Maternal and Child Health Services
Title V Block Grant

State Narrative for
WEST VIRGINIA

Application for 2007
Annual Report for 2005

Document Generation Date: Wednesday, September 20, 2006

Table of Contents

I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and Certifications are located at the following address:

WVDHHR
Bureau for Public Health
Office of Maternal, Child and Family Health
350 Capitol Street
Room 427
Charleston, WV 25301

Contact: Kathy Cummons, Director
Research, Evaluation and Planning Division
Telephone: (304)-558-7171
email kathycummons@wvdhhr.org

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

The following announcement was placed on the WVOMCFH web page:

Title V Block Grant 2006 - The public is hereby notified that the Department of Health and Human Resources, Office of Maternal, Child and Family Health, is posting the Federal application to the Health Resources and Services Administration under the U.S. Department of Health and Human Services for Title V Funds. The FY 2006 application is available for review at the West Virginia Secretary of State's Office, the Office of Maternal, Child and Family Health, or online at www.wvdhhr.org/mcfh/blockgrant2006 from May 3, 2006 through June 15, 2006. Persons wanting to submit written comments on the State's FY 2006 application in preparation for the FY 2007 application may do so by email to kathycummons@wvdhhr.org or by mail to: Kathy Cummons, Director, Research, Evaluation and Planning, Office of Maternal, Child and Family Health, 350 Capitol Street, Room 427, Charleston, WV 25301, prior to June 15, 2006.

Notices were also placed in the following newspapers statewide:

Charleston Gazette, Times West Virginian, The Journal Online, News and Sentinal, The Dominion Post, Register Herald, Charleston Daily Mail, Wheeling News - Register, Clarksburg Exponent, Beckley Newspapers, Herald Dispatch, and West Virginia Daily News.

A copy of the Block Grant was given to the West Virginia Chapter of the March of Dimes. There were minimal comments from the public forums and announcements. Partners and Medical Advisories are involved all year with Title V decision making as evidenced throughout the narrative. Reguests for services that originated from the web-site posting were referred.

II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

III. State Overview

A. Overview

West Virginia is surrounded by Pennsylvania, Maryland, Virginia, Ohio, and Kentucky and is commonly referred to as a South Atlantic state. The Appalachian Mountains extend through the eastern portion of the state, giving West Virginia the highest elevation of any state east of the Mississippi River. The second most rural state in the nation, 20 of West Virginia's 55 counties are 100% rural according to the Census Bureau definition, with an additional 14 more than 75% rural. Even so, West Virginia is located within 500 miles of 60% of the nation's population. The state is traversed by two north/south and one east/west interstates that connect its major population centers. In addition, I-68, which ends at Morgantown, where West Virginia University is located, provides access to Washington, D.C. and Baltimore, MD. Interstate 68 also connects with Interstate 79 providing access to Charleston, WV, our state capitol. Winding secondary roads connect the majority of the state's population, with little to no public transportation available between many of the small, isolated towns. Therein lies the single most often cited issue with access to health care for many of the state's residents.

Thirty-seven of West Virginia's 55 counties are classified as being medically underserved areas with an additional 12 counties classified as partially underserved. According to the West Virginia Office of Epidemiology and Health Promotion Bureau for Public Health, Department of Health and Human Resources, the current number of licensed physicians in WV was 4,067 as of September 28, 2004. Of these, 3,515 (86%) were licensed Medical Doctors and 522 (14%) were licensed Osteopathic Physicians. The unequal distribution of professional health care manpower, particularly in rural areas, is problematic for the state. As of September 2004, forty of West Virginia's fifty-five counties (73 percent) were fully or partially designated by the federal government as Health Professional Shortage Areas. This designation means that the ratio of primary care physicians to the total population is less than 1:3500.

Eighty-one (81) primary care centers are located in the forty-nine (49) counties federally designated in whole or in part as a Medically Underserved Area or Medically Underserved Populations (MCUAs/MUPs), thus making them eligible for federal assistance. There are fourteen (14) free clinics, otherwise known as Health Rights, eleven (11) of which are state funded. They offer care to uninsured West Virginians whose income is at or below 150% of the federal poverty level (FLP). These free clinics receive no federal funding. The primary care centers serve as the principal sources of primary medical services in the rural Medically Underserved Areas of West Virginia, and they are often the only source of medical care in many isolated rural communities.

Primary care centers, supported with state or federal funds, must see all patients regardless of their ability to pay. Beginning in FY 1982-83, the state began funding primary care centers through competitive applications to help centers survive financial difficulty associated with their provision of uncompensated care. State funding of primary care centers has curtailed closures and allowed some centers in financial difficulty to remain open.

In mid-March, West Virginia passed legislation intended to enable more small businesses to provide coverage to their employees. The State Coverage Initiatives (SCI) program helped to make the proposed expansion possible by providing the state with a $1.36 million demonstration grant in 2003; the grant was intended to support the design and implementation of a new coverage program.

The new law creates a public/private partnership between the West Virginia Public Employees Insurance Agency (PEIA) and insurance companies. The private carriers will be given access to PEIA's reimbursement rates, enabling them to sell coverage that is more affordable than they have been able to sell previously. In fact, the state expects the new small business coverage cost to be 20-25 percent below the usual market rate -- which will ultimately expand the pool of

insured working West Virginians.

During the fall, the West Virginia Health Care Authority reached out to health care providers and insurance carriers to solicit participation in the program. The new coverage plan will be open to small businesses with 2 to 50 employees who have had no coverage for 12 consecutive months. Employers will be required to pay a minimum of 50 percent of the premium cost for employee-only coverage and 75 percent of eligible employees must participate. Participating carriers must demonstrate a minimum anticipated medical loss ratio of 77 percent to be eligible for a rate increase after the first year of the plan (the current requirement is 73 percent). As of December 2004, one carrier has filed with the state to offer the new product which was available January 1, 2005.

According to the 2003 Data, Census Population, March 2004 Survey of the US Census Bureau, WV ranks 34 in lacking health insurance with 16.6% of the population not having health insurance.

West Virginia reached its population peak a half century ago with 2,005,552 residents counted in the 1950 census. The state's population has not exceeded the two million mark since then, but has fluctuated between 1.7 and 1.9 million depending on the state's economy. Four of the state's five largest cities have lost population since 1990. Charleston, the state capitol and largest city, and Huntington are the only places with populations exceeding 50,000. Population estimates from U.S. census show West Virginia among the most racially homogeneous states in the country. The 2000 census reported that 95.9% of WV residents are Caucasian, 3.5% Black or African American, .6% American Indian and Alaska Native, 0.7% Asian and 0.3 some other race. The ancestry of the state's population is primarily a combination of Irish and Celtic followed by a broad mixture from other European countries.

West Virginia now has the distinction of having the oldest median age in the nation (38.1 years). West Virginia has the highest median age in the nation at 38.9, and the state's percent of people age 60 and older is ranked second in the nation. Between 1990 and 2000 people 85 and older increased by 24.8%; the number of individuals age 90 and older grew by 41. 3%. Although the population has fluctuated between 1.8 and 2.0 million over the last 50 years, the rate of births have declined from 50,000 births in 1950 to 20,000 births in 2001 dropping from a rate of 25.4 births per 1,000 to 11.3 births per 1,000. In 1997 West Virginia saw its first natural decrease, having 137 more deaths in that year than births, the first state in the nation to experience such a phenomenon. This trend has continued through 2003. Because of its older population, West Virginia ranked 1st among the states in 1998 in the percentage of its residents enrolled in Medicare (18.4%, compared to a national average of 13.9%). Older West Virginians value their independence, self-sufficiency and preservation of the family homestead. This lifestyle is demonstrated by the fact that residents maintain the highest percent of home ownership in the nation at 75.15%. Almost 85% of individuals age 65 and older own their home.

Over the past 30 years the dominant industries in West Virginia have shifted from mining and manufacturing to services and service producing jobs. Traditionally, mining and manufacturing wage scales are much higher than those in service occupations and include benefits such as medical, dental, and vision plans. Service jobs, on the other hand, are often part-time and do not include insurance plans. The low wages earned at such jobs often do not allow individuals to purchase their own health insurance coverage.

West Virginia's annual average total nonfarm payroll employment increased by 9,700 jobs during 2005. Statewide goods-producing sector employment added 3,100 jobs, particularly in natural resources and mining (+2,100) and construction (+2,200). West Virginia's service-providing industries increased 6,600 over the year, with education and health services gaining 2,700 jobs.

West Virginia's annual average unemployment rate remains slightly below the US rate of 5.1% for the second year in a row. During 2005, the West Virginia rate declined by three-tenths of a

percentage point to 5.0%. In a pleasant surprise, the statewide civilian labor force also increased by 9,000 persons.

Also, work disability is a significant problem in West Virginia. The US Census Bureau states in 2000, 22.5% of the population 16-64 years of age had a disability, and 13.2% had a work disability.

Because of the loss of higher paying jobs over the past thirty years in West Virginia, there has been a concurrent rise in the state's poverty rate. According to figures supplied by the U.S. Census Bureau and reported in the State Rankings 2002 (published by Morgan Quitno), in 2002 West Virginia continued to rank fifth in the nation at 17.2% of state's residents living in poverty, compared to the national average of 12.4%. In 2000 the median household income in West Virginia was $36,484. Of residents age 65 and older, 11.9% are living below the poverty level, while 16.0% of children age 18 and under are living in poverty. The percent of high school graduates or higher, of the population 25 years and over, is 75.2%.

The Office of Maternal, Child and Family Health operates in partnership with the federal government and the State's medical community, including private practicing physicians, county health departments, community health centers , hospitals and various community agencies to address West Virginia residents' needs.

The Office of Maternal, Child and Family Health strives to provide the necessary education and access to treatment needed in order for our residents to make informed decisions regarding their own individual health needs. Categorical programs to address specific needs for targeted groups are limited with 80 percent of the Office's energy being used to develop systems for the provision of population-based and target specific preventive interventions, as well as infrastructure for the support of the maternal, child and family health populations.

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

In 2002, The American College of Obstetricians and Gynecologists (ACOG) named West Virginia as one of nine "Red Alert" states with a looming crisis in the availability of obstetrical care, due to physicians' problems in finding or affording medical liability insurance in the state. Without liability insurance, ob-gyns are forced to stop delivering babies, curtail surgical services, or close their doors--aggravating conditions in a state that already has many medically underserved areas. Information from ACOG surveys showed that without liability reform over half of all ob-gyn residents planned to leave West Virginia as did a majority of private practice ob-gyns. ACOG also reported problems in recruiting new ob-gyns to the state. On March 19,2003 ACOG applauded West Virginia lawmakers for their enactment of HB 2122, legislation to address the state's chronic medical liability insurance problems.

Additonal legislation includes; West Virginia House Bill 2388 established a mandate for the universal testing of newborns for hearing loss. The Newborn Hearing Screening Advisory, as established in statute, has made testing recommendations, developed screening protocols, and assisted the Office of Maternal, Child and Family Health with the development of user friendly education materials for inclusion in hospital birth packets and distribution through the State's perinatal program called Right From The Start. The passage of the West Virginia Birth Score, in

this same legislation, further strengthened the State's ability to universally screen all newborns for developmental delay, hearing loss, and conditions that may place infants at risk of death in the first year of life. The original birth score instrument was modified to accommodate hearing screening, so one instrument and one tracking system addresses the mandate. All WV birthing facilities began universal newborn hearing screening effective July 1, 2000. The MCFH Provider Education unit (nurses) visited the State's birthing facilities and offered technical assistance related to operationalizing the initiative.

In 2002, three additional Bills were passed, SB 672 establishing a Birth Defects Surveillance System, HB 216 requiring screening of all children under the age of 72 months for lead poisoning, and HB 3017 requiring the creation of a state oral health program. Although all of these programs existed previously, legislative mandates ensure continuance of these health efforts. The Birth Defects Surveillance Program and the Childhood Lead Screening Program are largely supported by grants from the Centers for Disease Control (CDC). Rules for The Birth Defects Surveillance Program and The Childhood Lead Poisoning Prevention Program were passed by the 2004 Legislature.

Population

Finally, more state residents were born than died after seven straight years. In 2004, 135 West Virginians were added to the total population as a result of natural increase, the excess of births over deaths. The rate of natural increase was 0.1 persons per 1,000 population. Results from the 2004 Census estimate show an overall increase (approximately 0.4%) in the state's population since 2000, from 1,808,344 to 1,815,354. This increase is the result of a slight growth in the excess of inmigration over outmigration during that span.

Live Births

West Virginia resident live births decreased by 75, from 20,986 in 2003 to 20,911 in 2004. The 2004 birth rate of 11.5 per 1,000 population also declined from 11.6 in 2003. The U.S. 2004 birth rate was 14.0 live births per 1,000 population, lower than 2003 (14.1). West Virginia's birth rate has been below the national rate since 1980. It has continued its overall decline, interrupted by slight upturns in 1989 through 1991. It has remained relatively stable since 1996.

The 2004 U.S. fertility rate of 66.3 live births per 1,000 women aged 15-44 was 0.4% higher than the 2003 rate (66.1). West Virginia's fertility rate also increased 4.1% from 56.1 in 2003 to 58.4 in 2004. The fertility rate among women aged 15-19 in West Virginia was 4.6% higher than that among young women in the U.S. (43.6 vs. 41.2). The fertility rate among women aged 20-44 was also lower (14.1%) in the state than in the nation (61.0 vs. 71.0).

The number of births to teenage mothers decreased by 87 (3.4%), from 2,576 in 2003 to 2,489 in 2004. The percentage of total births represented by teenage births decreased from 12.3% in 2003 to 11.9% in 2004. The significantly lower fertility rate among older women, however, resulted in teenage births continuing to constitute a higher proportion of total births than is found nationally (10.3% in 2003).

The percentage of births occurring out of wedlock rose from 2003. In 2004, over one out of every three (34.7%) West Virginia resident births was to an unwed mother. The percentages of white and black births that occurred out of wedlock in West Virginia in 2004 were 33.4% and 76.9%, respectively, compared to 33.1% and 75.4% in 2003. In the United States in 2004, 29.3% of white births (non-Hispanic) and 66.8% of births to black mothers (non-Hispanic) occurred out of wedlock. The percentage of teenage births to unmarried teenage mothers in the state noticeably increased from 76.1% in 2003 to 76.5% in 2004.

There were a total of 1,950 low birthweight babies (those weighing less than 2,500 grams or 51/2 pounds) born to West Virginia residents in 2004, or 9.3% of all births. Of the 1,942 low

birthweight infants with known gestational age, 1,338 or 68.9% were preterm babies born before 37 weeks of gestation. (Of all 2004 resident births with a known gestational age, 12.4% were preterm babies.) Of the births with known birthweight, 14.2% of babies born to black mothers and 9.2% of babies born to white mothers were low birthweight. Nationally, 8.1% of all infants weighed less than 2,500 grams at birth in 2004; 7.3% of white infants and 13.7% of black infants were of low birthweight.

Eighty-six percent (86.0%) of West Virginia mothers with known prenatal care began their care during the first trimester of pregnancy, compared to 83.9% of mothers nationwide in 2004. Among those with known prenatal care, 86.3% of the white mothers began care during the first trimester with 76.3% of black mothers seeking first trimester care. (U.S. figures show 88.9% of white mothers and 76.5% of black mothers.) No prenatal care was received by 0.6% of white mothers and by 2.3% of black mothers.

Over one-fourth (26.8%) of the 20,911 births in 2004 were to mothers who smoked during their pregnancies, while 0.6% of births were to women who used alcohol. National figures show that 10.2% of women giving birth reported smoking during pregnancy and 0.8% used alcohol. Of the state mothers who reported smoking during pregnancy, 14.3% of the babies born were low birthweight, compared to 7.3% for non-smoking mothers. U.S. statistics for 2002 show 12.2% births to smoking mothers were low birthweight and 7.5% for non-smoking mothers. Nearly one-third (33.1%) of 2004 state births were delivered by Cesarean section, compared to a national rate of 29.1%. One or more complications of labor and/or delivery were reported for 33.8% of deliveries in the State in 2004.

Deaths

Effective in 1999, the National Center for Health Statistics (NCHS) and World Health Organization (WHO) adopted the 10th revision to the International Classification of Diseases -- now known as ICD-10. This is the first revision since 1979 and includes a more comprehensive classification of causes of death. Previously, all causes of death were coded numerically. Now all causes of death are coded alpha-numerically, allowing many more possible causes. When comparing 1999 deaths to earlier years, differences between ICD-9 coding and ICD-10 coding must be taken into account.

The number of West Virginia resident deaths decreased by 523, from 21,299 in 2003 to 20,776 in 2004. The state's crude death rate also dropped from 11.8 per 1,000 population in 2003 to 11.4 in 2004. The average age at death for West Virginians was 72.5 (69.0 for men and 75.9 for women). One hundred and seventeen West Virginia residents who died in 2004 were age 100 or older. The oldest woman was 110 years old at the time of death, while the oldest man was 104 years old.

Heart disease, cancer, chronic lower respiratory diseases, and stroke, the four leading causes of death, accounted for 61.5% of West Virginia resident deaths in 2004. Compared to 2003, the number of state deaths due to heart disease decreased 9.2% while cancer deaths increased 1.3%. Deaths due to chronic lower respiratory diseases, which surpassed stroke for the fourth time in the past five years, decreased 5.8%, while stroke mortality increased 7.8%. Diabetes mellitus deaths increased 7.2%, while the number of reported deaths due to pneumonia and influenza decreased (9.0%) from 2003 to 2004. Alzheimer's disease, now the seventh leading cause of death in the Mountain State for the second year in a row, only decreased by just one death or 0.2%. Accident mortality increased marginally by 138 (14.3%), from 966 in 2003 to 1,104 in 2004. Motor vehicle accident deaths continued to number fewer than the 435 deaths in 1993, the year the West Virginia seatbelt law took effect; they increased by 16 (4.1%) from 392 in 2003 to 408 in 2004. Accidental poisoning deaths has been on the rise in West Virginia for the past five years, from 58 in 2000 to 127 in 2001; 156 in 2002, 252 in 2003l and 306 in 2004.

Accidents were the leading cause of death for ages one through 44 years. Even with the

precipitous drop in motor vehicle accident deaths between 1993 and 1994, such fatalities remained the single leading cause of death for young adults aged 15 through 34, accounting for 26.0% of all deaths for this age group in 2004, compared with 26.2% in 2003. West Virginia's 2004 motor vehicle fatalities included five children under five years of age, compared to four in 2003. Accidental poisoning accounted for 16.3% of all deaths in the age group of 15-34.

Suicides increased by only three (278 to 281, or 1.1%) between 2003 and 2004. Male suicides increased by one or 0.4%, from 234 in 2003 to 235 in 2004; the number of female suicides (46) increased by two or 4.5% from 2003. Over two-thirds (68.3%) of all suicide deaths were firearm related - 73.6% of male suicides and 41.3% of female suicides. The average age of death for a suicide victim in 2004 was 45.2 years. While suicide was the 11th leading cause of death overall, it was still the second leading cause of death for ages 15-34. The number of suicides among persons aged 19 and under rose by just one from 12 in 2003 to 13 in 2004.

Homicides in West Virginia decreased by thirteen, from 92 in 2003 to 79 in 2004. Fifty-three (53) of the homicide victims were male, 26 were female. The average age at death for a homicide victim in 2004 was 38.9 years. There were two homicide victims under the age of five in 2004, compared to four in 2003. Nearly two-thirds (65.8%) of 2004 homicide deaths were due to firearms.

Years of Potential Life Lost (YPLL)

YPLL is a measure of mortality, calculated as the difference between age 75 (an average life span) and the age at death. Using YPLL before age 75, the sum of YPLL across all causes of death represents the total YPLL for all persons dying before the age of 75. A person dying at the age of 45 would therefore contribute 30 years to the total YPLL (75-45=30). YPLL is an important tool in emphasizing and evaluating causes of premature death.

The YPLL from all causes decreased very slightly (0.4%), from 161,585 YPLL in 2003 to 160,916 in 2004. The four leading causes of YPLL in 2004 were malignant neoplasms (34,598 YPLL), diseases of the heart (24,695 YPLL), non-motor vehicle accidents (16,534 YPLL), and motor vehicle accidents (13,735 YPLL). Combined, these four causes accounted for over half (55.7%) of all years of potential life lost in 2004. In comparison to 2003, YPLL attributable to malignant neoplasms decreased from 22.3% of the total to 21.5%. YPLL due to diseases of the heart decreased from 17.9% to 15.3%, and YPLL due to non-motor vehicle accidents increased from 9.0% to 10.3%. The percentage of total YPLL due to motor vehicle crashes increased, from 8.1% to 8.5%.

Infant Deaths

Deaths of infants under one year of age rose by five, from 153 in 2003 to 158 in 2004. West Virginia's infant mortality rate also increased, from 7.3 per 1,000 live births in 2003 to 7.6. The U.S. infant mortality rate decreased minimally, from 7.0 (6.96) in 2002 to 6.9 (6.95) in 2003.

The state's 2004 white infant mortality rate increased 6.2%, from 6.9 in 2003 to 7.4, while the rate for black infants decreased over one-fifth (23.7%), from 19.8 to 15.1.

Approximately one in ten (9.5%) infant deaths in 2004 was due to SIDS (sudden infant death syndrome). Twenty-three percent (22.8%) were the result of congenital malformations, while 53.8% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birthweight (10.8%).

Neonatal/Postneonatal Deaths

The number of neonatal deaths rose by six, from 95 in 2003 to 101 in 2004; the neonatal death rate also increased from 4.5 deaths among infants under 28 days per 1,000 live births in 2003 to

4.8 in 2004. Neonatal deaths comprised 63.9% of all West Virginia resident infant deaths in 2004, compared to 62.1% in 2003. The rate of postneonatal deaths decreased from 2.8 deaths per 1,000 neonatal survivors in 2003 to 2.7 in 2004. The 2003 U.S. neonatal death rate was 4.7, while the postneonatal rate was 2.2 deaths per 1,000 neonatal survivors.

Fetal Deaths

The 135 resident fetal deaths occurring after 20 or more weeks of gestation reported in 2004 were six more than in 2003 (129). The fetal death ratio also increased from 6.1 deaths per 1,000 live births in 2003 to 6.5 in 2004. The majority (88.9%) of fetal deaths were due to conditions originating in the perinatal period, including complications of placenta, cord, and membrane (31.9%), maternal conditions (3.7%), maternal complications (10.4%), short gestation and low birthweight (8.9%), and other ill-defined perinatal conditions (25.2%). Congenital malformations accounted for 11.1% of all fetal deaths.

Marriages

For the fourth year in a row and following a dramatic increase due to the passage of a new law that became effective June 2, 1999, (the new law removed the three-day waiting period for persons aged 18 and older as well as the requirement for a blood test for syphilis) the number of marriages in West Virginia decreased from 13,697 in 2003 to 13,622 in 2004. The marriage rate in 2004 was 7.5 per 1,000 population, down from 7.6 in 2003. The 2004 U.S. provisional rate was 7.6.

For all marriages in 2004, the median age for brides was 27 and for grooms was 29. For first marriages, the median age for brides was 23 and for grooms was 24. The mode (most frequently reported age) for all marriages was 24 for both brides and grooms and for first marriages was 22 for brides and 24 for grooms.

Divorces and Annulments

The number of divorces decreased by 186 or 2.0%, from 9,335 in 2003 to 9,149 in 2004. The 2004 rate of 5.0 per 1,000 population was down from the 2002 rate of 5.2. The 2000 U.S. provisional rate was 4.0 per 1,000 population.

Of the 9,149 divorces in West Virginia in 2004, the median duration of marriage was 6 years. Over half (53.5%) of the divorces involved no children under 18 years of age in the family, while one child was involved in 23.4% of all divorces and two children were involved in 17.4%. Three divorces involved six children.

Summary

The number of West Virginia resident births decreased by 75 from 20,986 in 2003 to 20,911 in 2004. West Virginia resident deaths also decreased from 21,299 in 2003 to 20,776 in 2004. The number of infant deaths increased by five, from 153 in 2003 to 158 in 2004. Fetal deaths of 20 or more weeks gestation rose from 129 in 2003 to 135 in 2004. Marriages decreased for the fourth time in six years, from 13,697 in 2003 to 13,622 in 2004, while divorces also decreased from 9,335 in 2003 to 9,149 in 2004.

B. Agency Capacity

The Office of Maternal, Child and Family Health has historically purchased and/or arranged for health services for low income persons, including those who have health care financed under Title XIX. The Medicaid expansion of the 1980's resulted in health financing improvements, but it was Title V energy that developed obstetrical risk scoring instruments and recruited physicians to serve mothers and children, including those with special health care needs. It was also Title V that established standards of care, and developed formalized mechanisms for on-site quality assurance reviews.

We have expanded income eligibility coverage for pregnant women to 185% of the Federal Poverty Level, in response to patient demand, using Title V monies. Although the Office of Maternal, Child and Family Health is less and less involved as a health care financier, we continue to provide gap filling services when indicated.

To date, SSI populations have not been enrolled in Medicaid Managed Care (MMC), and we continue to present the case that this population requires services that do not fit well within the traditional medical model. In regards to other programs, we continue to recruit providers and provide training relative to EPSDT, including training for HMO providers. We also have maintained our existing network of outreach workers to encourage families to access primary preventive care, now offered by the HMO's.

The OMCFH is constituted of four divisions, plus a Quality Assurance/Monitoring Team, Provider Education and Recruitment Unit, and an Administrative Unit. With the exception of Children's Specialty Care, the Office of Maternal, Child and Family Health does not deliver direct services but rather designs, oversees and evaluates preventive and primary service systems for West Virginia women and men of reproductive age, infants, children, adolescents, and children with special health care needs.

Following is a brief description of the Divisions and the programs administered by OMCFH:

Division of Perinatal and Women's Health:
The focus of the Perinatal and Women's Health Division of the Office of Maternal, Child and Family Health is to promote and develop systems which address availability and accessibility of comprehensive health services for women across the life span and high risk infants in the first year of life. Administrative oversight includes an integrated perinatal care and education system paid for by Title V and Title XIX. Perinatal and Women's Health programs include the Family Planning Program under which the Adolescent Pregnancy Prevention Initiative is housed; the Breast and Cervical Cancer Program; and the Right From The Start (RFTS) Perinatal program that includes the Newborn Hearing program and Birth Score Project. Additionally, these programs provide linkage and referral to other women's, infant's, and children's services. The goal of this Division is to improve the health status of all women and infants up to one year of age, and to reduce the infant mortality rate.

Family Planning Program:
The Family Planning Program arranges and financially supports comprehensive reproductive health care for low-income women, men, and adolescents through community-based provider contractual agreements. The Family Planning Program provides reproductive health services, including complete gynecological and breast examinations, cervical cancer screening, diagnosis and treatment of sexually transmitted diseases (STDs), contraceptive supplies, pregnancy testing and referral for identified medical problems. Health education, including the importance of folic acid, and counseling are available for reproductive anatomy and physiology, all contraceptive methods, and HIV/AIDS and STD prevention. The Program offers basic infertility services with client interview, education, examination, appropriate laboratory testing, and referral to specialty care, if needed. In addition, voluntary sterilization services are available to low-risk, uninsured female and male clients.

Family Planning clinical services are offered statewide through a network of 138 locations in all

55 counties of the State. The sites include county health departments, primary care centers, hospital outpatient centers, private providers, free clinics and university health sites. Medical services, contraceptive and clinical supplies, laboratory services, and client educational materials are purchased, in part, with Title V funds.

In West Virginia, 177,300 women are in need of contraceptive services and supplies. Of these, 106,240 women need publicly supported contraceptive services because they have incomes below 250% of the federal poverty level. (77,880) or are sexually active teenagers (28,360). 138 of the publicly funded Family Planning Program clinics provide contraceptive care to 59,400 women -- including 17,070 sexually active teenagers. Family Planning clinics serve 56% of all women in need of publicly supported contraceptive services and 60% of the teenagers in need. The Family Planning Program served 58,988 unduplicated clients in CY 2005. The annual data is eight percent (8%) lower than at this time in CY 2004, due to revised billing procedures for clients enrolled in Medicaid Managed Care or receiving family planning services at Federally Qualified Health Centers (FQHCs).

Among the 50 States and the District of Columbia, West Virginia ranked 6th in the availability of publicly funded contraceptive services. An average of $68 was spent on contraceptive services and supplies per woman in need (adjusted for the cost of heath care in the State). These publicly funded clinics help women prevent 13,800 unintended pregnancies each year.

Surgical sterilization services were suspended from November 15, 2004 until October 1, 2005. A limited amount of funding ($150,000 which is less than half of the amount usually expended each year) became available to provide these services. The funding was closely monitored by Family Planning Program staff as not to exceed the funding level. Surgical sterilization services were suspended again February 6, 2006. The limited amount of funding ($150,000) available to cover the procedures had been expended.

Through the Region III Infertility Prevention Project, 36,607 chlamydia tests were completed in CY 2004, with a 2.8% positivity overall. In 2004, chlamydia increased by 0.6% statewide, as compared to the number of positive reports received in 2003. These tests were conducted using Region III selective screening criteria. Approximately 92% of all women in Family Planning clinics diagnosed with chlamydia received treatment within 14 days, as confirmed by WV STD MIS database. Currently, there is no 30-day treatment verification marker in the WV STD MIS database.

Chlamydia positivity in FP Program clients increased 0.6% overall from 2003-2004.

Chlamydia 2004: 1,031/36,707 (2.8%) Females: 954/35,837 (2.7%) Males: 77/696 (11%).

Adolescent Pregnancy Prevention Initiative:
Administered as a special focus area of the Family Planning Program, the Adolescent Pregnancy Prevention Initiative (APPI) focuses on statewide prevention services through education and increased public awareness of the problems associated with adolescent pregnancy. The APPI provides development, oversight, and coordination of statewide adolescent pregnancy prevention activities statewide. In West Virginia, multiple public, private and community service agencies are working diligently to reduce the incidence of adolescent pregnancy. The Office of Maternal, Child, and Family Health, Department of Education, State policy makers, administrators and school personnel have been working together to reduce teen pregnancies in West Virginia, since the 1980s.

Right From The Start Project:
The Right From The Start Project (RFTS) provides comprehensive perinatal services to low income women and infants up to one year of age. The project provides the following services: 1) Recruitment and credentialing of practitioners to care for Medicaid and Title V sponsored

obstetrical patients, including the completion of signed contractual agreements that establish expectation for care in accordance with national standards. 2)All participating providers complete signed agreements with OMCFH specific to services/benefits, risk scoring and patient information exchanges. 3)Title V provides financial assistance for obstetrical care for pregnant adolescents ages 19 and under who are not eligible for Medicaid regardless of income 4)Financial assistance for prenatal care for non-citizens. (They may be eligible for Medicaid at the time of delivery as this is considered an emergency situation.) 5)Direct financial assistance for obstetrical care for pregnant women denied Medicaid, but whose income is equal to or less than 185 percent of the Federal Poverty Level. 6)Limited coverage for prenatal patients who at the time of first prenatal visit have not received a Medicaid card and are subsequently denied, or prenatal patients whose Medicaid coverage is not backdated to cover the first visit. Services may include lab work, the initial prenatal visit, and ultrasound, if necessary, if the pregnant woman is uninsured or underinsured for maternity coverage. The cost of these services are paid for by the OMCFH using Title V funds. 7) Assistance for patient access to health care and the WIC Program. 8) Care Coordination for Title V and Title XIX obstetrical patients and their infants/children less than one year of age. Care Coordination components include a personalized in-home assessment to identify barriers to health care, an individually designed care plan to meet the patient's needs, community referrals as necessary, follow-up and monitoring. All pregnant Medicaid and Title V cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation, parenting, nutrition).

The OMCFH and West Virginia University finalized a contract for joint implementation of the Risk Reduction Through Focus on Family Well-Being (HAPI) Project, a Healthy Start grant. This Project works in tandem with Right From The Start and uses Healthy Start monies from the Maternal and Child Health Bureau. HAPI participants receive additional services not provided traditional RFTS clients to include mental health, dental screenings, and child care services. HAPI is confined to Region VII and expanded the number of counties served from 4 to 8 in 2004. Mental health and child care providers have signed agreements to participate in HAPI. The HAPI Project focuses on helping women become healthier before becoming pregnant, encourages spacing of pregnancies, and focuses on mental health issues. The long-term goal of the project is to decrease the incidence of low birth weight. OMCFH serves as the fiscal agent for HAPI.

The Smoking Cessation Program developed by Dr. Richard Windsor was implemented in West Virginia in January 2002, incorporating it into the RFTS Project. This smoking cessation program is called SCRIPT (Smoking Cessation/Reduction in Pregnancy Treatment). The WV RFTS 'SCRIPT' uses the existing home visitation network and protocols established in the current Right From The Start Project. Services are provided by registered nurses and licensed social workers throughout West Virginia. 2003 RFTS data show a 23% quit rate and a 34% reduction rate for pregnant smokers participating in care coordination. 2005 RFTS data show a 15.6% quit rate and 21.9% reduction rate.

The Access to Rural Transportation (ART) Project, in conjunction with the Office of Family Support, Non-Emergency Medical Transportation Program, administers a statewide system to provide transportation dollars to needy infants and pregnant women prior to the actual medical encounter to ensure access to "medically necessary" care. In 2002, changes were made to the reimbursement process, it is now handled through another policy arm of DHHR.

Preventive and primary care services to RFTS infants are provided in accordance with the EPSDT Program. The ultimate goals of Right From the Start are to reduce infant mortality and morbidity, increase birth weight, increase access to prenatal and delivery care that meets nationally recognized standards, and increase parenthood preparedness, including foster home environments. Besides the above listed activities, OMCFH offers a toll-free phone line statewide for referral, improved access to care and assistance with questions or problems that patients may encounter. The State's neonatal intensive care units, the Birth Score Program, and the medical community are key players in identification and referral of high risk infants to RFTS care coordination.

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

Birth Score:
A population-based surveillance activity administered by West Virginia University in partnership with OMCFH to identify infants at risk of post-neonatal death in the first year of life and to provide appropriate interventions for those determined at risk. Every infant is screened at birth using specific screening criteria. The follow-up of these infants occurs through the RFTS network.

Breast and Cervical Cancer Screening Program:
The West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP) is a comprehensive public health program that assists uninsured/underinsured, low income women (at or below 200% of the Federal Poverty Level) between the ages of 25 and 64 in receiving quality breast and cervical cancer screening services. These services are offered through a statewide network of over 300 screening and referral providers. The WVBCCSP is funded through a federal cooperative agreement with the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). West Virginia was one of the original eight states which received funding to implement this program in 1991. Today, the NBCCEDP spans all fifty states and the District of Columbia, four U.S. territories, and thirteen American Indian/Alaska Native organizations.

Since its inception, the WVBCCSP has enrolled over 100,000 woment into the Program and provided more than 124,000 mammograms, 177,000 clinical breast exams, and 195,000 Pap tests. Annually, the Program screens roughly 16,000 women. However, the Program does more than simply screen women. There are several core components of the WVBCCSP including Program Management; Public and Professional Education; Screening; Tracking and Follow-up; Case Management; Surveillance; Evaluation; Data Management; Quality Assurance; and Coalitions and Partnerships.

In 1996, the West Virginia Legislature enacted House Bill 1481, establishing the Breast and Cervical Cancer Diagnostic and Treatment Fund for the purpose of assisting medically indigent patients with certain diagnostic and treatment costs for breast and cervical cancer. The Fund provides resources to offset the cost of dignostic care not otherwise available to the WVBCCSP through the federal cooperative agreement.

To assist NBCCEDPs in providing treatment to women diagnosed with breast and/or cervical cancer, the 2000 Congress gave states the option to provide medical assistance for treatment through Medicaid as a part of the passage of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). West Virginia was one of the first states to take advantage of this opportunity. This means that when an uninsured woman under the age of 65 is diagnosed with breast and/or cervical cancer, she may be eligible to have her medical costs paid for through Medicaid.

Division of Infant, Child and Adolescent Health:
The goal of this Division is to promote parent/professional collaboration through parent

participation on advisories; develop and issue medical care protocols in collaboration with the medical community to ensure provision of quality community-based services for child populations; and develop patient education and outreach strategies to encourage use of preventive health care.

Abstinence Only Education:
The West Virginia Partnership for Abstinence Only Education was established in 1997 with federal funding provided under Title V. This project is housed in the Division of Infant, Child, and Adolescent Health, and the project's primary goal is to establish community partnerships that support abstinence educational opportunities at the local level. The program is designed to increase informed youth decision-making, discourage use of alcohol and drugs, and discourage the early onset of sexual activity. Local grantees are currently located in eight regions of the state. Abstinence is administered by local grantees who agree to support the federal tenets.

The Adolescent Health Initiative:
This program is financed solely by Title V, addressing the most prevalent health risks facing adolescents today. The primary goal of the Adolescent Health Initiative is to improve the health status, health related behavior, and availability/utilization of preventative, acute, and chronic care services among the adolescent population of West Virginia. Organized training opportunities are provided by a workforce hired from the community they serve and offered in the community that the youth live. This workforce, called Adolescent Health Coordinators, are located in each of the eight regions of the state. These Coordinators offer young people, parents, and other significant adults in a child's life skill building sessions on conflict resolution, communication , increased awareness of harmful consequences of substance use, and strategies to develop self-reliance and improve responsible decision making.

EPSDT/HealthCheck:
The OMCFH administers the mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, for the Bureau for Medical Services, which is also housed within the DHHR. This contract is renegotiated on an annual basis, but MCFH has administered the Program for almost 30 years.

Over 200,000 Medicaid-approved children in West Virginia are eligible to participate in the HealthCheck Program. EPSDT's promise to children eligible for Medicaid is the provision of preventive health exams and treatment of all medical conditions discovered during the exam even if the service is not a part of the Medicaid State Plan.

EPSDT services include: 1) one or more physical exams each year based upon an age dependent periodicity schedule; 2) dental services; 3) vision services; 4) immunizations; 5) hearing services; 6) laboratory tests; 7) treatment for any health problems discovered during the exams; 8) referrals to other medical specialists for treatment; 9) monitoring the child's growth and development; 10) follow-up check-ups; 11) health education and guidance; and 12) documentation of medical history.

The EPSDT Program has an extensive outreach component responsible for meeting federal EPSDT informing, linking and follow-up requirements. Pediatric Program Specialists and Family Outreach Workers (FOW) are assigned to each region and county to accomplish the outreach activities. FOWs are paraprofessionals, hired and housed in the community in which they live and work. The Pediatric Program Specialists are responsible for provider recruitment, training, technical assistance and all compliance related to monitoring issues.

Children's Dentistry Project:
Works in concert with other Office of Maternal, Child and Family Health programs, Head Start and the public schools to promote awareness and availability of dental health services as an integral part of preventive, primary health services. Dental health efforts are funded from the Preventive Health Block Grant, Title V, and State appropriation. The program conducts needs assessments,

provides fiscal resources to local communities to support learning opportunities for children which encourage behavioral change; i.e., regular check-ups, brushing/flossing, use of mouth guards during sports activities. OMCFH has contracts with local health departments, primary care facilities and dental health care professionals serving 32 counties of the state's 55. These local health departments are responsible for oral health education efforts including working with the public school system. The Office has developed education modules which were approved by the WV Dental Association and are used in public school instruction. This program also supports fluoridation and sealant efforts.

Preventive, primary, and rehabilitative services for Children With Special Health Care Needs: This program is housed under the Division of Infant, Child and Adolescent Health and has a strong direct service component. The Program is structured to be community based and family-centered. Clinics are established statewide to provide services as close to family residence as possible. In addition to contracted specialty physicians, clinics are also staffed by nurses, social workers and support staff who work as a multi-disciplinary team to provide health care management services and psycho-social support. These services include: authorization of Durable Medical Equipment; assistance with transportation; development of individualized care plans and assessments; arrangements for follow-up care; assessment of daily living skills; and assistance with transitioning to adult living and workforce entry. The OMCFH continues to work diligently with members of the SSI/OMCFH Task Force to formalize outreach and agency linkages to achieve awareness/knowledge of who and how programs can be accessed. While this cooperative agreement encompasses all disabled children, our initial efforts in 1996 targeted low birthweight babies and early intervention eligible children (birth to three years of age). More recently, the Task Force began efforts to ensure that children with disabilities who are within transitional age groups (specifically, three to six years and 16 to 21 years) receive prompt, appropriate services to enable a smooth transition to school and/or the workplace. Through a cooperative agreement dating back more than twenty years between the Office of Maternal, Child and Family Health and Bureau for Medical Services-Medicaid, Children with Special Health Care Needs staff provide care management services to Title XIX sponsored children, which maximizes Title V monies for non-insured and/or under insured, medically indigent children.

Parent Network Specialists System:
In conjunction with the West Virginia University Center for Excellence in Disabilities (WVUUCED), Title V funds the Parent Network Specialists system. These parent/family advocates participate at all levels of CSC operations, including development of program policy and forms. Five parents of developmentally disabled children serve an assigned regional area of West Virginia linking families to resources, information and community services. These parent/family advocates have been conducting surveys with all program participants to assess their understanding of and satisfaction with CSHCN services.

Long-term student trainees at the Center for Excellence in Disabilities (CED), funded by the Maternal and Child Health Leadership Education in Neurodevelopmental Disabilities (LEND) grant are currently attending and participating in a variety of clinics at the Health Sciences Center including the CED's own Feeding and Swallowing and LEND Clinics. In addition to their grant-related activities, students attend Professional Development Seminars, the most recent one being Ethics and Disability.

The Interdisciplinary Certificate Program in the Field of Disability Studies has seen consistent and significant growth over the past year with 19 new enrollees in 2005. Their academic disciplines include speech pathology, physical education/teacher education, nursing, child development and family studies, psychology, physical education/kinesiology, athletic coaching education, exercise physiology, engineering, occupational therapy, special education, early childhood education and family and consumer sciences. In addition, a student was awarded a CED Research Stipend to produce a training workshop for obstetric nurses who are working with new mothers who have disabilities. This was a collaborative effort among the CED, the Center for Women's Studies at WVU and the WVU School of Nursing.

In an effort to infuse information about disability into the curriculum at the West Virginia University School of Medicine, the CED presented a workshop with 4 concurrent sessions, through which medical students rotated. Students experienced a variety of disciplines and work on problem-solving case studies involving patients with disabilities. Faculty and staff from the CED facilitated the sessions and were available to offer suggestions and answer questions

Systems Point of Entry:
Serves as the centralized information, education and referral center for the Office of Maternal, and Family Health. SPE is responsible for the intake and eligibility review for the Children with Special Health Care Needs (CSHCN) program. SPE also does eligibility review for the Right From the Start (RFTS) program for West Virginia residents who have been denied services through Medicaid for their pregnancy. System Point of Entry is very unique in that whenever any type of contact is made, whether, by phone on one of OMCFH two Toll-Free lines, email, or applying for one of the various programs, SPE focuses on the overall needs of the client/family, making community referrals whenever appropriate.

Toll-Free Lines
Systems Point of Entry is responsible the two Toll-Free lines located in OMCFH. West Virginia callers are responded to Monday through Friday, except holidays 8:30-5:00, by either a licensed social worker or a registered nurse. The two Toll-Free Responders provide referrals and information to all of West Virginia statewide free of charge. In calendar year 2005 the two Toll-Free lines received 30,698 calls.

WV Birth to Three/Part C IDEA:
Provides therapeutic and educational services for children age 0-3 years and their families who have established, diagnosed developmental delays, or are at risk of delay. The goal is to prevent disabilities, lessen effects of existing impairments, and improve developmental outcomes. Services are provided based on individual child/family assessments and delivered by community-based practitioners who are credentialed by Birth to Three. The service system is supported by Title V, Part C, state appropriation and Title XIX.

Genetics Project:
Provides clinical genetic services preconceptually and for children with congenital defects at six satellite locations under the auspices of WVU, Department of Pediatrics. Services include diagnosis, counseling and management of genetically determined disease, prenatal diagnosis and counseling, and evaluation of teratogen exposure. These services are almost solely financed by Title V. The Genetics Program staff provides all technical guidance for the medical community caring for children with metabolic disease.

Division of Research, Evaluation and Planning:
This Division is responsible for the epidemiological and other research activities of the Office of Maternal, Child and Family Health, including all programmatic data generation and program/project evaluation endeavors, as well as ensuring that the Office of Maternal, Child and Family Health's planning efforts are data-driven. All of the Office of Maternal, Child and Family Health's program specific database and data entry personnel are housed in this Division, and are linked with program leadership to assure consistent visioning.

The Division administers the Pregnancy Risk Assessment Monitoring System (PRAMS) Project, the Childhood Lead Poisoning Prevention Project (CLPPP), and the Birth Defect Surveillance System, all sponsored by the Centers for Disease Control and Prevention (CDC); the Sudden Infant Death Syndrome (SIDS) Project mandated by State Statute but financed by Title V; and in conjunction with the Office of Laboratory Services, the Newborn Metabolic Screening Project also largely financed with Title V dollars. This Division is also responsible for SSDI activities and the Block Grant application.

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

Sudden Infant Death Syndrome (SIDS):
Collects and reports data regarding the occurrence of SIDS deaths in the State. When a SIDS death is reported, a local health department nurse is contacted to make a home visit to interview and assess the needs of the parents. Educational and grief information is sent to the family upon request. Training is provided to emergency room personnel, police, and funeral home personnel to sensitize them and offer strategies for responding to families. The Project coordinator, as well as, the OMCFH director are members of the Child Fatality Review Team.

Newborn Metabolic Screening:
Works with the Office of Laboratory Services to ensure that every newborn in the State is screened for PKU, Galactosemia, Hypothyroidism and hemoglobinopathies. Any necessary follow-up is provided by state office nursing personnel, in collaboration with the child's primary care physician. Children with inborn errors of metabolism receive special consultation through the West Virginia University, Department of Pediatrics-Genetics Program, as part of a contractual agreement with OMCFH. Title V state office nurses and administrative personnel track all medically prescribed food stuffs/formulas and have responsibility for assuring the timely "drop shipment" of formulas to families, in addition to coordination of care between the medical community and the family. Capacity is being assessed and plans developed to expand newborn screening testing to include the 29 nationally recommended tests.

Childhood Lead Poisoning Prevention (CLPP):
A collaborative effort between two Offices in the Bureau for Public Health, OMCFH and Environmental Health, funded by the CDC. An Advisory guides the operation of the Program, assisting the State with determining the extent of childhood lead poisoning in WV. To this end, extensive data gathering and analysis are routinely distributed. The Office of Environmental Health Services, using its local network of community-based sanitarians, provides assessment of home and environment, for residences of children with elevated blood lead levels. The OMCFH's CLPPP nurses case manage all children with positive BLL of >10mcg. State 2002 legislative action has resulted in the mandated screening/assessment of all high risk children age of 6 and under for lead poisoning.

Birth Defects Surveillance System:
Tracks the incidence of specific diagnostic codes using the birth files, death files and hospital charts of the infant as well as the mothers. All infants identified with a birth defect are referred to CSHCN for services and referrals.

Quality Assurance/Monitoring Unit:
The OMCFH Quality Assurance/Monitoring Team has over 25 years proven experience in conducting on-site clinical review. These reviews occur with every medical and educational provider who contracts with the Office - private physicians, primary care centers, local health departments, hospitals, etc. The reviews are conducted on site and include patient interviews, chart reviews, and provider interviews. Formal reports are submitted to each program. Technical assistance and corrective action plans are the next step in the process.

C. Organizational Structure

West Virginia's Office of Maternal, Child and Family Health is located within the State's Bureau for Public Health, administered by the umbrella organization, the Department of Health and Human Resources. The Bureau's overall goal is to attain and maintain a healthier West Virginia.

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

The Office of Maternal, Child and Family Health is comprised of multiple divisions, programs, and projects all designed to promote improved health including access and increased utilization of preventive care. The Office of Maternal, Child and Family Health's organizational structure includes the Division of Perinatal and Women's Health; Division of Infant, Child and Adolescent Health, including Children with Special Health Care Needs; Division of Research, Evaluation and Planning; and the Division of Financial Services. In addition, the OMCFH supports a Quality Assurance Monitoring Team.

(Bureau For Public Health and Office of Maternal, Child and Family Health organizational charts are attached)
An attachment is included in this section.

D. Other MCH Capacity

In all, there are 183 staff positions in West Virginia's Title V agency. Of these positions 6 are senior management, 63professionals, 26 medical professionals, 72 clerical workers, 8 technicians, and another 8 professionals under contractual hire.

During Fiscal Years 1997 and 1998, two parent advisors were recruited by the Office of Maternal, Child and Family Health, one as a paid employee and the other as a volunteer. Since that time these positions have been maintained and increased to a total of five paid parent advisors called Parent Network Specialists (PNSs). The CSHCN Program has continued funding the PNS system which is administered by the West Virginia University Center for Excellence in Disabilities (WVUCED). The PNSs are parents children with disabilities who are located in communities throughout the State. The State is divided into five (5) regions and each PNS is assigned a specific region of responsibility. The PNS is charged with conducting phone surveys of all CSHCN enrollees within their assigned region to determine satisfaction with services received from the CSHCN staff and providers. The results of the surveys are shared with the CSHCN Administration, Nurses and Social Workers to problem solve any issues identified. The PNS also has responsibility to supply resource information and Care Notebooks to each CSHCN participant. The Care Notebooks were developed as a casemanagement tool so that parents could track appointments, medicines and treatments. The PNSs have been involved in developing transition services offered to children and families and will assist the CSHCN staff in providing more comprehensive transition services.

West Virginia is aware that early childhood education is important and has a direct effect on children's cognitive skills, prior to school entry. Pre-school programs offered througout the State that contribute to the cognitive development of our youngest citizens are as follows:

Head Start: Comprehensive child development services for low income children and their families. Provides preschool children with a wide array of services to meet their educational, health, nutritional and psychological needs.

Early Head Start: Investment in low income families with infants and toddlers to promote healthy prenatal outcomes, enhance development of very young children and promote healthy family function.

Right From The Start: Home based, two generational (mother/parent and child) focus on accessing medical services, child development, parenting and reduction of risk behaviors, i.e., smoking exposure. Available statewide.

Birth To Three: Part C/IDEA -- provides a family service plan, in settings typical to children and families for babies and toddlers identified with or at risk of developmental delay. Services provided to all eligible statewide -- approximately 3,000 per year.

Starting Point Centers: Comprehensive centers to address parenting education, offer information and referral services, health screening and care, etc., at 18 sites statewide.

The West Virginia Department of Health and Human Resources, Bureau for Children and Families, and the West Virginia Department of Education, recognize that quality early care and education programs are contingent upon a qualified workforce. The State has developed a comprehensive system of professional development, credentialing and career ladder for early care and education service providers, which are connected to Standards for Preparing Early Childhood Professionals issued by the National Association for the Education of Young Children (NAEYC). The Office of Maternal, Child and Family Health is a partner in the effort.

Brief biographical sketches follow of the Office Director and the Division Leaders:

Patricia Moore-Moss, MSW, LCSW--Director Office of Maternal, Child, and Family Health
EDUCATION:

West Virginia University; School of Social Work, 1976 - M.S.W.
West Virginia State College, 1973 - B.A. Sociology - Social Work
M.S.W./L.C.S.W. - License No. CP00208394

PROFESSIONAL EXPERIENCE:

Director of the Office of Maternal, Child and Family Health (4/92 to Present)
Bureau for Public Health
Office of Maternal, Child, and Family Health
Social Service Consultant - Charleston Area Medical Center (1990 - 1992)
Bureau Administrator Social Services (9/88 - 11/89)
Assistant Director (1988 - 1989)
West Virginia Department of Health
Division of Maternal and Child Health
Executive Assistant to the Director (1986 - 1988)
Maternity Services Program Director (1980 - 1986)
Social Worker/Patient Educator (1/79 - 6/80)
West Virginia Department of Health
Improved Pregnancy Outcome Project
Assistant Director of Social Services (8/76 - 12/78)
Charleston Housing Authority

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

Master's of Social Work, West Virginia University, Morgantown, WV (1988)
Bachelor's of Social Work, West Virginia University, Morgantown, WV (1974)
Minors in Psychology and Speech
Attendance at a variety of training and educational seminars on a wide array of topics throughout the past 28 years related to employment at the time.

PROFESSIONAL EXPERIENCE:

Director, Research, Evaluation, and Planning (9/2000 - Present)
Bureau for Public Health
Office of Maternal, Child, and Family Health
Clinical Social Worker, (12/99 - 9/2000)
Comprehensive Psychological Services
Clinical Social Worker, (9/89 - 7/90) and (5/98 - 12/99)
Charleston Area Medical Center
Director of Social Work Services and Discharge Planning (8/90 - 5/98)
Charleston Area Medical Center
Administrator (7/84 - 5/89)
Northern Tier Youth Services
Supervisor, (6/81 - 7/84)
Lutheran Youth, and Family Services

Phil Edwards, M.A.--Director, Division of Infant, Child and Adolescent Health (including CSHCN)
EDUCATION:

Marshall University, Bachelors in Accounting, 1974.
Marshall University Graduate College, Masters in Industrial Relations, 1992.

PROFESSIONAL EXPERIENCE:

Director, Division of Infant, Child and Adolescent Health (1/01 to Present)
Office of Maternal Child and Family Health
Bureau for Public Health
Coordinator of the Abstinence Only Education (AOE) Project (10/99 - 1/01)
Program Specialist for EPSDT HealthCheck (1995 - 1999)
Administrative Assistant, Division of Women's Services (1993 - 1995)
Fiscal Officer, for Women, Infants and Children Program (1989 - 1993)
Office of Nutritional Services
Fiscal Officer, Administration (Central Office) - (1980 - 1989)
Office of Maternal, Child and Family Health

Anne Amick Williams, RN, BSN, MS-HCA -- Director, Division of Perinatal and Women's Health
EDUCATION:

West Virginia University School of Nursing, Bachelor of Science in Nursing, 1982-1986
Graduated Magna Cum Laude
Marshall University Graduate College, Master of Science in Management/Healthcare Administration, 1993-1999

PROFESSIONAL EXPERIENCE:

Director, Division of Perinatal and Women's Health (1/06 to Present)
Office of Maternal Child and Family Health
Bureau for Public Health

Director, Family Planning Program (1991 to 1/06)
Office of Maternal Child and Family Health
Bureau for Public Health

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

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

E. State Agency Coordination

The Office of Maternal, Child and Family Health has historically contracted with the Title XIX agency for the administration of EPSDT. In addition, there have also been formalized agreements for services offered through the Right From The Start Project, Family Planning and Children with Special Health Care Needs. The Office of Maternal, Child and Family Health administers and participates in the coordination of programmatic services funded under Title XIX to prevent duplication of effort, as required by federal regulation 42 CFR sub-section 431.615 (C)(4). The Office of Maternal, Child and Family Health has administrative responsibility for dental and vision care for persons moving from Welfare to Work. These efforts are financed by TANF resources; a copy of the grant agreement may be obtained from The OMCFH. As a component of the Birth to Three/Part C system change initiative, an additional interagency agreement has been finalized with the Bureau for Medical Services, utilizing the unique statutory relationship between Title XIX and Title V, the agreement established the Office of Maternal, Child and Family Health as the sole provider of early intervention services. The Department of Health and Human Resources has contracted with a private agency to serve as a central finance office to coordinate all funding sources for early intervention services, a centralized data system, and claims. This was let as a request for bid and is administered outside of state government by Covansys.

The Office of Maternal, Child and Family Health has in place many systems that contribute to the early identification of persons potentially eligible for services. These population based systems include birth score, birth defect registry, pregnancy tracking systems, metabolic screening, childhood blood lead level screening, and newborn hearing screening. In addition, because we administer the EPSDT Program, children who have conditions that may be debilitating and/or chronic disease, are referred to the CSHCN Program for further evaluation. This connection with EPSDT, which targets some 200,000 eligible children yearly, provides public health with a vehicle for identifying youngsters with problems, knowing that economically disadvantaged children are at increased risk. OMCFH, in an effort to increase public awareness, routinely participates in health fairs and community events. Our toll free lines, established in 1980, average close to 3,000 calls per month. Each caller receives individualized follow-up to assure the referrals and pertinent information related to the request met their need. Callers are also contacted by an administrative entity within OMCFH to ascertain the caller's satisfaction with our services. This quality assurance monitoring is prepared using random sampling. OMCFH toll free lines always receive accolades. Evaluation materials are on file and available if desired.

West Virginia Maternal, Child and Family Health is known for its positive partnerships with the medical community, the University Affiliated Program, Department of Education, the March of Dimes Chapter, among others. These partnerships have resulted in shared initiatives. One initiative is the folic acid campaign, a national March of Dimes assignment, used in West Virginia to advocate for the distribution of this supplement preconceptually to reduce the incidence of neural tube defects. Another initiative made possible was the Richard Winsor, smoking cessation program in partnership with the Office of Epidemiology and Health Promotion who contributed tobacco funds for the purchase of CO2 monitors by the 233 care coordinators for use with pregnant women statewide.

In 2005, the West Virginia Commission for the Deaf and Hard of Hearing surveyed all directors of special education, about the availability of and need for interpreters. Because WV does not have sufficient number of interpreters, trained and certified in ASL, the following steps have been taken:

-Fairmont State University has developed a Sign Language Interpreter Program. The Commission staff have been approved as a Local Test Administrator (LTA) for Educational Interpreter's Performance Assessment (EIPA) test.
-The Department of Health and Human Resources is promulgating rules related to establishing standards for interpreters.
-Workshops sponsored by the Commission have been offered across the State to improve skills of community and educational interpreters.

Agency Partners include: (list not all inclusive)
-400+ medical contracts with private physicians, community health centers, local health departments and hospital based clinics for the provision of EPSDT.
-Birth to Three/Part C provides grants to local entities to act as system point of entry for eligibles.
-Memorandum of Understanding with WIC and SSA for referrals as referenced earlier.
-Working agreement with the Office of Social Services (Title IVB) for children in state custody to receive enhanced health screens through MCFH's medical provider networks.
-Working agreement with the Office of Social Services for interagency training for professionals and para-professionals serving young children-including use of assistive technology and understanding ADA.
-Agreements with WVU for genetic services and administration of the Birth Score Project.
-145 agreements statewide with private physicians, community health centers and local health departments for Title X family planning services.
-153 agreements statewide for breast and cervical cancer screening program services.
-Agreements with 8 agencies to locally administer the Right From The Start Project and subsequent agreements with multiple agencies to provide direct services to perinatal populations who employ more than 165 licensed social workers and nurses, 83 Designated Care Coordination Agencies, 76 OB providers (contracted)
-March of Dimes
-Developmental Disabilities Council
-Medical Advisories for all programs and projects
-University Affiliated Program, Consumer Advisory Council membership
-Interagency Coordinating Council for Birth to Three/PartC (state statute established).
-Department of Education/Healthy Schools
-Starting Point Centers (Early Childhood Initiative, initially funded with Carnegie Foundation monies)
-Governor's Cabinet on Children and Families
-Head Start
-Cancer Coalition (established state statute)
-Membership, West Virginia Association of Community Health Centers
-WV Commission for the Deaf and Hard of Hearing (Board Member)
-Women's Health Advisory Council
-Children's Mental Health Collaborative
-WVU Healthy Start HAPI Project
-American Lung Association
-WV Division of Tobacco Prevention
-All Offices within WV DHHR

All agreements and contracts are kept on file within the West Virginia OMCFH.

Ruby Memorial Hospital, Morgantown, one of the States's three tertiary center facilities, has expanded its pediatric intensive care unit.

Coordination among agencies, community partnerships, and parents is discussed throughout the application and the previous Five-Year Needs Assessment.

Attached is a chart showing the Early Childhood Care and Educational Support Programs

associated with the Office of Maternal, Child and Family Health.

An attachment is included in this section.

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	93.6	91.8	123.0	104.5	100.7
Numerator	953	935	1252	1064	1025
Denominator	101805	101805	101805	101805	101805
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
data estimated from 2004 Hospital Discharge Data/Health Care Cost Review Authority

Notes - 2004
Data from 2004 Hospital Discharges/Health Care Cost Review Authority

Notes - 2003
2003 data not available at this time. Should be available in Sept. or Oct. of 04. This data reflects the discharges of West Virginia residents under age 5, with the principal or secondary diagnosis of Asthma (ICD-9 493.0-493.9)

Narrative:
The rate of children hospitalized for asthma (ICD-9 Codes 293.0-493.9) per 10,000 children less than five years of age.

The escalation in the prevalence of asthma among children over the past two decades has been noticeably greater than that among adults. For children under age five, the increase in prevalence between 1980 and 1994 was 160 percent, while the corresponding increase for the general population was 75 percent. Although there are more adult than child asthmatics, the prevalence of asthma among children is higher.

In West Virginia, in 2004, there were 1,064 hospital discharges for asthma for children under the age of five (5). There is an estimated 12.4% of WV high school children who suffer from asthma according to the 2003 Youth Tobacco Survey. Approximately 10.3% of middle school students and 8.8% of high school students had an attack of asthma in the past one year. WV has one of the highest smoking rates nationally and second hand smoke is a known irritant for asthma. In August of 200l, the OMCFH wrote a letter of support for a CDC sponsored grant submitted by the Office of Epidemiology and Health Promotion through their Tobacco Prevention Program. Appropriately so, tobacco monies are also being used to address the environmental factors that increase the risk of developing asthma or exacerbate the disease. The grant was approved to enable the development of a statewide plan to address prevention and treatment of asthma efforts. Although the OMCFH is not the home of the asthma initiative, since it is a disease that affects both children and adults, the OMCFH has a role in prevention via education of parents and children, plus a direct clinical care role which includes: 1) addressing maternal smoking during pregnancy and/or early infancy, and 2) provision of asthma therapy for children to include maintaining pulmonary function, normal activity levels, minimizing emergency room visits and hospitalization, and making available medication to control persistent asthma and "quick relief" medication to treat acute symptoms.

A West Virginia Asthma Coalition was formed with members from public health offices as well as community physicians and other interested agencies. In the information discovery phase a startling finding was that more students with asthma smoke than those who don't have asthma. The Coalition's role is one of prevention through education, establishing disease reporting parameters and mechanisms enabling tracking of incidence levels, advocacy for inclusion of benefit coverage across all payors for those affected by the disease, and payment for screening and prevention activities. There also remains the responsibility to assure screening, treatment, etc., is available and accessible to all, an assignment which exceeds the scope of health care financing available to MCFH.

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

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

Camp Catch Your Breath: The dates for the 16th annual camp are set for July 31 through August 4, 2006, at Jackson's Mills. A donation of $20,000 was made by Appalachian Electric Power. Last year approximately 21 out of 71 kids were able to pay in full for the camp.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	91.2	95.1	90.8	95.0	95.0
Numerator	13892	13145	12782	11630	11685
Denominator	15227	13818	14078	12242	12300
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2005
Data from Medicaid on enrollees is from July 1,2004 to June 30, 2005.

Notes - 2004
Estimated/Vital Statistics-- Data from Medicaid is enrollees from July 1, 2004 to June 30, 2005.

Narrative:

The OMCFH administers the mandated Medicaid EPSDT Program (HealthCheck). The HealthCheck Program educates families who receive Medicaid about preventive health care for their children and encourages their participation in the HealthCheck Program while ensuring the following: 1) children are screened/re-screened according to periodicity tables established by the American Academy of Pediatrics; 2) medical problems identified by examination are treated/referred; and 3) children/families receive transportation assistance and help with appointment scheduling. In WV, 95% of children under the age of one (1) who receive Medicaid, receive at least one initial or periodic screening. The HealthCheck Program focuses on recruitment and training of providers to assure compliance with program protocols, and targeted outreach by phone and mail.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	0	74.3	81.8	96.3	96.1
Numerator		75	90	103	99
Denominator		101	110	107	103
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2004
Estimated

Narrative:
WVCHIP embarked on a number of special projects this year. These included supporting local level pilot projects on reducing the number of unnecessary ER visits by providing a testbook "What to Do When Your Child Is Sick" and training to parents of young children. WVCHIP also completed its first year of partnering with the State's Immunization Program in order to improve immunization data, and encourage use of the State's Immunization Registry, as well as provide a modest savings to the program. The program also completed participation in the Payment Accuracy Measurement (PAM) project, which was continued as the Payment Error Rate Measurement (PERM) project. Both projects were federally funded to help WVCHIP identify areas that could leave the Agency vulnerable to making improper payments.

Enrollment for the program as of June 2005 is at one of the highest levels since its inception. Overall enrollment for the CHIP Program in FY 2005 has increased significantly from FY 2004 levels. The current program enrollment as of June 2005 consists of 24,515 children total: 15,571 children as partof Phase I and Phase II that consists of children whose families are below 150% of the federal poverty level and 8,944 children as part of Phase III that consists of children whose families are between 150% and 200% of the federal poverty level.

HEDIS is a set of standardized performance measures designed to ensure that purchases and consumers have the information they need to reliably compare the performance of managed health care plans. However, many states are using HEDIS to assess services delivered to both Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries to monitor program performance. Typically, the performance measures in HEDIS are related to many significant public health issues for adults such as cancer, heart disease, smoking, asthma and diabetes. Child health measures may include preventive and well child visits, immunization status, access to primary care practitioners, dental visits and can include selected chronic conditions.

WVCHIP is unable to report a HEDIS measure for all children receiving the recommended combinations of immunizations prior to age three. This is a combined result of the relatively few children covered by WVCHIP between birth to two years (since children in households with incomes up to 150% FPL are covered by Medicaid and since HEDIS data only counts those children enrolled for 12 months of a calendar year). Because of the Medicaid income eligiblity guidelines CHIP does not cover many children under the age of one (1). In CY 2004 there were only 107 covered and 103 or 96.3% had at least one periodic screen. In CY 2005, it is estimated that reporting data will be similiar.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	88.2	86.0	84.6	82.6	82.7
Numerator	18020	17271	17800	17267	17300
Denominator	20430	20081	21032	20911	20911
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
estimated based on 2004 Vital Statistics

Notes - 2004
from 2004 Vital Statistics

Notes - 2003
Data from WV Vital Statistics 2003. Denominator is the number of known women who received prenatal care.

Narrative:
According to 2004 WV Vital Statistics, 27.4% of women had 6-10 prenatal care visits, 55.3% had 11-15 prenatal care visits and 11.5% had 16 or greater prenatal care visits. Eighty- two point six percent of women began prenatal care in the first trimester, 11.4% began in the second trimester and 1.4% began prenatal care in the third trimester.

Improvement in the health of West Virginia's perinatal population is a result of a carefully crafted, highly-interdependent partnership. Tertiary care centers, primary care centers, local health departments, private practitioners and community agencies have worked with the Office of Maternal, Child and Family Health (OMCFH) for nearly 30 years to improve the health and well-being of the State's people. In conjunction with its medical advisory boards, OMCFH has designed a system that offers early and accessible health care to low income, medically indigent and underinsured women and children. A successful perinatal care system requires adequately trained professionals to provide complete reproductive health services that include family planning, preconceptual counseling, prenatal care, delivery, newborn care, and care for the woman in the postpartum period.

Early preventive prenatal care and education are recognized as the most effective and cost effective ways to improve pregnancy outcomes. West Virginia's Perinatal Program, the Right From The Start Project (RFTS), was birthed in 1989 as a partnership between OMCFH and Medicaid to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal services to low-income women up to sixty (60) days postpartum and care coordination for Medicaid eligible infants up to one (1) year of age. Right From The Start also provides direct financial assistance for obstetrical care for West Virginia pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if they are a West Virginia resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V-funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	98.7	98.5	98.9	98.9	98.9
Numerator	197672	205905	214154	214150	212200
Denominator	200205	208997	216516	216516	214500
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2003
Statistics from the Medicaid Program based on paid claims

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

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

During the 2003-2004 school year, there were 63,567 student visits to school-based health services during the day. There were 17,241 (75%) students in schools with a school-based health center who had parental consent to receive services from their centers. Sixty-four (64) percent of enrolled students used their school-based health center on at least one occasion during the school year. The centers provided access to 1,484 uninsured children, 4,493 children covered by Medicaid, 818 children covered by WV CHIP , and 5,544 children covered by private insurance.

The proportion of eligible children receiving a service from Medicaid has ranged over the past several years from a low of 53 percent in 1997 to a high, in 2002, of 95 percent. The EPSDT Program, administered by the Office of Maternal, Child and Family Health, provides dedicated outreach to eligibles in order to encourage participation and provide technical assistance support to school-based health centers to assure EPSDT compliance. The OMCFH administers the EPSDT Program, and uses the outreach requirement of the federal legislation to encourage families with children to participate in routine, primary preventive care. The total number of technical assistance trainings face-to-face with the medical community was 1,788 in FY 2004.

Infants whose birth was sponsored by Medicaid and served by RFTS was 36% of all Medicaid sponsored births. Approximately 57% of all state births were to Medicaid sponsored women, and all infants born to mothers with Medicaid coverage are eligible for Medicaid for the first year of life. The EPSDT program also works closely with the Office of Social Services in assuring that all children in State custody receive an EPSDT screen within thirty (30) days of placement.

Medicaid eligible children born in CY 2005 was 13,588
Infants referred to RFTS in CY 2005 was 5,435

Medicaid beneficiaries with chronic dibilitating conditions represent 80% of children in the CSHCN Program.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	44.3	47.5	47.9	48.0	48.0
Numerator	20775	19228	19747	19800	19800
Denominator	46917	40500	41244	41244	41244
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2005
The new Medicaid billing contractor, UNISYS, has not been able to provide claims data to the Management Information System (MIS) group in DHHR since July 1, 2004, as verified by Bureau for Medical Services (Medicaid).

Notes - 2004
data from OMCFH Children's Dentistry Program 2003

Narrative:
The Children's Dentistry Project (CDP) is a component of the Division of Infant, Child and Adolescent Health and is housed within the OMCFH. Preliminary data for 2003 suggests that 48% of West Virginia Medicaid recipients aged 6-9 received a dental service. In West Virginia, Medicaid child beneficiaries have financial access to dental services, yet most do not routinely seek care. Failure to keep appointments adversely affects willingness of dentists to serve the Medicaid population, thus limiting access. It is clear that public health must facilitate opportunities for youth to access dental care by educating children, youth, and their parents about the importance of oral health.

The CDP currently has 17 contracts with local health departments, primary care facilities and individuals to offer oral health education to students in public schools. Educators offer information about dental hygiene, the need for preventive dental visits, and the dangers of tobacco use. The CDP, in partnership with county school systems, Head Start agencies, and other community children's programs, are working together to offer a sealant and fluoride rinse program within schools. The CDP contracts with local dentists to purchase all supplies and perform all billing functions. Payments from existing insurance sources are sufficient to cover operational costs and ultimately improve oral health access.

There are significant numbers of West Virginians who do not have a fluoridated water supply. Some of those receive water from public systems. Fluoridation equipment is expensive and supplies are no more than $3 per customer per year. The savings in future dental carries is 5 to 6 times that amount. For example: For a town the size of New Martinsville (currently not receiving fluoridated water), the annual cost of fluoridation would be $25,500. If only one cavity is

prevented in an entire family, the net savings for the community is $124,200 annually. The CDP is beginning a project to work with a limited number of local communities and water systems to advocate for fluoridation and to assist communities to be able to obtain fluoridation. A small amount of funding is available to pay for necessary equipment. The Office of Environmental Health Services has been approached as a non-funding partner and is wiling to participate. Other funding sources are currently being explored. The infrastructure development will have lasting implications and may be supported through the Governor's Office of Community Development.

The CDP has a pilot project in McDowell County for a school-based dental clinic financed by Title V. The CDP has purchased equipment and supplies for this project. In addition to preventive services, students will be provided with oral health education materials and referred to local dentists for restorative care when necessary. Through this pilot project, over 4,000 students in McDowell County Schools have received toothpaste, toothbrushes, and dental floss. The CDP is also partnering with other Primary Health Care Facilities to offer school-based dental services and oral health education to students in Lincoln, Marshall, Jackson, Ritchie and Calhoun counties.

To design effective health promotion campaigns and materials, we must know what the customer is thinking. The CDP is implementing a research project in conjunction with higher education to learn more about the attitudes of youth and parents toward dental care, and learn more about the barriers to receiving dental care. To date, 2,359 surveys have been returned and are being processed through data entry.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	18.8	25.1	22.6	18.3	15.2
Numerator	1446	1725	1568	1256	1049
Denominator	7706	6880	6951	6856	6901
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The CSHCN program advances the health and well-being of children and youth with chronic health care needs, including those with cleft lip and palate, neurologic, and cardiac problems. The goal is to facilitate early care, offer consultation and clinical intervention, care management and planning, as well as to support the family and community in the care of children with special health care needs. The program provides services for children birth to age 21 years who have Medicaid, CHIP, Private Insurance, or Title V sponsorship. Components of the Program include: 1) assessment of children with special health care needs and enrollment in clinical care or referral to alternative sources as medically indicated; 2) participate in development of multidisciplinary treatment plans; 3) act as resource support to increase awareness of and need for primary, preventive health care; 4) establishes linkages with sub-specialty physicians, therapists and other providers; 5) CSHCN staff provide care management, including developing and monitoring treatment plans, assisting families with scheduling and transportation, and referral to other community services; and 6) adolescent/adult transition planning, including referral for work/training. All clinical services, including physician credentialing, peer review, and care protocol development are overseen by the CSHCN Medical Advisory.

The Children with Special Health Care Needs Program provides medical and care coordination services for children birth to 21 years of age. In CY 2005 3,111 children/youth received services

in 50 specialty care clinics throughout the state. There were 1,049 SSI recipients age 0-18 who also received CSHCN services. As of December 2005 there were 8,980 children in WV under the age of 18 receiving SSI benefits, this indicates that the CSHCN Program served 11.6% of WV children under the age of 18 who received SSI benefits.

The CSHCN Program is committed to assisting families with SSI applications and expediting SSA/Disability Determination process. To meet this goal the CSHCN Program continues to work with the SSI/OMCFH Task Force to formalize outreach and agency linkages, share knowledge of who and how programs can be accessed and ensure prompt and appropritate services to children with disabilities.

Some 7000 chilren statewide under the age of 16 receive SSI benefits. Not all conditions that qualify children for SSI are covered by one CSHCN program. For example, CSHCN does not have capacity, professionally or fiscal, to care for autism, serious emotional disorders etc., which are conditions which often trigger SSI eligibility.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2004	payment source from birth certificate	10.5	7.3	8.9

Notes - 2007
from 2004 vital statistics

Narrative:
West Virginia has struggled with the incidence of low birth weight infants. Risk factors for preterm birth and low birth weight include: previous preterm and/or low birth weight birth, multiple births, smoking, unplanned pregnancy, infections, poor nutrition, lack of access to adequate and early prenatal care, poor oral health, harmful substance abuse and domestic violence.

Although the RFTS Project provides in-home care coordination to a high risk population of pregnant women and infants, 2003 data shows the average birth weight for an infant born to Project participants was 6.6 pounds, 2004 shows the average as 7.4 pounds. In 2004, 1% of RFTS Project births were very low birth weight and 4% were low birth weight.

Planning and spacing for pregnancy is a key factor in reducing low birth weight incidence. The RFTS DCCs encourage participants to choose a method of birth control immediately after delivery in order to prevent repeat, unintended pregnancies. Documentation of family planning discussion is required as part of RFTS Project protocol prior to case closure at 60 days postpartum.

The high incidence of low birth weight is concentrated in a small number of counties. Activities to address this include RFTS follow-up to discuss nutrition during pregnancy, enrollment in WIC,

and education on the importance of adequate and early prenatal care and smoking cessation.

The RFTS Project continues to provide smoking cessation education for pregnant women through the efforts of the WV RFTS SCRIPT.

A growing body of evidence linking poor oral health (periodontal infection) to preterm births highlights the importance of good oral health. Research has indicated that pregnant women with periodontal disease may be at increased risk for delivering preterm and/or low birth weight infants. In West Virginia, the state Medical Card does not provide oral health care coverage for adults, including pregnant women.

The Division of Perinatal and Women's Health has five staff persons solely dedicated to teen pregnancy prevention efforts. These efforts include sex education/instruction in partnership with public schools.

The WV Healthy Start Helping Appalachian Parents and Infants (HAPI), WV's only Healthy Start Project, implemented an oral health component for pregnant women in the 8 project counties. This is in response to the identified need within the prenatal population and the initiative partners with the WVU School of Dentistry Department of Rural Outreach. Dentists have been recruited, payment negotiated, and all invoices are forwarded to OMCFH as HAPI's fiscal agent for payment.

RFTS continues to build relationships among care providers to assist in identifying women at risk of preterm labor or other complications. DCCs will continue to provide intense education and support to participants during the prenatal period about risk factors contributing to low birth weight infants. The RFTS Project individualizes education and patient support depending on the educational level of the families to ensure understanding of the importance of prenatal care.

The Director of Perinatal Programs and the Director of the Division of Perinatal and Women's Health participate on the March of Dimes Program Services Committee for the purpose of promoting public awareness regarding the health and social problems that accompany prematurity.

OMCFH is participating in the WV Perinatal Wellness Study, sanctioned by the governor, as a continued activity to reduce low birth weight. OMCFH will use data from this study to support changes in service delivery and to assist in system redesign as precipitated by study findings.

Using funding from the Division of Tobacco Prevention, the RFTS Project will continue to provide smoking cessation education and support to pregnant women and will provide education on the importance of maintaining a smoke-free environment.

OMCFH feels these strategies will help improve the incidence of low birth weight in the Project's targeted population which is WV families who are eligible for Medicaid assistance for prenatal and infant care. This could have a major impact on the statewide problem of low birth weight since approximately 60% of all WV residents are eligible for assistance through Medicaid. However, other factors causing low birth weight births such cannot be impacted by these interventions.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

State					
Infant deaths per 1,000 live births	2004	payment source from birth certificate	7.6	6.5	7.1

Notes - 2007
From Vital Statistics 2004...87 known Medicaid funded...7l unknown

Narrative:
The Perinatal Wellness Study,established as a planning grant from the Claude Worthington Benedum Foundation and supported by the Governor in 2006, is assessing perinatal outcomes using broad stakeholder participation. The study partners will recommend program and health policy to improve the health of mothers and babies in our State. Proposals to carry out one or more of the recommendations will be developed after the study has been completed, most likely in 2007.

In the last several years, West Virginia's infant mortality rate and percent of low birth weight babies have increased, ranking West Virginia well below other states and below the national average for these two indicators of child well being. As one example, West Virginia medical professionals report many pregnant women continue to smoke, one of the leading associated risk for low birth weight and for infant death. In 2003, over 26% of West Virginia pregnant women used tobacco during pregnancy. Of infant deaths that same year, 34% were to infants of mothers who smoked. Health professionals also report that West Virginia has a high percent of infants receiving expensive neonatal intensive care services and insufficient programs promoting perinatal wellness.

Improving the health and well being of West Virginia children means starting interventions and education before the prenatal period.

Across the country, employers and managed care organizations are recognizing the unique opportunity to protect and promote the health and well being of young children by supporting perinatal wellness. According to the National Business Group on Health, companies have a vested interest in improving maternal and child health. Not only are they concerned about the health and productivity of their current workforce, but also that of future workers. Childbirth related costs are the single largest component of health care costs for many employers. One unhealthy birth can cost anywhere from $20,000 to more than $1 million, compared to about $6,400 for a normal, healthy delivery. Perinatal wellness programs have reduced employer costs by millions of dollars. In addition to the direct health care costs, the related indirect costs of increased absenteeism, higher disability costs and lowered productivity magnify the problem. Consequently, many companies have implemented innovative programs aimed at ensuring good maternal and child health.

In West Virginia, 57% of all pregnant women receive prenatal care through Medicaid and the Public Employee's Insurance Agency. The Office of Maternal, Child and Family Health also provides coverage for additional women. This investment of public dollars in perinatal care provides a unique opportunity to raise issues and to direct resources towards prevention and wellness, quality care and best practices. Promoting perinatal wellness in West Virginia can assure better birth outcomes, give our chidren a better start on life, and will save medical care dollars.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-**	**ALL**

indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2003	other	76	93	86

Notes - 2007
from 2004 Vital Statistics

Narrative:
According to 2003 PRAMS data, the overall percentage of women entering prenatal care during the first trimester was 83.7%. Of women whose prenatal care was not paid by Medicaid 93.2% entered prenatal care during the first trimester compared to only 75.9% of women whose prenatal care was paid by Medicaid and entered prenatal care during the first trimester.

Ensuring access to health care for low-income women and children has been an ongoing concern for state and federal officials. The Bureau for Medical Services (Medicaid) and the Office of Maternal, Child and Family Health (OMCFH) have worked collaboratively to develop special initiatives that extend support services to women and infants at-risk of adverse health outcomes. This partnership has not only expanded the State's capacity to finance health care for medically indigent women and children, but has also strengthened the delivery of care by establishing service protocols, recruiting medical providers and developing supportive services such as case management and nutrition counseling which contribute to improved patient well-being.

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

Early preventive prenatal care and education are recognized as the most effective and cost effective ways to improve pregnancy outcomes. West Virginia's Perinatal Program, the Right From The Start Project (RFTS), was birthed in 1989 as a partnership between OMCFH and Medicaid to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal services to low-income women up to sixty (60) days postpartum and care coordination for Medicaid eligible infants up to one (1) year of age. Right From The Start also provides direct financial assistance for obstetrical care for West Virginia pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if they are a West Virginia resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V-funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit.

The Right From The Start Project was implemented in April 1990 for infants and July 1990 for women. In recognition of the importance of developing systematic approaches to deal with problems of access to prenatal care, Senate Bill 4242 was enacted. Under the provisions of the Bill, the WV Department of Health and Human Resources, Bureau for Public Health, was

assigned responsibility for administration of RFTS, with Title XIX and Title V designated as payor sources.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2004	payment source from birth certificate	74.6	94.6	84.6

Notes - 2007
from 2004 Vital Statistics

Narrative:
According to 2004 WV Vital Statistics, 27.4% of women had 6-10 prenatal care visits, 55.3% had 11-15 prenatal care visits and 11.5% had 16 or greater prenatal care visits. Eighty- two point six (82.6) percent of women began prenatal care in the first trimester, 11.4% began in the second trimester and 1.4% began prenatal care in the third trimester.

WV PRAMS data for 2003 show the overall percentage of women entering prenatal care during the first trimester was 83.7%. Of women whose prenatal care was not paid by Medicaid 93.2% entered prenatal care during the first trimester compared to only 75.9% of women whose prenatal care was paid by Medicaid and entered prenatal care during the first trimester.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2005	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2005	200

Narrative:
As of 6/30/04 12,345 infants under the age of one year were covered under Medicaid and 103 infants under the age of one were covered by WVCHIP. This population had about a 97% rate of having a primary care visit within this first year of life.

Ensuring access to health care for low-income women and children remains an ongoing concern for state and federal officials. The Bureau for Medical Services (Medicaid) and the Office of Maternal, Child and Family Health (OMCFH) have worked collaboratively to develop special initiatives that extend support services to women and infants at risk of adverse health outcomes. This partnership has not only expanded the State's capacity to finance health care for medically indigent women and children, but has also strengthened the delivery of care by establishing service protocols, recruiting medical providers and developing supportive services such as case management and nutrition counseling which contribute to improved patient well-being.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2005	 133 100 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2005	 200 200 200

An attachment is included in this section.

Narrative:
WVCHIP has worked closely with all partners and entities identified in its State Plan, however, the West Virginia Healthy Kids and Families Coalition has played a pivotal role in working with community based partners to reach uninsured children across the State of West Virginia. This is the Coalition's final year as a grant participant in the Robert Woods Johnson Foundation's "Covering Kids Project." This year's collaborations included media campaigns and community outreach grants in targeted counties. During the summer months alone, over 75 community events were held featuring WVCHIP promotion or outreach in some form throughout West Virginia in an effort to increase enrollment and awareness of the program along with a message focused on the importance of immunizations. As enrollment has increased, the partnership has evolved in working on health awareness campaigns, such as childhood obesity, immunizations, and the importance of a medical home.

Based on survey data from "Health Insurance in West Virginia", WVCHIP continues to prioritize/target outreach efforts to fifteen (15) counties (see attachment) of the State with either higher numbers or percentages of uninsured children.

The faith community plays a vital role in supporting families and nurturing the development of children, by integrating faith, access to care and health of the whole person. Health ministries, parish nurse programs, congregations and other faith-based organizations are getting acitvely involved in tending directly to the health concerns of their members and the community. Faith organizations that sponsor community-based programs such as child care centers, food pantries and summer camps are becoming more attentive to the problems children face.

For this reason, WVCHIP collaborates with the faith community in an effort to educate and

support families in obtaining health care coverage and promoting healthy lifestyles.

The WVCHIP has partnered with Programs within OMCFH that include HealthCheck, Children's Dentistry, Birth to Three (Part C) and Right From The Start to assist in coordinating outreach efforts.

HB 4021, the health care reform bill, passed the last day of the 2006 legislative session. The best part of HB 4021 is the expansion of the WVCHIP. The WVCHIP currently insures children in families with incomes below 200 percent of the FPL. HB 4021 increases this eligibility to 300 percent of the FPL, which has been reported to be $60,000 a year for a family of four. It is projected that 4,000 plus children will, over the next several years, enroll in CHIP as a result of this expansion. The children in families between 200 and 300 percent of the FPL will be required to pay monthly premiums, and deductibles and copayments. The expansion of CHIP is projected to increase from 92% of West Virginia children who currently have health insurance to 97%. This will nearly be universal health care coverage for children in West Virginia.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2005	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2005	200

Narrative:
The percent of the FPL for eligibility for infants up to one year of age and pregnant women is 150%.

The WVCHIP does not provide medical coverage for pregnancy. CHIP refers all pregnant teens to the MCFH/Title V for coverage.

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

Early preventive prenatal care and education are recognized as the most efficient and cost effective ways to improve pregnancy outcomes. West Virginia's Perinatal Program, the Right From The Start Project (RFTS), was birthed in 1989 as a partnership between OMCFH and Medicaid to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal services to low-income women up to 60 days postpartum and care coordination for Medicaid eligible infants up to one (1) year of age. Right From The Start also provides direct financial assistance for obstetrical care for West Virginia pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if

they are a West Virginia resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V-funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures, if ordered on their first visit.

The Right From The Start Project was implemented in April 1990 for infants and July 1990 for women. In recognition of the importance of developing systematic approaches to deal with problems of access to prenatal care, Senate Bill 4242 was enacted. Under the provisions of the Bill, the WV Department of Health and Human Resources, Bureau for Public Health, was assigned responsibility for administration of RFTS, with Title XIX and Title V designated as payor sources. Through the RFTS Project, the Office of Maternal, Child and Family Health fulfills this oversight responsibility by assuring:

• Availability of medical providers who agree to provide care in accordance with American College of Obstetricians and Gynecologists (ACOG) Standards of Care;
• Availability of licensed practitioners credentialed to provide care coordination and patient education for low-income women with high risk of adverse pregnancy outcomes or for low-income families with infants at risk of poor health or death;
• Technical assistance to RFTS providers; and,
• Quality assurance monitoring and improvement to assure government sponsored patients receive care provided in accordance with national standards.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No

Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2007

Narrative:
The Division of Research, Evaluation and Planning has access to both birth and death files on a regular basis.

The Birth Defects Surveillance System (CARESS - Congenital Anomolies Research, Education and Surveillance System) is currently operating as a passive system. There are MOU's in place with the birthing facilities across the state and the system and we rely upon them to submit monthly reports which include those infants born with defects meeting required diagnosis fields.

WV PRAMS was one of the initial states funded by CDC in 1987 and began collecting data in 1988 and has been actively doing so since that time. WV PRAMS data is used for several of the national and state performance measures.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2007

Narrative:
The 2005 Youth Risk Behavior Survey (YRBS) was completed by 1368 students in 34 public high schools in West Virginia during the spring of 2005. The results are representative of all students in grades 9-12.

The weighted demographic characteristics of the sample are as follows:
Males 50.8% Females 49.2%
9th grade 28.5% 10th grade 24.8% 11th grade 22.4% 12th grade 21.7%
White 94.5%
African American 2.0%
Hispanic/ Latino 0.8%
All other races 1.8%
Multiple races 1.1%

Students completed a self-administered, anonymous, 87-item questionnaire. Survey procedures were designed to protect the privacy of students by allowing for anonymous and voluntary participation. Local parental permission procedures were followed before survey administration. The YRBS is one component of the Youth Risk Behavior Surveillance System developed by the Centers for Disease Control and Prevention in collaboration with representatives from 71 state and local departments of education and health, 19 other federal agencies, and national education and health organizations. The Youth Risk Behavior Surveillance System was designed to focus the nation on behaviors among youth related to the leading causes of mortality and morbidity

among both youth and adults and to assess how these risk behaviors change over time. The Youth Risk Behavior Surveillance System measures behaviors that fall into six categories:

1. Behaviors that result in unintentional injuries and violence;
2. Tobacco use;
3. Alcohol and other drug use;
4. Sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies;
5. Dietary behaviors; and
6. Physical activity.

SAMPLE DESCRIPTION:

School Level - All regular public schools containing grades 9, 10, 11, or 12 were included in the sampling frame. Schools were selected systematically with probability proportional to enrollment in grades 9 through 12 using a random start. Eight schools were sampled with certainty because they had a higher proportion of minority students.
Class Level - All classes in a required subject or all classes meeting during a particular period of the day, depending on the school, were included in the sampling frame. Systematic equal probability sampling with a random start was used to select classes from each school that participated in the survey.

Percentage of students who smoked cigarettes on one or more of the past 30 days = 25.3% overall; 25.6% for males and 24.8% for females; 26.6% of ninth graders; 23.1% of tenth graders; 25.6% of eleventh graders; and 26.9% of twelfth graders.

Percentage of students who used chewing tobacco, snuff, or dip on one or more of the past 30 days = 14.9% overall; 26.5% for males; 3.0% for females; 16.8% for ninth graders; 13.4% for tenth graders; 12.7% for eleventh graders; and 16.7% for twelfth graders.

Percentage of students who ever smoked cigarettes daily, at least one cigarette every day for 30 days = 19.3% overall; 18.3% for males; 20.1% for females; 19.1% for ninth graders; 18.8% for tenth graders; 21.0% for eleventh graders; and 19.2% for twelfth graders.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Office of Maternal, Child and Family Health, Bureau for Public Health, Department of Health and Human Resources, is the "single state agency" for Maternal and Child Health in West Virginia. The OMCFH plans, promotes and coordinates a statewide system of comprehensive health services for women, infants, children, adolescents, and families of children who have special health care needs. The Office is known for longstanding community partnerships between the public and private sector which has ultimately resulted in improved health status and access for maternal and child health populations.

The Office of Maternal, Child and Family Health, since the 1980's, has contracted for the provision of direct health care. These contractual relationships include private sector physicians, university-medical school partners, hospitals, community health centers, and local health departments. All services are formally contracted with established performance standards portrayed in the written provider-OMCFH agreements. The exception to this format is CSHCN, which was, until the late 1980's, administered by the former Human Services arm of the now Department of Health and Human Resources organization. This unit has maintained its direct service responsibility because of the scarcity of pediatric and pediatric sub-specialty providers in certain geographical areas of the State. The program receives referrals from multiple sources. However, as the State has developed and improved population-based surveillance systems, more and more youngsters have been referred. It is also important to note that the State's universal risk scoring of infants, called Birth Score, was modified several years ago to assure the identification of infants with or at risk of developmental delay. These children are referred to the OMCFH administered Birth to Three Program/Part C/IDEA. In addition, OMCFH administers EPSDT, again with direct care through community provider partnerships, but we do have access to information on each child, enabling us to identify youngsters with chronic or disabling conditions for referral to CSHCN. The primary care physicians are encouraged to refer children to CSHCN, and are routinely visited by Pediatric field staff employed by EPSDT, who serve as technical resources to the medical community. A portrayal of how the system works is depicted in the diagram in the attachment. The West Virginia Office of Maternal, Child and Family Health, in collaboration with multiple agencies, family groups, and individuals, has determined several needs across the service system. The needs, as identified, have been linked to Healthy People 2010 Objectives when possible and are listed by targeted populations; i.e., perinatal, children, adolescents, and children with special health care needs.

Families of children with special health care needs require the same sorts of support as do families with children who do not have special needs; that is to say, they require basic health care, education, recreation, socialization, transportation, and other systems to support them in their roles as family members and to help them raise children to be healthy, responsible, competent adults. All families need these systems to be available, accessible, and responsive to their needs.

As a result of multiple surveys and public forums, several overall system needs became apparent. Within the Direct Health and Enabling Services category, West Virginia is severely lacking in respite services. Respite services are almost non-existent, even for high need, targeted population groups like Medley class members who were previously institutional residents. In addition, all focus groups reflected the importance of self-determination needs in the state. The State OMCFH received multiple documentation that reinforces this priority need.

Within the Population-based Services category, surveys and public forums, the Medley class survey and the Developmental Disabilities Council survey, show that oral health services are cited as the greatest need among adults with disabilities. There is no oral health care financing for adults in that Title XIX does not offer coverage and the previously referenced Pre-employment Project, administered by OMCFH is limited to adult TANF populations returning to the work force.

Also, even when children have health care financed (Medicaid), there is poor utilization of oral health services. Finally, survey results confirm that vocational transition services are in need of renewed support in West Virginia. Approximately 1/3 of survey responders indicated the need for children to receive transition or vocational planning.

Causes of infant death, low birthweight and maternal smoking must be addressed. Within the Infrastructure building category, recruitment and retention of qualified medical and other service delivery personnel in WV must receive priority attention in the future. Moreover, insurance systems within the state infrastructure require modification to better accommodate children and families in WV. Recognition of CSHCN services to include reimbursement for non-traditional services such as intervention by licensed behaviorist and other professionals must become a priority.

B. State Priorities

Each current state performance measure was selected because of the health status of the respective population and based on information derived from the Needs Assessment completed in 2005.

Although West Virginia has financial woes and many health care issues such as smoking among pregnant women, infants born prematurely, infants born with low birth weight, obesity and asthma, the WV OMCFH has woven together a patchwork of funding streams to create a system of care for women, infants, and children, including adolescents and those with special health care needs. The WV OMCFH has developed strong partnerships across the State with the medical community, private sector, as well as community health centers and local health departments, all in an effort to assure access. Medicaid has purchased services for their beneficiaries at the request of Title V but they, too, are facing financial woes.

It is clear that we cannot support all current programs and services at the existing level. In response to budget shortfalls, the WV OMCFH has advocated for the purchase of those services most critical to the health of maternal and child populations--family planning, prenatal care, support of EPSDT, population based surveillance programs, CSHCN services, etc. Another strategy that the WV OMCFH has undertaken is reduction of cost wherever possible. The Family Planning Program formulary has been changed to accomodate the purchase of generic treatment medications and contraceptives. These pharmaceuticals are purchased in mass and stored at a government operated warehouse that is supported by multiple programs, including West Virginia Healthy Start/HAPI. Recently, the data entry staff were merged with the Finance Division to maximize personnel effiency. With the constant use of computers and scanning equipment, secretarial staff have not been replaced in some cases. West Virginia is also efficient with resources, often administering programs and services that are used by multiple payor sources such as Title XIX and XXI. To assure that federal resources are maximized, all uninsured children and pregnant women seeking services must apply for Title XIX. If the patient is ineligible for the Title XXI or Title XIX, Title V resources are used to pay for their care.

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

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

A. Pregnant women, Women of childbearing age, Mothers and Infants

1. Decrease smoking among pregnant women
2. Reduce the incidence of prematurity and low birth weight
3. Reduce the infant mortality rate

B. Children and Adolescents
1. Decrease the incidence of fatal accidents caused by drinking and driving
2. Increase the percentage of adolescents who wear seat belts
3. Reduce accidental deaths among youth 24 years of age or younger
4. Assure that children and families access health care financing and utilize services
5. Reduce smoking among adolescents
6. Reduce obesity in adolescents

C. Children with Special Health Care Needs
1. Maintain and/or increase the number of specialty providers in health shortage areas
2. Assure that children and families access health care financing and utilize services
3. Increase Newborn Metabolic Screening test to include the 29 nationally recommended tests

We also have cervical cancer as one of the leading causes of death of WV women, and the opportunity to offer breast and cervical cancer screening for high risk women who might not otherwise access appropriate medical screening is a part of our effort to improve the quality of life for West Virginians. We also track WV women who have HPV, and subsequently follow how many of these women develop cancer of the cervix.

If every West Virginian is to have improved health status, we need to help families plan and space pregnancy. This has continued to be a challenge, and even with 150 family planning clinics offering services statewide, we still have unintended pregnancies that ultimately have implications for child well being and family functioning.

Following is additional needs by the levels of the pyramid:

Direct and Enabling Services
1) Key insurance systems within the state require modification to better accommodate the needs of children and families in WV. For example the Public Insurance Program does not provide coverage for hearing aids so CSHCN must purchase the equipment.
2) Persons with disabilities have declared the right to self-determination and advocacy as a WV priority. Included in this declaration is the issue of independent living, meaningful employment opportunity, etc.
3) The utilization of health care services by adolescents needs to increase and additional resources dedicated to affecting behavioral changes such as increased use of seatbelts, decreased use of alcohol and tobacco, increase in the number of adolescents abstaining from sexual activity, and decrease in school drop outs.
4) The number of women smoking during pregnancy must be decreased.

Population-Based Services
1) Quality contraceptive health services must be universal as a means of supporting healthy families and reducing unintended pregnancy.
2) All children must have a source of health financing and a health home.
3) Oral health services in WV should be improved, and their availability augmented, both for children and adults, especially adults with disabilities. Oral health must be integrated into general health.
4) Attention must be given to causes of infant death in WV - reduce the infant mortality rate.
5) Increase the Metabolic Newborn Screening panel to include all nationally recommended tests.

Infrastructure
1) Recruitment and retention of qualified medical and other service delivery personnel in WV must be given increased attention, including use of paid stipends.
2) Specialty medical services for children with chronic debilitating conditions are a priority as is

the improved availability of obstetrical services.
3) An adequate supply of safe and enriching center-based care must be available where acceptable relative care is unavailable with adequate subsidy to allow parents to work.
4) To reduce the proportion of women smoking during pregnancy.
5) To reduce the proportion of unintended pregnancies.
6) To increase the proportion of women receiving first trimester prenatal care whose prenatal care is paid for by Medicaid.
7) To increase the proportion of women >18 receiving Pap smears within the preceding three years.
8) To increase the proportion of eligible children who receive EPSDT services.
9) To identify as early as possible all children at risk of chronic or debilitating conditions and arrange for appropriate care.
10) To increase the proportion of age appropriate children screened for blood lead.
11) To increase the number of children receiving oral health care, with special emphasis on children whose health care is paid for by CHIP and Medicaid.
12) To increase the proportion of women >50 receiving mammograms within the preceding two years.
13) To reduce the incidence rate (per 100,000) of females aged 15-19 years diagnosed with Chlamydia.
14) To continue to work cooperatively with the Division of Surveillance and Disease Control, which is responsible for the STD Program. Patients participating in Family Planning are routinely screened for STDs.

C. National Performance Measures

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	99	99.5	99.5	100	100
Annual Indicator	99.8	100.0	99.1	100.0	99.9
Numerator	20950	21123	21280	21300	21286
Denominator	21001	21132	21480	21306	21306
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

Notes - 2004
Estimated

Notes - 2003
Denominator information for 2003 is provisional from the Vital Statistics Division. Numerator information was received from the State Lab.

a. Last Year's Accomplishments
In 2005, the WV Newborn Metabolic Screening Advisory Committee, as well as the Bureau For Public Health task force, recommended that the WV Newborn Metabolic Screening Program increase the screening panel to include the 29 recommended tests. The task force developed a feasibility study with accompanying recommendations to enhance screening ability. Project financing has been the biggest stumbling block. The current State plan is that the WV State Lab will send OMCFH the list of Infants screened and the OMCFH claims and benefit unit will bill all

insurers.

Recommendations included: 1) expanding the Newborn Metabolic Screening Program to include all 29 recommended tests by gradually adding tests, 2) increase capacity of the State Laboratory by providing equipment, as well as personnel and space, 3) increasing case management and educational components within OMCFH, and 4) increasing capacity of genetic and counseling services. The WV State Lab has upgraded its data collection system.

In 2005, 99.9% of infants born in the state of WV received newborn screening. In conjunction with the Office of Laboratory Services, the Newborn Metabolic Screening Project ensures that infants are screened for inborn errors of metabolism before hospital discharge. All abnormal test results are followed-up by Office of Maternal, Child and Family Health staff and confirmed abnormalities receive case management, with assistance from the Genetics Program at West Virginia University. The Office of Maternal, Child and Family Health provides, free of charge, regardless of family income, formula for those with confirmed PKU. The OMCFH, using Title V dollars, reimburses the State Lab for all newborn screening specimens, no insurers are billed.

The Genetics Program at West Virginia University provides genetic clinics at 6 strategic locations throughout the state, offering diagnosis, treatment and counseling and is funded using Title V dollars.

OMCFH staff routinely visits birthing hospitals as a means of identifying and resolving any problems or concerns.
Linkage of data from the State Laboratory and the Project have been reestablished creating a more efficient process.

One of the goals of the State Laboratory is the reduction in the numbers of specimens submitted to the laboratory which fail to meet the criteria established for a satisfactory specimen. Such failure results in compromised or no test results, making a repeat blood collection necessary, which is a great inconvenience to the patient, and a repeat test, which is time consuming and expensive for the OMCFH. The two principal reasons for repeat testing are (1) the inadequacy of the specimen, and (2) the collection of the initial specimen too soon after birth.

During the first year of collecting test data, 1996, the percentage of tests that had to be repeated was 20.8%. In 2004, this percentage had dropped to 4%.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All abnormal test results are followed by OMCFH case management.		X		
2. The pediatric genetics program at WVU provides six subspecialty clinics throughout WV.				X
3. An active advisory committee was re-established to assist with policy and program development.				X
4. The NBS Project staff work collaboratively with the State Lab to ensure screening before discharge.				X
5. Formula for PKU patients is provided free of charge, regardless of income, by OMCFH.		X		
6. Linkage of data between OMCFH and the State Lab has been re-established creating efficiency.				X
7. The Bureau for Public Health issued policy requiring universal testing of all infants for Hemoglobinopathies.				X

8. Formal relationships have been developed with Schools of Medicine to assure availability of medical experts.				X
9.				
10.				

b. Current Activities
The Bureau For Public Health as well as the Advisory Committee continue to work on the expansion of newborn screening. Funding for the expansion will be rolled up in a Newborn Screening Panel charge and billed to Insurance companies. The details of billing, implementation, and education are currently in the development stages.

c. Plan for the Coming Year
The goal for the upcoming year will be to develop the capacity to bill the insurance companies for the Newborn Screening panel. Costs will include lab costs, casemanagement services, nutrition supplements, genetic services etc. As funds are available, the test panel will increase incrementally beginning with those screens that do not require use of the tandem mass spectometry. Once the purchase and education on the use of the tandem mass spectometry is complete, additional tests will be added at the recommendation of the State Laboratory, based in-house capacity/capability. Physician education will occur in conjunction with the expansion of tests, and be the responsibility of OMCFH.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective		65	65	75	60
Annual Indicator		56.1	56.1	56.1	56.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	65	65	65	65	65

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
Parents or legal guardians are involved in the decision making for their child through the Patient/Family Assessment process and the development of the Patient Care Plan. A multi-disciplinary team approach is used to provide care-planning and care-coordination to CSHCN and Birth To Three Part C/ IDEA program participants. The multi-disciplinary team includes the child/parent, physicians, nurses, social workers, therapists, school systems, vendors and community services supports who are providing care for the child. Team members, led by the

CSHCN nurse and/or social worker, collaborate with the child/family in developing an appropriate, comprehensive care plan for the child.

In Birth To Three, individual child and family assessments are developed for every participant by a multidisciplinary team. Services to be offered based on the care plan are provided by practitioners enrolled in Birth To Three and selected by the family. Each Birth To Three Regional Administrative Unit ahs a full time Parent Coordinator to serve as a liaison between the program and families. These positions are paid for by the OMCFH using Part C funds. All services are at the discretion of the family.

During CY 2005, 3,499 CSHCN Program patient care plans were completed or updated to assure a continuum of comprehensive medical care and transition to adult care as appropriate. Plans are copied, signed and reviewed with parents. Transition services also involve parents, education specialists and other interested parties. Transition screening tools have been newly developed according to age appropriateness and added as part of the process. Transition services were provided to 1,049 youth, ages 14 to 21.

Parents of children with special needs participate in advisories for Birth To Three and CHSCN. Also parents are supported with stipends so they can participate in self-determination workshops, the Fairshake Network and other advocacy groups.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration with Marshall University in Parent Partners in Education (PPIE) funding results in parent advocates placed in Cabell-Huntington Hospital PICU and Pediatric Clinic.		X		
2. Parent/Professional Collaboration Conference sponsored by OMCFH and Marshall University Pediatrics.		X		
3. Survey of parents to determine priority topics of interests/concerns conducted by Center for Excellence through contract with OMCFH.		X		
4. The OMCFH Monitoring Quality Assurance unit conducts call-backs of Systems Point of Entry contacts to determine satisfaction.				X
5. Parents participate as part of the care coordination team for development of individual care plans.		X		
6. The parent signs the Care Plan to indicate their agreement with the plan.				X
7. Copies of Care Plans and updates are shared with the child's parent.		X		
8. Care Notebook and Resource Manual were revised for distribution to families and applicants.		X		
9. Paid Parent Coordinators, one in each of the Birth To Three Regions are available to families.				X
10.				

b. Current Activities

To include parents' voices and advice on decision making at the administrative level, the CSHCN Medical Advisory Board was reconstituted and expanded to become more inclusive. The membership of the Program Advisory was diversified to include adolescents, parents, representatives from state and private agencies, and medical professionals, all of whom have provided or received services through the CSHCN program. The Program Advisory advises the

Commissioner of the Bureau for Public Health relating to the care and treatment of children receiving services from CSHCN.

The partnering of parents in decision making at all levels of CSHCN is demonstrated through the participation of Parent Network Specialists (PNS). The PNS system is administered by the Center For Excellence for Disabilities (CED), to ensure impartiality.

During CY 2005, a new project was undertaken by the PNS when they were assigned the task of conducting surveys with all program participants to assess their understanding of and satisfaction with CSHCN services. PNS, in cooperation with the CSHCN, began the process of revising the Care Notebooks and Resource Manual.

c. Plan for the Coming Year

During FY 2006, Patient/Family Assessments and Care Plans will be completed or updated for all program-enrolled children through home visits, clinic visits and/or other face-to-face contacts. Priority will be given to newly enrolled children and to children requiring transition services, pre- and post-surgical care; private duty and intermittent skilled nursing; nutritional assessment; child protective services; technology dependent, and those requested by physicians, clinics, other agencies. Additional emphasis will be placed on care coordination services offered through the CSHCN Program by educating participants as to services offered and the role of their Care Coordinator in providing those services.

The CSHCN Family Survey will continue to be distributed to all enrolled participants in the CSHCN Program to monitor the needs fo the family/child relating to medical treatment, clinic services, medical home, transition services, care coordination and family's willingness to participate in group discussions about health care issues. The results/outcomes will be used to determine future direction for the CSHCN Program.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					60
Annual Indicator		56.9	56.9	56.9	56.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	60	60	60	60	60

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
Information about a child's primary care provider (medical home) is gathered by the Systems Point of Entry Unit during initial intake, and by CSHCN staff each time a child presents for service. During CY 2005, 2,462 children who received CSHCN services had an identified primary care practitioner. This represents 78.1% of children in enrolled and pending status with CSHCN. SPE service coordinators link children without an identified primary care practitioner to the OMCFH administration's Health Check Program, and to local sources for medical care. All children receiving benefits through the WV Medicaid Program, including participants in the CSHCN Program, are assigned a primary care physician either through the Physician's Assured Access Service (PAAS) Program or through the Medicaid Managed Care program. Children, diagnosed with mental health needs, ie; socially emotionally disturbed (SED) etc., are managed by CPS and the Bureau for Behavioral Health and Health Facilities within DHHR.

Copies of medical records, depicting care provided by CSHCN are sent to the participating child's primary care provider to assure coordination of care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 93% of children have insurance coverage		X		
2. All major insurance carriers encourage medical home				X
3. State CSHCN Program provides extensive care coordination		X		
4. Medicaid recipients are required to have a medical home				X
5. CSHCN requires application for Medicaid and CHIP				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Efforts are made to coordinate the CSHCN specialty care provided with the child's medical home, and to keep the primary care physician informed of treatment plans. CSHCN strives to provide service in a manner that is accessible, family-centered, and coordinated. Care coverage is provided throughout the state in either a specialty care physician's office or in face to face contacts in a CSHCN clinic site closest to a child's home. Medical transportation costs for appointments are reimbursed at the DHHR Medicaid established rate. The child and the principal care-givers are informed of treatment options and involved in development of the patient care plan for the child. Care is continued until the child's 21st birthday with transition services available to prepare for independence beginning at age 13 years. Through the Patient/Family Assessment and patient care plan development process families are linked to support, educational, and community-based services.

c. Plan for the Coming Year
CSHCN will continue to work with the WV Medicaid Managed Care to assure the needs of children with special health care needs are addressed. The planned expansion of WV Medicaid Managed Care through contracted health maintenance organizations, will have a continuing impact on the provision of care for children with special health care needs. The Medicaid program plans that all Medicaid beneficiaries, except the SSI population and foster children, will be

covered by a health maintenance organization within the year.

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

CSHCN will continue to collaborate with another office within the Bureau for Public Health, Office of Nutrition's Special Supplemental Nutrition Program for Women, Infant, Children (WIC) to assure children who are age eligible to receive WIC are identified.

The WV Medicaid Program does not provide coverage of nutritional or feeding supplements taken by mouth. Young adults receiving such supplements lose funding for medically necessary prescribed supplements when the young adult transitions from CSHCN at age 21 years. The WVU Center for Excellence in Disabilities (UAP), CED, nutritionist continues to work on the issue of formula needs, and OMCFH supports this effort using Title V funds.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					65
Annual Indicator		59.8	59.8	59.8	59.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	65	65	65	65	65

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
According to West Virginia Kids Count 2003, a survey on health insurance coverage completed in December 2003 showed 96.3 percent of all West Virginia children had health care coverage at some point during 2003. Systems Point of Entry (SPE) in OMCFH identifies families that do not have Medicaid, CHIP or private insurance coverage at the time an application is made for CSHCN. Families without resources to pay for medical services are referred to WV CHIP and to WV Medicaid, prior to Title V payment initiation.

During Calender Year 2004, Systems Point of Entry provided the following activities:

1. 790 requests for referral services received:

299 families of children identified on the Birth Defects Registry as having congenital problems

received OMCFH program information
402 families identified by the Social Security Administration as approved for Supplemental Security Income (SSI) were offered additional referral services
89 identified by OMCFH Reportable Disease, Newborn Metabolic, Newborn Hearing and Lead Screening Programs

2. 1,583 applications and informational materials distributed as follows:

596 Specialty Care Intake Form (SCIF) for CSHCN applications
42 CHIP applications
17 OBRA applications for Medicaid coverage for pregnancy
928 brochures/pamphlets for patient education and informing were distributed

3. 4,697 telephone inquiries received by the toll-free responders.

During CY 2005, 71.3% of children participating in CSHCN were Medicaid beneficiaries. To assure that families have the best available coverage for their child's medical care the CSHCN Program required all applicants to first apply for Medicaid and WVCHIP at their local Department of Health and Human Resources (DHHR) Office. Verification of their application was done through receipt of a written notice given to the family and/or by accessing the RAPIDS data system. Information submitted to the DHHR office during this process was also used as the determinant of a child's financial eligibility for CSHCN Program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 93% of WV children have insurance coverage (Medicaid, CHIP, primary carrier)		X		
2. CSHCN requires Medicaid and CHIP application				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WV CHIP, CSHCN, Birth to Three, and Right From the Start Programs continued efforts to involve the faith based community in identification and outreach to uninsured and under insured children.

Program specialists, EPSDT, continue to assure the availability of CHIP applications at all community health centers, physician offices, local health departments, etc. This availability is monitored by the Quality Assurance Unit in OMCFH.

c. Plan for the Coming Year
Building on outreach efforts for the past year, CSHCN will continue efforts to make potential recipients aware of services available through CSHCN. To expand CSHCN outreach efforts, the DHHR Division of Management Information Systems will identify approved or denied Medicaid

beneficiary children (age 0-20)who have a disability. The system will generate a monthly report to use in CSHCN outreach efforts by the Systems Point of Entry unit. The SPE unit will mail these families information about available CSHCN Program services and care coordination. This will augment population based surveillance efforts and children identified as consequences of an EPSDT screen.

The CSHCN Program has instituted policy changes relating to financial eligibility. Patients receiving medical treatment and/or care coordination through the CSHCN Program have their health care financed by Medicaid, CHIP, private insurance or Title V funds. Families with income of 200% of the Federal Poverty Level or below are now eligible for Title V sponsored services. Continued financial eligibility is determined on a yearly basis using a computer generated letter asking families to reapply for Medicaid and CHIP to assure Title V funds are used as payor of last resort. The Care Coordinator reviews financial information as well as determines continued medical eligibility.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					75
Annual Indicator		73.1	73.1	73.1	73.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	75	75	75	75	

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
The OMCFH Quality Assurance and Monitoring Unit monitored 309 of the total of the customers' call-in contacts received by System Point of Entry for consumer satisfaction. Approximately 20% of these calls were from families of children with special health care needs. Public response to SPE telephone referral and assistance operation continues to be completely positive. Those contacted stated that they were pleased with how they were treated. None indicated dissatisfaction with the services and guidance received.

Effective January 15, 2004, the Systems Point of Entry Unit began using an electronic format system for collecting information on calls received on the toll-free lines. This eliminated the manual record keeping system. This served to increase the efficiency of record keeping as well as improving access of the OMCFH Quality Assurance and Monitoring Unit to SPE recording for monitoring of customer satisfaction of service provided by the responders.

West Virginia's CSHCN Program conducted a survey of participants. The survey asked the following question: Do you need help with locating community services? 472 of 575 respondents (82%) answered "no".

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Parents participate in policy and procedures development for WV Birth to Three and CSHCN.		X		
2. Collaboration with WV Medicaid to optimize resources and plan efficient use of funds.				X
3. CSHCN collaborates with other OMCFH programs to coordinate needed services efficiently.				X
4. CSHCN Medical Director participates on Medicaid policy committee sharing input from families.				X
5. Parents and CSHCN staff take part in statewide mini conferences coordinated by the Parent Network Specialists and funded by contract with CED.		X		
6. CSHCN Program Advisory includes youth, parents and service providers.		X		
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN quality assurance component was strengthened by continuation of an internal process to monitor work of staff as documented in enrolled patient records. Each month the CSHCN Director of Nursing and the Director of Social Services review a portion of each of their staff's work using an Internal Chart Review form, which identifies important elements in care management and case recording. This process identifies areas needing improvement and serves as a bases for staff training and evaluation. This system serves to augment the periodic clinic/field office site visits completed by the CSHCN Director of Nursing and the Director of Social Services. An electronic data system was developed by OMCFH's Division of Research, Evaluation and Planning for recording and tracking of reviews completed. This allowed the CSHCN nurses and social workers to be more responsive to inquires by the tracking of authorization and delivery of patient equipment.

CSHCN participated with West Virginia University Health Associates at Women and Children's Hospital, Charleston, WV, in the FACES clinic. This clinic is a multi-disciplinary team effort that involves plastic surgery, orthodontia, dentistry, genetics, audiology, social services and speech therapy. CSHCN provides the social work component for a multi-disciplinary team.

In FY 2005, five FACES clinics were held. CSHCN applications were made for 2 of the 24 patients seen by the CSHCN social worker. Home visits were done at the request of the clinic physicians/treatment team for CSHCN enrolled children throughout the state. CSHCN applications were completed for 2 clients.

To enhance the operation of service systems and encourage community partnerships in the delivery of services, the CSHCN Program Director, or designated representatives, serve on multiple committees or advisory boards.

45 Family Resource Networks (FRNs), which are county based collaboratives that bring together business, religious, and civic leaders, service providers, and people who use services to facilitate

the coordination of a wide array of local services for children and families (more than 1,000 participants, serving 55 counties and leveraging funding from many sources, including state funds.)

c. Plan for the Coming Year
The results from the CSHCN Family Survey will be entered into a new database developed by the OMCFH Research Division. These results will be used to develop goals and objectives for the coming year by CSHCN Administration and staff.

The CSHCN Program differentiates itself from other programs/payers by continuing to emphasize the importance of care coordination services. Nurses and social workers will continue to look at the entire family and assess their needs, both medical and social services, and link them with available resources and community services.

All CSHCN families will receive a copy of the approved providers of durable medical equipment so that they can be familiar with the choices available to them and decide which vendor will best meet their needs.

The CSHCN Program continues to revise the Policy and Procedure Manual when changes in Program administration occur. Procedures for denying/authorizing services have been refined and updated. Using these changes, the Assessment Unit was able to eliminate the backlog of 800 cases. Numerous form letters have been developed to facilitate easier communication with the families served. The Specialty Care Intake Form used when applying for services is in the process of being revised and distributed to family care physicians, DHHR offices, hospitals and health departments around the state.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					6
Annual Indicator		5.8	5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	6	6	6.5	6.5	6.5

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments

Transition services are included as part of the development of the Patient Care Plan completed with youth enrolled in the CSHCN Program. During CY 2005, transition services were provided to 1,049 youth, age 14 through 21. Also CSHCN Program collaborate with the Division of Vocational Rehabilitation. The Division provides staff who are dedicated to transition planning for children with disabilities, using the public school system.

Consistent with survey findings of the US Department of Health and Human Services, Administration on Developmental Disabilities, WV continues to recognize that knowledge of disability issues, and individuals especially those living in rural, geographically challenged areas, have barriers related to transportation and lack of travel quality resources.

In addition, the WV Advocates and Developmental Disabilities Council have identified the need for more integrated work/training programs for persons with disabilities. While the CSHCN Program continues to address work and training for youth transition, there is a serious gap in available employment.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN offers trasition services to all program participants starting at age 14		X		
2. WVUCED has a transition advisory		X		
3. Marshall University School of Medicine is collaborating with Title V on transition programming		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN electronic data system produces reports identifying adolescents 14 through 21 years of age as a tracking system for social workers and nurses. These reports are produced on a monthly basis and used by CSHCN staff when determining need for frequency of contact with clients in providing transition services. Written policy concerning delivery of adolescent transition services has been reviewed and updated.

On May 3 & 4, 2006, the CSHCN Annual Staff Conference will focus on transition services offered by the state and county school systems. Presentations will be provided by the Transition Coordinator and Parent Coordinator from the WV Board of Education. Legal issues facing families with adult children requiring special health care needs will also be addressed by a representative from WV Legal Aid. Care coordination, Medicaid redesign and conflict resolution in the workplace are additional topics to be included in the two day conference.

The CSHCN Family Survey has helped identify families and adolescents who are interested in participating in group discussions regarding health care issues. These individuals will continue to be invited to join the CSHCN Program Advisory to offer the perspective of adolescent consumers and voice their concerns.

c. Plan for the Coming Year

A greater emphasis will be placed on transition services by exploring the feasibilty of having a Transition Coordinator/Team with the CSHCN Program. Greater collaboration between state and local school systems, Department of Rehabilitation, medical care providers, social service agencies and the CSHCN Program will be investigated to better provide transition services to the adolescent population. The feasibility of sponsoring group discussions focused on transition services in various regions of WV will be considered. Transition screening forms will be revised and updated to better determine the needs of the adolescent and their family.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	90	90	90	90	85
Annual Indicator	82.1	83.4	81.8	93.5	93.5
Numerator			50700	58000	58000
Denominator			62000	62000	62000
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	95	95	95	95	95

Notes - 2005
Provisional data from WV Immunization Program...numbers were provided for individual immunizations...numbers were added together and divided by total number for percentage.

Notes - 2004
Data from WV KidsCount 2004
Data from WV Immunization Program...percentages were provided for individual types of immunizations...numbers were added together and divided by 5 for percentage of all shots.

Notes - 2003
Data from the WV Immunization Program based on sampling through site visits performing quality assurance assessments.

a. Last Year's Accomplishments
While still below the targeted performance objective of 90%, as set by Healthy People 2010, the percentage of children being fully immunized by the age of 2 years has increased substantially over time. In 2004, 88.1% had been immunized for DTaP, 94.0% for IPV, 94.6% for MMR, 97.5% for Hib and 93.4% for Hep B as compared to 71.5% in 2003. West Virginia is ranked sixth in the nation for the percentage of children immunized.

The State's Immunization Program is housed in the Office of Epidemiology and Health Promotion's Division of Surveillance and Disease Control, Bureau for Public Health. This program works closely with local health departments, WIC, hospitals, the private practicing medical community, and other early childhood programs in an effort to get children fully immunized.

The EPSDT Program has actively worked to ensure that children participating in the program receive complete immunizations by age 2. The HealthCheck program publicizes the Childhood Immunization Schedule in a HealthCheck Provider Manual that is used by 463 HealthCheck providers. The providers immunize children in accordance with the schedule or they refer their clients for immunizations in accordance with the schedule.
The OMCFH monitoring team monitors the documented immunizations when monitoring HealthCheck pediatric providers.

The Immunization Program conducted a 2004-2005 Immunization Kindergarten School Survey in cooperation with the Department of Education, local Boards of Education, school nurses, principals and secretaries. Sixty schools were randomly selected from the 489 of the 585 responding public and private schools to receive a Validation Audit, which is conducted to verify the accuracy of the school survey as well as monitor the actual immunization records for correct doses, dose intervals and validity. Results showed 85% accuracy according to audit results. Of the 60 schools, the Immunization staff reviewed 2,137 kindergarten records and 69 out-of-state first grade transfer records. Results of the audit revealed: 1.63% (36 students) were missing at least one required immunization; 0.40% (9 students) had invalid doses; 0.27% (6 students) had no records and 2.31% (51 students) were non-compliant.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Need for imunizations is promoted by RFTS, WIC and other public health programs.				X
2. The EPSDT Program encourages providers to offer immunizations as part of health care.				X
3. An OMCFH monitoring team monitors the documented immunizations of HealthCheck clients.				X
4. The RFTS Project collects data on whether or not infant participants(who are up to 12 months) are up to date on immunizations.				X
5. All women giving birth in WV receive an information packet including an immunizations schedule.				X
6. WV is one of two states who do not allow exemptions for immunizations.				X
7. In 2005, WV was sixth in the Nation for completion of regularly scheduled immunizations on children up to 36 months of age.				X
8.				
9.				
10.				

b. Current Activities

The West Virginia Immunization Program is working to increase the number of providers using the Immunization Registry. Of the 370 providers of immunizations, 165 are currently enrolled with the Registry.

A certificate of immunizations has been developed. The Certificate of Immunizations will help improve preschool and school-age immunization levels by establishing a standard process by which children are given documents certifying receipt of age-appropriate immunizations. A uniform Certificate of Immunization will enable the consolidation of all valid immunization dates on one document that can be utilized by schools, child care centers and in other settings. The certificate is a tool used by the Immunization Program as an ongoing effort to increase preschool and school immunization levels in West Virginia.

Exceptions were allowed for children entering West Virginia schools for the first time for the 2002-2003 school year for required shots of diphtheria, tetanus and acellular pertussis (DtaP) and tetanus and diphtheria toxoids (Td) due to the then existing nationwide shortage of these vaccines. Shortages have since been resolved.

c. Plan for the Coming Year

The Office of Maternal, Child and Family Health's responsibility is one of tracking and increasing medical capacity to serve as health homes for children. The Immunization Program interfaces with the Office of Maternal, Child and Family Health in developing public health policy. The OMCFH workforce that provides technical assistance to the medical community on all child health issues also provides guidance on vaccine administration.

The OMCFH maintains a Pediatric Medical Advisory comprised of pediatricians, family practice physicians, dentists, etc. who assist with policy guidance but also serve as spokespersons offering guidance for public health policy. Persons serving in this capacity speak routinely at the West Virginia Chapter of the AAP and AAFP. Using these champions to voice public policy about immunizations and other child health issues assists the Department with compliance and keeps the medical community engaged in the provision of service.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	21	21	20	20	19
Annual Indicator	21.9	20.7	20.1	20.1	19.8
Numerator	774	733	711	712	700
Denominator	35411	35411	35411	35411	35411
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	19	19	18	18	18

Notes - 2004
Data from 2003 Vital Statistics based on the female population ages 15 to 17 years

Notes - 2003
Data from 2002 Vital Statistics based upon the female population ages 15-17.

a. Last Year's Accomplishments
Family Planning:
In West Virginia, 177,300 women are in need of contraceptive services and supplies. Of these, 106,240 women need publicly supported contraceptive services because they have incomes below 250% of the federal poverty level (77,880) or are sexually active teenagers (28,360). Approximately 138 of the publicly funded Family Planning Program clinics provide contraceptive care to 59,400 women -- including 17,070 sexually active teenagers. The Family Planning Program served 58,988 unduplicated clients in CY 2005 (56% of all women in need of publicly supported contraceptive services and 60% of the teenagers in need).

Among the 50 States and the District of Columbia, West Virginia ranked 6th in the availability of publicly funded contraceptive services. An average of $68 was spent on contraceptive services and supplies per woman in need (adjusted for the cost of heath care in the State). These publicly funded clinics help women prevent 13,800 unintended pregnancies each year. Birth rates for teens 15-17 decreased 30% between 1991-2002.

APPI:
The APPI Coordinator and Specialists worked collaboratively with 30+ public/private entities serving adolescent populations to address pregnancy prevention. Technical assistance was provided through onsite consultation or with the provision of literature and other resources. A list of activities includes:

•Conducted 241 school presentations, addressing student populations on the topic of teen pregnancy prevention (increased 57.5% from 153 school presentations in CY2003)
•Completed 105 school visits (plus 6 colleges/universities) to introduce the Adolescent Pregnancy Prevention Initiative and APPI Specialists
•Mailed out 341 informational packets to West Virginia schools
•Completed 14 community presentations (1 parent workshop)
•Displayed APPI information at 16 events
•39 School-based Health Centers

APPI Projects:
APPI offered free resources and technical assistance for "Let's Talk" Month in September 2005 to support activities encouraging parent/child communication about sexuality and other difficult issues. Approximately 20,000 pieces of literature (brochures, bookmarks and fact sheets) were distributed in September - October 2005. APPI actively promoted participation in May 2005 of National Teen Pregnancy Prevention Month. "National Day", held on May 8, 2005, was created to get teens to stop, think, and take action. By taking an online interactive quiz, teens reviewed real-life scenarios and decided how they would react in certain risky situations. APPI distributed 200 pens, 500 stickers, 200 brochures, and 300 postcards to encourage West Virginia teen participation in the "National Day". The "Wise Guys" pilot project was conducted during 2005 in McDowell County at 2 locations using the 10-12 week workshop design for the prevention of teen pregnancy and dating violence which targets 10-19 year old boys.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided confidential contraceptive services through the FP Program to 18,218 sexually active teens in 2004.			X	
2. Recognized and promoted "National Day To Prevent Teen Pregnancy" and "National Teen Pregnancy Prevention Month" (May 2004).			X	
3. Conducted "Mother's Day Too Soon" campaigns to increase public awareness of the incidence of teen pregnancy in WV.			X	
4. Promoted "Let's Talk" month (October 2004); Free resources to encourage parent/child communication about sexuality.			X	
5. Worked with Dept of Ed/Office of Healthy Schools to develop strategic plan to reduce sexual risk behaviors among students. Presented at 241 WV schools and 14 community presentations and 1 parent workshops on the topic of teen pregnancy prevention.				X
6. Adolescent Pregnancy Prevention Specialist conducted numerous community education and outreach activities on a regional/local level.				X
7.				
8.				
9.				
10.				

b. Current Activities
Adolescent Pregnancy Prevention Initiative:
To carry out the goals and objectives of the Adolescent Pregnancy Prevention Initiative work plan, three (3)permanent full-time personnel and one contract personnel were hired to conduct statewide community education and outreach activities on a regional/local level. The specialists are strategically located in community-based settings to have the flexibility of alignment as needs

change over time. These 4 Adolescent Pregnancy Prevention Specialists work to increase public awareness of problems associated with early sexual activity and childbearing and are developing, expanding or supporting teen pregnancy prevention initiatives on a regional/local level.

Family Planning Program:
Confidential contraceptive services and supplies are available to sexually active adolescents through a network of 138 health care agencies through the statewide Family Planning Program. Participating clinics promote postponement of sexual activity, mechanisms to reduce sexual coercion, and provide counseling to sexually active teens regarding the importance of family involvement in sexual decision-making.

c. Plan for the Coming Year
The Adolescent Pregnancy Prevention Initiative will continue to design and conduct community education and outreach activities to increase public awareness of adolescent pregnancy prevention and related issues for community groups, schools, health care professionals, parent groups, or businesses;
Address state level issues which impact access to or quality of adolescent pregnancy prevention services; confidentiality and parental consent; transportation, financial or other barriers; school health issues; and local availability of pregnancy prevention services.

Educate teens and young adult males on personal sexual responsibility; coordinate community education activities to promote clinical Family Planning Program Services for sexually active teens and those not yet sexually active; conduct presentations and exhibits of educational displays at health fairs, conferences, state fairs, and other public activities; maintain existing and establish new partnerships and initiate referral patterns with entities serving populations of potential clients; distribute Family Planning Program promotional products, i.e., brochures, posters, fact sheets, etc;

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	50	50	50	50	33
Annual Indicator	15.6	22.7	21.3	30.0	33.3
Numerator		326	514	1039	1416
Denominator		1435	2413	3466	4256
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	35	35	35	38	38

Notes - 2005
2005 data from Children's Dentistry Program
National Survey of Children's Health

Notes - 2004
Estimated 2004 data from Children's Dentistry Database. The Children's Dentistry Project covers 32 of WV's 55 counties and is being used as representative for the state's 3rd graders. The

numerator are those children who were observed to have had a sealant and the denominator are those children assessed.

Notes - 2003
Numerators and Denominators for CY 2002 and CY 2003 are taken from the OMCFH Children's Dentistry Project database. It refects the number of 3rd grade students who have been assessed and those that had an observed sealant. The Project covers 28 counties and is a sample representative of the State's population of all 3rd graders. Years 1999, 2000 and 2001 are based on Medicaid sealants only and not reliable.

a. Last Year's Accomplishments
The report "Oral Health of Children: A Portrait of States and the Nation 2005", indicates that most children up to age 17 receive annual preventive dental care, have excellent or very good oral health, and few go without needed care. Nationally, the percent of children receiving preventive dental care in the past 12 months is 72% compared to 74.8% of West Virginia children, source the National Survey of Children's Health - 2005. Other national findings from the survey confirm that WV has focused its attention and resources on the correct areas, making certain low income kids receive care. Results are 68.3% of children in WV with family income under 100% FPL are receiving preventive care, and 72.4% with family income between 100-199% FPL are receiving same service. In both instances this exceeds national average. We largely attribute this increase in utilization to oral health education efforts at the community level. We are also seeing improvements in the condition of children's teeth between ages of 1 to 5 years with 73.5% in excellent or very good condition, compared to the national average of 68.5% for this age group nationwide. Again, some of this is attributed to nursing bottle mouth education by the RFTS community-based, nurse/social worker workforce, and fluoridation of the community water supplies.

The Children's Dentistry Project (CDP) is a component of the Division of Infant, Child and Adolescent Health and is housed within the OMCFH. Preliminary data for 2003 suggests that 48% of West Virginia Medicaid recipients aged 6 to 9 received a dental service. In West Virginia, Medicaid child beneficiaries have financial access to dental services, yet most do not routinely seek care. Failure to keep appointments adversely affects willingness of dentists to serve the Medicaid population, thus limiting access. It is clear that public health must facilitate opportunities for youth to access dental care by educating children, youth, and their parents about the importance of oral health. Also the CHIP benefit package includes dentistry care equivalent to that provided children eligible for Medicaid.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Children's Dentistry Project (CDP) subgrants preventive health block funds for application of sealants		X		
2. CDP collaborated with a CHC and a county school system on a pilot project for sealant application		X		
3. CDP provides oral health education which includes information on sealants				X
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
The CDP currently has 22 contracts with local health departments, primary care centers and individuals to offer oral health education to students in public schools. Educators offer information about dental hygiene, the need for preventive dental visits, and the dangers of tobacco use. The CDP, in partnership with county school systems, Head Start agencies, and other community children's programs, are working together to offer a sealant and fluoride rinse program within schools.

The CDP is currently working on a project in Mercer and Wyoming Counties. The CDP has purchased supplies for this project. Students will be provided with oral health education and oral health education materials. Through this project, over 13,000 students in Mercer and Wyoming County Schools have received toothpaste, toothbrushes, and dental floss. The CDP is also partnering with other Primary Health Care Facilities to offer school based dental services and oral health education to students in Lincoln, Jackson, Ritchie and Calhoun Counties.

The CDP is working in conjunction with Valley Health Systems, Inc. (VHS/community health center network) to provide sealants to elementary students in Lincoln County. The Lincoln County school nurse is also involved in obtaining parental permission and scheduling on-site visits. The VHS staff (dentist and dental hygienists) travel to the selected schools and using portable dental chairs do screenings on all students with parental permission. Third graders with parental permission can have sealants applied. All students at the selected schools receive oral health education. Total enrollment at the four schools targeted was 1,045 students.

c. Plan for the Coming Year
To design effective health promotion campaigns and materials, we must know what the customer is thinking. The CDP implemented a research project in conjunction with higher education to learn more about the attitudes of youth and parents toward dental care, and learn more about the barriers to receiving dental care. Two thousand three hundred fifty nine surveys were returned and processed through data entry to date.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	4	4	4	3.5	3.5
Annual Indicator	6.1	4.9	4.6	6.1	4.3
Numerator	20	16	15	20	14
Denominator	329139	329137	329137	329137	329137
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	3	2	2	1	1

Notes - 2004
from 2003 vital statistics

Notes - 2003
Numbers from 2002 Vital Statistics

a. Last Year's Accomplishments

The West Virginia Highway Safety Office has some interesting programs, one of which is called Battle of the Belts. High Schools agree to participate. A baseline survey is done on seatbelt use as kids pull into the parking lot in the morning for school. Schools are given 30 days to improve the use percentage by any means they think will work. The survey is repeated 30 days later. The most improved schools receive cash prizes. The Project varies by region throughout the State. Some regions take an all or nothing approach. Each region has $2,000. to distribute. All three schools that participated in one of the regions showed an 88% usage rate.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The EPSDT Program provides anticipatory guidance to parents regarding childhood injuries.		X		
2. Adolescent Health Coordinators and others provide classroom injury prevention instruction.		X		
3. Department of Education/Health Education Assessment Project to calculate student health knowledge.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The community-based workforce that administers our Abstinence Only Education Program and another group of partners who administer the Adolescent Health Initiative all work to address the issue of health behaviors. Not every motor vehicle accident is alcohol related but our data tells us many of them are. The Adolescent Health Initiative offers parent/child communication skill building, community development activities that include plans for safe recreation after prom, etc. Helping families to talk with their children about risk behaviors is an essential part of effecting change. The Abstinence Only Effort is focused on a much younger population with the same emphasis about abstaining from alcohol and other risk behaviors.

The EPSDT Program continues to provide anticipatory guidance to parents about childhood injury that may result in death. The Adolescent Health Initiative also develops teaching tools which encourage the use of helmets as a means of preventing traumatic brain injury. At the time of discharge, all birthing hospitals in the State issue an infant car seat for those families who do not have/can't afford one. The Adolescent Health Initiative was designed to complement the HealthCheck Program with the express purpose of creating awareness among families and others of the need for young persons between the ages of 10 and 17 to be provided routine health services. Two components of this program include: 1) the provision of educational programs emphasizing preventive services/risk reduction behaviors such as seat belt use and tobacco/alcohol use; and 2) development of teaching modules that can be used in community-based training designed to improve the health and well-being of adolescents and their families. The Adolescent Health Initiative (AHI) staff are supported with Title V monies but physically housed and hired by community-based partnership organizations.

c. Plan for the Coming Year

We continue work with Transportation and Traffic Safety to develop materials that are directed to youth. We also are using our existing workforce and partnership network for distribution of this

anticipatory guidance.

Continue to support the Department of Education efforts to improve health education instruction in public schools designed to positively affect health and health related decision making.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					32.0
Numerator					6700
Denominator					20920
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	35	35	40	40	45

Notes - 2005
Data from WV WIC Program sources/Ross Mother's Survey

a. Last Year's Accomplishments
WV PRAMS data for 2003 indicate that nearly 25% of women are continuing to breastfeed at 6 months. This data is comparable to Ross Laboratories data which lists WV as having a breastfeeding rate of roughly 26% at 6 months after delivery.

The 2004-2005 Office of Nutrition Service Breastfeeding Initiatives included: 1) Expansion of the WIC Breastfeeding Peer Counselors Services; 2) Elevated staff knowledge so that all WIC staff positions are confident in promoting and supporting breastfeeding by providing a two day training for all clerical, medical and nutritionists; 3) Ensured program expansion by dedicated planning time for breastfeeding services; and 4) Enhanced breastfeeding support services by collaborating with physician practices.

West Virginia was one of 10 states nationwide that received a two-year grant, called "Using Loving Support to Build a Breastfeeding Friendly Community" covering the fiscal year 2004-2005. Technical assistance follow-up visits were made, the purpose of these visits was for assistance and other training opportunities to be given to states by trainers from Best Start Social Marketing. The Project enabled the West Virginia WIC program to increase breastfeeding initiation and duration rates in nine rural counties in southern West Virginia where there are low breastfeeding rates but growing community awareness and support. For example, the TSN WIC Program elected to have training at three major labor and delivery hospitals and local health clinics to better prepare health professionals for the first few days of supporting breastfeeding families. Also, Best Start billboards through Magic Media (billboard rental company) were purchased and put up in Mingo and Logan counties for 3-4 months. The selection of these counties was due to low breastfeeding rates and negative attitudes towards breastfeeding.

The Office of Nutrition Service, WIC program also received funding from Fiscal Year 2005 Operational Assistance Funds to provide the purchasing of the following: books and posters to distribute to health care providers, baby scales that measure the amount of breastmilk the infant ingests, banner stands to promote breastfeeding for outreach events and to loan to health care providers, hiring minority peer counselors and providing salaries for lactation consultants and peer counselors to visit hospitals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All women participants in the OMCFH programs receive benefits of breastfeeding information.		X		
2. The WIC Program strongly supports and promotes breastfeeding.		X		
3. RFTS collects data on prenatals who are breastfeeding at hospital discharge, and how many continue to breastfeed at case closure				X
4. WIC increased income guidelines to allow more women, infants and children to qualify				X
5. Display booth at the West Virginia State Fair sponsored by WIC				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
RFTS and WIC efforts continue to promote the importance of breastfeeding.

While the latest data on breastfeeding indicates that a low percentage of women chose to breastfeed their infants, this should not be taken as an indication of little effort on the part of the State's Bureau for Public Health or, in particular , the Office of Maternal, Child and Family Health. All pregnant women participating in the Office of Maternal, Child and Family Health's Right From The Start Project receive information about the benefits of breastfeeding their infants. Further, the Bureau for Public Health participates in all national breastfeeding media campaigns.

In addition, the State's Office of Nutrition Services, which administers the WIC Program, promotes breastfeeding and has on staff a Lactation Specialist. As stated previously, all pregnant women participating in Right From The Start, the State's Perinatal Program, or identified to public health, are referred to WIC.

WIC Breastfeeding Coordinators meet quarterly to discuss issues, plans, basically what activities they are involved in etc. Aagencies are having what they call breastfeeding baby showers for the communities to share information and stresss the importance/benefits of breastfeeding. WIC also recognizes breastfeeding mothers on Mothers Day as well. Two meetings, north and south with WIC Peer Counselors to give them a chance to network with one another continue. WIC now has 14 International Board Certified Lactation Consultants (IBCLC) and 22 Certified Lactation Counselors (CLC). These qualifications have helped our peer counselors offer quality guidance for new moms and their nursing baby.

c. Plan for the Coming Year
WIC's goals for nutrition education services for 2005-2006 include: Providing breastfeeding information and education to all pregnant participants and health care professionals which promotes breastfeeding in order to increase the number of babies who are fed breastmilk. Provide post-partum breastfeeding assistance and support which promotes continued breastfeeding throughout the first year of life. Preliminary data indicates that 22.4 of women who initiate breastfeeding are continuing to breastfeed for 6 months or longer. Provide additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and

physician practices in order to keep mothers breastfeeding longer. Promote the importance of breastfeeding to health care professionals through posters, banners, displays, and the distribution of Medications and Mother's Milk books. Provide one-on-one contacts for breastfeeding counseling. Promote the importance of breastfeeding to the public through World Breastfeeding Week (Month) activities in August, which entails Open houses, picnics, walk in the park with WIC mothers and babies, Signing of Breastfeeding Proclamations with local mayors, recognition and certification to all breastfeeding WIC participants in August, and network with Immunization Program through letters to new parents.

WIC will be placing a banner promoting breastfeeding in downtown Charleston, the state capitol. WIC also will be having a booth at the WV State Fair in Lewisburg in August 2006.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	95	97	97	98	98.5
Annual Indicator	95.5	96.7	97.7	98.2	99.0
Numerator	20047	20435	20993	18868	20698
Denominator	21001	21133	21480	19222	20911
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	99	99	99	99	99

Notes - 2005
data from 2005 WVU Birth Score

Notes - 2004
Statistics from WV University BIrth Score Program

Notes - 2003
Statistics from West Virginia University Birth Score Program that collects the Birth Score information for high risk infants and Hearing screens from the birthing hospitals.

a. Last Year's Accomplishments
West Virginia participated in the National Center for Hearing Assessment and Management, Survey of Physician's Knowledge, Attitudes and Practices, about EHDI Programs. This information along with key physician informant discussions in West Virginia identified several areas needing attention:

1. Physician and audiologist training, since many responded their training did not prepare them to adequately meet needs of infants.
•In response to this, West Virginia medical personnel have been afforded skill building/trainings at expense of the EHDI Project.
•Also, EHDI Project monies have been used to purchase state of the art diagnostic equipment for community use.
•EHDI Project staff have presented at the WVAAP & WVAAFP meetings to discuss screening, diagnosis and follow-up, as an outreach, medical engagement strategy.

2. Need for informational materials in practices.
•In response to this, West Virginia has modified national materials to reflect state resources for distribution.
•West Virginia's Office of Maternal, Child and Family Health has a professional workforce, that

provides technical assistance and support to all medical practitioners serving children. As a part of the technical visits, the staff educate the primary physicians/medical homes about the WV EHDI Project.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All WV birthing facilities are screening infants for hearing loss.			X	
2. Infants identified with a hearing loss are referred to the CSHCN Program.		X		
3. OMCFH maintains loaner equipment and shared hospital home equipment for care.				X
4. OMCFH purchasing diagnostic equipment to assure access/availability.				X
5. Redesign monitoring tool to better meet Program needs.				X
6. Redesign and update NHS website.				X
7. Create and distribute informative literature for providers/parents.				X
8. Recruit new Advisory Board members per WV state code.				X
9.				
10.				

b. Current Activities

The NHS Project continues to focus on improving access to timely audiological diagnosis and intervention. Four regional diagnostic centers will be provided with state-of-the-art equipment. Services that will be available include the ability to analyze hearing response and digital hearing aids without having to rely on voluntary responses, otoacoustic emission (OAE) and auditory brainstem response (ABR) screeners for use in neonatal intensive care units and as a backup to failed hospital screens, and high frequency tympanometry to assess middle ear function.

Additionally, birthing hospitals are provided with Newborn Hearing Screening information and education from the Birth Score Office. Audiology Services Availability and Reference Manuals and NHS brochures are continuing to be distributed to providers and audiologists by NHS in order to assist practitioners in directing infants and their families to appropriate hearing evaluation and intervention. The NHS Project also sends informative brochures to the parents of infants who were not screened in the hospital or those who were screened and failed.

The NHS Project is also redesigning the current NBH database to enhance data collection. With detailed data collection and information sharing, follow-up of infants who either failed or were not screened will be greatly improved. Not only will infants be tracked 100%, but outcomes of the tracking will reveal problems within the system. Solutions to these problems will help to streamline the entire referral process. Some effects of the improved framework will be electronic reporting; less money spent for manpower, repetitive actions, faxing, mailing, and printing; fewer entities receiving identical paperwork; and immediate correction of any errors on the follow-up tracking forms.

Further, the database will be a supportive monitoring tool. Although an actual monitoring tool will be updated and implemented for the Health Facilities Surveyor to use during site visits, the database will identify difficult areas as well as problem providers. The database will be fully operational in the upcoming year.

West Virginia's newborn hearing screening efforts have been recognized by the World Council on Hearing Health, formerly the National Campaign for Hearing Health, with a grade of "excellent" on

the published State report card for the past four years, 2001-2004. In part, the NHS Project maintains a high level of success through its outreach to the health community.

c. Plan for the Coming Year

The NHS Project focuses on undetected hearing loss which delays speech, language and cognitive development. West Virginia needs to assure timely, appropriate follow up diagnostic services and interventions. West Virginia continues to refine and implement statewide data management and program evaluation.

Goal 1: 100% of newborns born in West Virginia will be screened prior to discharge or within the first month of age.
Objective 1: Assure that all 36 birthing facilities have two trained staff competent in screening and referral protocols.
Objective 2: Assure that a minimum of 90% of WV resident infants born in hospitals bordering WV continue to be tracked via the Birth Scoring System and Vital Statistics and/or data sharing agreements and referred for services, when indicated.
Objective 3: Assure that WV resident infants born at home will receive follow up for screening.

Goal 2: 100% of infants requiring audiological follow up and/or intervention will receive a diagnostic evaluation by 3 months of age and receive intervention services by 6 months of age.
Objective 1: Assure that a minimum of 80% of all PCP/Medical Home from each of eight service regions are knowledgable about follow up and intervention resources.
Objective 2: Improve NHSP follow-up to assure an appropriate, timely audiological evaluation and intervention.

Goal 3: 100% of infants referred from screening will receive follow up and an audiological evaluation by a qualified provider.
Objective 1: Assure that one audiologist in each of the eight service regions is trained to provide diagnostic follow up and select/fit appropriate amplification.
Objective 2: Identify and recruit additional medical providers to improve the availability of diagnostic testing for infants who fail the screen.

Goal 4: Continue to assess resources to assure that 100% of children with hearing loss and their families are linked to community-based, culturally competent support systems.
Objective 1: Maintain a training level of at least 90% of the early intervention specialists and coordinators to address intervention with children with hearing loss. (Part C- BTT)
Objective 2: Parent information, letters, brochures and resource guides will be updated and created in English and Spanish.
Objective 3: Assure that 100% of children with hearing loss and their families will be referred for early intervention and parent-to-parent networks.
Objective 4: A Service Guide will be updated and distributed quarterly and a web based resource directory will be developed.

Goal 5: Continue to provide monitoring, evaluation, and quality assurance reports.
Objective 1: Produce quality comprehensive data reports and conduct program monitoring and evaluation quarterly and annually.
Objective 2: Continue data linking efforts enabling individual tracking and assurance of follow-up care through the creation of a user-friendly database.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	5	5	5	5	5
Annual Indicator	6.6	6.1	6.1	5.6	5.8
Numerator	28233	26213	26011	24025	24664
Denominator	427879	427879	427879	427879	427879
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	4	4	4	3	3

Notes - 2005
From CHIP

Notes - 2004
From CHIP

Notes - 2003
Information from CHIP.

a. Last Year's Accomplishments
Children are heavy consumers of health care, but they are the cheapest of patients. About a third of all children in American get health services through Medicaid or the State Children's Health Insurance Program (SCHIP), and that costs taxpayers an average of $1,475 for a child enrollee in 2002, compared with $12,764 for one who was elderly. The payoff for that $1,475 investment is large: Immunizations, annual visits to a pediatrician, dental care, and screening for vision, hearing and developmental problems are all long-term money savers for the health care system as a whole. The same goes for prenatal care for pregnant women. Premature babies cost about $13,1 billion annually, according to the March of Dimes Prenatal Data Center. The average premature baby racked up $75,000 in hospital fees in 2001, compared with $1,300 for a healthy full-term infant.

The Children's Report from the West Virginia Healthcare Survey contains very good news, since a substantial number of our children (93.4%) have health insurance coverage. On any given day, an estimated 6.6 percent of West Virginia's children (28,371) are uninsured. However, there are several notes of caution in this report. First, an additional 6.6 percent of the State's children are estimated to have insurance that pays only for catastrophic health care costs and so are classified as underinsured. Second, about 14 percent (59,699) of children were uninsured for some period of time during 2001.

While about 62.2 percent of insured children are covered through a parent's employment-based or family-purchased health insurance program, nearly a third of West Virginia children are insured by the State's public health insurance programs-Medicaid and CHIP. The survey's estimate of the number of uninsured children give the State's decision-makers a better target for additional outreach and enrollment efforts, since the survey indicates that a little over 74 percent of uninsured children may be eligible for Medicaid or CHIP on the basis of their family's income. The finding that parents of 31 percent of children who may be eligible for the CHIP program and 20 percent of those who may be eligible for Medicaid have never heard of these programs is notable. The survey indicates that nearly 80 percent of uninsured children are between the ages of 6 and 18 years old, a finding that is significant to the State's policymakers as they address the problem of providing insurance coverage for all children.

The Survey provides very good news about West Virginia children's access to health care services. About 93 percent have a usual source of care, mainly at a physician's office or at community and other local health clinics, and about 89 percent of those see the same physician

when they go for care. Approximately 96 percent of parents, asked if their child was able to receive needed medical care during the past year, responded in the affirmative.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State leaders promote SCHIP and increasing enrollment				X
2. Strong statewide school-based health system based in 33 counties serving 55 schools.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHIP enrollment, as of April, 2004, now covers 24,400 children and has expanded to 200% of the Poverty Level. The goal is to cover the additional children believed to be eligible for CHIP. CHIP has partnered with clinics across the state encouraging them to distribute applications for CHIP. The WV Primary Care Association received fiscal support to provide community-based outreach for CHIP statewide. Children's Specialty Care, Systems Point of Entry mailed out CHIP applications during FY 2004.

The Pediatric Program Specialist, as a part of EPSDT, administered by OMCFH, routinely distributes CHIP applications when visiting medical practioner sites serving children.

CHIP has been given the approval to expand coverage to those families with inclome up to 300% of the FPL. This expansion is expected to cover an additional 4,000 children increasing the percentage of children covered under insurance to 97%.

c. Plan for the Coming Year

West Virginia has become one of the most successful states in enrolling children in CHIP and Medicaid. More than 93 percent of the state's children now have health coverage. The increase in enrollment of children in both CHIP and Medicaid has been the result, in part, of the efforts of a public/private partnership between the WV Healthy Kids Coalition, primary care centers, Family Resource Networks, state government, and private and public funds. For the last four years, the WV Healthy Kids Coalition has conducted community-based outreach on CHIP and Medicaid through the placement of outreach coordinators who serve each of the state's 55 counties from 49 locations. Since the inception of this program, more than 40,000 children have been enrolled in CHIP and more than 5,000 children have been enrolled in Medicaid via the CHIP application. To maintain and even improve upon this high level of enrollment we must continue this effective outreach and enrollment effort and explore the recommendations from advocate group for affordable health coverage.

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

CHIP plans on expanding coverage to children of families in households with income up to 300% FPL. It is anticipated that this will allow an additional 4,000 children to have health care benefits allowing 97% of the State's children to be covered under a health care plan.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					27.2
Numerator					6488
Denominator					23861
Is the Data Provisional or Final?				Provisional	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	25	25	24	24	23

Notes - 2005
Data from WV WIC sources

a. Last Year's Accomplishments
For an increasing number of families, financial challenges are affecting their food purchases and diets. Out of necessity, the extra gallon of milk, box of cereal or fresh fruit and vegetables may get cut from the weekly grocery list. In the short term, cutting back on groceries may help bolster the family budget. But it also may harm the health and well-being of the family's infants, toddlers and pre-schoolers-both now and in the future.

WIC, the Special Supplemental Nutrition Program for Women, Infants and Children, recently expanded eligibility to the program with significant increases in the income guidelines. A family of two may now make up to $24,420 a year and be considered eligible for WIC services; for other household sizes, add $6,290 for each additional family member.

It is the goal of Nutritional Services to improve the quality of life and wellness (body, mind, and spirit) of WIC participants and WIC employees through innovative promotion of healthy lifestyle behaviors. With using Motitational Interviewing techniques learned in FY 04 and 05, a revision of the nutritionist monitoring and feedback tool has been completed in order to evaluate individual skills and feedback in order to effectively reach this goal. In August 2005, nutritionist learned strategies for enhancing a client's readiness to adopt a healthier lifestyle.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC supports healthy nutrition and breastfeeding				X
2. WIC increased income guidelines to allow more women, infants and children to qualify				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
Some of the goals WIC has for addressing obesity and overweight in the birth through 5 populations include, increase initiation and duration of breastfeeding, increase consumption of fruits and vegetables, increase physical activity and the use of lower fat milk in children over 2 years. This is done with parents in individual counseling and nutrition education classes.

See information and attachments for State Performance Measure number eight (8).

c. Plan for the Coming Year
Addressing obesity and overweight in the child populations will continue and the concentration remain increase initiation and duration of breastfeeding, increase consumption of fruits and vegetables, increase physical activity and the use of lower fat milk in children over 2 years. This will continue to be done with parents in individual counseling and nutrition education classes.

See information and attachments for State Performance Measure number eight (8).

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					25.3
Numerator					5225
Denominator					20630
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	25	24	23	22	21

Notes - 2005
Estimated from 2003 PRAMS Data...2004 not available at this time

a. Last Year's Accomplishments
According to West Virginia Vital Statistics, West Virginia pregnant women smoking rate for 2004 was 26.8%, U.S. rate was 10.2%. West Virginia still has the highest smoking rate for pregnant women in the United States. Data from the Birth Score Office shows that many counties in West Virginia have a self-reported rate of between 30 to 57% among Medicaid mothers who smoked during pregnancy. This creates an enormous health problem for West Virginia which impacts not only the developing infant but the pregnant woman, her children, and other exposed family and friends, not to mention the impact on the health care community. Pregnant women participating in the RFTS Project have a high incidence of smoking during pregnancy. To address this issue RFTS has adopted an intense smoking cessation initiative. The program was developed by Dr. Richard Windsor who has successfully implemented the program in Alabama.

The Smoking Cessation Program developed by Dr. Windsor, was implemented in West Virginia in January 2002, through the Office of Maternal, Child, and Family Health. It was incorporated into the RFTS Project and is known as "The West Virginia Right From The Start 'SCRIPT'". The WV RFTS 'SCRIPT' uses the existing home visitation network and protocols already established in the current RFTS Project. RFTS Project services are provided to pregnant women and infants by registered nurses and licensed social workers throughout West Virginia who are known as Designated Care Coordinators (DCCs).

In January 2002, specific areas of West Virginia were chosen to participate in two Natural History Studies based on the largest concentration of pregnant smokers. The purpose of the studies were to document the number of new Medicaid obstetrical patients who were smokers, to biochemically confirm self-reported smoking status, to establish the natural quit rate during pregnancy, and to document the relapse rate of women reporting they had quit on their own since becoming pregnant. Natural History Study Number One was conducted in six of the eight RFTS regions in West Virginia. One hundred seventy-four (174) pregnant women were enrolled in Study Number One and approximately 74 (42.8%) of these women were self-reported smokers. In the West Virginia counties who participated in Natural History Study Number One, data suggested that self-reported smoking rates among pregnant women ranged from 25 to 58.8%.

WV PRAMS data reported that the prevalence of smoking during the last 3 months of pregnancy was 25.28% in 2003.

2003 RFTS data shows that the 4 top risk factors identified on the PRSI (Pregnant Risk Survey Instrument) are: 1) partner smokes, 2) patient smokes, 3) partner drinks alcohol an 4) lack of transportation.

2003 data from the WV Tobacco Quit Line indicate 9,878 utilizers, of which 147 were pregnant women. This number has increased yearly from 68 in 2000, 104 in 2001 and 126 in 2002.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implemented the Smoking Cessation Program developed by Dr. Richard Windsor in January, 2002 and is ongoing. (SCRIPT)				X
2. The WV 'SCRIPT' uses the existing home visitation network and protocols in the RFTS Project.		X		
3. The effects of smoking during pregnancy are distributed to all women.			X	
4. SCRIPT mandated to be provided to all RFTS/HAPI participants.				X
5. Information collected in OMCFH Research Division's Tobacco Screening databases.				X
6. All pregnant RFTS smokers/former smokers are offered CO Testing.		X		
7. State government maintains Quit Line.				X
8.				
9.				
10.				

b. Current Activities

The RFTS DCCs provided education and support to pregnant smokers who desired to quit using the 5 A's along with the educational patient handbook, "A Pregnant Woman's Guide to Quit Smoking", and the video "Commit To Quit During Pregnancy and Beyond." The pregnant smokers were tested initially for the level of carbon monoxide(CO) in their body by the use of a breathalyzer on the first home visit by the RFTS DCC. After the initial test, they were tested again approximately 4 weeks later following the tobacco dependence treatment education process. Patients could also be tested as often as they requested during that time period. The training for these new interventions was provided to all RFTS staff statewide in March of 2002 by Dr. Richard Windsor and the West Virginia OMCFH Perinatal Services Director, Jeannie Clark. A final document of the results of the "Formative Evaluation of the WV RFTS SCRIPT' has been developed by Dr. Windsor and includes analysis of data gathered during the Natural History

studies. These studies collected data regarding the prevalence of smoking among WV pregnant women and the effects of the newly implemented interventions among the study participants. Initial data collected in the Natural History Studies suggested, through the use of carbon monoxide (CO) testing of the pregnant smokers, that the smoking rate among WV RFTS study participants may be as high as 46%.

c. Plan for the Coming Year
The smoking cessation program developed by Richard Winsor will continue through the next year utilizing the Right From The Start Statewide network of nurses and social workers.

According to RFTS data, services are provided to approximately 50% of the Medicaid/Title V eligible pregnant women.

This is a very important program that serves primarily Medicaid eligible pregnant women in an effort to diminish health disparities. Difficulty in pulling sufficient data to adequately determine outcomes of the women participating in this program has been determined as a problem that needs attention. Because of the multiple companion efforts that are offered by RFTS, data collection and analysis are cumbersome.

The following goals have been established for the SSDI Project to assist with Tobacco/RFTS data analysis for the next five years:

Goal I: Assure timely and accurate collection of data to ensure identification and access to care for at-risk populations, especially those of child-bearing age and their infants.

Objective 1: Redesign the State's Perinatal Program's (Right From The Start) database to capture Program and outcome information that can be easily reported.

Objective 2: Improve to 85% the collection of completed Right From the Start data from the Regional Lead Agencies that includes timely case closure information and pregnancy outcome information.

Objective 3: Develop a web-based data collection system for providers and out- stationed employees for the Right From The Start Program.

Objective 4: Continue relationship with Tobacco Program to maintain funging for CO monitors and other education tools necessary for the Project's effectiveness.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	8	8	7	6	6
Annual Indicator	6.4	15.1	7.2	9.6	8.0
Numerator	8	19	9	12	10
Denominator	125578	125578	125578	125578	125578
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	5	5	4	4	3

Notes - 2005
estimated based on 2004 WV Vital Statistics

Notes - 2004
data from WV Vital Statistics 2003

Notes - 2003
Statistics from Vital Statistics2002.

a. Last Year's Accomplishments
West Virginia has 125,578 youth between the ages of 15 and 19. There were 12 suicide deaths in 2004 among this population. Eight of the suicides were committed with firearms. Because of the small number, the rate can fluctuate significantly from one year to the next. Our lowest rate was in 2001 with 8 deaths. The goal however is to reduce suicide among this population. Between the ages of 15-24, West Virginia had 267 deaths in this age group. Intentional self-harm is the second leading cause of death in this age group with a total of 39 deaths, 31 male and 8 female.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OMCFH's Adolescent Health Initiative provides awareness of adolescent at-risk behaviors.			X	
2. In FY 2004, 26 out of the 47 school-based health centers offered mental health services		X		
3. Children's Mental Health has adopted the Columbia Teen Screening to identify suicide risk.				X
4. The EPSDT screen contains a behavior assessment instrument used for age 10 and above.				X
5. In FY 2004, visits to the school-based health center therapist accounted for 13% of all visits.		X		
6. In FY 2004, 1,394 students received mental health counseling at 6.3 visits per user.		X		
7. In FY 2004, 53% of the needs addressed were for depression and anxiety in school based health centers.		X		
8.				
9.				
10.				

b. Current Activities
A summer conference entitled "Palette Of Grief" Sudden Loss of Life Due to Suicide, Depression, Illness, Natural Disasters, was conducted June 2006, and sponsored by the West Virginia Council for the Prevention of Suicide in cooperation with the Office of Behavioral Health Services, Office of Drug and Alcohol Abuse, Department of Health and Human Resources, and Valley HealthCare System.

The mission for the West Virginia Suicide Council is to reduce statewide numbers of suicides through prevention and awareness workshops. Educating parents, teachers, therapists, nurses, police officers, clergy, families and the general population that wants to learn more about depression, alcohol/drugs, early signs of suicide and what to do when you notice the early signs.

Featured workshops include: Suicide and Serotonin: An Overview, Survivors of Suicide: Panel Discussions and Families Left Behind, Alcohol and Drugs - Mixing Alcohol and Drugs with

Depression/Mental Health Issues or Situational Problems - A Pathway to Suicide, Bullying at School, The Jason Foundation: We Won't Be Silent, and Palette of Grief.

c. Plan for the Coming Year
The conference is just a beginning in our "War on Suicide" and throughout the next several years the Suicide Council will continue to add new members and take our message to all corners fo our state and promote "good mental health" to all of our citizens. The Suicide Council will not allow the "Silent Epidemic" to be silent any longer here in West Virginia.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	100	100	100	100	85
Annual Indicator	82.6	75.1	84.0	96.5	97.3
Numerator	257	262	242	248	250
Denominator	311	349	288	257	257
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	98	98	98	98	98

Notes - 2005
estimated based on 2004 Vital Statistics

Notes - 2004
data from 2004 Vital Statistics

Notes - 2003
Statistics from Vital Statistics 2002. Based upon the number of live births with known birthweights born at facilities for high-risk deliveries. This also includes both residents and nonresidents.

a. Last Year's Accomplishments
Ninety-eight point four (98.4) percent of the State's infants born with very low birth weight were delivered at facilities for high-risk infants. The State has three tertiary care centers that support neonatal intensive care units, West Virginia University Hospital, Charleston Area Medical Center and Cabell-Huntington Hospital. All three have Neonatal Intensive Care Units and all are University affiliated with residency programs. These units encompass emergency, critical, diagnostic and therapeutic care for these babies who require constant care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OMCFH's perinatal program, Right From The Start (RFTS) serving Title XIX and Title V sponsored provides pregnancy risk assessments.				X
2. OMCFH advocates that all pregnant women to be screened for medical risk conditions.				X
3. OMCFH fiscally supports training teams to encourage early				X

screening and referral.				
4. The WV RFTS 'SCRIPT' educates, supports, and assists pregnant women to quit or lower # cigarettes per day.		X		
5. RFTS case managers educate women on health behaviors that contribute to low birth weight and/or prematurity.		X		
6. RFTS protocols support high risk patient deliveries at tertiary care.				X
7.				
8.				
9.				
10.				

b. Current Activities
Medical specialists, specially trained nurses and therapists devote themselves to caring for the special problems of these tiny patients. The NICU staff prepares father, mother and baby for life at home with home care training, physical therapy and developmental testing for the baby through NICU Follow-Up programs. These infants receive an automatic referral to the Birth to Three/Early Intervention/Part C Program.

Transport service to and from referring hospitals is provided by NICU transport nurses for neonates and infants younger than one year of age.

Early prenatal care has been a contributing factor to the high percentage of very low birthweight infants being born at facilities for high-risk deliveries and neonates.

c. Plan for the Coming Year
The West Virginia OMCFH will continue to nourish those relationships with obstetricians and primary care centers to enable early access to care for pregnant women. The OMCFH also plans to continue all current programs that support services for at-risk pregnant women.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	87	87	87	88	88
Annual Indicator	83.0	86.0	85.8	86.0	87.0
Numerator	16963	17271	17474	17983	18200
Denominator	20430	20081	20368	20911	20920
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	89	89	90	90	90

Notes - 2004
Estimated on provisional data from Vital Statistics. PRAMS data also used but not available for 2004

Notes - 2003
2003 data based on number of of live births with known onset of prenatal care. Data from the Vital Statistics Division. PRAMS data is also used but it is unavailable for 2003 at this time.

a. Last Year's Accomplishments

WV Vital Statistics reports that in 2004, 86% of all pregnant women in the State received first trimester prenatal care. WV PRAMS data report that in 2003, only 76% of women whose prenatal care was paid for by Medicaid received first trimester prenatal care. Trend data indicate that the proportion of such women has increased steadily over the years. Contributing to the overall increase is the State's Right From The Start Project and free pregnancy testing offered by Family Planning, referenced earlier. In addition to first trimester prenatal care being a factor associated with intendedness of pregnancy, payor source for deliveries is as well. Women who access medical care, but have no source of coverage at the initial visit are referred to OMCFH by the medical community for assistance, including securing health care financing. Also referenced earlier, OMCFH serves as the initial payor for the patient's preliminary care, while exploring all health financing options.

To increase the number of women receiving prenatal care during their first trimester of pregnancy, the Office of Maternal, Child and Family Health's Right From The Start Project provides comprehensive perinatal services to low income women, including direct financial assistance for adolescents and non-citizens who are ineligible for Medicaid, but whose income is equal to or less than 185 percent of the Federal Poverty Level; limited coverage for prenatal patients who at the time of first prenatal visit have not received a Medicaid card and are subsequently denied, or prenatal patients whose Medicaid coverage is not backdated to cover the first visit and initial laboratory services. Adolescents age 19 years and under are automatically eligible for financial assistance under Title V for medically indigent prenatal services regardless of income. In 2003, 5,652 prenatals enrolled in RFTS.

Because low income women are less likely to seek prenatal care for obvious reasons, we have instituted the following: 1) free pregnancy testing at 153 sites statewide; 2) a Power Point presentation has been presented that discusses the importance of prenatal care to train the Department of Health and Human Resources eligibility workforce to assure that as they identify potential eligibles and that they are referred for services; and 3) the perinatal workforce (Right From The Start) routinely does outreach in the community including newspaper ads, public presentations, and other mechanisms that are targeted toward pregnant women and the availability of service.

The OMCFH works in concert with the West Virginia Chapter of the March of Dimes to ensure information about the need for early and continuous care. This partnership supports a population-wide education effort. The OMCFH also works with the Tobacco Prevention Project to train staff, providers, and consumers about the effects of cigarette smoking on pregnancy and infants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Free pregnancy testing is available at 145+ sites statewide.			X	
2. Women who have a positive pregnancy test are assisted with securing health care coverage		X		
3. Adolescents age 19 years and under are automatically eligible for OMCFH financial assistance.		X		
4. Early prenatal care is strongly encouraged and supported through all family planning efforts.				X
5. The OMCFH partners with The March of Dimes to provide education targeting early prenatal care.			X	
6. The OMCFH supports efforts to develop capacity in physician				X

shortage areas.				
7. The OMCFH partners with Health Promotion, Tobacco Prevention Project, to educate and support pregnant women in smoking cessation and/or reduction.		X		
8. The OMCFH partners with the local DHHRs to encourage them to refer pregnant women who are denied Medicaid coverage for obstetrical care services consideration.		X		
9.				
10.				

b. Current Activities

The Family Planning Program provides free pregnancy testing at all sites in an effort to improve early identification and referral of pregnant women into care. Women who have positive pregnancy tests completed at one of our 145 sites statewide are immediately assisted with completing a shortened Medicaid application, linked to a physician, with initial care cost defrayed by Title V, etc., if they do not have health care financing.

Pregnancy testing and verification required for Medicaid eligibility is provided at no charge to women, without regard to income. All medical providers and all local Department of Health and Human Resources offices have been visited to remind them of the above OMCFH policy; that is, OMCFH will pay for the initial prenatal visit and all initial out-patient lab without benefit of any financial declaration for any medically indigent women.

The OMCFH also works in concert with the Divisions of Primary Care and Recruitment to develop capacity specific to the professional shortages; i.e., obstetrics.

c. Plan for the Coming Year

West Virginia has done a good job of getting their pregnant women into early care. The Perinatal Program, Right From The Start Project (RFTS) provides comprehensive perinatal services to low income women and infants up to one year of age. The project provides the following services: 1) Recruitment of medical practitioners to care for low income, government sponsored populations (Title XIX, Title V). 2) Recruitment and credentialing of practitioners to care for Medicaid and Title V sponsored obstetrical patients, including the completion of signed contractual agreements that establish expectation for care in accordance with national standards. 3) All participating providers complete signed agreements with OMCFH specific to services/benefits, risk scoring and patient information exchanges. 4) Direct financial assistance for obstetrical care for pregnant adolescents ages 19 and under who are not eligible for Medicaid. 5) Provides financial assistance for pregnant adolescents ages 19 and under regardless of income. 6)Direct financial assistance for prenatal care for non-citizens. (They may be eligible for Medicaid at the time of delivery as this is considered an emergency situation). 7) Direct financial assistance for obstetrical care for pregnant women denied Medicaid, with income at or below 185 percent of the Federal Poverty Level. 8) Limited coverage for prenatal patients who at the time of first prenatal visit have not received a Medicaid card and are subsequently denied, or prenatal patients whose Medicaid coverage is not backdated to cover the first visit. The services may include lab work, the initial prenatal visit, and ultrasound, if necessary. This was the closest we could come to presumptive eligibility. The cost of these services are paid for by the OMCFH using Title V funds. 9) Assistance for patient access to health care and the WIC Program. Coordination of medical care for Title V and Title XIX obstetrical patients and their infants/children less than one year of age. Coordination components include a personalized in-home assessment to identify barriers to health care, an individually designed care plan to meet the patient's needs, community referrals as necessary, follow-up and monitoring. 10) All pregnant Medicaid and Title V cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation, parenting, nutrition).

D. State Performance Measures

State Performance Measure 1: *Decrease the percentage of high school students in grades 9-12 who are overweight or obese.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			13.7	13.0	14.5
Numerator			17204	16325	18250
Denominator			125578	125578	125578
Is the Data Provisional or Final?				Provisional	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	12	10	9.5	9	8.5

Notes - 2005
2005 YRBS

a. Last Year's Accomplishments
One of the more serious aspects of the obesity epidemic is the dramatic increase in the incidence of overweight among children and adolescents. Using data from the National Health and Nutrition Examination Surveys (NHANES), it appears that overweight prevalence among our nation's children and adolescents doubled between 1980 and 1994.

The data available on the problem of overweight among West Virginia youth are limited. The latest statistics are from the 2005 Youth Risk Behavior Survey. Overall, 14.5% of West Virginia high school students in grades 9 through 12 were overweight (19.2%of males and 9.8% of females). Sixteen percent (16.0%) of students were at risk of overweight, 14.7% of males and 17.3% of females. Questions on daily diets revealed that roughly one in five students ate five or more servings of fruits and vegetables each day (22.1%) and those who drank three or more glasses of milk were only 17.3%.

Obesity can be classified as a worldwide epidemic, with the United States the undisputed leader in obesity prevalence. It is currently estimated that 97 million adults are overweight or obese in this country alone. Obesity contributes to numerous and varied comorbid conditions. The economic costs of obesity are also tremendous. The National Institutes of Health have estimated the total cost of overweight and obesity to the U.S. economy in 1995 dollars at $99.2 billion, approximately $51.6 billion in direct health care costs and $47.6 billion in indirect costs.

The situation is even worse in West Virginia. In 2000, the West Virginia rate of adult obesity was 23.2%, compared with a U.S. rate of 20.1%.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. National companies have agreed to remove harmful soft drinks from school machines				X
2. The DHHR Office of Healthy Lifestyles promotes physical activity				X
3. Recent legislation mandates three 30 minute physical activity periods during each week of the school year				X
4. The West Virginia Department of Education is promoting healthy lifestyles.				X

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Obesity is multifactorial, thus, addressing the burden of obesity cannot be a singular effort. It will take many programs working in collaboration to fully address and intervene effectively upon the behaviors of physical activity and healthy eating. The Bureau for Public Health will be using the "Guidelines for Comprehensive Programs to Promote Healthy Eating and Physical Activity" to develop and implement a comprehensive nutrition and physical activity program, or an Obesity Prevention Program.

Young people need to build healthy bodies and establish healthy lifestyles, yet the school environment is less supportive of health and has less access to healthful choices than ever before. The WV Bureau for Public Health has partnered with the WV Department of Education's Office of Healthy Schools to address the WV Healthy People 2010 Objectives. Collaborative projects have included collecting data to establish baselines, completing inventories, developing Walk to School initiatives, and training principals.

Several other youth programs are currently being implemented:

Coronary Artery Risk Detection in Appalachian Communities (CARDIAC) is facilitated by West Virginia University. This Project is a partnership between local schools and the Rural Health Education Partnership primary care centers. Fifth-grade students are screened for cholesterol, hypertension, and obesity to test the hypothesis that universal cholesterol screening of prepubertal school children is effective in identifying those families at risk of developing premature coronary heart disease in a high-risk population.

Healthy Hearts is a web-based instructional module for children on cardiovascular health. This is one of the first instructional (e-learning) modules that uses the Internet to teach youngsters about the risk factors associated with cardiovascular disease (cholesterol, poor nutrition, physical inactivity, and tobacco use). This project was piloted in approximately 20 fifth-grade classrooms and will allow student knowledge, attitudes, and behaviors related to nutrition, physical activity, and tobacco to be studied.

More on obesity and physical activity can be found in State Performance Measure #8 under the discussion.

c. Plan for the Coming Year

The West Virginia Medical Foundation along with the Partnership for a Healthy West Virginia will host a Summit, June 2006, to bring together health care providers, insurers, policy makers and community representatives, etc., to discuss strategies and interventions that encourage healthy eating and increased physical activity. In addition, training for health care practitioners in tobacco cessation intervention will be offered.

The West Virginia OMCFH indirectly supports these efforts through the HealthCheck Program, which is the state's EPSDT Program. Through its protocols, medical practitioners conducting well-child examinations are instructed to measure children for height and weight, to document that information and to discuss the topics of proper weight and nutrition with parents.

More on this topic can be found in the discussion of State Performance Measure #8.

State Performance Measure 2: *Decrease the percentage of high school students who smoke cigarettes daily.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			21.5	21.5	19.3
Numerator			26999	26999	24236
Denominator			125578	125578	125578
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	19	18.5	17.5	16.5	16

Notes - 2005
2005 YRBS

a. Last Year's Accomplishments
Smoking prevalence among high school students in West Virginia decreased from 42.2% in 1999 to 28.5% in 2003, representing a statistically significant decline of 32.5%. Though West Virginia has consistently ranked among the top five states in youth smoking, recent data reveal that a declining trend has begun. In 2000, West Virginia ranked the highest in the country with a rate of 39%, which was 32% higher than the U.S. median of 29%. Smokeless tobacco use among high school boys in West Virginia showed a similar decline of 19%, from 28.6% in 1999 to 23.3% in 2003. West Virginia ranked third highest in the country in smokeless tobacco use among male high school students.

The 2005 YRBS shows that the percentage of students who ever smoked cigarettes dialy, that is, at least one cigarette every day for 30 days has dropped slightly to 19.3%

RAZE, the statewide teen-led, teen-implemented anti-tobacco movement, is coordinated by the Youth Empowerment Team (YET). YET members include representives of the Division of Tobacco Prevention, the West Virginia Department of Education's Office of Student Services and Health Promotion, the American Lung Association of West Virginia and the West Virginia Youth Tobacco Prevention Campaign. The goal of Raze is to create a statewide youth anti-tobacco movement that initiates concern and activism, with peer-to-peer influence ultimately reducing tobacco use among teens. Their vision statement is: We are Raze: West Virginia teens, tearing down the lies of Big Tobacco and fighting them with all we've got: our passion, our power and our minds. Join up, if you think you can handle it.

The Youth Prevention Program receives the highest proportion of funding (62%) of the total budget for tobacco prevention programs because of the state's commitment to youth.

The WV PRIDE survey for 2004-2005 reported that of the high school students (grades 9 through 12) in the survey who responded, 37.5% reported smoking cigarettes within the past year, 17.9% reported using smokeless tobacco and 23.2% reported smoking cigars.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WV DHHR has a strong anti-tobacco program which			X	

includes a brand and promotional campaign designed in advice from youth in this age group				
2. The Adolescent Health Initiative and the Abstinence Education Project warn of the dangers of tobacco use		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Despite the fact that the consequences of tobacco use are well-known to West Virginians, residents continue to use tobacco in alarming numbers. Tobacco use is the number one preventable cause of premature death and disease. West Virginia is aggressively addressing this problem by implementing evidence-based comprehensive tobacco control programs. The comprehensive plan focuses on four goals: (1) Prevent the initiation of tobacco products among young people; (2) Eliminate exposure to secondhand smoke; (3) Promote quitting among adults and young people; (4) Eliminate tobacco-related disparities among different population groups.

Five thousand young people under age 18 become regular smokers each day in West Virginia.

Current short-term objectives for the prevention of youth tobacco use were: (1) By June 2006, reduce the proportion of youths in grades 9-12 who report smoking in the previous month to 33.5% or lower; (2) By June 2006, reduce the proportion of students in grades 9-12 who report smoking cigarettes on school property to 12% or lower; (3) By June 2006, reduce the proportion of young men in grades 9-12 who report smokeless tobacco use to 20.5% or lower; and (4) By June 2006, enforce state and federal laws that prohibit tobacco sales to minors to 10% noncompliance or less.

Among the current strategies to meet 2006 and 2008 goals are: (1) Train regional coordinators, regional tobacco prevention specialists, and youth in key youth prevention activities; (2) Maintain an active and well informed Teen Advisory Committee; (3) Develop and maintain 55 RAZE chapters; (4) County coordinators will meet with local Regional Tobacco Prevention Specialists quarterly; (5) One teen representative will join each adult county coalition; (6) Teens will conduct operation storefront in each region; (7) Provide research-proven effective tobacco prevention curriculum to all students grades K-12; (8) Establish partnerships with the West Virginia Department of Education, Regional Tobacco Prevention Specialists and Regional Tobacco Prevention Coalition Coordinators; (9) Establish and maintain school-based tobacco prevention programs as outlined in CDC's Best Practices; and (10) Maintain an active Youth Empowerment Team.

c. Plan for the Coming Year

The youth smoking prevention program has as some of their objectives: (1) By June 2008, reduce the proportion of youths in grades 9-12 who report smoking in the previous month to 33% or lower; (2) By June 2008, reduce the proportion of youths in grades 6-8 who report smoking in the previous month to 13% or lower; (3) By June 2008, reduce the proportion of students in grades 9-12 who report smoking cigarettes on school property to 11% or lower; (4) By June 2008, reduce the proportion of students in grades 6-8 who report smoking cigarettes on school

property to 3.5% or lower; and (5) By June 2008, reduce the proportion of young men in grades 9-12 who report smokeless tobacco use to 19.5% or lower.

A knowledge of the patterns of adolescent tobacco use is important when planning and implementing prevention programs. One of the most important questions asked on the PRIDE Questionnaire was when various drugs are used. Time of use responses consisted of Before School, During School, After School, Week Nights, and Weekends. This information is important in providing insight into the use patterns of tobacco products by students. Results for Senior High Students were: 12.1% Before School, 5.8% During School, 17.3% for After School, 13.9% for Weeknights and 22.6% for Weekends.

State Performance Measure 3: *Decrease the percentage of pregnant women who smoke.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			73.6	74.7	74.6
Numerator			15322	15410	15400
Denominator			20830	20630	20630
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	24	23	22	21	21

Notes - 2005
Estimated based on PRAMS data

a. Last Year's Accomplishments
According to West Virginia Vital Statistics, West Virginia has the highest smoking rate for pregnant women in the United States. The rate of smoking during pregnancy in 2004 was 27.1%, compared to the U.S. rate of 12% in 2003 (last date available). The Right From The Start (RFTS) Project has obtained past data from the Birth Score Office which shows that many counties in West Virginia have a self-reported rate of 30% to 57% among Medicaid mothers who smoked during pregnancy. This creates an enormous health problem for the State of West Virginia which impacts not only the developing infant but the pregnant woman, her children, and other exposed family and friends, as well as the health care community. Pregnant women participating in the RFTS Project have a high incidence of smoking during pregnancy. To address this issue, RFTS adopted a smoking cessation initiative. The program was developed by Dr. Richard Windsor who successfully implemented the program in Alabama.
The Smoking Cessation Program was implemented in West Virginia in January 2002, through the Office of Maternal, Child, and Family Health. It was incorporated as protocol into the RFTS Project in October 2003, known as "The West Virginia Right From The Start SCRIPT". The WV RFTS SCRIPT uses the existing home visitation network and protocols established in the RFTS Project, which provides services to pregnant women and infants by registered nurses and licensed social workers throughout West Virginia who are known as Designated Care Coordinators (DCCs).
Educational tools such as videos, CO monitors, smoking cessation guides, and smoking cessation incentives are available to the Right From The Start DCCs for use on home visits in the smoking cessation effort. RFTS DCCs received training in the tobacco dependence effort to provide pregnant women with best practice smoking cessation methods. RFTS Regional Care Coordinators (RCCs) also provide SCRIPT education to other prenatal care providers who are contracted to provide obstetrical services through the OMCFH.
Data from the RFTS Project show the following quit rates among pregnant participants:
2003 -- 23% quit rate
2004 -- 35.8% quit rate

2005 - quit rate pending data analysis

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented the Smoking Cessation Program developed by Dr. Richard Windsor in January, 2002 and is ongoing. (SCRIPT)				X
2. The WV 'SCRIPT' uses the existing home visitation network and protocols in the RFTS Project.		X		
3. The effects of smoking during pregnancy are distributed universally.			X	
4. SCRIPT mandated to be offered to all RFTS/HAPI participants.				X
5. Information collected in OMCFH Research Division's Tobacco Screening databases.				X
6. All pregnant RFTS smokers/former smokers are offered CO2 Testing.		X		
7. State government maintains Quit Line.				X
8.				
9.				
10.				

b. Current Activities

Collaborative efforts with WV partners interested in smoking cessation among pregnant women resulted in sharing to maximize resources. The March of Dimes provided the Project with literature, the American Lung Association provided DCC training on smoking cessation during pregnancy at a decreased cost in March 2006, and the American College of Obstetricians and Gynecologists provided free resources "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking" for DCCs and distributed at March 2006 trainings.

Training includes monthly SCRIPT training and updates for RCCs, quarterly mandatory training sessions for DCCs, and a mandatory statewide DCC conference to address tobacco/substance use during pregnancy.

In response to a statewide DCC survey completed December 2005, trainings on basic smoking cessation in pregnancy education and postpartum relapse prevention were provided in 2006.

Client Satisfaction Surveys completed by smokers/former smokers and women who never smoked in 2005 show 45% reported receiving smoking cessation education from DCCs.

OMCFH data collection improved with closer monitoring of reporting systems and procedures. Deadlines for OMCFH SCRIPT data submission were given to RFTS Regional Lead Agencies and DCCs. Regional clerical staff trainings were conducted in conjunction with monthly RFTS RCC meetings. Research, Evaluation and Planning staff made numerous site visits to RFTS Regional Lead Agencies to field test changes, investigate, monitor, provide technical assistance and correct identified issues. Changes made as a result of the training and technical support resulted in the improvement of the quality of SCRIPT data.

RFTS RCCs are participating in teleconferences with the National Partnership to Help Pregnant Smokers Quit provided by the CDC.

The WV RFTS SCRIPT initiative received national attention since the inception in 2001. A poster presentation on the SCRIPT initiative was provided at the National AWHONN in Salt Lake City, Utah, June 2005. As the SCRIPT exhibit continues to be displayed throughout WV by RFTS RCCs and State staff, many people express interest in the uniqueness of the RFTS Project. A presentation was provided at the Holzer Medical Center's Smoking and Pregnancy Seminar November, 2005 in Gallipolis, Ohio.

Carbon Monoxide (CO) poisonings were detected in several RFTS Project pregnant smokers

homes through use of CO monitors per Project protocol during home visits. These high CO levels were reported by the DCC to the investigative community agencies who confirmed the levels and assisted families in removal of the source of CO.
Pregnant women who are smoking at RFTS case closure or who relapse postpartum are referred to the WV Tobacco Quitline. The Quitline is used in coordination with WV RFTS SCRIPT while participating in Project services. 2003 Quitline data indicated 9,878 users, 1% were pregnant, 2005 indicated 6,2283 users, 3% were pregnant.

c. Plan for the Coming Year
The foundation has been laid in WV for an effective statewide initiative to continue reductions in the number of pregnant smokers. WV RFTS SCRIPT provides smoking cessation education to numerous low income pregnant women and families, more than half of WV pregnant women are eligible for this support. The RFTS Project expects to be effective to additional WV populations as education filters into socioeconomic subsets due to the interdependent nature of rural Appalachian families.
West Virginia's Public Employees' Insurance Agency (PEIA) provides benefits for participants who wish to quit smoking or using smokeless tobacco products. To enroll in the tobacco cessation program, interested individuals are encouraged to call the WV Quit Line at 1-877-966-8784 (1-877-YN0T-QUIT) for counseling, support, written materials and benefit information. For pregnant participants, PEIA will provide 100% coverage for the tobacco cessation benefit during any pregnancy in the participant's lifetime.
West Virginia Medicaid provides reimbursement for both pharmaceutical products and behavioral modification services to promote the discontinuation of tobacco products by eligible Medicaid recipients. Reimbursement for tobacco cessation pharmacological agents is available for one twelve week course of treatment per eligible recipient per calendar year. Services provided by the primary care physician and the WV Quitline are included in covered services for eligible Medicaid recipients. Pregnant females are eligible for additional courses of treatment if needed.
The RFTS Project plans to continue to educate pregnant women and families on the dangers of smoking during pregnancy and the importance of maintaining a smoke free environment. RFTS DCCs, registered nurses and licensed social workers, will continue to make home visits to provide in-home care coordination and support to Project participants, using the 5 A's best practice method for smoking cessation during pregnancy. The RFTS DCCs each use a carbon monoxide monitor for pregnant smokers to provide a visual message of the dangers of smoking during pregnancy.
Data is collected on all pregnant smokers participating in the RFTS Project. Database revisions allow more accurate data collection for the Project. A primary goal of the RFTS Project is to reduce the rate of pregnant smokers in WV due to the efforts of the SCRIPT Program. Funding provided by the Tobacco Prevention grant, standardized research-based educational materials and best practice curriculum have been obtained. Through implementation of these tobacco dependence treatment initiatives, the overall health of individuals, families and infants can be improved, and WV can see further reductions in poor pregnancy outcomes, infant mortality, prematurity and low birth.
The 2005 RFTS Client Satisfaction Surveys show 45% of women reported receiving smoking cessation education from RFTS DCCs.

State Performance Measure 4: *Increase the percentage of women who breastfeed their infants for at least six (6) weeks after birth.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			26.2	30.0	32.0
Numerator			5500	6270	6700

Denominator			20986	20911	20920
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	37	38	39	40	40

Notes - 2005
Estimated from 2003 PRAMS Data

Notes - 2004
Estimated from 2003 PRAMS Data

Notes - 2003
WV PRAMS data 2003

a. Last Year's Accomplishments
Data from RFTS Project Outcome Measures
While the latest data on breastfeeding indicates that a low percentage of women choose to breastfeed their infants, this should not be taken as an indication of little effort on the part of the State's Bureau for Public Health or, in particular, the Office of Maternal, Child and Family Health (OMCFH). All pregnant women participating in the OMCFH Right From The Start Project receive information about the benefits of breastfeeding their infants. RFTS Project DCCs provide comprehensive in-home breastfeeding education and support to prenatal participants through sixty days post partum and to breastfeeding mothers of eligible infants until their infant reaches age one year.
RFTS Project data for 2003 shows that 19% of Project participants chose to breastfeed at hospital discharge but only 3% were still breastfeeding at sixty (60) days postpartum. Data from the Project for 2004 shows that 20% of Project participants chose to breastfeed at hospital discharge and 9% were still breastfeeding at case closure.

WV PRAMS data for 2003 showed that approximately 43% of pregnant women chose not to breast feed. The reasons given by the women for not choosing to breastfeed were in order of priority:

- Didn't like breastfeeding
- Husband or partner did not want me to breastfeed
- Went back to school or work
- Embarrassed
- Too many household duties
- Didn't want to be tied down
- Wanted my body back to myself
- Other children to take care of

WV PRAMS data also showed that 26% of women breastfed up to 6 weeks after delivery. The percentage then drops off but picks up again at 20+ weeks which is 24% of women continuing to breastfeed at that time.

Data collected by the RFTS Project and by the PRAMS Project were similar in some areas. Both showed a low breastfeeding rate among mothers and a low rate of continued breastfeeding at sixty (60) days postpartum.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase WIC resources money and personnel dedicated to				X

breastfeeding.				
2. Increase attention by multiple service agencies serving pregnant women including physicians, RFTS, etc. need to encourage and offer breastfeeding support.		X		
3. WIC increased income guidelines in order to qualify more women and children				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Both babies and mothers gain many benefits from breastfeeding. Breast milk is easy to digest and contains antibodies that can protect infants from bacterial and viral infections. Research indicates that women who breastfeed may have lower rates of certain breast and ovarian cancers.

Pregnant women who choose to participate in the RFTS Project are encouraged to breastfeed their infants and educated on the health and socioeconomic benefits to mother and infant. The women are educated about improved health outcomes for the infant and how human milk is made to meet the specific needs of human babies. Women are educated on how breastmilk changes as the baby grows to offer the best combination of nutrients that make it easy for baby to digest and use. Some long-term health benefits of breastfeeding for infants are reduced childhood obesity, reduced risk of some chronic diseases, decreased risk of allergies, improved neurological development that may result in higher IQs and better eyesight, and increased jaw strength and straighter teeth as a direct result of suckling at the breast.

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

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

In 2004-2005 the RFTS Project learned of ineffective community collaboration between RFTS and WIC according to reports from RFTS Project DCCs. Jeannie Clark, Director of Perinatal Programs voiced concerns regarding DCC reports from specific areas of WV to Denise Ferris, Director of the WV Office of Nutrition Services. Ms. Ferris encouraged those specific local WIC providers to collaborate more effectively with RFTS DCCs. The RFTS Project encourages collaboration with local WIC offices statewide to ensure that Project participants continue to receive breastfeeding education and support after case closure. Improved collaborative efforts have been experienced during the past year according to RFTS DCC reports. These improvements have provided RFTS participants with better continuity of care and have resulted in an increase in the number of pregnant women referred to RFTS for care coordination which in turn provides an opportunity for more breastfeeding education and support.

c. Plan for the Coming Year

The RFTS Project will continue to provide educational materials on breastfeeding such as videos, pamphlets, and literature for DCCs to use during home visits. RFTS DCCs will continue to promote breastfeeding with each prenatal participant and provide support and referrals as needed. The Project will continue to train providers on the benefits of breastfeeding and how to encourage Project participants to try breastfeeding as their choice for infant feeding.
RFTS DCCs have access to the use of standardized step-by-step prenatal curriculum which includes education on breastfeeding. The curriculum, purchased by the OMCFH with March of Dimes grant funding in 2004 is entitled "The Pregnancy Workshop" and is available for use and reproduction of educational materials by each DCC at no cost through their Regional Care Coordinator.
The OMCFH is committed to increasing breastfeeding rates throughout WV and promoting optimal breastfeeding practices. This goal can be achieved through the existing RFTS Project network by supporting breastfeeding mothers, their families, communities, employers, and health care providers by providing education, training, funding, technical assistance, and research.
Women can be encouraged to breastfeed longer into the postpartum period by being educated to seek assistance from local support groups, other mothers who have successfully breastfed and from their local WIC lactation consultants.
WIC resources include funds and personnel dedicated to breastfeeding. Increase attention by multiple service agencies serving pregnant women, including physicians, RFTS, etc., the need to encourage and offer breastfeeding support.
WIC recently expanded eligibility to the program with significant increases in the income guidelines. A family of two may now make up to $24,420 a year and be considered eligible for WIC services; for other household sizes, add $6,290 for each additional family member.

State Performance Measure 5: *Decrease the percentage of high school students who drink alcohol and drive.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			12.0	12.0	11.5
Numerator			15069	15069	14441
Denominator			125578	125578	125578
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	10	10	9.5	9	8.5

Notes - 2005
2005 YRBS

a. Last Year's Accomplishments
This is a new measure for the state but there are programs in place that promote decision making reflecting drinking and driving.

Motor vehicle accidents are the leading cause of death for West Virginia children ages 15 through 18. This has remained consistent for the last 10 years, averaging more than 40% of deaths for this age group, showing no downward or upward trend: overall percentage rate of 43.3% for years 1995-2004.

It is likely that many of these deaths are attributable to driving under the influence of alcohol and/or drugs. Approximately 37% of motor vehicle related fatalities in all age groups involved alcohol. While there is no breakdown of this data focusing on the adolescent population, there are indications it applies to this age group as well. For instance, the 2005 YRBS states that 10.6% of high school students drove a car or other vehicle one or more times when they had

been drinking alcohol within the past 30 days.

West Virginia Alcohol Beverage Control Administration has stopped stocking 190 proof grain alcohol at its wharehouse, which provides all liquor sold in the State. Agency officials made this decision in response to concerns by college officials, law enforcement agencies and community groups about the alcohol, which is 95% pure, and consequently more potent than other distilled spirits.
At least a dozen other states including neighboring Pennsylvania and Virginia, sell 190 proof grain alcohol only for medicinal or commercial use.

The Adolescent Health Initiative (AHI) and the Abstinence Education Project (AEP) educate youth about the consequences of underage drinking and encourage responsible behavior. The AEP promotes sexual abstinence until marriage; however, there is a direct correlation of early onset of sexual activity related to the use of alcohol. Therefore, the AEP provides in-school lessons educating youth ages 12-18 on how alcohol increases vulnerability to sexual advances. The AEP utilizes Choosing The Best, a curriculum which devotes five lessons to discouraging alcohol use. More than 10,000 youth attended the AEP's educational classes during the 2004-2005 fiscal year. The AEP also informs professionals and families across the state by providing educational materials about alcohol and encouraging abstinence. Over 60,000 pieces of literature was distributed at more than 30 community events, health fairs and other outreach opportunities. More than 17,000 youth, parents and others community members attended the AEP's classes and events during the 2004-2005 fiscal year.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Students Against Destructive Decisions (SADD) works with communities to establish local chapters		X		
2. AHI and AEP promote healthy decision making			X	
3. Government discontinued sales of 190% alcohol				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The effort to reduce motor vehicle deaths to adolescents and to reduce teen driving after drinking is multi-pronged. It includes legal restrictions, education and encouragement to practice safe behaviours.

Legal restrictions:
Legal restrictions include efforts to require young drivers to obtain additional experience before having the full privilege of driving (graduated licensing) and to control alcohol use by this population.

Graduated licensing:
Age 15 - Level I Instruction Permit
Age 16 - Level II Intermediate Driver's License
Motorcycle Instruction Permit
Age 17 - Level III Full Class E License
Age 18 - Driver's License (Class E)

Driver License (Class D) with one year driving experience
Motorcycle Only License (Class F)

Alcohol Control:
Minimum ages for on premises servers and bartenders
Beer, wine, spirits - age 18
Minimum ages for off premises sellers
Beer, wine, spirits - age 18

Town Hall meetings on underage drinking were held across the state in March, 2006.

The Adolescent Health Initiative and Abstinence Education Project educate youth on the consequences of underage drinking and encourage responsible behaviour.

The WV SADD website www.wvsadd.org has a hand book with guidelines for creating a new or enhancing and existing SADD chapter in the local areas across the state.

c. Plan for the Coming Year
Future plans are based upon the current activities and will continue.

One weakness of West Virginia law is that there is no criminal penalty for hosting private parties where underage drinking is occurring, although there could be civil penalties should a child be injured. While an adult can't provide alcohol to minors, there is no penalty for the adult if the minor obtains the alcohol in some other manner.

The Adolescent Health Initiative engages in a number of activities designed to educate youth and families about alcohol use, such as SOBER Obstacle Driving Course where all students in drivers' education classes attend and experience driving the drivers' education cars with the fatal vision goggles simulating drinking and driving. The Alcohol Beverage Commission, FRNs, and local law enforcement are strongly involved with the local SOBER Program, through Juvenile Justice. The AHI is working in conjunction with two national organizations (Children's Safety Network and the National Initiative to Improve Adolescent Health) to develop a coordinated approach to injury prevention issues, as follows:

Key messages when planning interventions:
-Reducing teen-related fatalities will require a variety of coordinated efforts
-Parental involvement is key, parents play an important role in addressing teen driving risks.
-Use existing connections and resources; implement injury prevention into existing programs

Collaborate with partners to support laws that protect young drivers:
-GDL laws
-"Standard" or primary enforcement of seat belt laws
-Zero tolerance laws for all persons under the age of 21
-.02 as a per se offense (without having to prove intoxication)
-License suspension or revocations authorized for any violation of the state zero tolerance law.
-Restriction on sales of alcoholic beverages to all persons under the age of 21.

Support strong underage drinking and alcohol-related driving efforts, and participate in springs coordinated the WV State Team and the Federal Interagency Coordinating Committee for the Prevention of Underage Drinking. Maintain Minimum Drinking Age 21 laws.

Educate and train other professionals and youth about safe driving:
-Integrate safe driving messages into other school and community-based health education programs

-Integrate safe driving information into adolescent health school-based clinics, and as part of anticipatory-guidance at medical visits.

The AHI has also developed a draft action plan designed to address injury prevention issues as follows:

Office of Maternal, Child and Family Health-Five Year Needs Assessment
Child and Adolescent Health Priorities, include three related priorities:

I. Decrease the incidence of fatal accidents caused by drinking and driving,
II. Increase the percentage of adolescents who wear seat belts,
III. Reduce accidental deaths among youth 24 years of age or younger,
IV. Assure that children and families access health care financing and utilize services.

State Performance Measure 6: *Decrease the number of high school students who never or rarely wear a seatbelt when riding in a car driven by someone else.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator			15.2	15.2	15.2
Numerator			19087	19087	19087
Denominator			125578	125578	125578
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	15	14.5	14	13.5	13

Notes - 2005
2005 YRBS

a. Last Year's Accomplishments
Motor vehicle accidents are the leading cause of death for West Virginia children ages 15 through 18. This has remained consistent for the last 10 years, averaging more than 40% of deaths for this age group, showing no downward or upward trend: overall percentage rate of 43.3% for years 1995-2004.

In 2004, 58 percent of the 5,135 occupants of passenger vehicles and light trucks age 16 to 20 who were killed in crashes were not buckled up, according to NHTSA. Teenagers are less likely to wear safety belts even when their parents do, according to a survey conducted by the Insurance Institute for Highway Safety(IIHS) released in June 2002. The report found that 46 percent of the teenagers who were dropped off at school by their parents were not wearing safety belts, and in 8 percent of cases teens were using safety belts, while the adult driver was not. The survey, conducted at 12 high schools in Connecticut and Massachusetts, focused on four groups: teen drivers, teen passengers in vehicles with teen drivers, teen passengers with adult drivers, and adult drivers.

The survey also found that belt use differed based on gender and age. Belt use was lower among male teen drivers than male adults, while the difference between female teen drivers and female adult drivers was negligible. Teenage passenger belt use was much lower for both males and females than adults. Only 50 percent of males and 56 percent of females riding with adult drivers were buckled up in the morning going to school. In addition, the study revealed that when a teenage driver was behind the wheel, the use among teen passengers fell to 42 percent among males and 52 percent among females. To increase seat belt use among teens, the IIHS suggests

adding belt use provisions to graduated licensing systems.

In 2004, West Virginia implemented one of the most visible Click It or Ticket enforcement and media eforts ever conducted in the State. Approximately 9,500 safety belt and 455 child safety seat citations were written during the two-week period. In addition, West Virginia police made 910 DUI, 1,099 felony, and 776 drug arrest, and issued 17,927 sppeeding and reckless driving tickets. All 60 State Police troops, and more than 75 percent of the State's sheriffs and local police agencies participated in the campaign. The activity included 5,585 Click It or Ticket television and 2,565 radio spots being seen and heard throughout the State, and the safety belt use rate rose to 76%.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WV Department of Transportation promotes seat belt use				X
2. WV Department of Public Safety sponsors the Click It or Ticket campaign and has put an emphasis on enforcement of seat belt usage laws				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2000, West Virginia had the lowest seat belt usage rate in the country at 49%. The Governor's Highway Safety Program (GHSP) developed and the implemented the Click It or Ticket Challenge. The rate went to 52% in November 2001. As a direct result of the Click It or Ticket Program, with the assistance of our law enforcement partners, and a large paid media effort, West Virginia's seat belt usage rate soared to an all time high of 72% in June 2002. In June of 2003, after another sucessful year of the Click It or Ticket campaign, the usage rate jumped to 74%. In June of 2004, the seat belt usage rose another two percentage points to 76% and in June 2005, a scientific seat belt survey was conducted in West Virginia and the results were 85% were wearing their seat belt.

The West Virginia Highway Safety Office has some interesting programs, one of which is called Battle of the Belts. High Schools agree to participate. A baseline survey is done on seatbelt use as kids pull into the parking lot in the morning for school. Schools are given 30 days to improve the use percentage by any means they think will work. The survey is repeated 30 days later. The most improved schools receive cash prizes. The Project varies by region throughout the State. Some regions take an all or nothing approach. Each region has $2,000. to distribute. All three schools that participated in one of the regions showed an 88% usage rate.

c. Plan for the Coming Year

West Virginia was graded a D- for having 37 unrestrained fatalities (or 23.88 per 100,000) in the age category of 13 - 19 years of age. West Virginia's secondary enforcement seat belt law hinders its ability to achieve high seat belt use. If the legislature were to pass a standard enforcement seat belt bill, West Virginia's grade would significantly improve. Other methods to improve West Virginia's overall performance include: conducting high visibility seat belt enforcement campaigns to increase overall seat belt use compliance and strengthening penalties for violations of the adult and child occupant protection laws.

State Performance Measure 7: *Increase the percentage of the state's children <18 who are government sponsored beneficiaries who have at least one primary care visit in a 12-month period.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator				87.8	88.2
Numerator				199564	200354
Denominator				227222	227222
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	90	90	90	92	92

a. Last Year's Accomplishments
HealthCheck is West Virginia's name for the mandated pediatric Medicaid program, Early and Periodic screening, Diagnosis and Treatment (EPSDT). Over 200,000 Medicaid-approved children in West Virginia have been eligible to participate in the HealthCheck program for the past four years. EPSDT's promise to children eligible for Medicaid is the provision of preventive health exams and treatment of all medical conditions discovered during the exams.

All families of Medicaid beneficiaries who are children, receive a letter advising them of the EPSDT services and available practitioners.

In FY 2003 and FY 2004, EPSDT utilization was at 50%. EPSDT Family Outreach Workers, located in nine regions of the State inform parents and care-takers of Medicaid eligible children about EPSDT services and encourage them to use the EPSDT services for preventive health. A Program Specialist is assigned to each region and provides recruitment and orientation of new EPSDT providers, and provides technical assistance, orientation of new staff members, an Annual Review of all EPSDT program requirements, and a minimum of two site visits each fiscal year for all existing EPSDT providers.

A written survey of HealthCheck providers was conducted in calendar year 2002. The survey revealed that 90% of the providers who responded to the survey rated the services provided by the Program Specialists as either very effective or effective. Thirty (30) School-Based Health Centers located throughout the State provide EPSDT services at various elementary schools, middle schools, and high schools maximizing site resources.

HealthCheck only does outreach for EPSDT members not assigned to an HMO now per our FY 2006 grant agreement. Forty-four counties are covered 100% by HMOs and another 5 counties are covered by one HMO and PAAS. HealthCheck only influences the PAAS clients, SSI clients, and Foster children in trying to get Medicaid approved children to receive a primary care visit. PAAS covers 6 counties as the only managed care option available.

The Bureau for Medical Services (Medicaid) elected to have HMOs provide their own EPSDT outreach for their HMO EPSDT members. HMOs have most of the EPSDT members now so our

HealthCheck outreach workforce has significantly decreased from 51 to the current 28 staff.

Unicare has 51,215 EPSDT members, Health Plan has 27,524 EPSDT members and CareLink has 20,247 EPSDT member and each are responsible for their own outreach.

HealthCheck has 3,093 EPSDT members that are children in foster care and 36,782 EPSDT members not assigned to an HMO, some of which are awaiting assignment to an HMO.

Of 134,369 EPSDT members, 36,782 are not assigned an HMO.
Of the 36,782, 29,674 are assigned to HealthCheck for full outreach.
17,401 of the 29,674 (59%) have had a HealthCheck screen this fiscal year as of April 30, 2006.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Comply with Medicaid/OMCFH contractual agreements for EPSDT outreach		X		
2. Call EPSDT members who miss HealthCheck appointments as a followup activity		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The EPSDT Program has an extensive outreach component responsible for meeting federal EPSDT informing, linking and follow-up requirements. Program Specialists and Family Outreach Workers (FOW) are assigned to each region and county to accomplish the outreach activities. An array of services are provided to Medicaid-approved clients by the HealthCheck Program including: 1) one or more physical exams each year based upon an age dependent periodicity schedule; 2) dental services; 3) vision services; 4) immunizations; 5) hearing services; 6) laboratory tests; 7) treatment for any health problems discovered during the exams; 8) referrals to other medical specialists for treatment; 9) a check of the child's growth and development; 10) follow-up checkups; 11) health education and guidance; and 12) documentation of medical history. The EPSDT program staff partner and work closely with the Office of Social Services assuring that the 3,000 children who are in state custody, receive EPSDT screens within thirty (30) days of placement. These children receive initial health assessments by medical practitioners especially trained to service at risk populations.

In 2004, WVCHIP began working with several state agencies and community health programs as a way to refocus WVCHIP's outreach efforts as a leader in health prevention and promoting healthy lifestyle issues such as obesity, lack of immunizations, juvenile diabetes, asthma and other health problems are on the rise; early detection and prevention is imperative. WVCHIP's decision to make health intervention a priority in its outreach efforts supports our state's Healthy People 2010 objectives outlined for children . Currently, WVCHIP is focusing on educating families on the importance of well-child visits, immunizations, reducing unnecessary emergency room visits, child development and diabetes case management.

c. Plan for the Coming Year
The EPSDT Program will continue to be operated by the OMCFH through a contractual arrangement with the Bureau of Medical Services and renegotiated every year. EPSDT has contracted with the Health Maintenance Organizations (HMO) to provide outreach services for their child beneficiaries to encourage their participation in EPSDT. EPSDT providers plan to continue offering EPSDT services in the School Based Health Centers as a way to be more accessible for those children who may not otherwise receive services due to restricted access.

EPSDT has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides orientation for HMO providers serving Medicaid enrolled children. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community often lacks capacity in some areas of the state.

House Bill 4021, the health care reform bill, passed the last day of the session. Clearly, the best part of HB 4021 is the expansion of the Children's Health Insurance Program to include families with incomes up to 300% FPL. Over the next few years an additional 4,000 plus West Virginia children will receive health insurance through this this expansion. The CHIP expansion is projected to achieve a 97% rate of children who have health insurance.

State Performance Measure 8: *Increase the percentage of high school students who participate in physical activity for at least 20 minutes a day, 3 days a week.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator			66.3	66.3	63.7
Numerator			83258	83258	79993
Denominator			125578	125578	125578
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	68	69	70	70	70

Notes - 2005
2005 YRBS

a. Last Year's Accomplishments
The West Virginia Legislature, during its 2005 regular session, passed H. B. 2816 Healthy West Virginia Act as proposed by Governor Manchin. This legislation revised various sections of code related to public schools. In particular, it revised S18-2-7a to require specific time allowances for the instruction of physical education.

The legislation in part states: (a) The Legislature hereby finds that obesity is a problem of epidemic proportions in this state. There is increasing evidence that all segments of the population, beginning with children, are becoming more sedentary, more overweight, and more likely to develop health risks and diseases including Type II Diabetes, high blood cholesterol and high blood pressure. The Legislature further finds that the promotion of physical activity during the school day for school children is a crucial step in combating this growing epidemic and in changing the attitudes and behavior of the residents of this state toward health promoting physical activity.

(b) As a result of these findings, the State Department of Education shall establish the requirement that each child enrolled in the public schools of this state actively participates in physical education classes during the school year to the level of their abilities as follows:.....(3) Grade nine to and including grade twelve. -- Not less than one full course credit of physical education, including physical exercise and age appropriate physical activities which shall be required for graduation and the opportunity to enroll in an elective lifetime physical education course.

Every school is encouraged to develop schedules that meet or exceed the requirements. However, a proviso was added to allow schools that cannot meet the requirements with existing staff and facilities to submit alternate programs to the Department of Education (WVDE) and the West Virginia Healthy Lifestyle Coalition (WVHLC) for approval. In an effort to streamline the approval process and to help schools with their scheduling needs for 2006-07, the WVDE prepared model plans based on ideas submitted by school administrators during the past six months. These model plans were submitted to the WVHLC and have been pre-apporved by both the WVHLC and the WVDE. In addition it is hoped that a section will be added to the School Strategic Plan that will allow the WVDE to electronically collect required information pertaining to the physical education requirements.

Senate Bill 785 passed the State Legislature, making changes to the 2005 laws relating to school physical education requirements. The latest bill clarifies the requirement for physical education at elementary, middle and high school levels. Additionally Senate Bill 785 stipulates the testing for Body Mass Index (BMI) and reporting of aggregate data.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The WV DHHR Office of Healthy Lifestyles promotes physical activity.				X
2. Recent legislation requires three periods of physical activity each week (30 minutes in length) during the school year for grade school.				X
3. Recent legislation requires one semester each year for middle school.				X
4. Recent legislation requires one class of physical education during high school.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In the Child Nutrition and WIC Reauthorization Act of 2004, the U.S. Congress established a new requirement that all school districts with federally-funded school meals programs develop and implement local wellness policies by the start of the 2006-07 school year that address nutrition and physical activity.

In order to promote students' physical, social and emotional health, the WV Board of Education adopted among its strategic goals the following as Goal #3: All students and school personnel shall develop and promote responsibility, citizenship, strong character and healthful living. This goal supports the Board's desire to have "wellness" as a priority issue in all schools. The WV

Board of Education believes that county boards of education can make a positive impact on promoting healthy lifestyles among students and staff through the development and implementation of proactive local wellness policies. In addition, the Board believes all schools should provide a consistent environment that is conducive to healthful eating behaviors and regular physical activity. The WVBE set forth expections and encouraged county boards to prepare, adopt and implement a comprehensive nutrition and physical activity plan that included specific standards.

c. Plan for the Coming Year

The plan for this upcoming year will be to monitor the activities and legislative laws that were put in place this year. There are several youth programs that encourage healthy lifestyles. Among them are; The Choosy Kids Club at West Virginia University is an afterschool program for elementary schoolchildren from a tri-county area. Active lifestyles based on healthy decisions is the theme of the program. WVU students, serving as personal trainers for the children, monitor blood pressure and changes in height and weight. "Activity homework" is given to help reinforce lessons at home. Another such program is called Helping Educators Attack CVD Risk Factors Together (HEART). The goal of HEART is to develop an infrastructure to support school-based programs to improve cardiovascular health in grade-school children, increase the number of students and staff who engage in healthy behaviors, screen students and families for CVD risks, and evaluate effectiveness of interventions. This project is being implemented in Cabell, Lincoln, and Wayne counties by St. Mary's Regional Heart Center.

Additional information can be found in State Performance Measure #1.

E. Health Status Indicators

The first part of this section will address Health Status Indicators 01A, The percent of live births weighing less than 2,500 grams; 01B, The percent of live singleton births weighing less than 2,500 grams; 02A, The percent of live births weighing less than 1,500 grams; 02B, The percent of live singleton births weighing less than 1,500 grams; 05A, The rate per 1,000 women aged 15 through 10 years with a reported case of chlamydia; and 05B, The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Improvement in the health of West Virginia's perinatal population is a result of a carefully crafted, highly-interdependent partnership. Tertiary care centers, primary care centers, local health departments, private practitioners and community agencies have worked with the Office of Maternal, Child and Family Health (OMCFH) for nearly 30 years to improve the health and well-being of the State's people. In conjunction with its medical advisory boards, OMCFH has designed a system that offers early and accessible health care to low income, medically indigent and underinsured women and children. A successful perinatal care system requires adequately trained professionals to provide complete reproductive health services that include family planning, preconceptual counseling, prenatal care, delivery, newborn care, and care for the woman in the postpartum period.

PRECONCEPTUAL SERVICES

Preconception care is a critical component of health care for women of reproductive age. The primary goal of preconception care is to provide health promotion, screening, and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Preconception health care is critical because several risk behaviors and exposures affect fetal development and subsequent outcomes. The greatest effect occurs early in pregnancy, often before women enter prenatal care or even know they are pregnant.

For more than three decades, the WV Family Planning Program has been an integral component of the public health system, providing high-quality reproductive health services and other preventive health care to low-income or uninsured individuals who may otherwise lack access to health care. Subsidized medical care provided by Family Planning Program clinics prevents unintended pregnancies, reduces the need for abortion, lowers rates of sexually transmitted diseases, including HIV, detects breast and cervical cancer at its earliest stages and improves the overall health of women, children and families.

Family planning has been a public health success story, across the nation as well as in West Virginia. Family Planning Program clinics not only provide quality health care services, but also save the government money. Investments in discretionary programs often lead to savings in mandatory spending. For every dollar spent on publicly funded family planning, $3 is saved in pregnancy-related and newborn care costs for Medicaid.

Any female or male capable of becoming pregnant or causing pregnancy whose income is at or below 250% federal poverty level is income eligible to receive free or low-cost clinical examinations and free contraceptives through the Family Planning Program. In West Virginia, 138 publicly funded family planning clinics provide contraceptive care to 59,400 women -- including 17,070 sexually active teenagers. Family Planning clinics in West Virginia serve 56% of all women in need of publicly supported contraceptive services and 60% of teens in need. Every county in West Virginia has at least one family planning clinic. Among the 50 states and the District of Columbia, West Virginia ranked 6th in service availability in 2006. Publicly funded family planning clinics in West Virginia help women prevent 15,700 unintended pregnancies each year.

In West Virginia, 177,300 women are in need of contraceptive services and supplies. Of these, 106,240 women need publicly supported contraceptive services because they have incomes below 250% of the federal poverty level (77,880) or are sexually active teenagers (28,360). West Virginia's teenage pregnancy rate declined by 21% between 1992 and 2000, due in part to teen's access to confidential services.

Family Planning Program clinics offer counseling and referral for patients regarding future planned pregnancies, management of current pregnancies, or other individual concerns (i.e., nutrition, sexual concerns, substance use and abuse, sexual abuse, domestic violence, or genetic issues). Preconception counseling is provided if patient history indicates a desired pregnancy in the future. Clients in need of enhanced preconception counseling or genetics testing are referred to tertiary care facilities or specialty providers for additional assessment.

PERINATAL INFRASTRUCTURE

Ensuring access to health care for low-income women and children has been an ongoing concern for state and federal officials. The Bureau for Medical Services (Medicaid) and the Office of Maternal, Child and Family Health (OMCFH) have worked collaboratively to develop special initiatives that extend support services to women and infants at-risk of adverse health outcomes. This partnership has not only expanded the State's capacity to finance health care for medically indigent women and children, but has also strengthened the delivery of care by establishing service protocols, recruiting medical providers and developing supportive services such as case management and nutrition counseling which contribute to improved patient well-being.

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

reduction education, and development of comprehensive programs that address both medical and behavioral issues.

Early preventive prenatal care and education are recognized as the most effective and cost effective ways to improve pregnancy outcomes. West Virginia's Perinatal Program, the Right From The Start Project (RFTS), was birthed in 1989 as a partnership between OMCFH and Medicaid to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal services to low-income women up to sixty (60) days postpartum and care coordination for Medicaid eligible infants up to one (1) year of age. Right From The Start also provides direct financial assistance for obstetrical care for West Virginia pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if they are a West Virginia resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V-funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit.

The Right From The Start Project was implemented in April 1990 for infants and July 1990 for women. In recognition of the importance of developing systematic approaches to deal with problems of access to prenatal care, Senate Bill 4242 was enacted. Under the provisions of the Bill, the WV Department of Health and Human Resources, Bureau for Public Health, was assigned responsibility for administration of RFTS, with Title XIX and Title V designated as payor sources.

Right From The Start works with approximately 76 community agencies throughout West Virginia under contract to provide care coordination and enhanced education services to high risk pregnant women and infants. The State is divided into eight (8) regions for management of RFTS. Each region has a Regional Care Coordinator (RCC) overseeing the activities of Designated Care Coordinators (DCC). In addition to assigning patient referrals and promoting the project, the RCC coordinates training and education for DCC staff, and recruits obstetrical care providers and designated care coordination agencies. The Prenatal Risk Screening Instrument (PRSI) is completed upon referral to RFTS and identifies risk factors. The risk factors for the program include, but are not limited to, medical complications, nutritional needs, and psychosocial factors.

The 165 Designated Care Coordinators (DCCs), who are licensed social workers and registered nurses, have been dedicated to the core public health function of assisting with access to early and adequate prenatal health care. In addition to RFTS DCCs, there are many obstetricians, nurse practitioners, nurse midwives and family practice physicians in West Virginia and bordering states under contractual agreement with the RFTS Project to provide quality obstetrical and delivery care to pregnant women.

Right From The Start care coordination components include an in-home assessment to identify barriers to health care, an individually designed care plan to meet the patient's needs, community referrals as necessary, follow-up and monitoring. Care coordination services are provided to families in the privacy of their own homes or other agreed upon locations. Another crucial component of RFTS is health education which includes preventive self-care such as the signs of pregnancy complication, smoking cessation, childbirth education, parenting education and nutrition counseling. The RFTS Project also assists women in accessing transportation to medical appointments through a community-based initiative called the Access to Rural Transportation (ART) Project.

High risk infants are referred to RFTS by the West Virginia University, Birth Score Program. The Birth Score Developmental Risk/Newborn Hearing Screen Instrument is a population-based assessment designed to identify infants at birth who may be at risk for developmental delay or

death within the first year of life. Other Medicaid-sponsored infants who are considered at risk are referred to RFTS from various sources for care coordination.

Patient information and utilization data is provided to the Right From The Start regional offices by providers of obstetrical care services using standardized project screening tools. Those screening tools include the Prenatal Risk Screening Instrument (PRSI), the Alternate Entry Form, the Infant Birth Score Card, Tobacco Screening Forms, Tracking Form and Outcome Measures Form.

The Office of Maternal, Child and Family Health and West Virginia University continue to collaborate to provide services to high-risk pregnant women and infants through the Healthy Start, Helping Appalachian Parents and Infants (HAPI) Project. The HAPI Project focuses on helping women become healthier before becoming pregnant, encourages spacing of pregnancies, and focuses on mental health issues. Care coordination services for pregnant women and infants are offered in accordance with standard RFTS Project protocols, but services are expanded to include the preconception phase as well. Initially started in four (4) West Virginia counties, the HAPI Project has been expanded to eight (8) counties, with the addition of new service components (oral health services, substance abuse screening and referral, and outreach services utilizing former consumers).

Access to Prenatal Care:
Nationally, federal health agencies, insurance companies, health researchers, and policy groups promote the need for a "continuum of care" with patients. It is recognized that continuity of coordinated, quality care is the best model of care for patients and is the most cost effective method for providing and paying for services. A continuum of care is best achieved through consistent access to quality health providers and services. Gaps in consistent care result in increased need for intensive and crisis care, which results in higher costs for health care services. Research supports greater patient compliance with care plans when positive relationships with health care providers are well established.

The Right From The Start Project has utilized the established DCC network of Registered Nurses and Licensed Social Workers to provide this model of care since the 1980's. Because of this network, West Virginia's access to first trimester prenatal care rate has improved from 60-70% in the 1980's to nearly 86% in 2003. In comparison, national access to first trimester prenatal care was 84.3% in 2003.

Provider Availability:
A key component of ensuring continuing access to prenatal care services is having sufficient provider availability. Obviously, gaps in the distribution of providers create geographic barriers that affect access to prenatal care.
Obstetricians, nurse practitioners, nurse midwives, and family practice physicians in West Virginia and bordering states contract with OMCFH to provide obstetrical care and delivery care to pregnant women. This network of providers has offered services to eligible West Virginia families since 1989 and continues to do so even though many express reimbursement concerns.

Financial Constraints:
Medicaid is a major source of financing for health care services provided to pregnant women and infants. According to the WV Health Statistics Center, 53.2% of West Virginia births were paid for by Medicaid in 2003. Due to declining economic circumstances in West Virginia, the percentage of Medicaid eligible families has continued to increase.

West Virginia has experienced numerous funding cuts in reimbursement rates for service provision in the past few years, which have compounded difficulties in service delivery. The RFTS Project provider network has not received an increase in care coordination or medical service reimbursement rates for Medicaid eligible patients since inception of the Project. Because the cost to provide prenatal and infant care has dramatically increased in the last ten

years, providers report experiencing difficulty maintaining their practices due to poor reimbursement for medical services. As a result, some providers have opted to discontinue provision of prenatal care services for Medicaid covered patients. Even though access to first trimester prenatal care for West Virginia women has improved in the last ten years and pregnant women are now healthier, the improvements may begin to decline and poor birth outcomes may be experienced unless there is an increase in provider reimbursement.

Even with the most comprehensive and competent system of care, some women and infants will experience adverse outcomes. The outcome of pregnancy is influenced by both medical and social conditions, so affecting pregnancy outcomes will require non-traditional interventions. In West Virginia, 28,260 of the 372,890 women of childbearing age become pregnant each year. Seventy-four percent (74%) of these pregnancies result in live births, 10% in abortion, and the remainder end in miscarriage.

Pregnancies and Their Outcomes:
West Virginia has struggled with the incidence of low birth weight infants. Birth weight is the single most important predictor of survival. Low birth weight is defined as a weight of less than 2,500 grams at birth and may result from preterm birth (before 37 weeks) or poor fetal growth for a given duration of pregnancy (intrauterine growth retardation) or both. In the United States, most infant deaths are associated with low birth weight. Risk factors for preterm birth and low birth weight include: previous preterm and/or low birth weight birth, multiple births, smoking, unplanned pregnancy, infections, poor nutrition, lack of access to adequate and early prenatal care, harmful substance abuse, and domestic violence.

WV Health Statistics Center, Vital Statistics data prove that although access to first trimester prenatal care in West Virginia is approximately 86%, the State continues to experience a higher than average number of babies born preterm and/or low birth weight. Between 1991 and 2000, the percent of all mothers in West Virginia receiving adequate or adequate plus prenatal care increased 16%. However, between 1992 and 2002, the rate of infants born preterm in West Virginia increased 30%. Because of this continued upward trend for the last several years, there is still much work to be done in the arena of prenatal care and education.

While the specific causes of spontaneous preterm labor and delivery are largely unknown, research indicates they are likely due to a complex interplay of multiple risk factors, as opposed to any single risk factor. The most consistently identified risk factors for preterm labor and birth include a history of preterm birth, current multi-fetal pregnancy, and some uterine and/or cervical abnormalities. West Virginia has three (3) tertiary care facilities providing fertility care and treatment services. Multiple births represent 3% of live births in West Virginia. In 2002, 11.9% of singleton births were preterm, compared to 60.6% of multiple births.

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

Smoking During Pregnancy:
Although smoking during pregnancy has declined in the United States in response to public education and public health campaigns, smoking among West Virginia pregnant women remains a problem. Cigarette smoking during pregnancy adversely affects the health of both mother and child. The risk for adverse maternal outcomes (i.e., premature rupture of membranes, abruptio placenta, and placenta previa) and poor pregnancy outcomes (i.e., neonatal mortality and stillbirth, preterm delivery, and sudden infant death syndrome) is increased by maternal smoking. Infants born to mothers who smoke weigh less than other infants; low birth weight (<2,500 grams)

is a key predictor for infant mortality.

Women who quit smoking before or during pregnancy can substantially reduce or eliminate risks to themselves and their infants. Evidence suggests that specific smoking cessation programs have been at least partially successful. However, not all women have responded to these public health messages. Over one-fourth (26.2%) of the 20,986 births in 2003 were to mothers who smoked during their pregnancies. Although overall national rates reported a 38% decrease in the rate of pregnant smokers, the rate in West Virginia only dropped from 27.8% to 26.2%, a 5.8% decrease.

Due to West Virginia frequently ranking worst in the United States for smoking during pregnancy, the Right From The Start Project implemented the RFTS Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) initiative as statewide protocol in October 2003. This initiative has been funded using tobacco settlement monies and Medicaid fee-for-service resources to target pregnant women for education on smoking cessation and second-hand smoke. Standard program protocol requires Designated Care Coordinators to analyze the smoking status of pregnant participants and offer best practice methods for cessation or reduction. Carbon monoxide monitors have proven to be a valuable tool allowing DCCs to measure smoking cessation/reduction results of RFTS participants. RFTS SCRIPT data (2003) showed that at case closure, 34% of the pregnant women decreased the number of cigarettes smoked per day and 23% had quit.

Although a significant number quit smoking during pregnancy, RFTS data also indicates that most pregnant smokers relapse after the infant is born. In response, the RFTS Project concentrates on smoking cessation during pregnancy and establishing a smoke-free environment for the infant after birth. RFTS Client Satisfaction Surveys (2003) showed that 64.1% of pregnant smokers who participated in the Project received education on smoking cessation from their DCC. Continued efforts are needed to educate women of the health risk posed to their infants and themselves from smoking during pregnancy.

Substance Abuse:
Prematurity can be a complication of substance abuse which can cause a child to suffer life long adverse physical effects and may also cause the child to be slow to develop and prone to disease or disability. After birth, infants may experience serious or even fatal substance withdrawal symptoms. Besides being a contributing factor to preterm births, substance abuse often leads to risky behaviors for the pregnant woman which can lead to other complications such as premature rupture of membranes, stillbirth, sexually transmitted infections, domestic violence, increased stress, poor nutrition, inadequate finances, lack of resources, and lack of adequate support.

When a pregnant woman with substance abuse issues requests help, RFTS Project DCCs provide empathetic case management and support, education, referrals for treatment, and follow-up. RFTS Project DCCs develop trusting relationships with clients and follow them for extended periods of time, enabling excellent opportunities for clients to access substance abuse treatment. It also provides support for clients to begin addressing their substance issues and acquire tools which could assist them in attempting to remain substance abuse free.

Unintended Pregnancy:
An unplanned pregnancy can be a barrier to obtaining timely prenatal care because it may take weeks or months for a woman to realize or accept she is pregnant. The consequences of unintended pregnancy can be serious, even life altering, particularly for women who are young or unmarried, have just recently given birth or already have the number of children they want. Lack of prenatal care, along with poor birth spacing, or giving birth before or after one's childbearing prime can pose health risks for the woman and her newborn.
In addition, an unintended pregnancy can interfere with a young woman's education, limiting her employment possibilities and her ability to support herself and her family.

Even though the Centers for Disease Control and Prevention in 1999 declared family planning to be one of the 10 most significant U.S. public health achievements of the 20th century, half of all pregnancies in the United States are still unintended. In 2002, 41.7% of women living in West Virginia and delivering a live infant reported their pregnancies to be unintended, representing a decrease in the number of unintended pregnancies.

Many conditions such as maternal death or ill health decrease when women have births that are adequately spaced giving their bodies' sufficient time to regain strength. Babies born less than two years after a prior birth are much more likely than those born after a longer interval to be premature or low-birth-weight. Increased use of Family Planning Program services enables women to reduce closely spaced births and limit childbearing to their 20's and 30's, which may greatly reduce the infant mortality rate.

Domestic Violence:
Spousal domestic violence is more prevalent during the time that a couple experiences pregnancy. For the first time in RFTS data collection, Project participants listed domestic violence as one of the top four risk factors, suggesting that RFTS DCCs establish trusting relationships with pregnant women which enables disclosure of this sensitive issue. The RFTS DCCs are experienced in recognizing signs and symptoms of domestic violence among pregnant women and are trained on how to interview women in a safe environment and how to refer to community resources for intervention when indicated.

Although West Virginia has serious perinatal health care issues such as smoking among pregnant women, premature deliveries, and low birth weight infants, OMCFH has woven together a patchwork of funding streams to create a system of health care for women, infants and children. OMCFH maintains strong partnerships across the State with the medical community and private sectors, as well as community health centers and local health departments, in an effort to assure continued access to care.

The following narrative will discuss Health Status Indicators 03A, The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger; 03B, The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes; 03C, The death per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle creashes; 04A, The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger; 04B, The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger; and 04C, The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Motor vehicle accidents are the leading cause of death for West Virginia children ages 15 through 18. This has remained consistent for the last 10 years, averaging more than 40% of deaths for this age group, showing no downward or upward trend: overall percentage rate of 43.3% for years 1995-2004.

In 2004, 58 percent of the 5,135 occupants of passenger vehicles and light trucks age 16 to 20 who were killed in crashes were not buckled up, according to NHTSA. Teenagers are less likely to wear safety belts even when their parents do, according to a survey conducted by the Insurance Institute for Highway Safety(IIHS) released in June 2002. The report found that 46 percent of the teenagers who were dropped off at school by their parents were not wearing safety belts, and in 8 percent of cases teens were using safety belts, while the adult driver was not. The survey, conducted at 12 high schools in Connecticut and Massachusetts, focused on four groups: teen drivers, teen passengers in vehicles with teen drivers, teen passengers with adult drivers, and adult drivers.

The survey also found that belt use differed based on gender and age. Belt use was lower among male teen drivers than male adults, while the difference between female teen drivers and female

adult drivers was negligible. Teenage passenger belt use was much lower for both males and females than adults. Only 50 percent of males and 56 percent of females riding with adult drivers were buckled up in the morning going to school. In addition, the study revealed that when a teenage driver was behind the wheel, the use among teen passengers fell to 42 percent among males and 52 percent among females. To increase seat belt use among teens, the IIHS suggests adding belt use provisions to graduated licensing systems.

In 2004, West Virginia implemented one of the most visible Click It or Ticket enforcement and media eforts ever conducted in the State. Approximately 9,500 safety belt and 455 child safety seat citations were written during the two-week period. In addition, West Virginia police made 910 DUI, 1,099 felony, and 776 drug arrest, and issued 17,927 sppeeding and reckless driving tickets. All 60 State Police troops, and more than 75 percent of the State's sheriffs and local police agencies participated in the campaign. The activity included 5,585 Click It or Ticket television and 2,565 radio spots being seen and heard throughout the State, and the safety belt use rate rose to 76%.

In 2000, West Virginia had the lowest seat belt usage rate in the country at 49%. The Governor's Highway Safety Program (GHSP) developed and the implemented the Click It or Ticket Challenge. The rate went to 52% in November 2001. As a direct result of the Click It or Ticket Program, with the assistance of our law enforcement partners, and a large paid media effort, West Virginia's seat belt usage rate soared to an all time high of 72% in June 2002. In June of 2003, after another sucessful year of the Click It or Ticket campaign, the usage rate jumped to 74%. In June of 2004, the seat belt usage rose another two percentage points to 76% and in June 2005, a scientific seat belt survey was conducted in West Virginia and the results were 85% were wearing their seat belt.

The West Virginia Highway Safety Office has some interesting programs, one of which is called Battle of the Belts. High Schools agree to participate. A baseline survey is done on seatbelt use as kids pull into the parking lot in the morning for school. Schools are given 30 days to improve the use percentage by any means they think will work. The survey is repeated 30 days later. The most improved schools receive cash prizes. The Project varies by region throughout the State. Some regions take an all or nothing approach. Each region has $2,000. to distribute. All three schools that participated in one of the regions showed an 88% usage rate.

West Virginia was graded a D- for having 37 unrestrained fatalities (or 23.88 per 100,000) in the age category of 13 - 19 years of age. West Virginia's secondary enforcement seat belt law hinders its ability to achieve high seat belt use.

F. Other Program Activities

The Office of Maternal and Child Health, since the 1980's, has contracted for the provision of direct health care. These contractual relationships include private sector physicians, university-medical school partners, hospitals, community health centers, and local health departments. All services are formally contracted with established performance standards portrayed in the written provider-OMCFH agreement. The exception to this format is Children Special Health Care Needs, which was, until the late 1980's, administered by the former Human Services arm of the now Department of Health and Human Resources organization. This unit has maintained its direct service responsibility because of the scarcity of pediatric and pediatric sub-specialty providers in certain geographical areas of the State. The program receives referrals from multiple sources. However, as the State has developed and improved population-based surveillance systems, more and more youngsters have been referred, as a result of the birth defect registry, birth score, blood lead testing, newborn hearing screening and metabolic screening. It is also important to note that the State's universal risk scoring of infants, called Birth Score, was modified several years ago to assure the identification of infants with or at risk of developmental delay. These children are referred to the OMCFH administered Birth to Three Program/Part C IDEA. In addition, MCFH administers EPSDT, again with direct care through community provider

partnerships, but we do have access to information on each child, enabling us to identify youngsters with chronic or disabling conditions for referral to CSHCN. The primary care physicians are encouraged to refer children to CSHCN, and are routinely visited by Pediatric field staff who serve as technical resources to the medical community.

All children assessed by CSHCN receive evaluation and case management services to facilitate access to alternative systems of care. All children enrolled in CSHCN, Birth to Three (Part C IDEA), or even our perinatal RFTS program receive case management and care coordination. Children participating in the Children with Special Health Care Needs Program access Medicaid, at a rate of 71.3%. This high percentage is attributed to CSHCN commitment to assist families with SSI applications, the expedited SSA/Disability Determination process, and our attention to obtaining health care financing for this targeted group.

The Office supports the Birth Score Project and Genetics Program administered by West Virginia University, Department of Pediatrics. The support for these programs are at the heart of building capacity for the system of care by providing preconceptual counseling; assessment and support for persons with congenital anomalies' and operating a population-wide surveillance system designed to identify infants at possible risk of post-neonatal death (birth score, which includes newborn hearing screening).

Primary preventive health care for the State's children has been historically administered by OMCFH through provider contracts for EPSDT and/or the companion program called Pediatric Health Services (PHS). Pediatric Health Services previously picked up the cost of care for children who had not accessed Medicaid or CHIP. PHS was discontinued as CHIP enrollments became more stable. The PHS did an excellent job of gap filling, and yearly provided payment for 35,000 or more child health visits, and all treatment medications at no cost to the family. Community partners and the MCH population ineligible for Medicaid, were recipients of the OMCFH resource.

The OMCFH continues to provide monies for maintenance of a data repository which keeps current health, social, and community information by county and by type of service statewide. This data repository, linked to OMCFH via modem, is used to access information for client specific questions, received on the OMCFH toll-free lines. As previously discussed, OMCFH has well used toll-free lines which are monitored by independent reviewers. All calls, unless client refuses, are followed up by letter. We also maintain resource information on a variety of topics enabling us to respond to specific concerns. OMCFH program information is also available via Web access with multiple links to access informational guidance on a variety of topics.

Care management and care coordination is provided through established systems, with program specific protocols for each targeted population. In RFTS, social workers and registered nurses involve parents in discussion of family planning, and assist clients who are economically disadvantaged in accessing health care. Our cadre of community-based family outreach workers (FOW's) encourage families to participate in preventive, primary health care for their children.

G. Technical Assistance

West Virginia would like technical assistance to examine our systems and identify strategies to positively impact the low birthweight incidence. There were a total of 1,814 low birthweight babies (those weighing less than 2,500 grams or 5 1/2 pounds) born to West Virginia residents in 2003, representing 8.7% of all births. Of the 1,797 low birthweight infants with known gestational age, 1,253 or 69.7% were preterm babies born before 37 weeks of gestation. (Of all 2003 resident births with a known gestational, 11.7% were preterm babies.) Over one-fourth of the births was to a mother who smoked during her pregnancy. Over the years smoking mothers while pregnant has increased as well. Interestingly enough, infants born to mothers who received 1st trimester

care was above the national average and continued to increase. Nearly eighty-six percent (85.8%) of West Virginia mothers with known prenatal care began their care during the first trimester of pregnancy, compared to 84.3% of mothers nationwide. West Virginia has a strong prenatal program and has implemented the smoking cessation program developed by Richard Windsor with the goal of reducing the number of pregnant women who smoke. With one of the highest smoking rates in the nation for pregnant women, our low birthweight continues to rise.

V. Budget Narrative

A. Expenditures

Please reference notes contained with forms 3, 4 and 5 for a dicussion of budgeted estimates and actual expenditures.

B. Budget

The Office of Maternal, Child and Family Health has done a good job of leveraging resources. The Block Grant Title V, serves as the foundation but the Office also administers Title X Family Planning; Title XV Breast and Cervical Cancer Screening Program; Part C DEA; Childhood Lead Prevention Program, CDC funded; EPSDT, funded by Title XIX; Children with Special Health Care Needs, funded by Title XIX and Title V; and PRAMS, funded by CDC. All of these funding streams augment what is purchased with Title V monies. Like many states across the country, Title V has moved away from the sole focus of purchasing or providing individual health services and has placed most of our attention and fiscal resources on developing a system of care. For example, because the state had high incidences of neural tube defect and other congenital anomalies, the OMCFH approached the WVU School of Medicine to develop satellite clinics providing genetics counseling and screening. Although the medical expertise came from the WVU School of Medicine, the funding to make these services more accessible throughout the state came from Title V. These clinics serve everyone, not just persons who have government sponsored health care.

Because WV has a median income of $27,000 for a family of four, the need for services has been great but our resources have been limited. The State Legislature routinely supports Maternal, Child and Family Health, but over the years this commitment has not kept pace with the demand for services and escalating cost. This is largely attributable to the fact that as Medicaid expansions occurred and the CHIP program was introduced, there was an assumption by members of the State Legislature that Maternal, Child and Family Health would not need as many resources. We have attempted to educate the Legislature explaining to them that while these alternate health financing strategies have come into being, the MCH monies are needed to improve the quality of services rendered and improve the availability of care. Like states across the country, WV does not have enough money to fund all the many things that we would like to have for our citizens. For example, several years ago newborn hearing screening legislation was passed but there was no accompanying state appropriation. What was obvious to us was that, while there was a commitment to identify children who needed intervention, be it hearing aids or whatever, there was no consideration given to the fact that there has to be a mechanism for identifying the children, tracking the children, and making sure the intervention occurred, all of which costs money. OMCFH staff argued this to no avail, so we were very pleased to be a recipient of the Title V monies to support this project. It is true that Medicaid and some insurers would offset the cost of the newborn hearing screening services, but there was no way to individually bill and recover monies necessary for the population-based tracking and surveillance that was necessary...no insurances or Medicaid pay for this activity.

In order to be good stewards of the system, the OMCFH provides leadership for much of the health care services provided in the state. Medicaid, CHIP and others are purchasers, but the OMCFH and its staff recruit the clinicians, establish the care protocols, monitor provider behavior, offer skill building opportunities, etc. all using the resources identified above to improve WV's health care system.

The WV OMCFH administers EPSDT on behalf of Medicaid and has done so for approximately 30 years. The Medicaid Bureau supports the program by paying for the individual health services that the children access. The OMCFH develops, distributes, and purchases anticipatory guidance which is used by the participating providers. We also are responsible for bringing together members of the medical community to provide guidance as it relates to child health, not just

EPSDT, but Newborn Hearing, Children with Special Health Care Needs, Birth Defects, Lead, etc. We use many of the programs cited to identify children who are ultimately referrred to CSHCN. The CSHCN Program, financed under Medicaid and Title V, not only serves children who have diagnosed chronic and debilitating conditions but arranges assessment for children referred by their primary care/medical home. All of these efforts are our commitment to primary and preventive care of the state's children and ultimately have a tie-in to CSHCN when indicated.

Using the statutory authority under Title V that allowed for cost based reimbursement for Medicaid beneficiaries and the authority invested in Title V to be responsible for all populations, we embarked upon an ambitous redesign plan for our Birth to Three/Part C system. This redesign has allowed the State of WV to implement a system change that is more in keeping with tenents of Part C and to obtain financing necessary to support the system. This system is designed to serve children who are developmentally delayed or at risk of developmental delay but the many programs administered by the Office serves as a referral conduit. Referral sources include the Birth Score screening that is completed on every baby born in WV to screen for developmental delay or identify those at risk of post neonatal death; our Birth Defects Surveillance System, Metabolic and Newborn Hearing Screening programs, and of course EPSDT. This system change has been in the process for about four years and has resulted in families having an opportunity to select a provider of service, improved financing for the system, and assurance that families are served by appropriately credentialed personnel. We have used Title V connections and fiscal resources to secure support from the medical community including developing physician training programs, offering skill building around the early detection of developmental delay, and to champion messages to their colleagues that the early identification of children who are at risk are important to us all.

An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.