consideration of diverse communities; and
- ***Sustainability:*** Identify new funding sources and resources and sustainable service delivery.

In addition to the SPF, theoretical or conceptual frameworks that support the premise of the West Virginia Strategic Prevention Plan include the following:

- Social Ecological Model;
- Social Determinants of Health;
- SAMHA's Eight Dimensions of Wellness;
- Theory of Change; and
- Lifelong impact of Adverse Childhood Experiences (ACEs).

The theoretical and conceptual frameworks of the Strategic Prevention Plan are discussed in Chapter One.

Strategic Prevention Framework

SPF is a major national initiative of the Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA).

The SPF focuses on a "systematic process" and the process requires frequent revisits to previous steps.

(https://www.slideserve.com/qamra/strategic-prevention-framework)

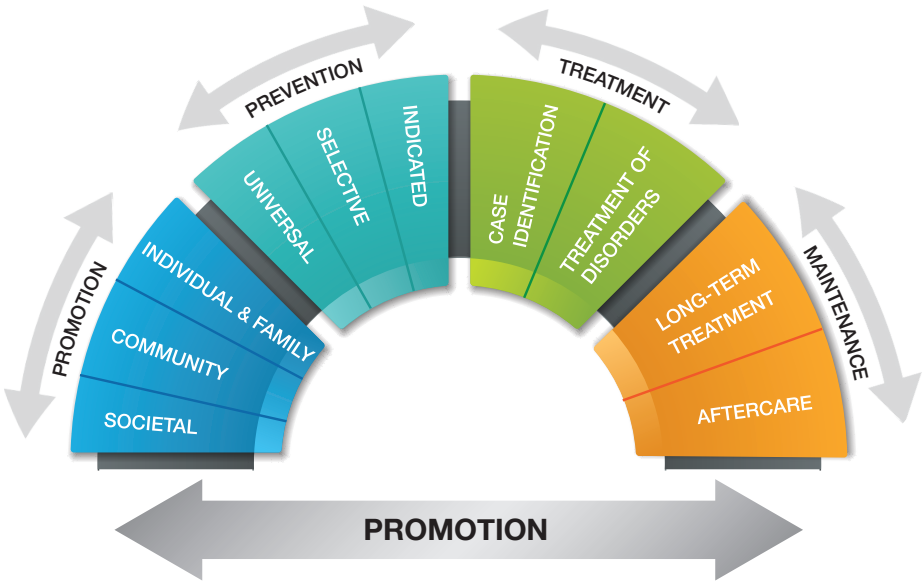
CHAPTER ONE

CHAPTER ONE
EXECUTIVE SUMMARY

SECTION 1:1 OVERVIEW OF PREVENTION

What is prevention? Merriam-Webster defines prevention as the act of preventing or hindering.[1] What is meant by *Prioritizing Prevention in West Virginia*? This overview will answer this question and discuss the delivery of effective evidence-based programs and prevention strategies for substance use, suicide, child abuse, sexual violence, and domestic violence.

According to SAMHSA, prevention is one component of the continuum of behavioral healthcare (the promotion of mental health, resilience, and well-being), along with promotion, treatment, and recovery. Prevention helps individuals develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors related to substance use/misuse prevention, suicide prevention, and mental health promotion.[2] The prevention field relies heavily on research and practice working in concert within local communities to effectively create positive outcomes in building healthy families and communities.



The Institute of Medicine (IOM) categorizes prevention into three categories in relation to substance use/misuse. Universal prevention strategies address the entire population and are not directed at a specific risk group. Selective prevention focuses on subpopulations that are

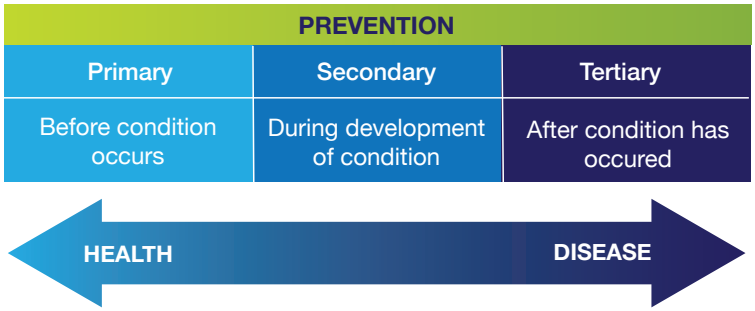
1 Merriam-Webster. (n.d.). Prevention. In *Merriam-Webster.com dictionary*. Retrieved August 23, 2020, from https://www.merriam-webster.com/dictionary/prevention
2 Learn About Prevention, Prevention Action Alliance. (n.d.) Retrieved August 23, 2020 from https://preventionactionalliance.org/learn/about-prevention/.

According to the Centers for Disease Control and Prevention (CDC), public health works to prevent disease and promote health rather than diagnose and treat diseases.

at increased risk for substance use/misuse due to exposure to identified risk factors. Indicated prevention targets those already using or engaged in other high-risk behaviors to prevent heavy or chronic use.[3] Service strategies and classification of strategies are based on service delivery method and targeted populations. After the strategies and classifications are determined, evidence-based programming selection begins. IOM notes evidence-based programming is defined as conceptually sound, internally consistent, reasonably well implemented and evaluated.

According to the Centers for Disease Control and Prevention (CDC), public health works to prevent disease and promote health rather than diagnose and treat diseases. This form of prevention is related to an individual's physical health. The public health approach to prevention is also categorized into three levels:

- Primary prevention aims to reduce risk factors to prevent disease onset;
- Secondary prevention screens to identify diseases in the earliest stages, before the onset of signs and symptoms; and
- Tertiary prevention is managing disease post-diagnosis to slow or stop the disease progression.[4]



An example of a public health approach to prevention in these stages would be education on the harms of tobacco use (primary), routine screenings for disease due to tobacco use (secondary), and managing disease to stop or delay progression due to tobacco use (tertiary).

3 Institute of Medicine (IOM) Classifications for Prevention. Retrieved August 23, 2020 from http://mh.nv.gov/uploadedFiles/mhnvgov/content/Meetings/Bidders_Conference/Institute%20of%20Medicine%20Prevention%20Classifications-rev10.20.14.pdf

4 Center for Disease Control. Prevention. Retrieved on August 23, 2020 from https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf

Prevention in relation to intimate partner abuse, child abuse, rape, and victimization also use the terms primary, secondary, and tertiary prevention. Primary prevention interventions occur before abuse takes place and is delivered to all populations. Secondary prevention interventions focus on subpopulations that are at higher-risk and have fewer protective factors in place. Tertiary prevention interventions seek to prevent further incidences of abuse/sexual violence from happening again with individuals or families where it has already happened.

Universal, selective, and indicated prevention interventions can be integrated into an overall public health approach in primary healthcare settings, schools, work sites, churches, and other community settings.[5] Studies have shown the benefits of integrated primary and behavioral healthcare. The links between mental illness and physical illness are well documented, as risk factors for poor health outcomes are also the same risk factors for substance use/misuse and behavioral health disorders. Prevention is an important piece of this continuum of care, and preventionists can work together to deliver interventions in a coordinated way, especially during the COVID-19 pandemic which could adversely affect individuals, families, and communities. Understanding the interconnections of individual prevention interventions as a system and how a systematic perspective works is critical as West Virginia moves forward to build and strengthen its prevention infrastructure.

Prevention work in the state is based on data and the implementation of proven, evidence-based programs and practices. The application of local, regional and state data applies to universal, selective, indicated levels of prevention and primary, secondary, and tertiary levels of prevention. Evidence-based programs are programs that have been rigorously tested in controlled settings, proven effective, and translated into practice models that are widely available to community-based organizations.

The Health Policy Institute of Ohio defines “evidence-based practice” and “evidence-based public health” as broad terms, often used interchangeably, that refer to the process of using scientific evidence to identify health problems and effective health improvement strategies.[6] Evidence-based practice involves making prevention decisions on the best available scientific evidence and data; applying program and planning frameworks; engaging the community in the decision-making and implementation; conducting sound evaluation; and disseminating what is learned. Federal funders, such as SAMHSA and CDC, require grantees to utilize evidence-based programs and practices in prevention, treatment, and recovery services and programs.

Evidence-based programs must also subject their evaluations, after rigorous testing, to critical peer review. This means that experts in the prevention field exam the evaluation methods and agree with the conclusions about the program’s effects.

5 Institute of Medicine (US) Committee on Prevention of Mental Disorders; Mrazek PJ, Haggerty RJ, editors. Reducing Risks for Mental Disorders. Frontiers for Preventive Intervention Research. Washington (DC): National Academies Press (US); 1994. 2, New Directions in Definitions. Available from: https://www.ncbi.nlm.nih.gov/books/NBK236318/.
6 Health Policy Institute of Ohio. Guide to evidence-based prevention. Retrieved from https://nnphi.org/wp-content/uploads/2015/08/GuideToEvidence-BasedPrevention.pdf.

Implementing an evidence-based program is widely considered a "best practice" strategy for community health promotion/prevention. Evidence-based programs add value in many ways:[7]

- Positively impacting the health of the program participants is more likely with an evidence-based program;
- Funders increasingly demand that programming be based on solid evidence;
- Agency leaders want to concentrate limited resources on proven programs;
- Program managers can concentrate their efforts on program delivery rather than program development, allowing them more time to reach a larger population and have a greater impact;
- Older adults are savvy and want to invest their time and money in programs that have been proven to work; and
- The demonstrated outcomes of evidence-based programs are attractive to community members and potential partners, facilitating community buy-in and the formation of partnerships.

It is important to note the distinction between "Research-Based" and "Evidence-Based." It is a common misconception that programs based in research fit the criteria to be an evidence-based program, but just because a program contains research-based content, or was guided by research, that does not mean the program itself has been proven effective. As noted above, the program must be tested and shown to be effective to qualify as an evidence-based program.

SECTION 1:2 RISK AND PROTECTIVE FACTORS

Risk and protective factors help explain why a problem exists and are the framework upon which prevention research and practice are based. These factors suggest why certain individuals or groups are likely or unlikely to become victims of crime, abuse, neglect, poor health outcomes, mental illness, suicide, or substance use/misuse.

According to SAMHSA, protective factors are characteristics associated with a lower likelihood of negative health outcomes or that reduce a risk factor's impact. Therefore, helping an individual to build protective factors reduces the risk of developing a risky health behavior or for an existing high-risk behavior to worsen. Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.[8]

An initial first step the Strategic Prevention Planning Team completed was comparing identified risk and protective factors across all the strategic plans submitted to the planning team. This process permitted the team to identify shared risk and protective factors across systems. While not an exhaustive list of all factors, the chart on the next page identifies some common protective and risk factors.

7 Enhance. What is an Evidence-Based Program. Retrieved from https://projectenhance.org/what-is-an-evidence-based-program/.
8 Substance Abuse and Mental Health Service Administration. Risk and Protective Factors. Retrieved on August 24, 2020 from https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf.

PROTECTIVE FACTORS

- Strong family unit
- Active/positive involvement with schools
- Positive peer relationships/role models
- Resiliency and coping skills
- Economic security
- Stable home
- Health needs met
- Social-emotional learning skills
- Positive Behavioral Interventions and Supports (PBIS)
- Trauma-informed schools
- Community support/connectedness
- Coordination of resources and services among community agencies
- Access to mental health and substance misuse services
- Affiliation with pro-social peers

RISK FACTORS

- Poverty
- Anxiety
- Depression
- Current mental health diagnosis
- Adverse childhood experiences (ACEs)
- Substance use/misuse
- Child abuse
- Academic issues
- Lack of parental involvement/monitoring
- Bullying
- Lack of employment opportunities
- Lack of institutional support from police and judicial system
- Weak health
- Economic
- Gender
- Educational and social policies
- High levels of crime and other forms of violence
- Family environment characterized by physical violence and conflict
- Adherence to traditional gender role norms

Risk and protective factors can have influence throughout a person's lifespan. For example, risk factors such as poverty and family dysfunction can contribute to the development of obesity, heart disease, high blood pressure, and mental or substance use disorders. The impact of risk factors also affects the community. Risk factors tend to be positively correlated with one another and negatively correlated to protective factors, which means individuals experiencing some risk factors have a greater chance of experiencing more risk factors.[9]

Working in collaboration with communities around shared risk and protective factors is an effective way to stretch limited funding, strengthen partnerships, and increase reach. Understanding risk and protective factors helps to identify appropriate interventions and methods to build protective factors. The more protective factors an individual has decreases risk factors. The essence of prevention practice is to decrease risk and increase protection by creating positive individual and community change. Working collaboratively across sectors helps build these protective factors for individuals, families, and communities.

9 Substance Abuse and Mental Health Service Administration. Risk and Protective Factors. Retrieved on August 24, 2020 from https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf.

SECTION 1:3 ADVERSE CHILDHOOD EXPERIENCES

The CDC-Kaiser Permanent Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being. Conducted from 1995 to 1997 with two waves of data collection, the study included more than 17,000 health maintenance organization (HMO) members receiving physical exams in southern California who completed confidential surveys regarding their childhood experiences and current health status and behaviors.[10] The study found that adverse childhood experiences (ACEs), or potentially traumatic events that occur in childhood, are aspects of the child's environment that can undermine their sense of safety, stability, and bonding.[11] ACEs include the following:

- Experiencing violence, abuse, or neglect;
- Witnessing violence in the home or community;
- Having a family member attempt or die by suicide;
- Substance use in the home;
- Mental health problems; and
- Parental separation or household members being in criminal justice system.

10 Centers for Disease Control and Prevention. Retrieved August 24, 2020 from https://www.cdc.gov/violenceprevention/acestudy/about.html.
11 Centers for Disease Control and Prevention. Retrieved August 24, 2020 from https://www.cdc.gov/violenceprevention/acestudy/about.html.

Researchers estimate that 55.8 percent of West Virginia adults report at least one ACE, while 13.8 percent reported four or more. The most common experience reported was substance use in the household at 29 percent, followed by parental separation/divorce at 26.6 percent and verbal abuse at 22.7 percent.[12]

It is important to note, however, that having a high number of ACEs does not mean that a person will necessarily develop correlating physical and mental health problems.[13] It simply means they are at a greater risk. Moreover, while ACEs can impact the development of the brain, the effect is not irreversible. Parts of the brain can grow and new pathways can be developed.

ACEs are counteracted by resiliency, which is the individual's ability to overcome adversity and continue normal development.[14] The single most important factor that influences a child's resiliency is having the support of at least one stable and committed relationship with a parent, caregiver, or other adult. The American Psychological Association also suggests the following for promotion of resiliency in children:[15]

- Teach children how to make friends, and build a strong family network;
- Introduce child to a belief/faith system;
- Teach child to help others;
- Maintain a daily routine;
- Encourage play;
- Teach child self-care, including eating properly, exercising, and getting adequate rest;
- Teach child to set reasonable goals;
- Nurture a positive self-view;
- Keep things in perspective and maintain a hopeful outlook;
- Look for opportunities of self-discovery;
- Accept change

America's Health Rankings by the United Health Foundation has provided an analysis of national health on a state-by-state basis for 30 years. The foundation evaluates a historical and comprehensive set of health, environmental and socioeconomical data to determine national benchmarks and state rankings. Data obtained from West Virginia's Health Rankings is valuable in guiding prevention work.

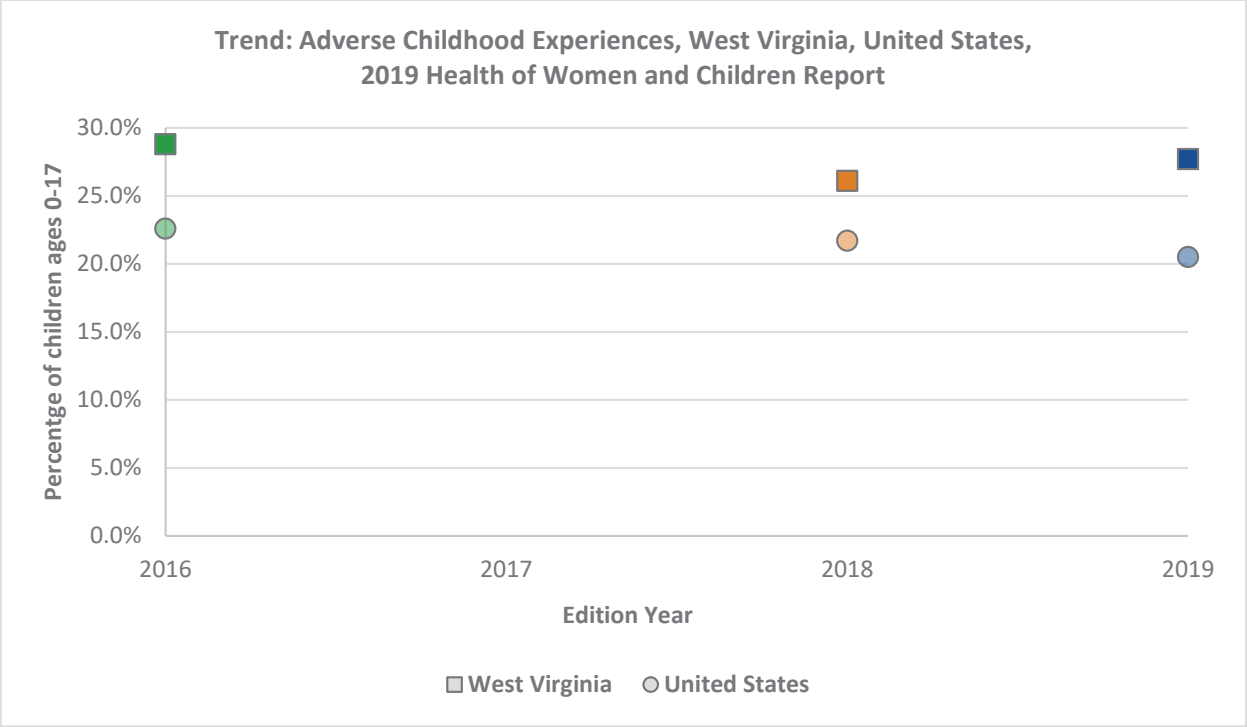
The tables on the following pages show ACEs for West Virginia as ranked by America's Health Rankings by the United Health Foundation.

12 Charleston Gazette-Mail. Traumatic childhood events common in WV, report says. February 10, 2018, https://www.wvgazettemail.com/news/health/traumatic-childhood-events-common-in-wv-report-says/article_7efb3d3b-9940-51c9-9ba1-4f162656ba7e.htm

13 Adverse Childhood Experiences (ACEs) and Their Impact on Brain Development. Maryland Coalition of Families. Blog. May 11, 2018. http://www.mdcoalition.org/blog/adverse-childhood-experiences-aces-and-their-impact-on-brain-development

14 Adverse Childhood Experiences (ACEs) and Their Impact on Brain Development. Maryland Coalition of Families. Blog. May 11, 2018. http://www.mdcoalition.org/blog/adverse-childhood-experiences-aces-and-their-impact-on-brain-development

15 Resilience guide for parents and teachers. American Psychological Association. August 26, 2020. https://www.apa.org/topics/resilience-guide-parents



2019 — Percentage of children ages 0-17 who experienced two or more of the following: economic hardship; parental divorce or separation; living with someone who had an alcohol or drug problem; neighborhood violence victim or witness; living with someone who was mentally ill, suicidal or severely depressed; domestic violence witness; parent served jail time; being treated or judged unfairly due to race/ethnicity; or death of parent (2-year estimate)

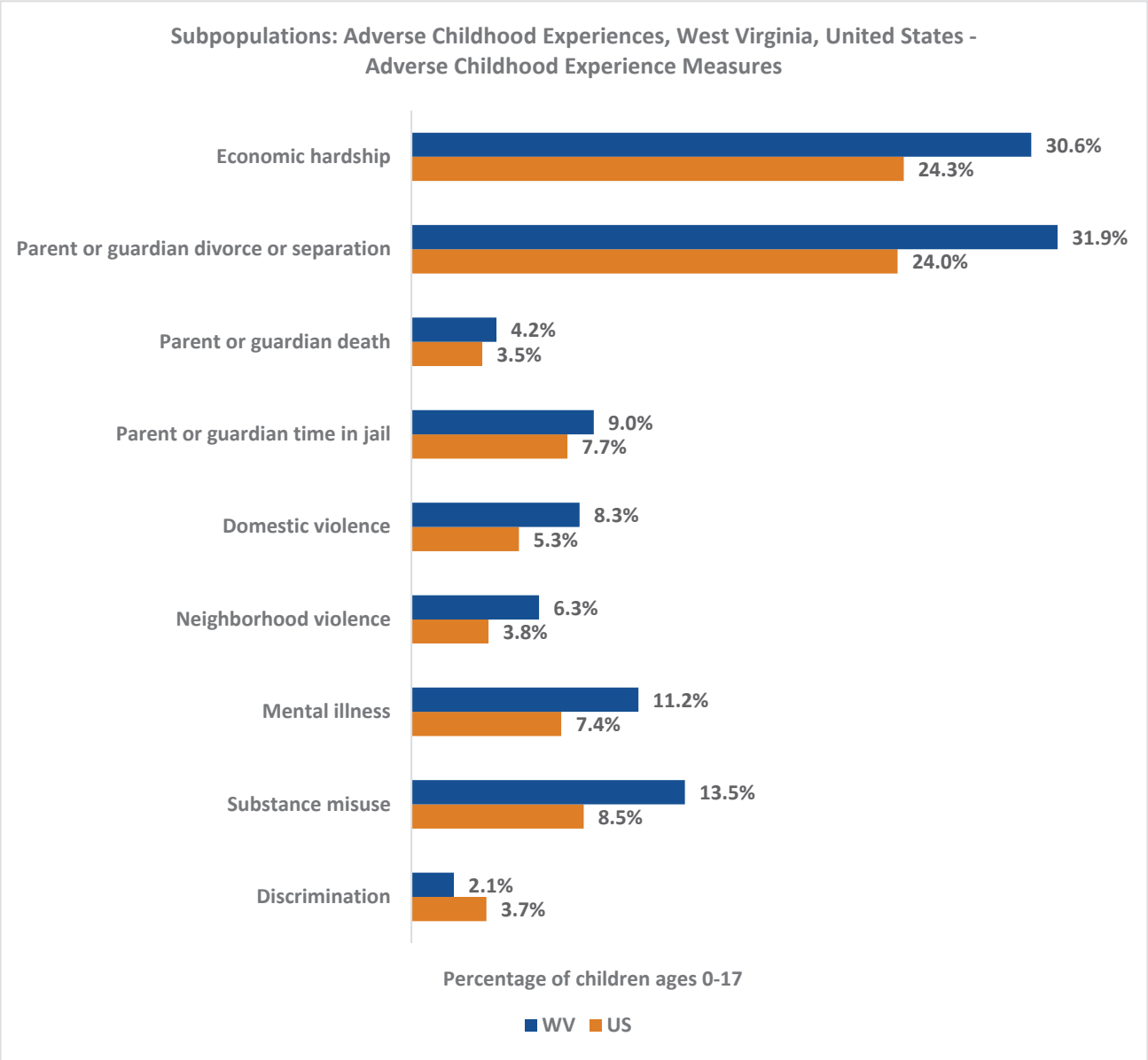
2018 — Percentage of children ages 0-17 who experienced two or more of the following: economic hardship; parental divorce or separation; lived with someone who had an alcohol or drug problem; victim or witness of neighborhood violence; lived with someone who was mentally ill, suicidal or severely depressed; domestic violence witness; parent served time in jail; treated or judged unfairly due to race/ethnicity; or death of parent (1-year estimate)

2016 — Percentage of children aged 0-17 who experienced two or more of the following: economic hardship; divorce/parental separation; lived with someone who had an alcohol or drug problem; victim or witness of neighborhood violence; lived with someone who was mentally ill or suicidal; domestic violence witness; parent served time in jail; treated or judged unfairly due to race/ethnicity, or death of parent (pre-2016 NSCH redesign)

Source:
U.S. HHS, HRSA, Maternal and Child Health Bureau (MCHB), Child and Adolescent Health Measurement Initiative (CAHMI), National Survey of Children's Health Indicator Data Set, Data Resource Center for Child and Adolescent Health

Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, Data Resource Center for Children and Adolescent Health

AMERICA'S HEALTH RANKINGS
UNITED HEALTH FOUNDATION



Data suppression rules are as defined by the original source.

Race and ethnicity populations are as defined by the original source.

Source:
U.S. HHS, HRSA, Maternal and Child Health Bureau (MCHB), Child and Adolescent Health Measurement Initiative (CAHMI), National Survey of Children's Health Indicator Data Set, Data Resource Center for Child and Adolescent Health, 2016-2017

AMERICA'S HEALTH RANKINGS
UNITED HEALTH FOUNDATION

ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood, and they also negatively affect education and job opportunities. However, ACEs can be prevented and mitigated.[16] Understanding of ACEs helps guide prevention work and ensures the appropriate interventions are selected and delivered to meet the individual's needs.

SECTION 1:4 STRATEGIC PREVENTION FRAMEWORK

For communities to establish and implement effective plans to address substance misuse, they must first understand that prevention must begin with an understanding of the complex behavioral health problems within their complex environmental contexts.[17] Research and experience have proven this to be the most effective means to provide substance misuse prevention strategies and program.

To facilitate this understanding, SAMHSA developed the Strategic Prevention Framework (SPF). The five steps and two guiding principles of the SPF provide a comprehensive approach to understanding and addressing the substance misuse and related behavioral health problems facing states and communities.[18]

The SPF includes these five steps:

1. **Assessment:** Identify local prevention needs based on data (e.g., What is the problem?)
2. **Capacity:** Build local resources and readiness to address prevention needs (e.g., What do you have to work with?)
3. **Planning:** Find out what works to address prevention needs and how to do it well (e.g., What should you do and how should you do it?)
4. **Implementation:** Deliver evidence-based programs and practices as intended (e.g., How can you put your plan into action?)
5. **Evaluation:** Examine the process and outcomes of programs and practices (e.g., Is your plan succeeding?)

16 Resilience guide for parents and teachers. American Psychological Association. August 26, 2020. https://www.apa.org/topics/resilience-guide-parents
17 A Guide to SAMHSA's Strategic Prevention Framework. June 2019. Substance Abuse Mental Health Services Administration. Retrieved from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf.
18 A Guide to SAMHSA's Strategic Prevention Framework. June 2019. Substance Abuse Mental Health Services Administration. Retrieved from https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf.

The SPF is also guided by two cross-cutting principles that should be integrated into each of the steps that comprise it:

- **Cultural competence:** The ability of an individual or organization to understand and interact effectively with people who have different values, lifestyles, and traditions based on their distinctive heritage and social relationships.

- **Sustainability:** The process of building an adaptive and effective system that achieves and maintains desired long-term results.

SECTION 1:5 SOCIAL ECOLOGICAL MODEL

The Social Ecological Model is a theory-based framework, endorsed by the CDC, for understanding how the social determinants of health influence and maintain health and health-related issues.[19] The Social Ecological Model moves beyond a focus on individual behavior and towards an understanding of the wide range of factors that influence health outcomes. The model illustrates how factors influence each other at different levels.[20]

1. Societal (e.g., laws, systems, the media, and widespread social norms)
2. Community (e.g., neighborhoods, schools, faith communities, and local organizations)
3. Individual (e.g., a person's attitudes, values, and beliefs)
4. Relationship (e.g., relationships with family, partners, friends, and peers)

The Social Ecological Model is used within prevention frameworks to understand the multiple contexts in which risk and protective factors exist. Individuals have biological and physical characteristics that can put them at greater risk or protect them from the effects of emotional, mental, and behavioral health problems:

- Risk and protective factors exist within relationships such as peers, partners, family members, and colleagues;
- Community factors occur within schools, workplaces, and neighborhoods; and
- Societal factors exist in cultural norms of communities.

19 Increasing Our Impact by Using a Social Ecological Approach. March 2015. Retrieved from https://www.healthyteennetwork.org/wp-content/uploads/2015/06/TipSheet_IncreasingOurImpactUsingSocial EcologicalApproach.pdf.
20 Centers for Disease Control and Prevention. (2019). The social-ecological model: A framework for prevention. Retrieved from https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html

The figure above illustrates the five levels of the model:

- **Individual/Intrapersonal:** The individual characteristics that influence behavior, including knowledge, skills, motivation, and personality traits.
- **Interpersonal:** Relationships with others and effects on social identity.
- **Organizational/Institutional:** Rules and regulations of organizations and institutions that can impact behavior.
- **Community:** Availability and location of resources that promote health, social networks, and social norms.
- **Policy:** Local, state, and federal policies and laws that impact health.

The Social Ecological Model explains factors affecting behavior and provides guidance for developing successful programs through social environments. Furthermore, the model emphasizes multiple levels of influence and the idea that behaviors both shape and are shaped by the social environment. The principles of the model are consistent with social cognitive theory concepts, which suggest that creating an environment conducive to change is important to making it easier to adopt health behaviors.[21]

21 Social and Behavioral Theories. e-Source Behavioral and Social Sciences Research. Retrieved from http://www.esourceresearch.org/Default.aspx?TabId=736.

SECTION 1:6 SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[22]

Research by the CDC on SDOH topics expands the scientific evidence that will help build the pathway to health equity. Based on specified criteria, the following categories have been published by Healthy People 2020 utilizing a place-based framework to identify SDOHs.[23] Each of these five determinant areas reflects a number of key issues that make up the underlying factors in the arena of social determinants of health:

- **Economic stability** (employment, food insecurity, housing instability, and poverty);
- **Education** (early childhood education and development, enrollment in higher education, high school graduation, lifelong learning, and language and literacy);
- **Social and Community Context** (civic participation, discrimination, incarceration, and social cohesion);
- **Health and Healthcare** (access to healthcare, access to primary care, and health literacy); and
- **Neighborhood and Build Environment** (access to foods that support healthy eating patterns, crime and violence, environmental conditions, and quality of housing).

As noted in *Creating a Culture of Health in Rural West Virginia: State Rural Health Plan 2018-2022*, many health issues in West Virginia are a product of cultural and socioeconomic factors outside of the control of the healthcare delivery system. Social and cultural factors in rural West Virginia lead to increased likelihood for residents to pick up unhealthy behaviors. These

22 Social Determinants of Health. Healthy People 2020.
Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.
23 Social Determinants of Health: Know What Affects Health. CDC Research on SDOH.
Retrieved from https://www.cdc.gov/socialdeterminants/research.html?Sort=Article%20Date%3A%3Adesc&Category=Economic%20Stability.

Healthy communities involve many facets that will work together to promote a high quality of life. Culture, education, economy, and ecology are all part of healthy communities.

behaviors include tobacco use, lack of physical activity, and substance misuse. Generational poverty, income level, and low priority on education can often span generations. Many children are now being raised by grandparents, other extended family members, or foster parents due to substance use/misuse, overdoses, or incarceration. These social and cultural factors are the areas that can be hardest to change but are the most changeable factors.[24]

Healthy communities involve many facets that will work together to promote a high quality of life. Culture, education, economy, and ecology are all part of healthy communities. This idea correlates with the ideas of SDOH. Promoting these ideas involves a broader group of stakeholders to encourage positive change. General areas of concern noted in *Creating a Culture of Health in Rural West Virginia: State Rural Health Plan 2018-2022* include the following:

- Alcohol, substance, and tobacco dependence/misuse;
- Insufficient physical activity;
- Poor nutrition (food access, diet choices, income);
- Risky sexual behaviors; and
- Violence (child abuse, intimate partner abuse).

This Strategic Prevention Plan aligns with the Rural Health Plan in promoting positive health behaviors by West Virginians through promotion, awareness, education, problem identification and referral, information dissemination, and implementation of evidence-based programs and practices.

The 2017 West Virginia Behavioral Risk Factor Surveillance System Report notes the following for SDOH in West Virginia:

- Approximately 14.5% of West Virginia adults reported being unable to pay bills in the past year;
- Approximately 12.9% of West Virginia adults reported that they did not have enough money to make ends meet at the end of the month;
- Approximately 8.2% of West Virginia adults reported that they considered their neighborhood to be unsafe;
- Approximately 23.4% of West Virginia adults reported that they had been food insecure in the past year;

24 Department of Health and Human Resources State Office of Rural Health. Creating a Culture of Health in Rural West Virginia; State Rural Health Plan 2018-2022. Retrieved from https://wvrha.org/wp-content/uploads/2017/08/2018-State-Rural-Health-Plan-Final.pdf.

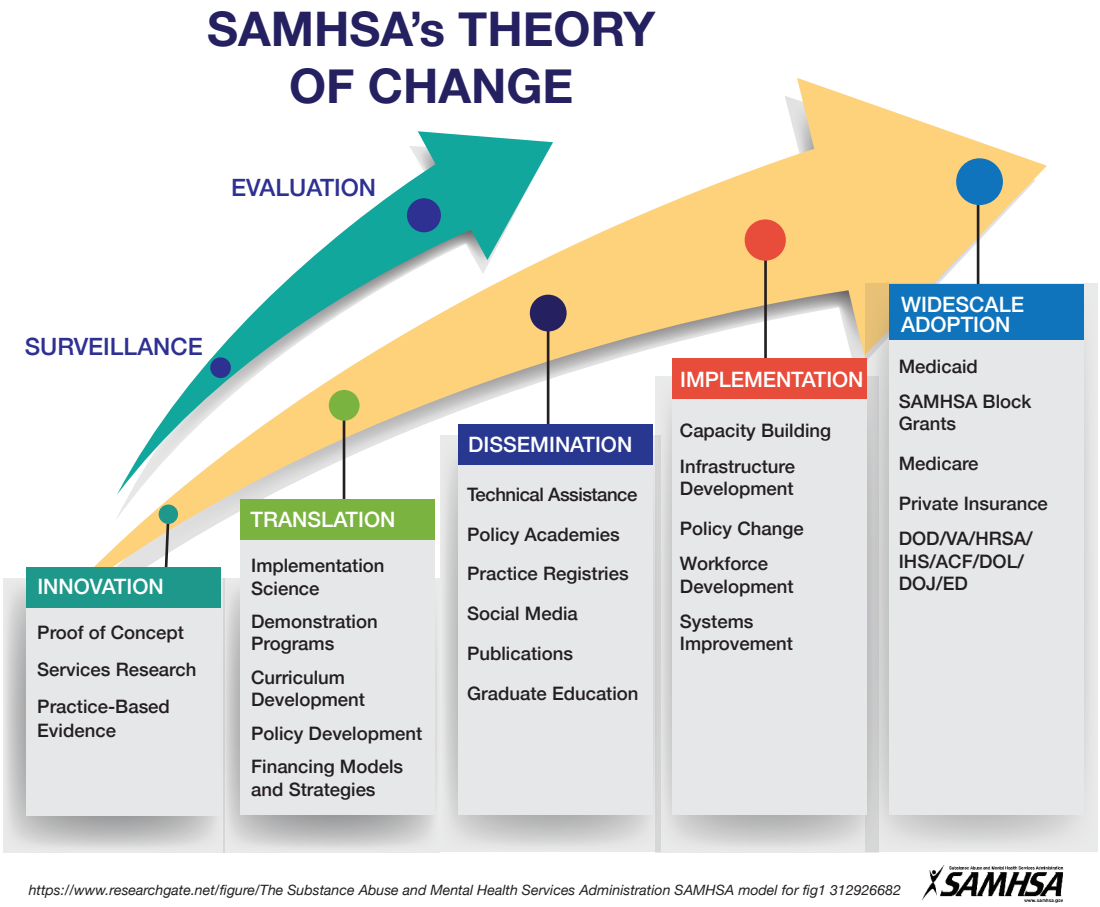
- Approximately 24.3% of West Virginia adults reported that they could not afford to eat balanced meals at times in the past year; and
- Approximately 18.6% of West Virginia adults reported that they were stressed all or most of the time in the past month.[25]

SECTION 1:7 THEORY OF CHANGE

Theory of Change (TOC) describes how and why a desired change is expected to happen and connects intervention activities with the expected outcomes. Interventions that are based on theory are more likely to be effective and thus recommended by SAMHSA.[26] TOCs also facilitate program evaluation because the important outcomes are explicitly defined.

SAMHSA developed a Theory of Change to guide work to support the development and implementation of innovations in behavioral health service delivery. Interventions that are based on theory are more likely to be effective and thus recommended by SAMHSA. TOCs also facilitate program evaluation because the important outcomes are explicitly defined.

25 Department of Health and Human Resources State Office of Rural Health. Creating a Culture of Health in Rural West Virginia; State Rural Health Plan 2018-2022. Retrieved from https://wvrha.org/wp-content/uploads/2017/08/2018-State-Rural-Health-Plan-Final.pdf.
26 SAMHSA's Theory of Change. Retrieved from https://www.tn.gov/content/dam/tn/mentalhealth/documents/Theory%20of%20Change.pdf.



https://www.researchgate.net/figure/The Substance Abuse and Mental Health Services Administration SAMHSA model for fig1 312926682

The TOC depicts how innovations can move through stages of development through widespread adoption. SAMHSA's TOC has provided the conceptual foundation for efforts to promote wide-scale adoption of the system of care approach to serving children, youth, and young adults with mental health challenges and families.[27]

SECTION 1:8 SAMHA'S EIGHT DIMENSIONS OF WELLNESS

Wellness is a broad concept. Merriam-Webster defines wellness as the quality or state of being in good health especially as an actively sought goal. The Cambridge Dictionary defines wellness as the state of being healthy. Dictionary.com defines wellness as an approach to healthcare that emphasizes preventing illness and prolonging life, as opposed to emphasizing treating diseases.

SAMHSA has a wellness initiative that pledges to promote wellness for those with behavioral health conditions by motivating individuals, organizations, and communities to act and work

27 Substance Abuse and Mental Health Services Administration (SAMHSA). Applying SAMHSA's Theory of Change to Systems of Care: Summary of Expert Panel Meeting July 2015.

toward improved quality of life, heart, health, and increase years of life.[28] SAMHSA's eight dimensions of wellness are emotional, physical, occupational, intellectual, financial, social, environmental, and spiritual.[29] SAMHSA defines wellness as being healthy in these eight mutually interdependent dimensions. Each aspect of these dimensions of wellness can affect overall quality of life. The following illustration of the eight dimensions of wellness shows them as being in multiple circles overlapping one another, as each aspect of wellness can affect another aspect of wellness in the circle.

28 J. Flowers Health Institute. 8 Dimensions of Wellness. Retrieved from https://jflowershealth.com/8-dimensions-of-wellness/.
29 Creating a Healthier Life. A Step-by-Step Guide to Wellness. Substance Abuse Mental Health Services Administration (SAMHSA). Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4958.pdf.

Adapted from Swarbrick, M. (2006). A Wellness Approach. Psychiatric Rehabilitation Journal, 29(4), 311-314.

CHAPTER TWO

CHAPTER TWO
STRATEGIC PLAN

SECTION 2:1 SETTING THE CONTEXT

The West Virginia Strategic Prevention Plan was informed by the preceding frameworks, models, and theories; a horizontal view of current state prevention plans; a review of key data indicators; and input from partners on key planning themes through an electronic feedback process. The information gathered provided a decision-making framework to develop key components of the strategic plan, including a shared vision, core values, and strategic priorities.

Through partnerships, the West Virginia Strategic Prevention Plan strengthens and supports an integrated state-wide system of community-driven physical and mental health promotion, substance-use prevention, suicide prevention, prevention of child abuse, sexual violence prevention, and other related prevention efforts. Key opportunities and challenges identified throughout the planning process are noted as follows:

OPPORTUNITIES

- Increase collaboration and communication at the community and state levels
- Streamline and align our programs and interactions with the school system to create a comprehensive, singular approach within the education system (include local coalitions to help with the delivery of prevention services)
- Integrate evidence-based prevention services within current service systems
- Create unified, consistent messaging and build upon asset-based positive community norms
- Bridge/braid funding and share resources and training. Braided funding is the combination of 2 or more funding sources to support a program/initiative
- Seek private-public partnerships, especially toward sustainable funding opportunities
- Encourage prevention screenings and cross-training opportunities within prevention workforce
- Develop and fund a statewide data collection infrastructure to ensure that research, policy, and practice inform each other in a bidirectional manner
- Partner to support families and caregivers in building social and emotional competence of children
- Provide preventive and supportive services at the community level to strengthen families
- Collaborate to address workforce retention and recruitment
- Coordinate statewide education for communities about substance use disorders, and stigma
- Explore expansion of the Icelandic Model to every county

CHALLENGES

- Lack of consistent and reliable community-level data and current data around core measures
- Funding – overreliance on federal dollars
- Buy-in and support from policy makers and other stakeholders in making prevention a priority
- Sigma across all environments
- The impact of COVID-19
- Health literacy levels
- A sense of complacency at the community level
- The use of one-size-fits-all programs – not all programs can work in all localities – some have limited capacity
- Silos and duplication within provider organizations and organizations themselves

While planning the West Virginia Strategic Prevention Plan, stakeholder involvement emphasized the importance of building, understanding, and using common language. Based on this, the following has been included in this strategic plan:

- A crosswalk of common terms and definitions of prevention to be used include universal, selective, and indicated (tier one, tier two, tier three; primary, secondary, tertiary in addition to defining public health approach doses); and
- Clearly defined and included definitions of risk and protective factors.

The Strategic Prevention Planning Committee met on the following dates during the development phase of the plan with specific purposes for each meeting.

SESSION	PURPOSE	DATE
Session I	Organize, imagine, and launch the comprehensive prevention strategic planning process by addressing key "planning the plan" questions.	April 15, 2020
Session II	Build upon current preven-tion plans to align and in-form the development of our comprehensive prevention strategic plan.	May 20, 2020
Session III	Using the Strategic Prevention Framework, review key data assessment findings as we continue to develop a comprehensive plan to strengthen and sustain West Virginia's prevention system.	June 4, 2020
Session IV	Reach agreement on shared vision concepts, strategic priorities, and expected results as we continue to develop our comprehensive, unified plan to strengthen and sustain WV's prevention system.	June 24, 2020
Session V	Building upon our strengths and opportunities, identify current and additional strategies to achieve our strategic outcomes and priorities.	July 8, 2020
Session VI	Building upon our strengths and opportunities, review and reach agreement on strategic objectives and timeframes for implementation.	July 30, 2020
Session VII	Discuss and reach agreement on implementation and monitoring recommendations to launch the strategic plan.	August 27, 2020
Session VIII	Provide feedback on the initial strategic plan draft utilizing the Six Thinking Hats process.	September 11, 2020

SECTION 2:2 CURRENT PREVENTION LANDSCAPE

Shared values that emerged from Session I were to honor, support, and build upon the current efforts of prevention partners. As a starting point, there was agreement to review existing plans to inform and align development of the comprehensive prevention plan.

The following organizations or strategic prevention plan focus areas were identified by partners and reviewed for additions. As part of discussion, two additional plans were added to the list for a total of 21 strategic plans: the West Virginia Drug Intervention Institute and the Mountains of Hope State Cancer Prevention Plan.

ACES Coalition

Family First Prevention

Mountains of Hope State Cancer Prevention Plan

Overdose to Action

Problem Gambling

Sexual Violence

SPF Prescription Drug Overdose

Teen Pregnancy/THINK

Underage Drinking

WV Domestic Violence

WV Rural Health Association

Prevent Child Abuse WV

Icelandic Model Collaborative

Office of Drug Control Policy

Prevention First

Reclaim WV

State Opioid Response Prevention

Suicide Prevention

Tobacco Prevention

WV Domestic Violence

WV Drug Intervention Institute

Partner organizations submitted their respective strategic plans to Basecamp and completed a summary template of their plan to inform the review process. Template informational areas include the following:

- Prevention Plan Sector;
- Specific Population Addressed;
- Focus Area (statewide, regional, or local);
- Funding Streams;
- Timeline of Implementation;
- Data or Assessments Available Which Can Be Shared;
- Risk and Protective Factors the Plan Addresses; and
- Levels of Social Ecology the Plan Addresses.

Using information gathered from submitted strategic plans, the following common themes, opportunities, and challenges were identified.

Prevention Plans Reviewed on 5/20/2020	Common Themes Identified Across Plans	Opportunities on the Horizon for Cross-Collaboration	Issues Holding Us Back/Slowing Us Down
Office of Drug Control Policy Sexual Violence Problem Gambling SPF RX Plan Family First WV Prevention First SOR Teen Pregnancy /THINK Tobacco Prevention	Except for THINK, these plans have a **statewide focus** (THINK teen pregnancy plan focuses efforts in 21 counties) Reviewed plans are **environmentally focused** Several plans focus on **policy and community and are individually focused** The target populations are **school-age children, youth, and high-risk populations** (several plans reviewed also target college-age groups) **Screening** is encouraged Several plans are working with **families to strengthen structure and access** to needed services and supports **Common risk factors** were noted in several plans and included: poverty, anxiety, depression, MH diagnosis, ACES, family use/RX of substance use/misuse, abuse, academic issues, lack of parental involvement/ monitoring, bullying, A risk factor that is often missing across plans is the sense of hopelessness **Protective factors** Present include strong family unit, active/positive involvement with schools, positive peer relationships/role-models, resiliency and coping skills, economic security, stable home, health needs met, social-emotional learning skills, Positive Behavioral Interventions and Supports, and trauma-informed schools **Community level data** is often not referenced or is missing across plans The importance of **empowering and training adults to be positive role models and to share consistent messaging** is another missing component across plans **Youth led prevention efforts** in tobacco prevention have been shown to be an effective strategy It appears that most plans are **federally funded which impacts sustainability**	Many plans focus on partnering with the school system – **there is an opportunity to streamline our inter-actions with school systems and align after-school and summer program-ing, and combine efforts to create a compre-hensive, singular ap-proach within the education system** **Sexual violence socioecological framework** would be a good vertical comparison for horizontal comparison across plans **All plans require assessment and on-going data collection and measure-ment collection - this could allow us to determine pockets of resistance and resilience** to help us understand what communities are doing well and to apply similar efforts to the com-mu-nities that need additional assistance to succeed There is an opportunity to **bridge/ braid and align funding and to share resources and training opportunities.** There is an opportunity to **increase collaboration at the local or commu-nity level** so that the community can identify where braiding should occur since they are best to identify their needs - collect **local data** and divide results by region There is an opportunity to **create unified, consistent messaging/** develop a social norm campaign/find new ways to delivering messaging in the current environment (embed messaging in tele-health) and to use non-traditional ways to get the message to youth in the new environment There is an opportunity to **provide prevention services and supports to children in the foster care system and other high-risk populations** to prevent out-of-home placements **Expanding education and communication** across providers/ organizations was identified as an additional opportunity to collaborate Due to workforce is-sues in our state, there is an opportunity **to collaborate our efforts help address workforce shortages across the prevention field** **Encourage screening and cross-training for co-occurring issues**	**There is no mechanism for local level data or plans** to address identified issues in communities. **Local planning and local data are needed at the forefront = more local control**. This will permit a process that is consistent. Need to encourage local data collection but acknowledge limitations. There is **a lack of consistent and reliable community level data** **Up-to-date solid data is not available around core measures**, especially regarding the youth's experience in substance use **Funding** is limited, especially for tobacco prevention **Buy-in and support** from partners, legislature and other policy makers is another challenge. Although prevention is recognized as important at the state level, it is not made a priority There is **a sense of complacency** at the community level The **use of one-size-fits-all programs** – not all programs can work in all localities – some have limited capacity. **Confidentiality** is an additional constraint **The COVID-19 Pandemic** has hindered implementation and the need to shift to new innovative means of service delivery through electronic means **Workforce issues/shortages** continue to impact services and delivery **Health Literacy** level of populations being served **Stigma** surrounding individuals across all socio-economic levels

The following considerations and questions emerged regarding the current prevention landscape in West Virginia:

- *The importance of incorporating mindfulness practices into the schools by a statewide group, Mindful WV, is having a substantial impact.*
- *How will West Virginia shift to prevention, which is employee-heavy, in comparison to residential types of treatment?*
- *It appears that most funding for prevention is federal. How does this hold us back? How do we identify and collaborate with private and state-level funding partners and policy makers to make prevention a priority? State funds could be matched with federal funds.*
- *Systemic and collaborative efforts are needed to garner additional prevention funding that would support statewide data collection at the community level.*
- *There is an analysis for cost savings if evidence-based programming is implemented with fidelity. Nationally, for every $1 invested in prevention, there is a $17-$27 return on investment. What other prevention services around the state could help show there is a cost savings associated with effective prevention?*
- *How can we grow economically if our children are not healthy physically and mentally?*
- *Who are our Prevention Champions who can help facilitate the changes and who else would we want to involve?*

The Strategic Prevention Planning Committee agreed that all the above questions and considerations were important to the development of an overall prevention strategic plan for the state. The key opportunities and issues identified are as follows:

OPPORTUNITIES

- Streamline and align our programs and interactions with the school system
- Collaborate to address workforce shortages
- Bride/braid funding and share resources and training
- Create unified, consistent messaging

ISSUES HOLDING US BACK

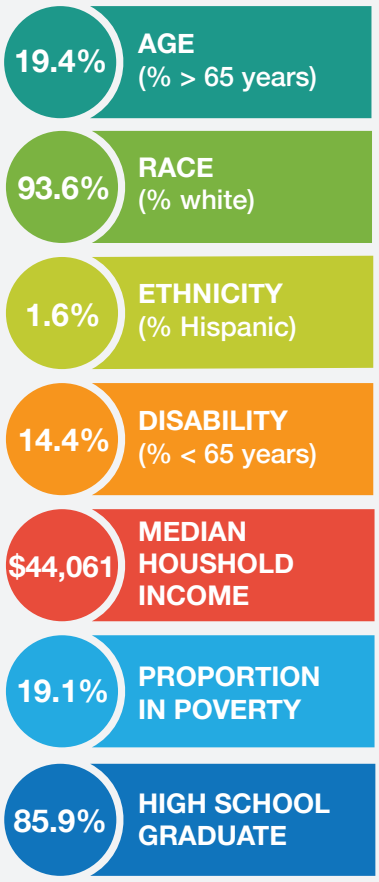
- Lack of consistent and reliable community-level data
- Funding – overreliance on federal dollars
- Buy-in and support from policy makers and other stakeholders in making prevention a priority
- Stigma across all environments

SECTION 2:3 HEALTH DISPARITIES IN WEST VIRGINIA

A health disparity refers to a higher burden of illness, injury, disability, or mortality experienced by one group relative to another. According to the CDC, health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Populations can be defined

Statistics About the Population of West Virginia [32]

U.S Census 2018, VIntage 2018



WHY ARE THESE STATISTICS IMPORTANT?

Statistics like age, sex, income and education are part of the Social Determinants of Health. https://www.cdc.gov/socialdeterminants/

These factors have been shown to affect a person's health outcomes. Understanding these factors can help organizations like the West Virginia Bureau for Public Health improve health for each citizen of our state.

32 Centers for Disease Control and Prevention. Adolescent and School Health. Health Disparities. Retrieved from https://www.cdc.gov/healthyyouth/disparities/index.htm.

by factors such as race or ethnicity, gender, education or income, disability, geographic location, or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.[30]

Health disparities result from multiple factors, including:

- Poverty;
- Environmental threats;
- Inadequate access to healthcare;
- Individual and behavioral factors; and
- Educational inequalities.

Good health is associated with academic success. Individuals with less education are more likely to experience health risks, such as obesity, substance misuse, and intentional or unintentional injury, compared to individuals with more education. Good health is associated with academic success.

Additionally, higher levels of protective health behaviors and lower levels of health risk behaviors are associated with higher academic grades among high school students. Health risks such as teen pregnancy, poor dietary choices, inadequate physical activity, physical and emotional abuse, substance misuse, and gang involvement have a significant impact on how well students perform in school.[31]

Each year since 1984, the West Virginia Behavioral Risk Factor Surveillance System (BRFSS) has measured a range of risk factors that can affect West Virginians' health. The most recent report presents state survey results for the year 2018 as well as county data combined for the latest available five years (2013 through 2018).

The information in this report serves as a resource for governments, business leaders, schools, and community groups, all of which are helping to shape the health of West Virginia. The following tables represent data related to health disparities for West Virginia for 2018.

30 Centers for Disease Control and Prevention. Adolescent and School Health. Health Disparities. Retrieved from https://www.cdc.gov/healthyyouth/disparities/index.htm.
31 Centers for Disease Control and Prevention. Adolescent and School Health. Health Disparities. Retrieved from https://www.cdc.gov/healthyyouth/disparities/index.htm.

Health Status	West Virginia ranked 2nd highest nationally in the prevalence of general health of adults as either fair or poor. More than one-fourth of West Virginia adults (26.3%) considered their health to be either fair or poor. Fair or poor health was most common among groups of adults aged 55-64, those with less than a high school education, and those who have an annual household income of less than $15,000. The prevalence of fair or poor health was highest in Boone, Fayette, Lincoln, Logan, McDowell, Mercer, Mingo, and Wyoming counties. West Virginia ranked 1st highest in the nation for the prevalence of poor physical health, poor mental health, and activity limitations due to poor physical or mental health.
Healthcare Access	The prevalence of no healthcare coverage among West Virginia adults aged 18-64 was at an all-time low of 9.3%, compared to 14.1% nationally. The prevalence of no healthcare coverage among those aged 18-64 was highest in Barbour and Logan counties. Nearly half of West Virginia adults have private insurance (45.1%), followed by Medicare (24.3%) and Medicaid (15.9%). Nearly one-fifth of all adults do not have a personal doctor or healthcare provider (19.5%). Approximately 14.6% of West Virginia adults could not afford needed medical care in the past year. More than one-fifth of West Virginia adults did not have a routine checkup in the past year (21.4%).
Weight Status	The prevalence of obesity in West Virginia was 37.7%, which was 1st highest in the nation. The prevalence of obesity was significantly higher in Fayette, Logan, and McDowell counties than in the rest of the state. More than two-thirds (70.9%) of West Virginia adults were overweight or obese, the 2nd highest in the U.S. The prevalence of overweight or obese was highest among men, those aged 45-54, those with a high school education, and those with an annual household income of $50,000-$74,999.

Physical Activity	More than one-fourth of West Virginia adults (28.5%) did not participate in leisure-time physical activity or exercise, West Virginia 11th highest in the nation. The prevalence of physical inactivity was significantly higher among females than males. Physical inactivity was highest among those aged 65 and older, those with less than a high school education, and those with an annual household income of less than $15,000. The prevalence of physical inactivity was significantly higher in Grant, Logan, McDowell, Mercer, Mingo, Webster, and Wyoming counties than the rest of the state.
Sugar-Sweetened Beverages	More than one-fourth of West Virginia adults (28.8%) consume soda or pop on a daily basis. The prevalence of daily soda or pop consumption was highest among men, those aged 25-34, and those with less than a high school education. The prevalence of daily consumption of sugar-added beverages was highest among males, those aged 18-24, and those with a high school education or less. Approximately 39.2% of West Virginia adults consume either soda, pop, or a sugar-added beverage daily. Nearly one in five West Virginia adults (19.1%) consume sugar-added beverages on a daily basis.
Cardiovascular Disease	West Virginia ranked 1st highest in the nation in the prevalence of heart attack (7.5%) and coronary heart disease (8.0%). West Virginia ranked the 7th highest in the nation in the prevalence of stroke (4.4%). The prevalence of cardiovascular disease was highest among men, those aged 65 and older, those with less than a high school education, and those with an annual household income less than $15,000. The prevalence of cardiovascular disease was significantly higher in Grant, Logan, McDowell, Mingo, and Wyoming counties than the state. More than half of West Virginia adults (50.8%) are currently watching or reducing their sodium intake.

Menu Labeling	Nearly half of West Virginia adults (47.2%) use calorie information provided on menus. The prevalence of using calorie information on menus was highest among women, college graduates, and those with an annual household income of $75,000 or more.
Cancer	Approximately 7.4% of West Virginia adults had ever had skin cancer and 8.1% had ever had some other type of cancer. About 1 in 7 West Virginia adults had been diagnosed with cancer, but were still living (14.0%), which ranked West Virginia the 3rd highest for overall cancer prevalence. Cancer prevalence was highest among adults aged 65 and older and those with an annual household income of $25,000-$34,999. Among cancer survivors, 35.4% received a written summary of all cancer treatments and 4.9% participated in a clinical trial. Among cancer survivors, 63.9% received instructions about routine cancer check-ups after treatment and 76.2% of those were written instructions.
Cancer Screening	The prevalence of had a mammogram in the past 2 years among women aged 50-74 was 77.8%, similar to the U.S. prevalence. The prevalence of had a Pap test in the past 3 years among women aged 21-65 was 79.5%, similar to the U.S. prevalence. West Virginia men aged 40+, 52.9% discussed advantages of prostate specific antigen (PSA) test with a doctor, 31.8% discussed the advantages of the prostate specific antigen (PSA) test with a doctor, 31.8% discussed the disadvantages of the PSA test with a doctor, 52.5% had a doctor who recommended having the PSA test, and 42.7% had a PSA test in the past 2 years. Among adults aged 50-75, 10.0% had a Fecal Occult Blood Test (FOBT) test in the past year and 16.8% had a FOBT test in the past 3 years. Among adults aged 50-75, 63.3% had a colonoscopy in the past 10 years, similar to the U.S. prevalence. More than two-thirds of West Virginia adults aged 50-75 had at least one of the recommended colorectal cancer screenings (67.0%), which was similar to the U.S. prevalence.

Diabetes	More than 1 in 10 West Virginia adults had diabetes (15.0%), which ranked West Virginia the 2nd highest nationally. The prevalence of diabetes was highest among those aged 65 and older, those with less than a high school education, and those with an annual household income of less than $15,000. The prevalence of diabetes was significantly higher in Grant, Logan, McDowell, and Wayne counties than the state as a whole. Among West Virginia adults with diabetes, 24.3% had 2 or more A1C test in the past year and 48.0% have taken a diabetes self-management class. Approximately 11.0% of West Virginia adults had pre-diabetes. The prevalence of borderline or pre-diabetes was highest among those aged 65 and older and those with less than a high school education.
Diabetes Testing	Among West Virginia adults who do not have diabetes, 62.9% have had a diabetes test in the past 3 years. The prevalence of had a diabetes test in the past 3 years was highest among those aged 65 and older, college graduates, and those with an annual income of $25,000-$34,999.
Comorbidities	Approximately 1 in 6 West Virginia adults (17.3%) were both obese and had arthritis. About 1 in 6 West Virginia adults (14.8%) had arthritis and did not exercise. About 1 in 8 West Virginia adults (12.9%) were obese and did not exercise. About 1 in 11 West Virginia adults (9.2%) were obese and had diabetes. Approximately 1 in 20 West Virginia adults (5.3%) had both cardiovascular disease and diabetes. About 1 in 11 West Virginia adults (8.7%) were current smokers who had depression.

Respiratory Diseases	Approximately 16.2% of West Virginia adults have ever been diagnosed with asthma and 11.8% of West Virginia adults currently had asthma. Women had significantly higher prevalence of both lifetime and current asthma than men. The prevalence of both lifetime asthma and current asthma was highest among those with less than a high school education and those with an annual household income of less than $15,000. The prevalence of current asthma was significantly higher in Harrison and McDowell counties than the rest of the state. The prevalence of chronic obstructive pulmonary disease or COPD in West Virginia was 13.9%, which was 1st highest in the nation. The prevalence of COPD was highest among adults aged 55-64, those with less than a high school education, and those with an annual household income of less than $15,000. The prevalence of COPD was significantly higher in Fayette, Lincoln, Logan, McDowell, Mercer, and Mingo counties than the rest of the state.
Tobacco Use	Nearly one-fourth of adults (24.8%) currently smoke cigarettes every day or some days, which ranked West Virginia the 2nd highest nationally. The prevalence of current smoking was highest among those aged 25-34, those with less than a high school education, and those with an annual household income of less than $15,000. The prevalence of current cigarette smoking was highest in Calhoun and Wyoming counties. Approximately 54.7% of current smokers had tried to quit smoking in the past year, which was the 46th highest (equating to 9th lowest) in the nation. West Virginia ranked the 2nd highest in the nation in the prevalence of smokeless tobacco use (8.5%) among adults. The prevalence of smokeless tobacco use was highest in Grant and Lincoln counties. The prevalence of respondents who currently use e-cigarettes was 4.7%, similar to the U.S. prevalence, and was highest among adults aged 18-24.

SECTION 2:4 DATA ASSESSMENT AND GAPS

Prevention research has underscored the importance of strategically using data to inform efforts to reduce problems related to substance use/misuse, mental, emotional, and behavioral disorders. SAMHSA has funded State Epidemiological Outcomes Workgroups (SEOWs) to assist states, jurisdictions, tribal entities, and communities to adopt and implement the Strategic Prevention Framework (SPF).[33]

SEOWs are a network of people and organizations that bring analytical and other data competencies to prevention. Their mission is to integrate data about the nature of substance use and Mental Emotional Behavioral (MEB) disorders and related consequences into ongoing assessment, planning, and monitoring decisions at state and community levels.

The West Virginia SEOW is housed and led by the West Virginia Bureau for Behavioral Health in order to facilitate the use of data in policymaking and program decision-making for substance use prevention at the state and community level. The SEOW is comprised of 26 organizations and individual partners, listed below, who serve as subject matter experts.[34]

CAMC Center for Health Services & Outcomes Research

WV Bureau for Children and Families

WV Bureau for Medical Services

WV Bureau for Public Health, Health Statistics Center

WV Bureau for Public Health, Epidemiology and Prevention Services

WV Bureau for Public Health, Office of Maternal Child and Family Health

First Choice Services, Inc.

Governor's Highway Safety Program

WV Higher Education Policy Commission

WV Coalition Against Domestic Violence

CAMC Center for Health Education & Research Institute

WV Statistical Analysis Center

CAMC Health Education & Research Institute

WV Coalition to End Homelessness

WV Division of Corrections

WV Department of Education, Office of Healthy Schools

WV Department of Education, Office of Research

WV Healthcare Authority

WV National Guard

WV Poison Center

WV Division of Motor Vehicles

WV State Police

WV Supreme Court of Appeals

WV Division of Justice & Community Services, Office of Research & Strategic Planning & Justice Center for Evidence Based Practice

WV Rural Health Association

WV Controlled Substances Monitoring Program – WV Board of Pharmacy

Tammy Collins, PhD., COS, OCPC and Lead Evaluator & Family Scientist, Marshall Center

33 Substance Abuse Mental Health Services Administration (SAMHSA). Data-Based Planning for Effective Prevention: State Epidemiological Outcomes Workgroups. Retrieved from; https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4724.pdf.
34 WV Department of Health and Human Resources: Bureau for Behavioral Health. Data: West Virginia State Epidemiological Outcomes Workgroup. Retrieved from: https://dhhr.wv.gov/bhhf/Sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Research/Pages/DataResearch.aspx.

of Excellence and Recovery gave an overview of key data findings to help provide data assessment and identify gaps in current state data in the third planning session. Sources Dr. Collins utilized included national surveys and monitoring efforts, state surveys, and state and local administrative data. The following are excerpts from her presentation which include consumption data, risk factors, and consequence data.

Substance Use of Middle & High Schoolers

Annual Averages Based on 2016 and 2017 NSDUHs - Percentages	US	WV	WV School Climate Survey Item Equivalent
Alcohol Use in the Past Month among individuals aged 12 to 17	9.54	10.1	12.21
Binge Alcohol Use in the Past Month among individuals aged 12 to 17	5.06	5.67	6.41
Marijuana Use in the Past Month among individuals aged 12 to 17	6.46	5.45	6.61
Alcohol Use and Binge Alcohol Use in the Past Month among individuals aged 12 to 20	19.5	20.38	

West Virginia youth talked with at least one parent or guardian about the dangers of tobacco, alcohol, or drug use in the 12 months prior to the survey. (School Climate Survey 2018-19) Solutions to address this problem focus on improving alcohol and drug prevention education

How much do people risk harming themselves physically and in other ways when they do the following?	
Drink alcohol occasionally	50.2%
Have five or more drinks of an alcoholic beverage once or twice a week	77.2%
Smoke marijuana occasionally	56.2%
Smoke marijuana once or twice a week	65.0%
Use prescription drugs that are not prescribed to them	84.3%

and creating healthier school environments. The 2016 West Virginia School Health Profiles indicated the percentages of West Virginia high schools that implemented the following policies and practices.[35]

- 90% of schools require alcohol and drug prevention courses for students.
- 36% of schools have lead health teachers who received prevention training in the past 2 years.
- 36% of schools provide parents with alcohol/drug prevention information.
- 29% of schools have programs using community members as role models/mentors.

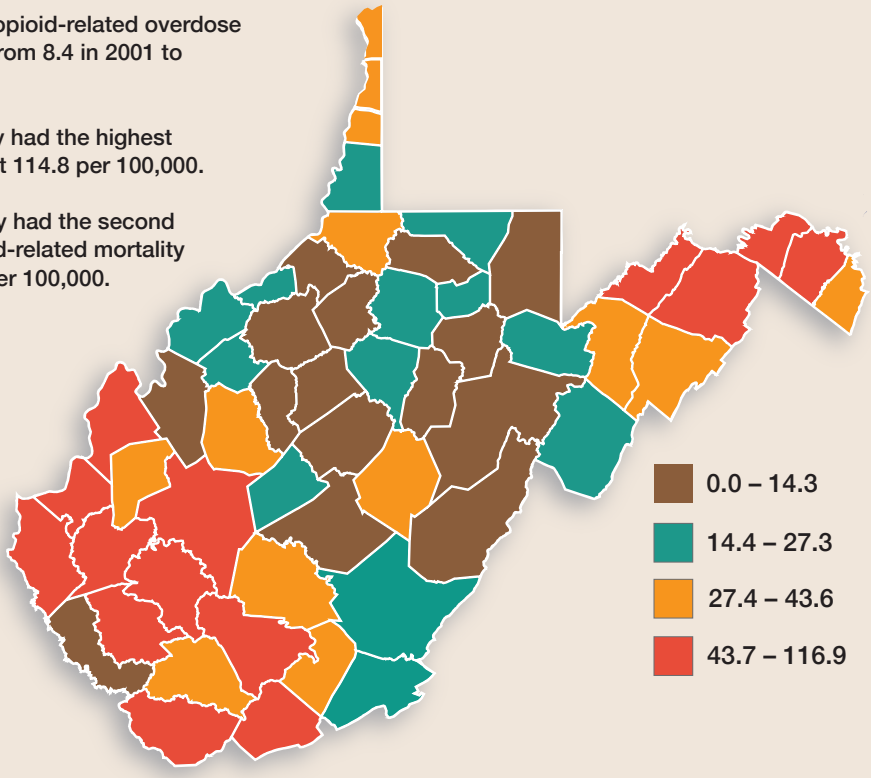
GEOGRAPHIC

WV Resident Opioid-Related Overdose Mortality Rate, 2018*

Crude Rate per 100,000

The statewide opioid-related overdose mortality rose from 8.4 in 2001 to 37.7 in 2018.

- Cabell County had the highest rate in 2018 at 114.8 per 100,000.
- Boone County had the second highest opioid-related mortality rate at 82.0 per 100,000.



* 2018 data are preliminary and subject to change. Rates calculated for counties with fewer than 10 overdose deaths are unreliable and subject to large fluctuations. *Source: WV Health Statistics Center, Vital Statistics System, December 2019.*

35 West Virginia Department of Education, 2017 Youth Risk Behavior Survey, 2016 Health Profiles. Retrieved from https://www.wvfree.org/wp-content/uploads/high-school-yrbss-data.pdf

Overdose Morbidity & Mortality

STATEWIDE EMS OVERDOSE DATA

Month and Year	Number
January 2019	630
February 2019	441
March 2019	608
April 2019	648
May 2019	651
June 2019	655
July 2019	582
August 2019	461
September 2019	528
October 2019	584
November 2019	608
December 2019	633
January 2020	704
February 2020	534
March 2020	550
TOTAL TO DATE	**8,817**

Overdoses by Age Group	
Age	**Number**
0 – 19	708
20 – 29	1,879
30 – 39	2,396
40 – 49	1,580
50 – 59	1,023
60 – 69	634
70+	426
Unknown	171

Overdoses by Sex	
Females	3,638
Males	4,962
Unknown	217

Naloxone (Narcan) Given	
Yes	4,017
No	4,800

STATEWIDE EMERGENCY ROOM OVERDOSE DATA

Month and Year	Number
January 2019	529
February 2019	499
March 2019	617
April 2019	601
May 2019	596
June 2019	576
July 2019	520
August 2019	609
September 2019	615
October 2019	561
November 2019	525
December 2019	550
January 2020	582
February 2020	566
March 2020	550
TOTAL TO DATE	**8,496**

Overdoses by Age Group	
Age	**Number**
0 – 19	1,252
20 – 29	1,819
30 – 39	2,056
40 – 49	1,359
50 – 59	960
60 – 69	602
70+	446
Unknown	1-6

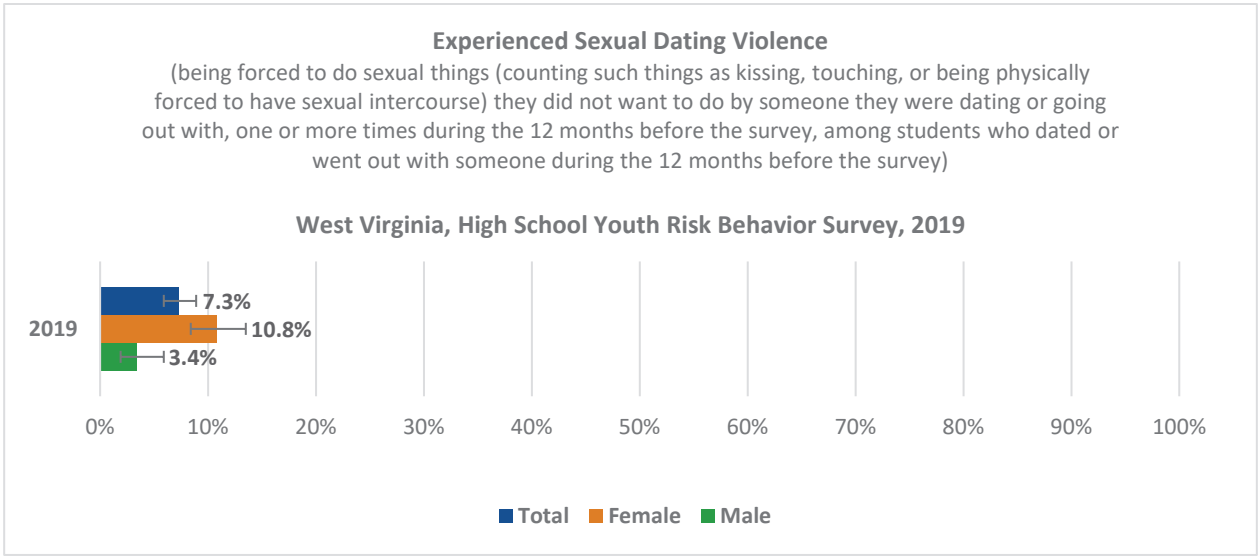
Overdoses by Sex	
Females	4,070
Males	4,349
Unknown	77

The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults including:

- Behaviors that contribute to unintentional injuries and violence
- Sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection
- Alcohol and other drug use
- Tobacco use
- Unhealthy dietary behaviors
- Inadequate physical activity

YRBSS is a system of surveys. It includes a national school-based survey conducted by the CDC and local surveys conducted by state, territorial, and local education and health agencies and tribal governments.[36]

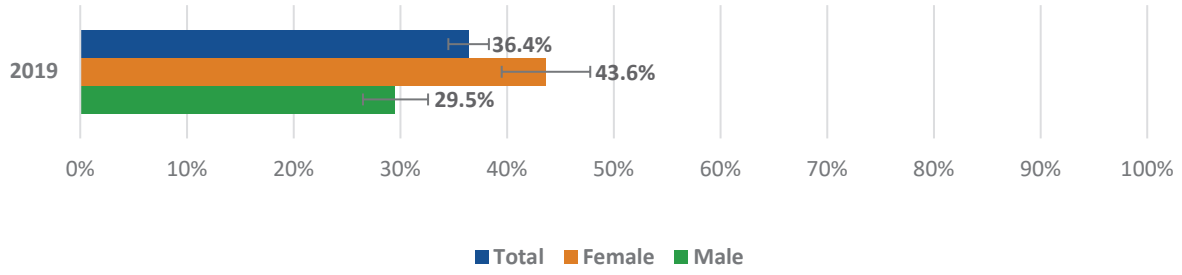
The West Virginia Youth Risk Behavior Survey/School Health Profiles for High School 2019 provide the following data related to sexual dating violence, feelings of sadness or hopelessness, suicidal behaviors, and lack of sleep, which are linked to both physical and mental health.[37]



36 Centers for Disease Control and Prevention. Adolescent and School Health YRBSS. Retrieved from https://www.cdc.gov/healthyyouth/data/yrbs/index.htm.
37 Centers for Disease Control and Prevention. High School YRBS. West Virginia 2019 Results. Retrieved from https://nccd.cdc.gov/Youthonline/App/Results.aspx?LID=WV.

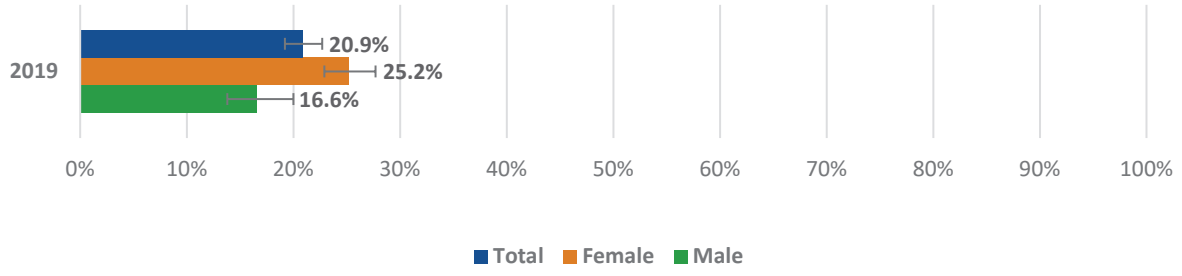
Felt Sad or Hopeless
(almost every day for 2 or more weeks in a row so that they stopped doing some usual activities, during the 12 months before the survey)

West Virginia, High School Youth Risk Behavior Survey, 2019



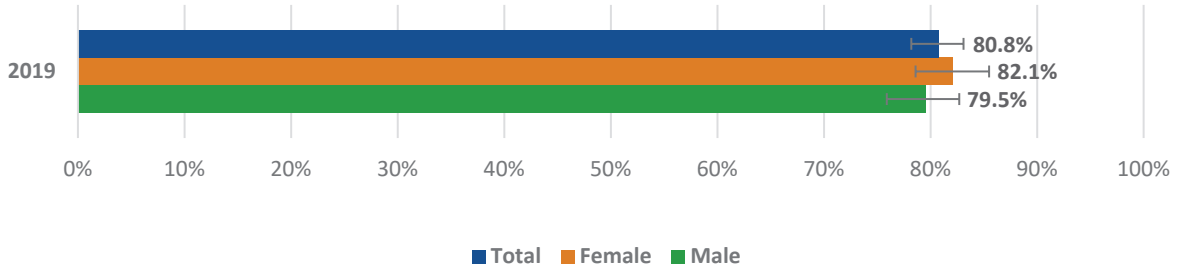
Seriously Considered Attempting Suicide
(during the 12 months before the survey)

West Virginia, High School Youth Risk Behavior Survey, 2019



Did Not Get 8 Or More Hours Of Sleep
(on an average school night)

West Virginia, High School Youth Risk Behavior Survey, 2019



Following the presentation, committee members had a discussion around two focus questions:

- What is the data or information telling us that demands change (gaps, needs, challenges)?
- Where is the greatest moment or opportunity for prevention work?

The following summarizes this discussion:

What is the data or information telling us that demands change (gaps, needs, challenges)?	Where is the greatest moment or opportunity for prevention work?
Everything is connected. Nutrition, economy, mental health – they all connect to each other and need addressed for one another. Data collected through ACES does have good representation, but it needs overlaid to create visual representation. Social norms need to be addressed and deinstitutionalization pursued. College students, for instance, are not all partakers of risky behaviors although they are publicized as doing so. This has become a social norm that is not accurate. Social norm messaging is necessary. Need to work on not sensationalizing use – this can have unintended consequences in relation to social norms. We don't have enough data on what is effective In WV – we normally just see the data for what works in larger cities. This means we cannot compare apples to apples for our population. We need to find what works for WV – we see things that work in other areas but not if it works here (evaluation is needed but that requires resources). We have made progress in some key indicators as a state; however, our risk factors are overwhelming – there are also increases in marijuana use and vaping rates in young adults – we need to proactively address these increases and consider the impact of legalizing medical marijuana. There needs to be more of a focus on the family unit/use of the social ecological framework and universal prevention in the schools, in addition to social norms and perceptions. Social-emotional learning is critical – people are resilient in WV, but they need the right tools. A dose of prevention is needed at every developmental stage: target ages 18 – 25. Lack of transportation. Lack of a sustainable workforce. Disparities regarding technology and access to broadband. High level policies are not supportive of actual needs, i.e., strict guidelines of allowable purchases for food – basic needs must be met before people will listen to change. Sustainability of prevention efforts – as noted in the last session, most funding is federal/no state dollars – policy makers and legislators need to be educated about the importance to invest in prevention if we can explain it. Historically, we have not done a good job explaining and advocating for the role of prevention.	Be more efficient with our resources to help collaborate and play to our strengths but not duplicate. Share strategies and evidence-based practices – develop a collective knowledge base. Examine how to evaluate programs in WV and in the areas of WV. WV tends to do program evaluation to prove that the program works versus using it to see what needs adjusted and how to use data for improvement – need is as a process improvement. Make sure we are willing to adjust to needs as they come. Increase comfort levels with sharing data across agencies (data sharing agreements?). Need to be more willing especially non-state entities. We need to engage people to become change agents – the infrastructure needs to be developed at the community level through youth-led coalitions – infrastructures are a force multiplier, specifically in educating legislators on the importance of investing in prevention. Expand certified prevention specialist as a true profession/grow the profession. Develop a social norms media campaign. Understand and use the data to improve our work and make decisions. Take a proactive approach on risk factors – everyone will be at-risk coming out of the pandemic. With the election, there will be new players entering the field which provides a good opportunity to get the message/need out to legislators and policy makers. We need to change the narrative… WV does not have a drug problem – WV has an addiction problem. Good, solid, reliable local level and state level data is needed that can paint the story that is analytical, anecdotal, and pictorial. In other words, the narrative must be consumable based on the population that it is presented. Legislators think in terms of money….so how prevention costs can demonstrate a positive return and can decrease costs related to treatment and recovery services.

SECTION 2:5 MISSION, SHARED VISION, AND CORE VALUES

MISSION:
The mission or purpose of the unified plan is to strengthen and sustain West Virginia's prevention system. To guide the plan, a shared vision of the future was agreed upon to focus possibilities and lead collaborative efforts. A set of core values was also affirmed.

SHARED VISION:
We envision a proud West Virginia comprised of healthy, resilient communities, where all individuals are supported, purposeful and hopeful throughout their lifespan.

CORE VALUES:
Implementation of the strategic plan is guided by the following set of core values.

We believe and are dedicated to:

- Cross-sector collaboration and building upon current planning efforts
- Community engagement
- Evidence-based practices, policies, and programs
- Sustainability
- Data-driven and stakeholder driven decision-making
- Cultural competency (race, ethnicity, age, ability, language, gender, socio-economic status, sexual orientation, gender identity, nationality, religion)
- Strengths, assets and protective factors

SECTION 2:6 STRATEGIC GOALS AND OBJECTIVES

Based upon the current prevention landscape, strategic goals and objectives were identified, in addition to expected results to be achieved over the next three years. Successful strategies from current strategic plans being implemented by partners were also shared.

There was consensus that over the next three years, prevention partners will seek to focus collaborative efforts in four priority goal areas:

1. Increase, sustain and align investments in prevention (including recruiting and retaining our prevention workforce and advocating for policy reforms)
2. Maximize cross systems planning and collaboration
3. Improve data collection, integration and use
4. Align strategic communications, awareness and education

Strategic objectives and suggested timeframes for implementation are outlined on the following pages.

Strategic Goals and Objectives

STRATEGIC GOAL 1 **Increase, sustain and align investments in prevention (including strengthening our prevention workforce and advocating for policy reforms)**			
2021 - 2023 Strategic Objectives	**2021**	**2022**	**2023**
1.1 Develop a consistent updated method for coalition funding distribution.		X	X
1.2 Coordinate talking points across systems for legislators/policymakers.	X	X	X
1.3 Form a professional statewide Prevention Association (warehouse) that can support advocacy and policy change, workforce, training, credentialing. Steps: Information Gathering: what organizations exist, what training exists, what credentialing exists, what education level and training is required to do work, identify mentors within each area of prevention, establish a prevention collaborative virtual workspace/library, and identify gaps. Form a committee to do this.	X		
1.4 Establish cross-system training opportunities related to prevention. Hold 3-4 annually.	X	X	X
1.5 Identify and engage Prevention Champions within medical fields, recovery, legislative, etc.	X	X	X
1.6 Continue to identify opportunities to collaborate, braid funding, share resources among prevention organizations/efforts. The Prevention Steering Team is a good source to do this.	X	X	X
The same committee would also start the process of information gathering for 1.2, 1.4, 1.5 and 1.6 for all FY21 objectives and aligning structures within prevention organizations.			

Long-term expected results, achievements or outcomes we hope to accomplish:

1. State-level funding for prevention will be increased through a dedicated line item in the State Budget.
2. A Professional Prevention Association that can also serve as a clearinghouse for best practices/theories/trainings/resources will be created.
3. Criteria for how prevention will continue to progress and build infrastructure will be developed, include recruitment and retention.
4. Opportunities to braid funding and increase collaboration among prevention sectors will be advanced. Identify a minimum of 2-3 opportunities to braid funding.

STRATEGIC GOAL 2 Maximize cross systems planning, collaboration, and integration			
2021 - 2023 Strategic Objectives	**2021**	**2022**	**2023**
2.1 Inform and shape prevention policy and practices by building upon research, proven models such as the CDC Knowledge to Action framework and meaningful data. • Identify and research proven models	X	X	X
2.2 Formalize an infrastructure of prevention stakeholders (state organizations, local non-profits, behavioral health organizations, Prevention Lead Organizations, coalitions, Department of Education, et.al.) across systems to lead integration of prevention efforts, mobilize resources, enhance communication, and to set the expectation that collaboration is the norm. (Prevention Steering Team) • Survey members to ensure we have everyone at the table to make sure every aspect of prevention is represented. • Develop a partnership agreement to define roles and expectations.	X		
2.3 Clarify the roles of community-based coalitions to create stronger linkages, maximize funding, and increase understanding and access to a continuum of prevention programs.		X	
2.4 Align and streamline interactions with the school system. • Identify and build upon existing relationships. • Assess partnership readiness.	X		
2.5 Create a state-level clearinghouse of promising practices, tools, and win-win opportunities to support collaborative learning processes. • Identify where clearinghouse where be housed and what platform would be used. • Review existing guides and toolkits and streamline/align into a comprehensive document.	X		
2.6 Expand and translate current prevention curriculum and programs to alternative delivery modes. (It should be noted that all evidence-based prevention programs are not allowed to be delivered virtually at this time.) • Review what curriculum is being transferred to online and lessons learned (be open to meeting schools where they are and being patient to identify where we might "fit" and how components can be delivered). • Explore opportunities to expand train-the-trainer opportunities/ component. • Build our capacity to utilize technology and online platforms to deliver programming (identify and promote use of best practice guidelines that are being used to deliver programs online).	X	X	X
2.7 Host an annual statewide prevention summit to promote knowledge sharing, innovation, and commitments to shared outcomes.	X	X	X

Long-term expected results, achievements or outcomes we hope to accomplish:

1. Evidence-based practices and indicators will be identified and promoted.
2. There will be an increased recognition at the local level that prevention work aligns and interfaces across multiple levels.
3. Major gaps and redundancies in programming will be eliminated.
4. Best practices and lessons learned will be shared and built upon.
5. Internal and external communications across partners will be enhanced.
6. Local planning efforts will be built upon.
7. A formalized infrastructure will be created to reduce silos and increase collaboration.

STRATEGIC GOAL 3 Improve data collection, integration, and use at the regional level to track progress and promote shared accountability			
2021 - 2023 Strategic Objectives	**2021**	**2022**	**2023**
3.1 Data will be used to develop/utilize evidence-based resources and needed prevention programming based upon regional needs.	X	X	X
3.2 Centralize data collection through designated regional coordinators.		X	X
3.3 Improve multi-agency data sharing.	X	X	X
3.4 Develop a data sharing process for regional and statewide needs assessment collaboration and use.		X	
3.5 Create and maintain a data assessment task force to review and continually evaluate regional data collectively, and plan prevention work accordingly.	X	X	X
3.6 Identify data sources and fill data gaps across the continuum of care and systems and improve data collection processes.	X		
3.7 Identify, secure, and analyze data resources to build capacity for prevention support and data resource dissemination.	X		
Long-term expected results, achievements or outcomes we hope to accomplish: 1. Data will be accessible. 2. Data will inform and improve quality, policy, changes, and decisions. 3. Data will be shared across the continuum of care and systems.			

STRATEGIC GOAL 4 Align strategic communications, awareness and education			
2021 - 2023 Strategic Objectives	**2021**	**2022**	**2023**
The following principles undergird the following objectives: • Individual/community acceptability • Data-driven • Best or promising practices • Culturally relevant and inclusive			
4.1 Convene a Prevention Internal Marketing Team to coordinate prevention education and media campaigns across regions/sectors *(ex. DHHR, WVDE, Prevention First, non-governmental entities).*	X		
4.2 Develop a common language to speak with one voice by using social norm messaging to develop consistent, unified language that is inclusive, culturally competent and stigma free.	X		
4.3 Develop prevention messaging that targets the social ecological model *(Individual, Interpersonal, Organizational, Community, Public Policy)* and can be customized for local campaigns, coalitions, and audiences *(i.e., youth vs. law enforcement).*	X		
4.4 Develop standardized communication designed to reach vulnerable subpopulations identified for increased risk. Why is this important? Host stakeholder meetings of target populations to develop/disseminate messaging. *(Selected media channels need to be accessible to priority populations - ex. TikTok and YouTube vs. billboards and newspapers.)*	X	X	X
4.5 Utilize Data from Goal 3 to drive consistent prevention messaging, media campaigns, and promotion of success stories *(ex. WV Kids Count - ability to tell story and outcomes; Icelandic Model project - data and stories).*	X	X	X
4.6 Utilize Prevention Champions and community stakeholders identified in Goal 1 as trained Media Messengers *(inclusive and culturally competent)*. Include Youth voice/champions. Provide media/communication training.	X	X	X
4.7 Provide media and communication training to prevention staff and organizations and media messengers *(ex. how to use local data to tell a story; how to cultivate relationships with media; how to select appropriate imagery and language).*	X	X	X
4.8 Host Annual Prevention Day at the Legislature	X		
Add Behavioral Change Strategies, separate out public health media campaigns/marketing principles - different "products."	X		
Engage and utilize university staff and students.	X		
Long-term expected results, achievements or outcomes we hope to accomplish: 1. Sectors and stakeholders will collaborate to align data driven prevention education and messaging. 2. Consistent messaging across sectors will be enhanced through a clearing house and protocols will be developed. 3. Public understanding and awareness will be increased through universal media campaigns and materials.			

SECTION 2:7 IMPLEMENTATION

The committee makes the following recommendations for implementation of the Prevention Strategic Plan:

Who should oversee implementation?	The Governor's Council on Substance Abuse and Prevention will formally oversee the Strategic Prevention Plan. Prevention Steering Committee, which consists of the same partnering organizations identified in the plan will form subgroups that will assist with the oversight of the plan throughout the state. BBH will also have a lead role to help ensure implementation, evaluation, and leveraging resources/funding.
How should workgroups and organizations leads be established?	Workgroups should be established around the 4 plan goals. The workgroups should be part of the Prevention Steering Committee.
Who will be responsible for developing plans and timelines?	Sub-groups from the Prevention Steering Team, BBH, and local input from vested stakeholders.
How will the work be communicated (types and frequency?)	Bi-monthly and/or quarterly and communicated from BBH.

The need for funding to implement this plan is recognized by the committee. Discussions included utilizing Block Grant funds and braided funding opportunities with other bureaus. However, the committee believes continuing support for services provided by each partnering agency/organization, coupled with working collaboratively on state-level strategies, will contribute to the overall collective impact.

The implementation of strategies includes workgroup implementation and maintenance of action plans. Each workgroup will be responsible for ensuring the completion of action plans aligned with the four priority areas identified in the plan, as well as following up with local coalitions to review action items as accomplished.

Through the oversight of the Governor's Council, the Strategic Planning Committee will continue to work with work groups to to identify and engage new partners in implementation workgroup action items and the strategic prevention plan. Each year, the plan will be reviewed and the Action Plans updated as needed to make sure that goals are being met.

The planning committee recognizes that this plan will be used as the foundation for ongoing planning. It is important to continue to review, analyze, and update the strategies within this plan as needed to meet the most relevant needs at that time. The first year of the plan will focus on the development of the specific actions plans for each of the strategies.

SECTION 2:8 EVALUATION

The committee recommends working in tandem with the West Virginia SEOW to select the best measures available that provide points from which we can monitor progress of the plan.

The Strategic Prevention Planning Committee recommends that the West Virginia SEOW partner with the Prevention Steering Team to conduct an assessment of the needs, resources, and gaps of state substance use, mental health disorders, sexual violence, suicide, and child abuse using state level data.

Several data sets are utilized to obtain relevant data for prevention efforts in West Virginia. These data sets provide information on social impact indicators, as well as local community and service level data. Due to the complexities of the various funding allocation methods used by state agencies and the focus of services being delivered, the committee is not able to combine all service data collection systems. The committee recognizes the need for a uniformed database that can function as a warehouse for state level data.

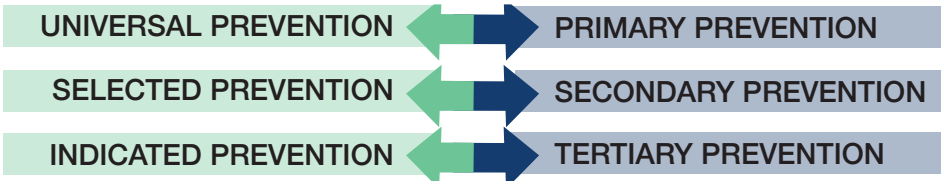
CHAPTER THREE

CHAPTER THREE
APPENDICES

APPENDIX 1: ACRONYMS & ABBREVIATIONS

ACES	Adverse Childhood Experiences
BBH	Bureau for Behavioral Health
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Center for Disease Control
COS	Chief of Staff
COVID	Corona Virus
CSAP	Center for Substance Abuse Prevention
DHHR	West Virginia Department of Health and Human Resources
FY	Fiscal Year
IC & RC	International Certification & Reciprocity Certification
IOM	Institute of Medicine
MEB	Mental, Emotional, and Behavioral
MH	Mental Health
NSDUH	National Survey on Drug Use and Health
OCPC	Ohio Certified Prevention Certification
ODCP	Office of Drug Control Policy
PhD	Doctor of Philosophy
PLO	Prevention Lead Organization
RX	Prescription
SAMHSA	Substance Abuse Mental Health Services Administration
SEM	Social Ecological Model
SEOW	State Epidemiological Outcomes Workgroup
SOC	System of Care
SPF	Strategic Prevention Framework
TOC	Theory of Change
WVDE	West Virginia Department of Education
YRBSS	Youth Risk Behavioral Surveillance System

APPENDIX 2: PREVENTION TERMINOLOGY CROSSWALK



The Institute of Medicine (IOM) categorizes prevention into three categories in relation to substance use/misuse.

- Universal prevention targets the entire population and is not directed at a specific risk group.
- Selective prevention targets subpopulations that are at increased risk for substance use/misuse due to exposure to identified risk factors.
- Indicated prevention targets those already using or engaged in other high-risk behaviors to prevent heavy or chronic use.[38]

Service strategies and classification of strategies are based on service delivery method and targeted populations. After the strategies and classifications are determined, evidence-based programming selection begins. The IOM notes evidence-based programming is defined as conceptually sound, internally consistent, reasonably well implemented and evaluated.

According to the CDC, public health focuses on prevention of disease and health promotion rather than the diagnosis and treatment of diseases. This form of prevention is most familiar as it is related to an individual's physical health. The public health approach to prevention is also categorized into three levels.

- Primary prevention targets risk factors to prevent disease onset.
- Secondary prevention screens to identify diseases in the earliest stages, before the onset of signs and symptoms.
- Tertiary prevention is managing disease post diagnosis to slow or stop the disease progression.[39]

38 Institute of Medicine (IOM) Classifications for Prevention. Retrieved August 23, 2020 from http://mh.nv.gov/uploadedFiles/mhnvgov/content/Meetings/Bidders_Conference/Institute%20of%20Medicine%20Prevention%20Classifications-rev10.20.14.pdf
39 Center for Disease Control. Prevention. Retrieved on August 23, 2020 from https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf

APPENDIX 3: STRATEGIC PLANNING TEAM MEMBERS

We would like to thank the following partner organizations and individuals for their participation in this collaborative planning process, and for sharing their expertise and insights. Your commitment to achieving our shared goals is greatly appreciated.

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BUREAU FOR
BEHAVIORAL HEALTH