



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

**State Narrative for
West Virginia**

**Application for 2009
Annual Report for 2007**



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I. General Requirements

A. Letter of Transmittal

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

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

Kathy Cummons, Director
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Office of Maternal, Child and Family Health
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D. Table of Contents

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

E. Public Input

The following announcement was placed on the WV OMCFH web page:

//2009/ Title V Block Grant 2008 - 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 2008 application is available for review at the Office of Maternal, Child and Family Health, or online at www.wvdhhr.org/mcfh/blockgrant2007 from June 6, 2007 through June 30, 2008. Persons wanting to submit written comments on the State's FY 2008 application in preparation for the FY 2009 application may do so by email to kathycummons@wvdhhr.org or by mail to: Kathy Cummons, Director, Research, Evaluation and Planning Division, Office of Maternal, Child and Family Health, 350 Capitol Street, Room 427, Charleston, WV 25301, prior to July 1, 2008.

After completion of the 2009 Application, a copy will be available on the OMCFH web page as well as copies sent to partners throughout the state. //2009//

Partners and Medical Advisories are involved all year with Title V decision making as evidenced

throughout the narrative. The WV OMCFH has developed strong partnerships across the State with the medical community, university medical centers, private sector, as well as community health centers and local health departments, all of which has enabled OMCFH to provide services and information to all West Virginia residents.

Advisories are important to the WV OMCFH. Almost every Program within the Office has an active advisory. The advisories meet at least once a year with some meeting twice a year, some quarterly and the Child Fatality Review Team meets once a month. The advisories are stakeholders of the Program and are active participants.

There is an attachment to this section that lists the OMCFH Advisory Committees and their participants. Participants range from parents, community organizations, physicians, insurance companies, Federal agencies, to other State agencies who have a stake in the process of the specific Program. Advisory meetings are not always held in our Office, but in locations around the State where access may be easier for more members to attend.

West Virginia OMCFH leadership serves on several committees and/or councils within the maternal and child health community including the Disabilities Council, Kids First Committee, Child Fatality Review and the Perinatal Wellness Committee. Each of these groups offer improvements in serving clients.

//2009/ There are five parent advisors who are hired part-time through the CSHCN Program to offer guidance to Program staff to improve or maintain services that support families with children who have disabilities. The Birth To Three Program/Part C has eight parent partners in each of the eight regional lead agencies who offer emotional support to families and guidance to staff on family needs. //2009//

//2009/ Excerpts of the Block Grant specific to the CSHCN component, which include early intervention, newborn metabolic screening, newborn hearing screening and identification of high risk infants, was presented before the Developmental Disabilities Council in 2007 for public input.

//2009/

An attachment is included in this section.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Although West Virginia has 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. ***//2009/ The Commonwealth Fund Commission Scorecard recently published ranked West Virginia as number one (1) for the category of "The percent of children ages 0-17 whose personal doctor or nurse follows up after they get specialty care and the State ranked 8th in the percent of children who have a medical home. Of the four categories, WV ranked 43rd for the Potential to Lead Long, Healthy Lives, 11th for Access, 18th for Quality and 39th in Costs. Overall on the scorecard, WV ranked 20th among the states. //2009//***

The State MCH program is in jeopardy of not being able to carry out the mandate to assure family health. Inflation has seriously reduced the purchasing power of Title V funds and compounded with stagnant funding levels over the past five years leaves West Virginia and states across the Nation unable to meet public demand.

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 formulary has been changed to accommodate the purchase of generic treatment medications and contraceptives. These pharmaceuticals are purchased en mass and stored at a government operated warehouse that is supported by multiple programs, including West Virginia Healthy Start/HAPI. 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. As stated earlier, if the patient is ineligible for Title XXI or Title XIX, Title V resources are used to pay for their care.

The West Virginia five year needs assessment indicates the following priorities in the MCH population groups:

- 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 through recruitment and credentialing
2. Assure that children and families access health care financing and utilize service
3. Increase Newborn Metabolic Screening tests to include the 29 nationally recommended tests

House Bill 2583 was passed during the 2007 Legislative session mandating the expansion of newborn metabolic screening to include the 29 nationally recommended tests and agreed to give the Department \$460,000 to assist with start up costs. ***//2009/ The 2008 legislature passed newborn screening rules that established the expectation that all insurers offering infant coverage will provide reimbursement for metabolic screening services. The fee/reimbursement rate for the service is established by the Department of Health and Human Resources and is based upon the cost of administering the system. WV now screens for 10 disorders in newborns which include PKU, Congenital Hypothyroidism, Galactosemia, three (3) Hemoglobinopathies, Hearing, Biotinidase which was added to the screening panel, July 1, 2007, Congenital Adrenal Hyperplasia (CAH) which was added November 1, 2007 and Cystic Fibrosis which was added in March, 2008. Addition of the remaining 29 disorders is planned for January 2009. The Bureau for Public Health began billing hospitals per birth in July, 2007 based on the previous years system cost, with all insurers reimbursing birthing facilities for this mandated Public Health service. //2009//***

//2009/ The 2008 Legislature also gave monies to ensure that Birth To Three/Part C would remain viable and gave an additional one million dollars for the Family Planning Program. //2009//

//2009/ Title V stakeholder meetings are held throughout the year. The Office Director participates on the Developmental Disabilities Council and solicits feedback for Title V programming from Council members as well as from parents who also attend. //2009//

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. **//2009/ West Virginia is the only state that lies entirely in the Appalachian Region. //2009//** 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. **//2009/ According to the West Virginia Board of Medicine annual report to the Legislature 2007, the current number of licensed physicians in WV is 5,379 as of December 31, 2007. Of these, 3,837 were actively practicing in the state. There are a total of 542 Physican Assistants practicing in the state. According to the WV Board of Osteopathy there are 691 Doctors of Osteopathy actively practicing in the state as of April 2, 2008. //2009//** 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.

It remains unclear as to exactly how many obstetricians stopped providing obstetrical services in the 1980s and 1990s. A study completed in 1989 showed that 179 physicians (133 ob/gyn and 46 family practice) were delivering babies in West Virginia in that year. The study also showed that between 1987-1989, 110 physicians (37 ob/gyn and 83 family practice physicians) had stopped delivering babies. The most frequent reason given for the stoppage of delivering babies was the cost of malpractice premiums. The second most important reason given was that the hospital had dropped its obstetrical service.

A second study in 1992 confirmed the numbers of the previous study and showed that the number of providers delivering babies had stabilized.

A third study was completed in 2006 and presented at the 2006 Perinatal Wellness Summit held in Charleston. This study showed a slight increase in the number of obstetric providers and a slight decrease in the number of births. Both the 1992 and 2006 studies showed a shortage of obstetric providers in rural areas of the state.

The 2006 study showed an increase in the number of certified nurse midwives (CNM) and a decrease in the number of family practice physicians (FP) attending births. Most of the family practice physicians who attend births are faculty in family practice residency programs.

Primary Care Centers are health care organizations which are founded, and operated, by rural communities in West Virginia with approximately 23 more that are 330 funded. The State and Federal grant monies administered by the Division of Primary Care are essential for health care access in WV. Federal and State assistance help the clinics offer more services and better healthcare for their patients, regardless of the patient's ability to pay for the services.

The mission of the Division of Primary Care is to improve the quality and accessibility of health care for every West Virginian, regardless of their ability to pay. The Division of Primary Care provides advocacy, quality assurance, technical assistance, other program services, and funding to community-based health care organizations which include:

- Federally Qualified Health Centers (FQHC)
- Federally Designated Community Health Centers (CHC)
- Community-based Rural Health Centers (RHC)
- Organizations designated to receive Federal 330 funding
- Federal Black Lung Clinics Program (WVBLCP)
- School-Based Health Centers (SBHC)
- Free Clinics (Health Rights)

Working with State and Federal entities, the Division of Primary Care provides funding and professional support to 34 community-based Primary Care Center organizations. These organizations fund another 72 satellite clinics for a total of 106 healthcare sites. ***//2009/ Also, 14 of the Primary Care organizations operate more than 36 School-Based Health Clinics (serving 45 schools in 18 counties). This Division also provides support and funding to 17 Black Lung Clinic Programs at 17 sites, and 11 urban Free Clinics for the indigent. //2009//*** This system of healthcare is constantly endeavoring to grow in accessibility and variety of services provided.

According to the 2004 Census Data 16.1% of the population in the state does not have health insurance. In March 2006, West Virginia Governor Joe Manchin III signed legislation to expand SCHIP eligibility up to 300 percent of the federal poverty level, and on January 1, 2007, the state began a phase-in expansion by enrolling children in SCHIP with family incomes up to 220 percent of the federal poverty level. Adoption of this change is estimated to provide comprehensive health care coverage to approximately 400 uninsured children of working families during the first year of implementation. When SCHIP expands to 300% of the federal poverty level, 4,000 children are expected to be eligible.

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 is home to approximately 60,000 African Americans. The African American community has a rich and diverse history in West Virginia dating to the early settlement period prior to the Civil War. Some of the older communities include those in the Eastern Panhandle and around Charleston. The majority of African American communities in the state originated during the coal mining boom in the late 1800's and early 1900's. After the Civil War, many blacks left the Southern states for work in the coal mines of West Virginia. This period of relocation gave rise to many of West Virginia's older rural black communities as well as contributing to the growing communities in the larger cities.

The African American population has strong regional communities and numerous statewide organizations reflecting a network for all aspects of black culture. Individuals and groups are actively involved in the promotion of African American heritage through organizations, community events, and festivals throughout the state. In West Virginia there are African American historical societies, heritage museums, and traditional music festivals as well as community action groups,

performance ensembles, academic research facilities, and arts organizations.

Spiritual life is a significant element of the black community and an important part of the history of the black community in West Virginia. Church life has been a major focus for as long as the black communities have existed. As a source of both unity and heritage, the churches provide opportunities for spiritual and social activities which regularly bring family and community together. Important church functions include day-long Sunday programs, weekly socials, and annual homecoming celebrations which provide a weekend of events for the extended church community. Most black churches have Men's Days and Women's Days which include a special Sunday morning service, a meal shared with the church community, and an afternoon of socializing. Gospel music is an important part of church and community, and West Virginia is home to several nationally recognized gospel performers and festivals. African American churches in many communities throughout the state are involved with activities encouraging positive race relations and cross-cultural awareness.

The largest contemporary African American populations are in the Metro Valley in the vicinity of Charleston and Huntington, and in the New River/Greenbrier Valley, particularly in the vicinity of Beckley. African American communities are also found in Clarksburg, Bluefield, Fairmont, Morgantown, Parkersburg, Princeton, Weirton, and Wheeling.

West Virginia has numerous thriving Jewish communities, some of which are as old as the towns in which they are located. The members of these communities are primarily of Eastern European and German descent, and are now predominantly American-born. The first major wave of Jewish immigration occurred in the nineteenth century from approximately 1840 to 1880, mostly from Germany and Germanic states. Small but vibrant Jewish communities associated with this first period of immigration existed in Wheeling, Charleston, Huntington, and Parkersburg as early as the mid-1800's. Synagogues and Hebrew schools were soon established in the larger communities, creating a strong community focus which has helped to preserve both religious and ethnic identities up to the present. The first synagogue in West Virginia was founded in 1849 in Wheeling, the home of West Virginia's oldest Jewish community.

Events in Russia in the 1880s began the second major wave of Jewish immigrants to America, and had a profound effect on the size of the Jewish population in West Virginia. Jewish settlers from Eastern Europe came from countries such as Russia, Poland, Hungary, Latvia, and Lithuania. During the period from approximately 1888 to 1930, almost 3,000,000 Jews immigrated to America. The period also coincided with the coal boom, and many Jewish immigrant families moved into these new rural Appalachian communities in the vicinity of such towns as Beckley and Welch.

The arrival of Jews from Eastern Europe had a major impact on Jewish life in America, bringing a diversity of ethnic traditions as well as variations in religious practices. Small Jewish communities were present in most of the growing cities in West Virginia, and the new immigrants became a vital part of these existing Jewish communities. Shortly after the turn of the century some communities had two or more congregations, reflecting variations in religious practice from Orthodox to Conservative. Over the past 150 years, for example, the Northern Panhandle has had at least six congregations. Most of the larger communities in the cities have survived to the present, although Charleston is the only community which still has two congregations. There were also numerous smaller communities throughout the state, particularly in association with the mining towns. Most of these smaller Jewish communities have since folded along with the industries. The West Virginia Jewish population in general is much smaller now than it has been in the past.

Today there are numerous activities which promote heritage and strengthen bonds within the Jewish community. Religious life plays a primary role in preserving Jewish traditions and culture. A wealth of heritage is to be found in traditional Jewish services, and in community and family celebrations honoring religious holidays. These activities serve the dual role of maintaining

tradition and bringing the local community together. The schedule of religious services varies from community to community, depending mostly on the size of the congregation. Larger communities hold a weekly cycle of religious services, while smaller communities might meet bi-weekly or monthly. Many of the smaller communities have services with visiting rabbis.

Today, the largest Jewish communities in West Virginia are in Beckley, Bluefield, Charleston, Clarksburg, Huntington, Morgantown, Parkersburg, Princeton, Weirton, and Wheeling. Smaller communities are still found in Logan, Martinsburg, and Williamson.

In West Virginia, the contemporary Native American population can best be described as a statewide network of individuals who claim Native American ancestry, and related organizations. There are thought to be approximately 5,000 Native Americans in West Virginia, including individuals and from at least 80 different bloodlines and tribal associations. These include descendants from regional Native Americans, including Cherokee and Shawnee, and individuals who more recently relocated to West Virginia from throughout North America. Other people in West Virginia have Native American blood, but do not have a historical tribal association; others have mixed blood, that is, ancestry from different tribes as well as different races in addition to Native American. Tracing family history and conducting accurate genealogical research is especially challenging for those individuals.

Historically, numerous tribes traveled through the state, and many individuals escaped into West Virginia to avoid persecution and forced migration. The diverse indigenous peoples of this part of the country are sometimes collectively called the Eastern Woodland Indians. This name refers to a regional group rather than a single tribe in the traditional sense, and it reflects numerous bloodlines in West Virginia and neighboring states. Some refer to the regional group as the Appalachian Tribe. West Virginia was home and hunting territory to Shawnee, Cherokee, Delaware, Seneca, Wyandot, Ottawa, Tuscarora, Susquehannock, Huron, Sioux, Mingo, Iroquois, and other tribes. Many individuals in the state claim this heritage. Other tribes and groups represented in the contemporary community include Lakota, Blackfoot, Apache, Navaho, Choctaw, Cree, and Aztec. Members of these tribes maintain a distinct sense of identity, but are also part of the larger statewide network.

The contemporary community includes longtime residents who are finding new pride in their native heritage, and Native Americans who are newcomers to this area and who represent the pan-Indian community. The Native American community has struggled with oppression, imposed disruption, and insecurity since the arrival of European settlers in West Virginia. According to newspaper reports, individuals were being shipped away to Oklahoma reservations as late as the 1950's. Until 1965, it was considered technically illegal for a Native American to own property in West Virginia, though this law was seldom enforced. In spite of these hardships, vestiges of communities survived and their heritage is re-emerging with renewed pride.

There are numerous elders in the state who offer guidance for the community and are the bearers of older traditions, including traditional crafts and oral history. A strong reverence and protection of the elders is common among Native American communities, and this is particularly true in West Virginia.

Numerous individuals in the Native American community are involved in outreach activities, including presentations at schools. These presentations usually include song, dance, and other Native American heritage traditions. One strong tradition in the Native American community is narrative or storytelling.

The Appalachian American Indians of West Virginia (AAIWV) has approximately 4,800 members, and represents 80 different blood lines. There are four regional gatherings of AAIWV: in Delbarton (Mingo County), in Alderson (Greenbrier County), in Lumberport (Harrison County), and in Charleston (Kanawha County). There is also a monthly statewide meeting held in Summersville (Nicholas County). The organization is involved in the promotion of Native

American interests at all levels in the community, including human rights issues, public awareness, education and outreach, social activities, festivals, spiritual retreats, and powwows. More information is available at <http://aaiwv-ani.org/>

West Virginia Native American Coalition, Inc. (WVNAMCO), a community and nonprofit organization, has approximately 65 members. Started in 1987, this group has been concerned with major issues and abuses involving Native Americans, including exploitation of cultural sites artifacts, the proliferation of incorrect information, and similar issues. They have also worked on civil rights and environmental issues, including the loss of native flora and fauna which Native American people depend upon to practice their traditional cultures. They have get-togethers, and put out flyers, newspapers, and educational materials about Native American culture.

The Organization for Native American Interests, ONAI, is an organization at West Virginia University in Morgantown. The group mainly consists of West Virginia University students and works closely with regional Native American groups. ONAI hosts the American Indian Heritage Festival and many other education events.

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 75.17%. 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.

//2009/ West Virginia's unemployment rate held steady in May 2008 at 5.1% for the second year in a row. Workforce West Virginia said that the number of unemployed West Virginians increased by 100 to 42,000. West Virginia's seasonally adjusted unemployment rate was 5.3 percent in May 2008, three-tenths of a percentage point higher than the same period last year. The national jobless rate was 5.5 percent. //2009//

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%.

With such a large percentage of our children living in poverty it is important that we ensure access to health care.

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.

/2009/ The Perinatal Partnership found that many providers, especially at small rural hospitals, complained that pregnant women and/or their newborn infants needing tertiary care were being turned away due to a lack of bed capacity at the three tertiary care centers in the State. Further study demonstrated this to be true and that the Neonatal Intensive Care (NICU) facilities have been functioning at 100 percent capacity. Physicians with the tertiary care facilities reported that they were turning away both high-risk maternal transports and infant transports, primarily due to no availability of NICU beds.

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

The Perinatal Partnership noted that to avoid unnecessary admissions to NICU, each

birthing facility and all maternity providers should curtail elective delivery prior to 39 weeks gestation thus implementing ACOG recommended guidelines for elective delivery. //2009//

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.

Additional legislation: 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.

//2009/ The 78th West Virginia Legislature passed in the 2007 session, H. B. 2583 which mandates the expansion of newborn screening to include 29 disorders. The West Virginia Newborn Screening Program, housed within the Office of Maternal, Child, and Family Health within the Bureau for Public Health, will partner with the State Laboratory to expand newborn screening to include twenty-nine (29) disorders in order to adhere to national standards recommended by the United States Department of Health and Human Services Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases. Of the twenty-nine (29) recommended disorders, West Virginia currently screens for ten (10): three (3) hemoglobinopathies, phenylketonuria (PKU), galactosemia, congenital hypothyroidism, hearing, biotinidase which began July 1, 2007, congenital adrenal hyperplasia (CAH) which began November 1, 2007 and cystic fibrosis (CF) which began in March 2008. The Bureau for Public Health submitted rules to the 2008 Legislative session that allowed for financial sustainability by invoicing the hospitals for each live birth receiving a screen. The fee charged will be sufficient to cover the cost of the newborn metabolic system. It is hopeful that the remainder of the recommended screens will be performed beginning January 1, 2009. //2009//

Following is a Vital Statistics Summary:

/2009/ Population

In 2006, 282 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 0.16 persons per 1,000 population. Results from the 2006 Census estimate show an overall increase (approximately 0.6%) in the state's population since 2000, from 1,808,344 to 1,818,470. This increase is the result of a slight growth in the excess of in-migration over out-migration during that span, as well as the natural increase.

Live Births

West Virginia resident live births increased by 97, from 20,834 in 2005 to 20,931 in 2006. The 2006 birth rate of 11.5 per 1,000 population was the same as the 2005 rate. The U.S. 2006 birth rate was 14.3 live births per 1,000 population rising above the 2005 rate of 14.0. West Virginia's birth rate has been below the national rate since 1980. It continued its overall decline until 1996, interrupted by slight upturns in 1989 through 1991. It has remained relatively stable since 1996.

The 2006 U.S. fertility rate of 68.5 live births per 1,000 women aged 15-44 was 2.7% higher than the 2005 rate (66.7). West Virginia's fertility rate also increased 1.0% from 58.8 in 2005 to 59.4 in 2006. The fertility rate among women aged 15-19 in West Virginia was 6.9% higher than that among young women in the U.S. (44.8 vs. 41.9). The fertility rate among women aged 20-44 was lower by 15.6% in the state than in the nation (62.1 vs. 73.6).

The number of births to teenage mothers increased by 111 (4.5%), from 2,472 in 2005 to 2,583 in 2006. The percentage of total births represented by teenage births also increased from 11.9% in 2005 to 12.3% in 2006. The significantly lower fertility rate among older women, however, resulted in teenage births continuing to constitute a higher proportion of total births than was found nationally (10.4% in 2005).

The percentage of births occurring out of wedlock continued to rise in 2006. Again, over one out of every three (37.8%) 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 2006 were 36.7% and 73.5%, respectively, compared to 35.2% and 75.5% in 2005. In the United States in 2006, 26.6% of white births (non-Hispanic) and 70.7% of births to black mothers (non-Hispanic) occurred out of wedlock. The percentage of teenage births to unmarried teenage mothers in the state increased from 77.1% in 2005 to 77.9% in 2006.

//2009//

/2009/ There was a total of 2,020 low birthweight babies (those weighing less than 2,500 grams or 5 1/2 pounds) born to West Virginia residents in 2006, 9.7% of all births. Of the 2,020 low birthweight infants, 1,363 or 67.7% were preterm babies born before 37 weeks of gestation. Of all 2006 resident births with a known gestational age, 12.4% were preterm babies. Of the births with known birthweight, 9.5% of babies born to white mothers and 15.8% of babies born to black mothers were low birthweight. Nationally, 8.3% of all infants weighed less than 2,500 grams at birth in 2006; 7.3% of white infants and 14.0% of black infants were of low birthweight.

Eighty-one percent (81.5%) of 2006 West Virginia mothers with known prenatal care began their care during the first trimester of pregnancy, compared to 86.1% of mothers nationwide in 2005 (the latest data available). Among those with known prenatal care, 82.0% of the white mothers began care during the first trimester with 68.4% of black mothers seeking first trimester care. (U.S. figures show 86.7% of white mothers and 76.5% of black mothers had first trimester care). No prenatal care was received by 0.6% of white

mothers and by 1.8% of black mothers.

Over one-fourth (27.4%) of the 20,929 births in 2006 were to mothers who smoked during their pregnancies, while 0.4% of births were to women who used alcohol. National figures from 2005 show that 10.7% of women giving birth reported smoking during pregnancy and 0.8% used alcohol. Among the state mothers who reported smoking during pregnancy, 14.6% of the babies born were low birthweight, compared to 7.8% among non-smoking mothers. Over one-third (35.3%) of 2006 state births were delivered by Cesarean section, compared to a 2005 national rate of 30.3%. One or more complications of labor and/or delivery were reported for 31.5% of deliveries in the State in 2006. //2009//

Deaths

//2009/ The number of West Virginia resident deaths decreased by one hundred and twenty-four, from 20,773 in 2005 to 20,649 in 2006. The state's crude death rate was unchanged from 2005 at 11.4 per 1,000 population in 2006. The average age at death for West Virginians was 72.1 (68.4 for men and 75.7 for women) slightly lower than the 2005 average of 72.4 (68.9 for men and 75.8 for women). One hundred and thirty-two West Virginia residents who died in 2006 were age 100 or older. The oldest woman was 107 years old at the time of death, while the oldest man was 103 years old.

Heart disease, cancer, and chronic lower respiratory diseases, the three leading causes of death, accounted for 54.1% of West Virginia resident deaths in 2006. Compared to 2005, the number of state deaths due to heart disease decreased 4.1% while cancer deaths decreased by only one death. Chronic lower respiratory diseases, which has been the third leading cause for the sixth time in the past seven years, decreased 7.3%, while stroke mortality decreased 7.1%. Diabetes mellitus deaths decreased 1.8%, while the number of reported deaths due to pneumonia and influenza decreased 4.1% from 2005 to 2006. Alzheimer's disease, now the seventh leading cause of death in the Mountain State for the fourth year in a row, increased by seven deaths or 1.3%. Accident mortality is now the third leading cause of death. The number of accidental injuries rose by 107 (9.7%), from 1,098 in 2005 to 1,205 in 2006. Motor vehicle accident deaths continued to number fewer than the 435 deaths in 1993, the year the West Virginia seatbelt law took effect; they decreased by 31 (7.9%) from 391 in 2005 to 422 in 2006. Accidental poisoning deaths have been on the rise in West Virginia for the past five years, 156 in 2002, 252 in 2003, 306 in 2004, 336 in 2005, and 407 in 2006. The vast majority of these deaths were due to both legal and illicit ingestion of prescription over the counter pharmaceuticals.

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 26.6% of all deaths for this age group in 2006, compared with 27.4% in 2005. West Virginia's 2006 motor vehicle fatalities included five children under five years of age, compared with three in 2005. Accidental poisoning accounted for 23.0% of all deaths in the age group of 15-34.

Suicides remained the same at 282 between 2005 and 2006. Male suicides increased by one or 0.4%, from 224 in 2005 to 225 in 2006; the number of female suicides (57) decreased by one or 1.7% from 2005. Over two-thirds (68.1%) of all suicide deaths were firearm related - 71.6% of male suicides and 54.4% of female suicides. The average age of death for a suicide victim in 2006 was 47.1 years. While suicide was the 11th leading cause of death overall, it was still the third leading cause of death for ages 15-34. The number of suicides among persons aged 19 and under was 14 in 2006.

Homicides in West Virginia increased by five, from 98 in 2005 to 103 in 2006. Sixty-seven (67) of the homicide victims were male, 36 were female. The average age at death for a

homicide victim in 2006 was 41.2 years. There was only one homicide victim under the age of five in 2006, compared to six in 2005. Less than sixty percent (59.2%) of 2006 homicide deaths were due to firearms. //2009//

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.

//2009/ The YPLL from all causes increased 2.3%, from 163,704 YPLL in 2005 to 167,481 in 2006. The four leading causes of YPLL in 2005 were malignant neoplasms (35,353 YPLL), diseases of the heart (24,810 YPLL), non-motor vehicle accidents (20,586 YPLL), and motor vehicle accidents (14,562 YPLL). Combined, these four causes accounted for over half (50.9%) of all years of potential life lost in 2006. In comparison to 2005, YPLL attributable to malignant neoplasms decreased from 21.9% to 21.1%. YPLL due to diseases of the heart decreased from 16.0% to 14.8% of the total, and YPLL due to non-motor vehicle accidents increased from 10.8% to 12.3%. The percentage of total YPLL due to motor vehicle crashes increased, from 7.9% to 8.7%. //2009//

Infant Deaths

//2009/ Deaths of infants under one year of age dropped by 13, from 168 in 2005 to 155 in 2006. West Virginia's infant mortality rate also decreased, from 8.1 per 1,000 live births in 2005 to 7.4 in 2006. The U.S. infant mortality rate was 6.9 in 2005 (the latest data available).

The state's 2006 white infant mortality rate decreased 11.4%, from 7.9 in 2005 to 7.0, while the rate for black infants increased 48.1%, from 15.8 to 23.4.

Nearly three out of ten (29.7%) infant deaths in 2006 was due to SIDS (sudden infant death syndrome). Approximately one in six (16.1%) were the result of congenital malformations, while 40.0% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birthweight (9.7%). //2009//

Neonatal/Postneonatal Deaths

//2009/ The number of neonatal deaths dropped by 25, from 106 in 2005 to 81 in 2006; the neonatal death rate also decreased from 5.1 deaths among infants under 28 days per 1,000 live births in 2005 to 3.9 in 2006. Neonatal deaths comprised 62.1% of all West Virginia resident infant deaths in 2006. The rate of postneonatal deaths increased from 3.0 deaths per 1,000 neonatal survivors in 2005 to 3.5 in 2006. The 2005 U.S. neonatal death rate was 4.5, while the postneonatal rate was 2.3 deaths per 1,000 neonatal survivors. //2009//

Fetal Deaths

//2009/ The 120 resident fetal deaths occurring after 20 or more weeks of gestation reported in 2006 were five more than in 2005 (115). The fetal death ratio also increased from 5.5 deaths per 1,000 live births in 2005 to 5.7 in 2006. The majority (91.7%) of fetal deaths were due to conditions originating in the perinatal period, including complications of placenta, cord, and membrane (35.0%), maternal conditions (1.7%), maternal complications (13.3%), short gestation and low birthweight (6.7%), and other ill-defined perinatal conditions (27.5%). Congenital malformations accounted for 8.3% of all fetal deaths. //2009//

Induced Termination of Pregnancy (ITOP)

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

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

The only two free-standing clinics that perform ITOPs on demand in West Virginia are in Charleston, which makes the likelihood of out-of-state ITOPs greater in some regions of the state. It is unlikely that the majority of women living in the northern or eastern panhandles of the state seek an ITOP in West Virginia. Due to known incomplete reporting, therefore, the procedures performed on West Virginia residents in other states have been excluded from the compiled statistics.

//2009/ In 2006, there were 2,037 ITOPs performed in West Virginia, 21.6% fewer than in 2005 (1,674). Nearly nine out of every ten (89.7%) 2006 ITOPs involved a West Virginia resident, while 5.4% were Ohio residents and 3.8% were residents of Kentucky, compared with 2005 percentages of 86.6%, 7.0%, and 5.6%, respectively. The median age of women having an ITOP in 2006 was 24 compared to 23 in 2005. There were 108 procedures in 2006 involving females under the age of 18, of which 100 were to unemancipated minors, compared with 105 in 2005, of which 96 were unemancipated minors. //2009//

Declaration of Paternity Affidavit

A declaration of paternity affidavit, commonly called a paternity affidavit or a paternity acknowledgement, is a legal instrument signed by both parents in which both attest to the paternity of their child. In most situations, paternity affidavits are used when the mother was unmarried at the time of conception or birth. It is unlawful to file a certificate of live birth with a father for a birth to a woman who was unmarried at the time of conception or birth without having first received an acceptable declaration of paternity affidavit or an order from the court of competent jurisdiction. Under West Virginia State Code and, generally, nationwide, the husband of a woman at the time of conception or birth of her child is presumed to be the legal father of the child. Until July, 2006, the birth certificate for a child born in wedlock could only bear the name of the mother's husband unless there was a court order that specified otherwise. In July, 2006, an administrative procedure was put in place to allow a mother, her husband, and a putative father to attest that the husband was not the father and that the putative father was the biological father. This "three-way" paternity process is in use in over half of the states in the nation.

//2009/ There were 21,137 babies born in West Virginia during 2006. Of those, 8,236 or 39.0% were born to unmarried mothers, compared with 37.7% in 2005. A father was established through a paternity affidavit in 5,382 or 65.3% of the unmarried births (25.5% of all occurrence births) in 2006, compared with 65.3% of unmarried births or 24.6% of all births in 2005. //2009//

Marriages

//2009/ For the sixth 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 13,423 in 2005 to 13,276 in 2006. The marriage rate in 2006 was 7.3 per 1,000 population, down from 7.4 in 2005. The 2006 U.S. provisional rate was 7.3.

For all marriages in 2006, the median age was 26 for brides and 29 for grooms. For first marriages, the median age for brides was 22 and for grooms was 24. The mode (most frequently reported age) for all marriages was 23 for brides and 25 for grooms, while for first marriages the mode was 22 for brides and 23 for grooms. //2009//

Divorces and Annulments

//2009/ The number of divorces decreased by 78 or 0.8%, from 9,269 in 2005 to 9,191 in 2006. The 2006 rate of 5.1 per 1,000 population was the same as the 2005 rate.

Of the 9,191 divorces in West Virginia in 2006, the median duration of marriage was 6 years. Over half (53.4%) of the divorces involved no children under 18 years of age in the family, while one child was involved in 22.8% of all divorces and two children were involved in 18.1%. Six divorces involved six or more children. //2009//

Summary

//2009/ The number of West Virginia resident births increased by 96 from 20,834 in 2005 to 20,930 in 2006. West Virginia resident deaths decreased by 124 (20,773 in 2005 to 20,649 in 2006). The number of infant deaths dropped by 13, from 168 in 2005 to 155 in 2006. Fetal deaths of 20 or more weeks gestation increased from 115 in 2005 to 120 in 2006. Marriages decreased for the sixth time in eight years, from 13,423 in 2005 to 13,276 in 2006, while divorces decreased from 9,269 in 2005 to 9,191 in 2006. Abortions in West Virginia rose from 1,674 in 2005 to 2,037 in 2006. A father was established through a paternity affidavit in 5,382 (or 25.5%) of the births occurring in West Virginia. //2009//

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, most SSI EPSDT clients have not been enrolled in Medicaid Managed Care (MMC). We continue to present the case that this population of SSI EPSDT clients requires services that do

not fit well within the traditional medical model.

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 The Children with Special Health Care Needs Program, 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.

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 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 (FPP) provides an array of confidential preventive health services for low-income women, men and adolescents through community-based provider network of **/2009/ 148 locations //2009//**. Sites include county health departments, primary care centers, hospital outpatient centers, private providers, free clinics and university health sites. FPP services include contraceptives; health histories; gynecological exams; pregnancy testing; screening for cervical and breast cancer; screening for high blood pressure, anemia, and diabetes; screening for STDs, including HIV; basic infertility services; health education and counseling, and referrals for other health and social services. Free or low cost pregnancy testing is offered to enable early identification of pregnancy and timely referral into prenatal care.

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.

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. Among the 50 States and the District of Columbia, West Virginia ranked 6th in the availability of publicly funded contraceptive services. These publicly funded clinics help women prevent 13,800 unintended pregnancies each year.

Surgical sterilization services were suspended February 6, 2006 due to inadequate funding. A waiting list of clients requesting voluntary surgical sterilization procedures is being kept at each provider site. The WV legislature in 2007 authorized 1.4 million for family planning. This money has enabled us to restore sterilizations.

Adolescent Pregnancy Prevention Initiative:

The Adolescent Pregnancy Prevention Initiative (APPI) provides development, oversight and coordination of adolescent pregnancy prevention activities. As a focus area of the Family Planning Program, the goal of the Adolescent Pregnancy Prevention Initiative is to reduce the

number of pregnancies among adolescents through improved decision-making skills, abstinence, and/or access to contraceptive services.

APPI is made up of 5 full-time employees: 1 Coordinator and 4 Adolescent Pregnancy Prevention Specialists, who conduct community education and outreach activities on a regional/local level. These 4 Adolescent Pregnancy Prevention Specialists work to increase public awareness of problems associated with early sexual activity and childbearing and collaborate with existing community organizations to promote local activities for adolescent pregnancy prevention. APPI offers abstinence based education but includes information about contraceptives and access to family planning services.

Confidential access to Family Planning Program services is crucial in helping sexually active teenagers obtain timely medical advice and appropriate medical care to continue the decline in teen pregnancy and childbearing. Minor clients seeking reproductive health care can only be assured of confidential services by a Title X-funded Family Planning Program network provider. Current research documents show that fewer teens will seek preventive reproductive health services if confidential care, without parental consent, is not available.

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.

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). FPP clients seeking pregnancy or planning a pregnancy in the future are offered prenatal multi-vitamins with folic acid as part of their pre-conceptual counseling. Clients in need of enhanced preconception counseling or genetics testing are referred to tertiary care facilities or specialty providers for additional assessment.

Domestic Violence:

Screening for Domestic and Intimate Partner Violence continues to be monitored by the Family Planning Program. Findings are documented in their reports and entered in a data base. All Family Planning Program providers provide resources on site for services to those who are victims of domestic or intimate partner violence.

//2009/ The Director of Perinatal Programs participates on the WVDHHR Domestic Violence Workgroup. The workgroup is exploring the development of a statewide tool to be used to screen for domestic violence. The committee planned next steps in writing the State Public Health Plan for Reducing Domestic Violence through public education, use of media and collection, and monitoring and presentation of State data. The RFTS Project screening tool, the Initial Client Assessment, was shared with the workgroup. The tool includes questions that are used to screen RFTS pregnant women for domestic violence during home visits. In 2007, the fifth top risk factor disclosed by RFTS Project participants was domestic violence indicating that the tool is successful in eliciting disclosure. This also indicates the trust relationship which exists between RFTS DCC and client. //2009//

Insurance/Access:

The Family Planning Program has been an integral component of the public health care 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 preventive and reproductive medical care provided by Family Planning Program clinics prevents unintended pregnancies, reduces the need for abortion, lowers rates of sexually transmitted

diseases (STDs), including HIV, detects breast and cervical cancer at its earliest stages, and improves the health of women, children and families.

Right From The Start Project:

/2009/ Early preventive prenatal care and education are recognized as the most effective and cost effective ways to improve pregnancy outcomes. West Virginia's RFTS Project was birthed in 1989 as a partnership between OMCFH and West Virginia 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. RFTS 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.

Through the RFTS Project, OMCFH 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.***

Right From The Start has Letters of Agreement with approximately 78 community agencies throughout West Virginia to provide care coordination and enhanced education services to high risk pregnant women and infants. These services are provided by Registered Nurses and Licensed Social Workers, Designated Care Coordinators (DCC), employed by community agencies.

The State is divided into eight (8) regions for management of RFTS. Each region has a Regional Lead Agency (RLA) that provides a Regional Care Coordinator (RCC) to oversee the activities of the 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.

As of 2007, 180 DCCs are 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 seventy-five (75) obstetricians, nurse practitioners, nurse midwives and family practice physicians in West Virginia and bordering states that have Letters of Agreement with the Project to provide quality obstetrical and delivery care to pregnant women. Each RFTS prenatal client is assessed for depression at least once during the prenatal period and again within the postpartum period prior to case closure at 2 months postpartum. The standard tool used by the RFTS Project to assess the prenatal client's mental status is the Edinburgh Postpartum Depression Screen (EPDS). The DCC has set guidelines to follow regarding the numerical score such as mandatory referral level and where the client must be referred.

In 2007 2,888 RFTS Project participants were screened for depression using the EPDS. 1,894 women were screened in the prenatal period and 994 women were screened in the

postpartum period.

The RFTS website, launched January 11, 2007 has generated many inquiries from the email account at both the State and Regional levels. Inquiries have been received by women interested in becoming Project participants as well as individuals and/or medical providers interested in becoming Project providers. In 2007 the website was updated to allow client referral into the RFTS Project. For access, the web address is www.wvdhhr.org/rfts. //2009//

RFTS SCRIPT:

/2009/ Pregnant women participating in the RFTS Project have a high incidence of smoking during pregnancy. To address this issue, RFTS adopted an intense smoking cessation initiative, The WV Right From The Start SCRIPT (Smoking Cessation/Reduction in Pregnancy Treatment). SCRIPT was developed by Dr. Richard Windsor, MS, PhD, MPH, George Washington University Medical Center, Department of Prevention and Community Health, who successfully implemented the program in Alabama.

The smoking cessation program was implemented statewide in West Virginia in January 2002, through the OMCFH and incorporated as protocol into the RFTS Project in October 2003. The WV RFTS SCRIPT uses the existing home visitation network and protocols established in the RFTS Project. Registered Nurses and Licensed Social Workers, DCCs, provide services to pregnant women and infants throughout West Virginia.

Data from the RFTS Project show the following quit rates among pregnant participants: 2003 = 23%; 2004 = 22%; 2005 = 26%; 2006 = 27%; 2007 = 22%

WV ACOG has received a grant urging the use of best practice smoking cessation methods, the 5 A's, which will affect Ob/Gyn physician practices. Because the WV RFTS SCRIPT uses the 5 A's best practice method for smoking cessation education with pregnant women, to have physician support and their widely implemented use of the 5 A's by WV physicians will be beneficial to the Project. //2009//

ART:

/2009/ Access to Rural Transportation (ART) provides payment for transportation of RFTS Maternity Services eligible clients to medical or other predetermined medical care appointments (i.e. childbirth classes). The provision of transportation assistance is important to the goal of improving pregnancy outcomes and to the wellness of women and infants in West Virginia.

RFTS Maternity Services clients receive transportation assistance via the ART system while Medicaid eligible clients receive transportation via the Non-Emergency Medical Transportation (NEMT) system. //2009//

Birth Score:

/2009/ High risk infants are referred to RFTS by the WVU, Birth Score Program. The Birth Score Developmental Risk/Newborn Hearing Screen Instrument is a population-based assessment designed to identify infants at birth that may be at risk for developmental delay or death within the first year of life. Infants who are identified as high risk receive an accelerated number of six medical visits in the first six months of life.

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

one year.

By December 31, 2007 there were 908 active primary care providers (681 private physicians and 227 clinics) accepting Birth Score referrals. There were thirty-five (35) new physicians added in CY 2007.

The Birth Score Office, in collaboration with the WV School of Dentistry developed and distributed an oral health brochure for birthing hospitals to share with parents of infants born in West Virginia. A total of 70,000 brochures were printed: 24,000 were provided to the WV Dental Association for distribution to dentists across the State, another 20,000 were forwarded to OMCFH/ Right From the Start Project, and 500 were distributed to WVU School of Dentistry-Oral Health Promotion during Pregnancy Project. //2009//

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, five U.S. territories, and twelve American Indian/Alaska Native organizations.

//2009/ Since its inception, the WVBCCSP has enrolled over 110,000 women into the Program and provided more than 141,500 mammograms, 208,500 clinical breast exams, and 218,000 Pap tests. Annually, the Program screens over 16,000 women. However, the Program does more than simply screen women. There are several core components of the WVBCCSP including: Program Management; Screening, Tracking and Follow-up; Surveillance/Data Management; Quality Assurance and Improvement; Professional Development; Recruitment; Partnerships; and Evaluation. //2009//

//2009/ West Virginia's WISEWOMAN Program is a comprehensive public health program that works with the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP) to provide women access to screening services to determine their risk of heart disease and stroke. WISEWOMAN is directed at low-income, uninsured/underinsured women aged 40-64 years. As part of a WVBCCSP eligible woman's routine breast and cervical cancer screening exam, she will be provided blood pressure readings, total and HDL cholesterol screening, blood glucose measurements, calculation of body mass index, assessment of smoking status, and evaluation of personal and family medical history. As follow-up to her screening exam, she will be offered risk reduction counseling and lifestyle interventions that will address nutrition, physical activity and tobacco use.

The West Virginia WISEWOMAN Program plans to recruit and provide services to 2,500 women during the 2008-2009 grant year through a network of over thirty community healthcare provider sites. Contracted providers and WISEWOMAN staff will ensure that women with abnormal screenings receive timely follow-up through the active monitoring of Program data. The WISEWOMAN Grant provides \$750,000 in funds. //2009//

In 1996, the West Virginia Legislature enacted House Bill 4181, 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 diagnostic 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 and/or certain precancerous conditions, she is eligible for a Medicaid card. The card will pay for all her health care services that are included in the Medicaid State Plan, not just those to treat the cancer diagnosis.

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 was housed in the Division of Infant, Child, and Adolescent Health, and the project's primary goal was to establish community partnerships that support abstinence educational opportunities at the local level. The program was designed to increase informed youth decision-making, discourage use of alcohol and drugs, and discourage the early onset of sexual activity. Local grantees were located in eight regions of the state. Abstinence was administered by local grantees who agreed to support the federal tenets. Because federal funding for this project was not reauthorized, West Virginia's project closed June 30, 2007.

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

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.

EPSDT, known as HealthCheck in West Virginia, has an outreach component responsible for meeting federal EPSDT informing, exam scheduling assistance, and follow-up requirements. Pediatric Program Specialists are assigned by region to accomplish outreach activities for EPSDT members. The Pediatric Program Specialists are responsible for provider training and on-going technical assistance. Paraprofessionals known as Family Outreach Workers provide outreach and informing services to those children not enrolled in managed care.

/2009/ On July 6, 2007, 143,534 children were approved for Medicaid. Because Medicaid has mandated HMO enrollment, some counties are now completely served by HMOs. Of the 143,534 children enrolled in Medicaid, 115,150 are with an HMO, and 28,384 are currently assigned to the OMCFH for management. Of the 28,384 managed by the OMCFH 10,716 are SSI, 13,928 are in a Physician Assured Access Service and 3,740 are fee-for-service Medicaid.

During FY 2007, (10/1/06 - 9/30/07), the number of Outreach Workers assigned to manage Medicaid child beneficiaries not enrolled in an HMO was reduced from 25 to 19. Attrition of Outreach Worker positions will continue until the number is down to 9 //2009//.

Children's Dentistry Project:

This 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 of the state's 55 counties. 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.

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: assistance with obtaining 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 (WVUCED), Title V funds the Parent Network Specialists system. 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:

Systems Point of Entry serves as the centralized information, education and referral center for the Office of Maternal, Child 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 for 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 2006 the two Toll-Free lines received 24,880 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 **/2009/ through a network of credentialed practitioners statewide. //2009//** 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. A chart is attached of CY 2006 data.

Genetics Project:

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

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, and Newborn Hearing Screening. This Division is responsible for SSDI activities and 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):

This project 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:

//2009/ Expansion of newborn screening testing to include the 29 nationally recommended tests was mandated by the 2007 Legislature. Newborn screening rules were passed during the 2008 Legislative session mandating insurance companies to pay for system costs. WV now screens for PKU, galactosemia, hypothyroidism, three hemoglobinopathies including sickle cell, biotinidase deficiency, CAH and cystic fibrosis. The remaining screens are scheduled to begin in January 2009. //2009// 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.

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.

Childhood Lead Poisoning Prevention Project (CLPPP):

This project is a collaborative effort between two Offices in the Bureau for Public Health, OMCFH and the Office of Environmental Health, 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 provides assessment of home and environment for residences of children with elevated blood lead levels. The OMCFH's CLPPP nurse case manages all children with a positive BLL of greater than or equal to 10mcg.

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.

A CDC grant funded active case ascertainment in 2004 and 2005, but loss of that funding meant the closure of actively obtaining information from the medical record. Birthing facilities now send in monthly reports listing the diagnostic codes obtained at birth. Data is then entered into the surveillance system.

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. Housed within the Bureau for Public Health are the following Offices: Office of Community and Rural Health, Office of Environmental Health Services, Office of Epidemiology and Health Promotion (Vital Statistics), Office of Chief Medical Examiner, Office of Health Facility Licensure and Certification, Office of Laboratory Services, Office of Maternal, Child and Family Health and the Office of Nutrition Services (WIC).

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.

//2009/ It is important to remember that improvement in the health of West Virginia's perinatal population is a result of a carefully crafted, highly-interdependent partnership. Tertiary care centers, primary care centers, local health departments, private practitioners and agencies have worked with the Office of Maternal, Child and Family Health (OMCFH) for 30 years to make a difference in the health and well-being of the State's people. In conjunction with its medical advisory boards, OMCFH has designed a system that offers early and accessible health care to low income, medically indigent and under insured women and children.

Nationally, federal health agencies, insurance providers, health researchers, and policy groups are promoting the need for "Continuum of Care" with patients. It is recognized that continuity of coordinated, quality care is the best model of care for patients and is the most cost effective method for providing and paying for services. Continuum of care is best achieved through consistent access to quality health providers and services. Gaps in consistent care result in increased need for intensive and crisis care, which leads to higher costs for health care services. Research supports greater patient compliance with care plans when a positive relationship with their health care provider is well established. The Right From The Start (RFTS) Project has an established network of Registered Nurses and Licensed Social Workers who have provided this model of care since the 1980s. Because of this strong network West Virginia's access to first trimester prenatal care rate has improved from 60-70% in the 1980s to 81.5% in 2006. The nationwide percent for first trimester prenatal care access was 86.1% in 2005 (latest data available). (West Virginia Vital Statistics 2007)

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.

West Virginia Medicaid and the OMCFH share a common commitment to the goal of ensuring healthy births, reducing the incidence of low birth weight, and improving the health status of West Virginia's children. 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. //2009//

//2009/ 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; and Division of Research, Evaluation and Planning. 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) //2009//
An attachment is included in this section.***

D. Other MCH Capacity

//2009/ In all, there are 180 staff positions in West Virginia's Title V agency. Of these positions 7 are senior management, 71 professionals, 31 medical professionals, 66 clerical workers, and 5 technicians. //2009//

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 of 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 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.

//2009/ Beginning in July 2007, the Parent Network embarked on two new efforts: transition services for young adults and the development of parent support groups. The PNS have participated in community health fairs and shared medical and educational transition information with adolescents and young adults. Additionally, they sought the assistance of a licensed counselor to teach them how to organize parent support groups. Both of these efforts will continue through the next contract year. The Parent Network Specialists also have the responsibility of supplying resource information and Care Notebooks to each CSHCN participant. The Care Notebooks were developed as a case management tool so that parents could track appointments, medicines and treatments. //2009//

//2009/ The West Virginia Developmental Disabilities Council ran an ad in the Charleston, WV newspapers on June 16, 2008 soliciting applications from adults with developmental disabilities and parents of young children with developmental disabilities to participate in the Partners in Policymaking series. The Council stated they were seeking highly motivated men and women who represent different ethnic backgrounds , different geographic regions of the state and a variety of developmental disabilities. The Partners in Policymaking is a leadership training program for self-advocates and parents. Partners learn about current issues and state-of-the-art practices. They also become familiar with the policymaking and legislative processes at the local, state and federal levels. The program teaches competencies necessary for individuals to become advocates who can influence the system of services for people with developmental and other disabilities. Partners attend two-day training sessions eight times, from September through May, a year. The program covers the cost of lodging, meals and travel. Additionally, stipends are available for respite care services or personal assistance services. //2009//

//2009/ Also available to WV residents is the Tiger Morton Catastrophic Medical fund. This fund assists persons with medical expenses who have had a catastrophic medical incident and either are underinsured or uninsured. //2009//

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 throughout 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 3,500 per year. The number of referrals for CY 06 totaled 4,236.

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.

//2009/ Special Olympics West Virginia is sponsoring Camp Tommy, a day camp held annually for the developmentally and physically disabled. The camp is held in the Buckhannon-Upshur High School and is held the third week in July. Approximately 100 campers of all ages participate. A variety of planned programs as well as crafts, sports, games and socialization is provided. //2009//

Other topics of capacity interest include:

//2009/ The WV OMCFH has applied for and received the State Systems Development Initiative Grant from HRSA for many years. This Grant has allowed us to increase our data collection and analysis over the years. The SSDI Project is housed within the Division of Research, Evaluation and Planning. The Division has developed a Data Mart that has access to data from all of OMCFH's programs as well as birth records, infant death records and Medicaid eligibility files. This enables the OMCFH to look at and analyze data from different perspectives. //2009//

During CY 2006, System Point of Entry (SPE) purchased software and equipment allowing SPE staff to digitize the CSHCN client's medical information. ***//2009/ This information is housed on a secure server that only CSHCN and SPE staff have access. This process has continued through 2007 and into 2008. A staff person to do scanning and archiving was hired.***

//2009// This process will reduce office space needs for filing cabinets and greatly reduce monthly archiving costs. This will also allow immediate access to the client's current medical information without waiting for it to be delivered via normal channels. The client's information is being stored on DVD's or CD-ROMs as determined by the size of the client's medical information. State and/or Federal laws mandate that medical information be kept for a predetermined period of time. By digitizing this information we will be able to keep it past the required number of years without incurring storage costs.

SPE proposed that the transcription company, Transcription and Typing, who contracts with the

CSHCN program to provide typed and printed clinic dictations for the CSHCN program, begin sending the finished product to SPE staff in secure electronic format via GroupWise so that it could be placed on the OMCFH shared drive for immediate access. This process has totally eliminated clinic dictations from being lost in the mail, which has occurred in the past and allows more efficient access to patient information.

Also during CY 2006 SPE worked with the WVDHHR Office of Management Information Systems (MIS), who maintains the mainframe application for the CSHCN program, to receive 17-20 monthly reports in electronic format as opposed to paper copies. SPE now receives the reports via GroupWise at which time they are electronically converted and placed on a secure location on the OMCFH shared drive where CSHCN staff throughout the state have immediate access. Receiving the reports in electronic format allows for greater retention of specific clinic information, saves time and valuable resources.

The SPE Director is working closely with MIS to develop a new data collection system for the CSHCN program. Currently several data depositories both internal and external to the CSHCN program are used for many reporting purposes including the Block Grant. SPE is working with MIS to develop a web-based system that will allow for all data to be housed in one place and be accessed by all CSHCN staff throughout the state as well as the capability to send daily client eligibility information to the designated contractor responsible for paying WV Medicaid and CSHCN bills. Housing all client information in one location allows the CSHCN staff more immediate access to information and assists in providing better care coordination. The web-based system will be easier to use than the current mainframe application that is very limited in its functionality and reporting capability.

The Right From the Start Program's data collection system went web-based in May, 2007. Previously there were eight Regional centers who collected data on eight stand alone computers. Not only did we have user and computer problems across the State, but the data was not always complete. It was difficult to report accurate information. The web-based data collection not only saves traveling time to the different sites, but provides more accurate data.

The Division of Research, Evaluation and Planning has access to multiple data sets to be able to match data for different studies. These data bases include: birth and infant death files, newborn hearing screening, newborn metabolic screening, childhood lead screening, birth defects, SIDS/SUID, PRAMS, Birth Score (newborn high risk assessment screening), Medicaid eligibility files, FACTS, Family Planning, Right From The Start, Early Intervention/Part C and CSHCN.

Brief biographical sketches of the Office Director and the Division Leaders are outlined below:

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 with community agencies for services offered through the Right From The Start Perinatal Program, 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.

The Office of Maternal, Child and Family Health has in place many systems that contribute to the early identification of persons potentially eligible for services. These population based systems include birth score (administered by WVU), birth defect registry, pregnancy tracking systems, newborn 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 diseases, are referred to the CSHCN Program for further evaluation. This connection with EPSDT, which targets some 200,000 eligible children yearly, provides public health with a vehicle for identifying youngsters with problems, knowing that economically disadvantaged children are at increased risk. OMCFH, in an effort to increase public awareness, routinely participates in health fairs and community events. Our toll free lines, established in 1980, average close to 3,000 calls per month. Each caller receives individualized follow-up from our Systems Point of Entry staff 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.

/2009/ RISK REDUCTION THROUGH FOCUS ON FAMILY WELL-BEING (HAPI) PROJECT

The OMCFH and West Virginia University (WVU) finalized an Agreement for joint implementation of the Risk Reduction Through Focus on Family Well-Being/Helping Appalachian Parents and Infants (HAPI) Project, a Healthy Start grant, in RFTS Region VII. Several providers including mental health providers and dentists signed Agreements to participate in the program to provide patient services. The services encompass the care coordination services provided to pregnant women and infants as per the existing RFTS Project with HAPI also including a preconception phase as well. The HAPI Project focuses on helping women to become healthier before becoming pregnant, encourages spacing of pregnancies, provides child care services and oral health care reimbursement payment for mental health services. Curriculum for patient education was developed by WVU, medications obtained and transportation assistance is also provided to aid patients in getting to doctor appointments. OMCFH, as the subcontractor, acts as the fiscal agent for HAPI. Billing procedures have been developed by OMCFH and patient services invoices are processed by the State on behalf of the grantee, WVU.

The OMCFH and WVU continue to collaborate to provide services to high-risk pregnant women and infants through the Healthy Start, HAPI Project. 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).

The long-term goal of the project is to decrease the incidence of low birth weights in West Virginia by reducing recurrent low birth weight. It is our hope that resulting data may also show that there is a significant benefit of cost savings through the risk reduction plan for at risk families. Hopefully from this data, RFTS can show the benefit in expanding current case management program to include the risk reduction plan for families and allow the implementation of a longer period of time for case management to these at-risk families.

//2009//

/2009/ PRENATAL RISK SCREENING

Concerns about maternal and infant health were the catalysts for convening the WV Perinatal Partnership in 2006. The resulting "Blueprint to Improve West Virginia Perinatal Health," contained multiple recommendations and action steps to make needed system improvements.

Policy recommendation one was to create a coordinated statewide perinatal system including the request that the state identify a maternal risk scoring instrument to be used universally by all obstetrical medical providers and all payers.

Comprehensive risk assessment enables the prenatal care provider to determine whether the woman, the fetus, or the infant are at increased risk and provides the basis for further assessment and intervention. Risk factors are characteristics that indicate a higher probability of adverse outcome and help guide the action by the woman, social supports, and the medical provider.

The Universal Risk Screening committee believes that early prenatal care, with an emphasis on risk assessment at the first prenatal visit and appropriate follow-up, is critical. In WV, the most likely adverse pregnancy outcome is preterm labor and/or low

birthweight. A review of health data and key informant survey responses confirms that smoking during pregnancy plays a huge role in poor pregnancy outcomes. In WV, 27.2% of pregnant women smoke compared to the national average of 12.7%.

Since the 1980s, West Virginia has screened low income, government-sponsored women for adverse outcomes, and although the screening instrument has changed numerous times over the last 25 years, the use of the information to prevent or treat conditions associated with poor pregnancy outcomes has remained the same. Currently, low income pregnant women who receive government-sponsored health care are routinely screened using the Prenatal Risk Screening Instrument (PRSI), developed by WVU, Department of Ob/Gyn. The risk scoring forms completed by the pregnant woman's medical practitioner trigger a referral to the RFTS Project. The RFTS provider network are community-based licensed social workers and nurses who provide individual care planning, taking into account medical and psychosocial patient risks. The RFTS workforce has responsibility to arrange for community resource referral and consultation, as well as offering in-home educational services designed to affect patient behavior. The challenge is, while the screening has enjoyed widespread use, it is not used for pregnant women who have commercial coverage, and even if the PRSI were completed, a pregnant woman who is not in government-sponsored care is not eligible to receive the in-home care coordination offered by the RFTS network. Further, participation in RFTS, in its current iteration, is strictly voluntary, although all pregnant Medicaid beneficiaries and Title V beneficiaries are eligible for the program.

While other insurers do support prenatal risk screening for their beneficiaries, the intensity and the type of management offered in response to the probability of adverse patient outcome varies by carrier. There is no insurer that provides the care management equivalent of RFTS, i.e., home visits and one-on-one education.

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

The Universal Prenatal Screening committee recommended (1) the PRSI, a screening instrument unique to West Virginia and not copyrighted, can be used statewide without significant cost investment; (2) the PRSI is one page and not burdensome for the medical practitioner or other office staff; (3) the PRSI, as evidenced by the survey, already enjoys widespread acceptance and use; (4) because the form is homegrown, there is the option to modify it; (5) modifications to the form can, in time, be a result of data gathering, analysis and evaluation to better reflect West Virginia's need and patient risks.

HB 4052, the Uniform Maternal Screening Act, was introduced during the 2008 WV Legislative session but did not pass. The proposed bill stated the "Legislature finds that there is a need for a more comprehensive and uniform approach to any screening conducted by physicians and midwives to discover at-risk and high-risk pregnancies. A uniform approach would simplify the process, standardize the procedure and better identify those pregnancies that need more in-depth care and monitoring. Additionally, a uniform application would provide better and more measurable data regarding at-risk and high-risk pregnancies. This would allow public health officials to gain a better understanding of those conditions that are most frequently observed and to develop methodology to address those concerns." The bill would have established an advisory council within the WV DHHR, Office of Maternal, Child and Family Health to provide the

Office with assistance in the development of a uniform maternal risk screening tool. Once developed, all health care providers offering maternity services would be required to utilize the tool in their examinations of any pregnant woman, maintain confidentiality and notify the woman of any high-risk condition which they identify along with any necessary referral. //2009//

West Virginia's Office of Maternal, Child and Family Health is known for its positive partnerships with the medical community, the University Affiliated Programs, the State Department of Education, 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. **//2009/ A recent initiative is kindergarten screening using the EPSDT (HealthCheck) protocol, called Kids First. The objectives of the initiative are: to establish a medical home for the child, to allow school systems to focus on providing needed services for children with identified deficits, to assist families in finding treatment resources, and to promote healthy lifestyle activities. The focus of the screening will be on the domains of oral health, vision, hearing, speech and language, and behavior/development. Kids First is an example of high-level collaboration in government. Three Cabinet level agencies, the Department of Education, the Department of Health and Human Resources and the Department of Administration, are working closely together to bring this project to the families of West Virginia. Medicaid and CHIP had to agree to pay for the services. //2009//** Another initiative is the West Virginia Perinatal Wellness Partnership that includes stakeholders from all across the State. Stakeholders include obstetrical and neonatal physicians, Medicaid, private insurance providers, OMCFH, Vital Statistics staff, the Hospital Association and the March of Dimes to mention a few. The 2007 work plan of the Partnership includes the following: 1. Establish a statewide perinatal transport system, 2. Identify and address obstetrical provider shortage areas, 3. Address the lack of oral health care in pregnancy, 4. Identify costly medical procedures associated with poor birth outcomes, 5. Develop an approach to identifying and treating drug use during pregnancy, 6. Promote perinatal worksite wellness, and 7. Support and promote breastfeeding.

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 numbers 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, using monies provided by Title V.

The Birth to Three/Part C Program partners with a multitude of agencies to assist with child find efforts and to ensure needed services are arranged. In 2007, some 5600 infants and toddlers received BTT services. This number is reflective of 2000 additional infants over a 5 year period. The increase is reflective of interagency child find efforts on the state and regional level. WV Birth to Three has institutionalized a variety of strategies for the early identification of infants and toddlers with developmental delay or significant risk factors. WV Birth to Three's interagency agreements with Title V, CHIP, Bureau for Children and Families, Head Start, and Medicaid assist in the early identification and referral of potentially eligible children. West Virginia finds that coordination with primary health care providers and other community partners is important to

assure that children potentially in need of early intervention services are identified as early as possible.

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

Child find strategies have also included coordination with the Right From The Start and HealthCheck Programs coordinated through the Office of Maternal, Child and Family Health. Local Right From The Start personnel who work directly with high risk mothers and infants, and are able to identify those children who may be in need of early intervention services. Program Specialists within the HealthCheck Program, in their work with physicians, are able to provide information about the criteria and requirements, and importance of identifying children who may be in need of early intervention services. ***/2009/ Recent policy direction by the AAP to its members encouraging early screening for developmental delays and subsequent referral to Part C have also contributed to increases in the number of children served by the program. //2009//***

WV Birth to Three staff have coordinated with the Bureau for Children and Families, Child Protective Services, in the development of procedures to assure the referral of children who have experienced substantiated abuse and/or neglect. Training is provided to WV Birth to Three service coordinators and practitioners related to the requirements and coordination with Child Protective Services and Foster Care, ***/2009/ as required by the Federal Child Abuse and Protection Act (CAPTA). The number of child referrals from this requirement have increased from 89 to 580 in FY 2007. //2009//***

The Select Committee on Veterans met to discuss health care, mental health care and other services available to active military service persons as well as veterans. The Committee heard from two representatives of the West Virginia Council of Churches about a new project called "When Our Military Members Are Deployed: Supporting West Virginia Military Members and Their Families." This statewide project is being spearheaded by the Council of Churches in cooperation with the Claude Worthington Benedum Foundation. Their mission is to engage community agencies and veterans into a process that will identify and establish "community support in areas of stress management, substance abuse prevention and treatment, children's needs, and financial counseling and financial support." A staff person from the OMCFH's Systems Point of Entry is serving on the Select Committee. A Summit of veterans, active service, government officials, faith based groups, employers and labor organizations was held June 11-12, 2007, in Charleston, WV, to assess the needs of veterans in the community, establish networking capabilities, and to mobilize support for the project.

/2009/ The prevalence of Autism Spectrum Disorder (ASD) is approximately 1 in every 150 American children. In an effort to secure more commitment to expanding access to services such as early identification, diagnosis, early intervention, family support, etc. in

West Virginia the Autism Training center at Marshall University received a funding increase of 1 million dollars for FY 09, making a total appropriation of \$2,075,739 per year from the West Virginia Legislature.

In addition, the State Legislature, in 2008, introduced a bill to require health insurers to provide full coverage of prevention, detection, diagnosis and treatment of Autism Spectrum Disorder. The legislation did not leave Committee, inspite of much public advocacy during Disability Awareness Day at the State Legislature. Obviously this legislation was of interest to OMCFH, since the early intervention, Part C Program called Birth to Three serves many toddlers with autism. //2009//

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 OMCFH'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.

**/2009/ WVU School of Medicine Ranked in the "Top Ten" for Rural Medicine
The West Virginia University School of Medicine has been recognized as one of the top ten schools of medicine in the country for rural medicine. WVU made the top ten list for the first time in U.S. News & World Report's 2009 edition of "America's Best Graduate Schools."**

The rankings are based on ratings by medical school deans and senior faculty in the nation's 125 accredited medical schools and 20 accredited schools of osteopathic medicine.

School of Medicine students learn and care for patients in rural areas of West Virginia as part of the requirements for graduation. They work in partnerships with rural communities and with other health care providers in rural clinics across the state.

Rural health training at WVU is about education and community service. Forty-eight percent of WVU School of medicine graduates choose to practice in primary care areas, such as family medicine, internal medicine, emergency medicine, and pediatrics.

The number of physicians who practice in rural, underserved communities has increased by 200 percent in recent years. //2009//

//2009/ Educational Improvements:

Wayne County 21st Century Community Learning Centers (WCCLC) are assisting with the learning and development of school-age children and their families during out-of-school time; before school, afterschool and during the summer months. Twenty-two school-based and community-based programs are serving over 1,500 elementary and middle school students. The goals of the program are to : 1) improve academic performance, 2) increase technology education, 3) increase recreational and physical activities, 4) prevent drug use, 5) reduce negative student behaviors and increase character education, 6) improve school attendance, 7) increase parental and community involvement and support, 8) develop critical thinking, problem solving, teamwork and communication skills, and 9) implant a sense of social responsibility. All activities are aligned with West Virginia Department of Education's 21st Century Learning Skills and Technology Tools Content Standards and Objectives for West Virginia Schools.

West Virginia is ranked at the top in the new report grading states on their use of technology in the classroom over the past decade. Education Week's Technology Counts 2008 report, released on March 26, gives the Mountain State an overall score of 95.3. The national average was a 76.9. West Virginia was the only state to receive a solid A in the survey of technology performance in kindergarten through 12th grade education. //2009//

F. Health Systems Capacity Indicators

Introduction

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	2003	2004	2005	2006	2007
Annual Indicator	123.0	104.5	111.2	164.0	157.2
Numerator	1252	1064	1132	1670	1600
Denominator	101805	101805	101805	101805	101805
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

based upon 2006 Hospital Discharge Data, HCCRA

Notes - 2006

2006 Hospital Discharge Data, HCCRA

Notes - 2005

2005 Hospital Discharge Data/Health Care Cost Review Authority

Narrative:

//2009/ Nationally, asthma is one of the leading chronic diseases among children and causes more absence from school than any other chronic disease. Approximately 12% or 42,000 West Virginians under the age of 18 have at some point been diagnosed with asthma by a health care professional. It is estimated that in 2006, 8.4% or 31,000 West Virginia children currently have asthma. Approximately 60% of children under the age of 18 and 60% of public high school students with asthma had an asthma attack in the past 12 months. More than one-third (37%) of public high school students with asthma missed school due to asthma during the 2004-2005 school year. Children under the age of 15 accounted for 23% of asthma hospitalizations in 2006. Between 1996 and 2003, the asthma hospitalization rate was higher in the US than in WV. However, asthma hospitalization rates nationwide have recovered from the 2003 spike and are now slightly lower than the rates in WV. In 2005, there were 17.0 asthma hospitalizations per 10,000 WV residents, compared with 16.6 hospitalizations per 10,000 people nationwide. //2009//

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

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

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, asthma inhaler legislation affecting in-school use, exercise and asthma, and managing students with asthma.

//2009/ The WV Bureau for Public Health's Asthma and Education and Prevention Program (WV-AEPP) maintains an asthma surveillance system, promotes statewide partnerships, and implements interventions to reduce the burden of asthma in WV. As a member of the Centers for Disease Control and Prevention's National Asthma Control Program, WV-AEPP has a priority goal of decreasing hospitalizations due to asthma complications. //2009//

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.

//2009/ Camp Catch Your Breath: The dates for the 18th annual camp are set for July 27 through August 1, 2008, at Jackson's Mills.

United Hospital Center and the American Lung Association of West Virginia, together with their sponsors and supporters, sponsor the camp for children with asthma. CCYB is week-long, overnight, co-ed summer camp that provides a fun and educational experience for children with asthma - children who might not otherwise get to go to camp. During camp, the children learn by sharing their experiences, making decisions about their conditions and expressing their feelings about having asthma. In addition to the educational components, children participate in games, sports, swimming, and crafts. Campers are supervised by staff from participating hospitals. A physician is present at all times and emergency medical support is readily available. The camp counselors are respiratory specialists. Staff from the Lung Association is also in attendance.

While the camp is co-sponsored by United Hospital Center in Clarksburg, Cabell Huntington Hospital, Camden-Clark Memorial Hospital, Jefferson Memorial Hospital and Ohio Valley Medical Center are also participating. //2009//

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	2003	2004	2005	2006	2007
Annual Indicator	90.8	95.0	95.0	98.0	99.3
Numerator	12782	11630	11685	13101	13808
Denominator	14078	12242	12300	13368	13905
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

Medicaid enrollees from July 1, 2005 to June 30, 2006

Notes - 2005

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

Narrative:

The OMCFH administers the mandated Medicaid EPSDT Program (known in West Virginia as HealthCheck) for EPSDT clients not enrolled in an HMO. 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 training of EPSDT providers to assure compliance with program protocols.

In 2006-2007, WVCHIP continued partnership with DHHR's Office of Maternal, Child, and Family Health's Division of Infant, Child and Adolescent Health, to promote full periodic and comprehensive well child visits recommended by pediatricians in a "HealthCheck" Campaign. Health messages focusing on vision, dental, development, and hearing screenings appeared in Child Care Provider Quarterly Magazine. Through this partnership, WVCHIP identified the "HealthCheck" form as the standard form providers are to use in all well-child exam visits.

Most infants under the age of one in WV are either covered by Private Insurance or Medicaid. WVCHIP did cover 106 children under the age of one in 2007 and reported that all had a well child visit using the periodic screen.

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	2003	2004	2005	2006	2007
Annual Indicator	81.8	96.3	96.1	97.9	100.0
Numerator	90	103	99	92	106
Denominator	110	107	103	94	106
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

2007 Annual Report - data for fiscal year ended June 30, 2007

Notes - 2006

2006 Annual Report - data for fiscal year ended June 30, 2006

Narrative:

/2009/ The bipartisan Rockefeller-Kennedy-Snowe CHIP Reauthorization Act of 2007 (S.1224) provided significant new federal resources for children's health coverage that will enable states to substantially expand the number of children in this country who have health care. The legislation assures states a stable and sufficient source of financing to cover uninsured children. Because of this, West Virginia's Governor Joe Manchin III signed into Legislation, during the 2007 session, CHIP eligibility expansion up to 300 percent of the federal poverty level. A phase-in eligibility of up to 220 percent of the federal poverty level began July 1, 2007.

The following projects were implemented in fiscal year 2007:

-WVCHIP continued partnership efforts to promote healthy lifestyles with the West Virginia Immunization Network, Action for Healthy Kids Coalition, West Virginia Asthma Coalition, and the Medical Advisory Council.

-In 2006-2007, WVCHIP continued partnership with OMCFH's Infant, Child and Adolescent Health to promote full periodic and comprehensive well child visits recommended by pediatricians in a "HealthCheck" campaign. Health messages focusing on vision, dental, development, and hearing screenings appeared in Child Care Provider Quarterly Magazine. Through this partnership, WVCHIP identified the "HealthCheck" form as the standard form providers use in all well-child exam visits.

-The West Virginia Immunization Network, the State's Immunization Program and WVCHIP continue working on strategies to implement an immunization campaign targeting adolescents. WVCHIP provided matching funds to Raleigh County to implement the "Take Your Best Shot" adolescent campaign, which began in October, 2007.

-WVCHIP provided flyers and ABC's of Baby Care to include in Day One Packets for distribution to all new mothers at participating West Virginia hospitals.

-WVCHIP materials were included in the State's Immunization Program packets to new mothers through the Right From the Start Coordinators. //2009//

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	2003	2004	2005	2006	2007
Annual Indicator	84.6	82.6	81.5	83.0	85.0
Numerator	17800	17267	16982	17375	17860
Denominator	21032	20911	20834	20931	21000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

based upon 2006 PRAMS data

Notes - 2006

2006 PRAMS data

Notes - 2005

2005 Vital Statistics

Narrative:

//2009/ According to 2006 WV Vital Statistics, 5.2% of women had 1-5 prenatal care visits, 27.8% of women had 6-10 prenatal care visits, 54.5% had 11-15 prenatal care visits and 11.1% had 16 or greater prenatal care visits. Of women with known prenatal care 81.5% of women began prenatal care in the first trimester, 14.7% began in the second trimester and 3.1% began prenatal care in the third trimester while 0.7% of women received no prenatal care. //2009//

Two colorful, informative flyers created in 2006 and updated in 2007 provide RFTS Project information and are distributed as requested. One flyer is entitled West Virginia RFTS Project Overview and the second flyer is entitled West Virginia RFTS Project FAQ. The flyers describe the Project in detail, explain how the Project differs from other home visiting programs and list recent Project data. The flyers have been well received by providers and are requested on a regular basis. A third flyer is under development which will describe the financial support and structure of the Project and describe how states can save funding by supporting home visiting care coordination to high risk families and significantly improve birth outcomes.

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	2003	2004	2005	2006	2007
Annual Indicator	98.9	98.9	98.9	98.5	98.5
Numerator	214154	214150	212200	207060	204413
Denominator	216516	216516	214500	210181	207606
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:

/2009/ Medicaid paid for a service to 98.5 percent of the children eligible for Medicaid. One in three WV children are eligible for Medicaid. In May, 2006, West Virginia received approval from the federal government to move ahead with a unique and controversial program to restrict access to certain health care services if Medicaid beneficiaries do not sign and/or comply with a "personal responsibility" agreement. Known as the "Medicaid Redesign", the centerpiece of the initiative is an agreement that beneficiaries must sign with their doctors, promising that they will comply with a health improvement plan and outlining broad patient responsibilities. Beneficiaries who complete and return the agreement receive an "Enhanced" benefits package while those who do not, receive a "Basic" plan. The "Basic" plan restricts prescription drugs and limits mental health services and limits access to physical and speech therapy. The enhanced plan does not include these limits and adds benefits designed to encourage wellness such as weight management and nutritional education. //2009/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 are assigned to geographical regions to recruit, orient and provide ongoing technical assistance to EPSDT providers and have been especially active in recruiting additional providers for underserved areas. This workforce has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides EPSDT orientation for HMO providers serving Medicaid enrolled children. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP

eligibles has presented an additional challenge since the WV medical community is presently at capacity. The Program provides ongoing staff development to enhance skills needed to better market the EPSDT Program to both providers and families. Program Specialists, who recruit, train, and provide technical assistance to participating medical providers, have also been active in working with local school systems to increase the number of school-based clinics and on site EPSDT evaluations. The number of students using school-based health centers (SBHC) has steadily increased over the past few years. The School-Based Health Center Initiative's goal is to develop a coordinated system of health care for children that increases access to primary and preventive care, especially for students who are uninsured, who lack a medical home, or who are at risk for health problems.

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.

Infants whose birth was sponsored by Medicaid and served by RFTS was 36% of all Medicaid sponsored births. Approximately 57% of all WV 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 beneficiaries with chronic debilitating 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	2003	2004	2005	2006	2007
Annual Indicator	47.9	48.0	48.0	54.0	54.5
Numerator	19747	19800	19800	22339	22398
Denominator	41244	41244	41244	41353	41073
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

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).

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. ***//2009/ Data for FFY indicates that 54.5% of West Virginia Medicaid recipients aged 6-9 received a dental service. //2009//*** 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.

/2009/ The CDP currently has 29 contracts with local health departments, primary care centers and individuals to offer oral health education to students in public schools in all 55 West Virginia Counties. //2009// 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.

/2009/ The CDP, in partnership with county school systems, Head Start agencies, WIC, 4-H, and other community children's programs, are working together to offer a sealant and fluoride rinse program within schools. The CDP contracts with local primary care centers 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. This project was initially provided only to students in Lincoln County but the OHP is working to expand this service to students in Mason and Mingo Counties as well. //2009//

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 not 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. ***/2009/ The CDP will assist two community water systems in obtaining fluoridation equipment in 2008. //2009//*** The Office of Environmental Health Services has been approached as a non-funding partner and is willing 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.

/2009/ While State Medicaid Programs are required by federal law to provide dental services to eligible children, enrollees' access to dental care is poor. In 2006, only one in three children in Medicaid received a dental service (source: National Academy for State Health Policy, March 2008).

The great majority of dental care in West Virginia and across the country is delivered by private practicing dentists, so their participation is key to improving access for publicly-sponsored patients. Approximately 2/3 of dentists in West Virginia have agreed to accept Medicaid and CHIP beneficiaries. They, like dentists across the country, cite three primary reasons for their low participation in state Medicaid programs: low reimbursement rates, burdensome administrative requirements and problematic patient behaviors.

OMCFH has been charged with convening an expanded Oral Health Advisory to study policy and procedures necessary to improve oral health access and utilization in West Virginia. This charge by the Legislature is complicated by the fact that the assignment is population-based, and so many West Virginia adults (and some children) lack access to dental health service financing/insurance. For example, West Virginia Medicaid does not provide dental coverage to adult beneficiaries except to alleviate pain and suffering, i.e., extraction. There is no special coverage extended to pregnant Medicaid beneficiaries, although there has been discussion around pregnancy, periodontal disease and preterm labor.

As a part of the West Virginia Advisory study we plan to offer information gathered by the

National Academy of State Health Policy (NASHP) as to the effect raising Medicaid reimbursement rates has on access to dental care. //2009//

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	2003	2004	2005	2006	2007
Annual Indicator	22.6	18.3	15.2	16.6	10.7
Numerator	1568	1256	1049	1079	987
Denominator	6951	6856	6901	6489	9196
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

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.

//2009/ The Children with Special Health Care Needs Program provides medical and care coordination services for children birth to 21 years of age. In CY 2007 1,155 children/youth received services in 39 specialty care clinics throughout the state. There were 987 SSI recipients under 18 years of age who also received CSHCN services. As of December 2007 there were 9,196 children in WV under the age of 18 receiving SSI benefits, this indicates that the CSHCN Program served 10.7% of WV children under the age of 18 who received SSI benefits.

In CY 2007, 2,060 clinic visits took place which included both enrolled clients and those in pending status receiving a first time evaluation in 39 specialty clinics throughout the state. Note: an enrolled client may have had more than one clinic visit in 2007. There were 1,902 enrolled clients in the CSHCN Program by the end of 2007. //2009//

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 appropriate services to children with disabilities.

//2009/ Some 7,698 children statewide under the age of 16 receive SSI benefits. //2009// Not all conditions that qualify children for SSI are covered by one CSHCN program. For example, CSHCN does not have capacity, professionally or fiscally, to care for autism, serious emotional disorders etc., conditions which often trigger SSI eligibility.

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	other	10.4	6.6	9.7

Notes - 2009

Vital Statistics and PRAMS

Narrative:

//2009/ Although the RFTS Project provides in-home care coordination to a high risk population of pregnant women and infants, 2007 data show the average birth weight for an infant born to Project participants was 6.96 pounds.

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.

Planning and spacing for pregnancy is a key factor in reducing low birth weight incidence. The RFTS Project DCCs encourage participants to choose a method of birth control early in the pregnancy 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 sixty (60) days postpartum. RFTS data for 2007 show 67% of postpartum participants chose a birth control method, an increase of 4% from 2005.

The Division of Perinatal and Women's Health has five staff persons solely dedicated to teen pregnancy prevention efforts. These efforts include sex education and instruction in partnership with public schools. Warning signs of preterm labor are printed on brightly colored labels and shipped to RFTS Maternity Services enrolled obstetrical providers along with each order of prenatal vitamins from Materials Management. These vitamins are supplied at no charge to enrolled providers and are dispensed to pregnant women who are ineligible for Medicaid coverage but are eligible for assistance with funding of their obstetrical care through RFTS Maternity Services.

The RFTS Project will continue to work collaboratively with West Virginia OB providers, March of Dimes, WIC, American Lung Association, West Virginia Perinatal Partnership, and many other groups to educate women on the health consequences of premature births. The OMCFH remains dedicated to reducing the number of babies born early and/or too small.

The RFTS Project will continue to provide intense education for women who participate in

services, and will continue to be the statewide network through which the March of Dimes provides education, literature, information on prematurity awareness to West Virginia residents and medical providers. March of Dimes programs focus on education about the signs of preterm labor and research into the causes. The current campaign for the West Virginia March of Dimes is prematurity awareness.

The OMCFH will use outcomes from the Perinatal Partnership to plan future risk reduction activities for WV pregnant women. RFTS Project RCCs and DCCs are participating in specific workgroups and planning activities to address issues identified as risk reduction activities.

Using data collected on Project participants, the OMCFH will plan future training for Project providers that promotes risk reduction during pregnancy. Database revisions are complete and allow more accurate data collection for the Project. The new RFTS Electronic Data System (EDS) was implemented June 1, 2007. //2009//

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	other	9	6	7.4

Notes - 2009

Vital Statistics

Narrative:

/2009/ The WV Perinatal Wellness Study was conducted by the WV Healthy Kids and Families Coalition and WV Community Voices, Inc., through a planning grant from the Claude Worthington Benedum Foundation. Initiated in February 2006, the Study evaluated changes in the infant mortality rates and percent of low birth weight babies, assessing what perinatal preventive health programs exist and identifying ways to improve perinatal wellness. The Study organizers involved stakeholders concerned with perinatal health, that included the OMCFH Office Director, Division of Research, Evaluation and Planning Director, the Division of Perinatal and Women's Health Director, hospital NICU physicians, insurance company personnel and representatives from numerous other public agencies and private organizations. Study results were released at a WV Perinatal Wellness Summit on May 18, 2006. According to the study efforts to address the multiple issues impacting perinatal health in WV must include establishing an ongoing and collaborative process. After the Summit a document entitled "A Blueprint to Improve West Virginia Perinatal Health" was created which summarizes the study results.

The vision of the group is to develop an ongoing collaborative process so that WV continuously makes progress toward improving perinatal health and will require unprecedented cooperation and collaboration among medical schools, tertiary care centers, local community hospitals, state and privately funded health coverage programs, state agencies responsible for perinatal care, businesses with worksite wellness, and all of the major associations representing health professionals.

In the last several years, West Virginia's infant mortality rate and percent of low birth

weight babies have increased, rating WV well below other states and below the national average for these two indicators of child well being. According to 2006 WV Vital Statistics, approximately three out of ten (29.7%) infant deaths was due to SIDS. Approximately one in six (16.1%) were the result of congenital malformations, while 40.0% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birth weight (9.7%) The overall infant mortality rate for West Virginia in 2006 was 7.4 deaths per 1,000 live births whereas the overall infant mortality rate for the United States in 2005 (last date available) was 6.9 per 1,000 live births.

According to WV SIDS Project there were forty-four (44) Sudden Unexplained Infant Deaths (SUID) in West Virginia in 2006. All infants were less than seven (7) months of age, 73% of the infant deaths involved co-sleeping, 86% involved hazardous bedding and 59% involved maternal smoking during pregnancy.

RFTS DCCs have been reminded of the importance of providing anticipatory guidance to participating families on the risks of co-sleeping, the importance of placing infants on their back to sleep, the importance of smoking cessation during pregnancy and the importance of creating a smoke free environment for all infants. DCCs have been instructed on how to document this information and all other on-site observation in client files.

West Virginia continues to struggle with a high rate of smoking during pregnancy which is one of the leading associated risks for low birth weight and infant deaths. Over one-fourth (27.2%) of WV births in 2006 were to mothers who smoked during the pregnancy while national figures from 2005 (last data available) show that 10.7% of women giving birth reported smoking during pregnancy.

In WV, approximately 60% of all pregnant women receive prenatal care through Medicaid and the Public Employee's Insurance Agency (PEIA). The RFTS Maternity Services also provides coverage for additional women who are ineligible for Title XIX. In 2007, 773 pregnant women who were denied WV Medicaid applied to RFTS Maternity Services for financial assistance with the cost of their obstetrical care and 453 had a portion of their prenatal care costs covered. Funding for RFTS Maternity Services is provided by federal Title V and WV State appropriations.

The Right From The Start (RFTS) Project in collaboration with the Office of Maternal, Child and Family Health (OMCFH) Newborn Hearing Screening and SIDS Projects conducted four statewide Designated Care Coordinators' (DCC) training sessions in 2007. Topics included Sudden Infant Death Syndrome, Newborn Hearing Screening and RFTS Updates. //2009//

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	other	77	91	81.5

Notes - 2009

Narrative:

//2009/ Since the Right From The Start Project was first initiated in 1989, access to first trimester prenatal care has shown improvement from 69.7% to 81.5% in 2005 and remained 81.5% in 2006. This correlates with intense care coordination and support provided RFTS staff to families in rural WV.

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, Right From The Start Project (RFTS), was birthed in 1989 as a partnership between OMCFH and West Virginia 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 WV resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit.

Project providers and partners understand and embrace the philosophy that meeting the health care needs of women requires a comprehensive approach of multiple interrelated issues including: social, cultural, economic, and physical environments; financial and physical access to health care services; provider and partner awareness of the need for health services; and the resulting outcomes.

Although WV 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.

Results from a study conducted by the WV Perinatal Partnership reveal the need to increase the number of perinatal care providers in underserved counties. In 2007, the Partnership conducted a statewide study to identify private obstetrical practices in the state that might benefit from being matched to an existing Federally Qualified Health Center (FQHC) site. This designation would allow the medical professionals to have medical liability coverage under the Federal Trades option. The group also worked with the 2007 WV State Legislature to support elements identified to improve perinatal health.
//2009//

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	YEAR	DATA SOURCE	POPULATION
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Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			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])	2006	other	75	95	83

Notes - 2009

Vital Statistics and PRAMS

Narrative:

/2009/ According to 2006 WV Vital Statistics, 27.8% of women had 6-10 prenatal care visits, 54.5% had 11-15 prenatal care visits and 11.1% had 16 or greater prenatal care visits. WV Vital Statistics also shows that in 2005 and 2006 81.5% of women began prenatal care in 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 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 women and children, but has also strengthened the delivery of care by establishing care protocols, recruiting medical providers and developing supportive services such as case management and nutrition counseling which contribute to improved patient well being.

The WV perinatal program known as the Right From The Start (RFTS) Project worked with 72 community agencies throughout WV under contract to provide care coordination and enhanced education services to high risk pregnant women and infants. Approximately 180 Designated Care Coordinators (DCCs), who are Registered Nurses and Licensed Social Workers, 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 were 75 obstetricians, nurse practitioners, nurse midwives and family practice physicians in WV and bordering states that have Letter of Agreements with the Project to provide quality obstetrical and delivery care to pregnant women.

The DCCs are specially trained Registered Nurses and Social Workers licensed to practice in WV, and follow American College of Obstetrics and Gynecology (ACOG) guidelines and protocols identified in the RFTS Project Policy and Procedure Manual that focus on the mother's personal health, quality of care-giving and life-course development. Women voluntarily enroll as early in pregnancy as possible with home visits beginning ideally by the 16th week of pregnancy, and continuing through the first year of the infant's life. DCCs involve the mother's support system, including family members, fathers and friends, and help families access other health and human services they may need. Each pregnant woman and family of the infant receives individualized services which they develop jointly with the DCC. Additional medical and social services offered in the community are also used to assure efficient use of resources. //2009//

/2009/ WV has two toll-free lines with over 23,000 calls coming in annually. The toll-free responders are licensed social workers and nurses. These professionals assist callers,

some of whom are pregnant women, in receiving financial support and securing prenatal care. //2009//

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)	2007	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)	2007	220

Narrative:

//2009/ As of June 30, 2007, 12,635 infants under the age of one year were covered under Medicaid and 106 infants under the age of one were covered by WVCHIP. This population had almost a 100% rate of having a primary care visit within this first year of life. Since the inception of WVCHIP, all pregnant participants have been cared for using Title V resources, and are offered RFTS services. //2009//

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.

West Virginia Governor, Joe Manchin III, signed into legislation during the 2007, expansion of WVCHIP eligibility of up to 300 percent of the federal poverty level. A phase-in eligibility of up to 220 percent of the federal poverty level began July 1, 2007.

WVCHIP does not provide medical coverage for pregnancy but refers all pregnant teens to OMCFH/Title V for coverage to assure early prenatal care and improved pregnancy outcomes. OMCFH Single Point of Entry provides information on available financial and medical coverage and assists with prompt referrals to obstetrical providers for care during pregnancy and delivery.

WVCHIP provides coverage for family planning office visits, lab services and prescription drug benefits, but does not give providers the ability to offer confidential services for sexually active adolescents, as this is permissible only by Title X regulation or State law, which WV does not have. WVCHIP clients are frequently referred to the Family Planning Program, since confidential access to contraceptive services is crucial in helping sexually active teens obtain timely medical advice and appropriate medical care to reduce teen pregnancy.

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	YEAR	PERCENT OF POVERTY LEVEL
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Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2007	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)	2007	220 220 220

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 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 actively 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	2007	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	2007	220

Notes - 2009

WV SCHIP does not cover pregnant women. Title V covers any pregnant woman who is not eligible for Medicaid, does not have private insurance, and is 150-185% of the poverty level. SCHIP does, however, support contraceptive care for teens.

Narrative:

/2009/ The percent of the federal poverty level (FPL) for Medicaid eligibility for infants up to one year of age and pregnant women is 150%. WVCHIP does not provide medical coverage for pregnancy but refers all pregnant teens to the OMCFH/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 effective and cost effective ways to improve pregnancy outcomes. West Virginia's Perinatal Program, RFTS Project, was birthed in 1989 as a partnership between OMCFH and WV Medicaid to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal 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 WV resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit.

The Right From The Start Project was implemented in 1989, recognized the importance of developing systematic approaches to deal with problems of access to prenatal care, and 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 OMCFH fulfills this oversight responsibility by assuring:

- Availability of medical providers who agree to provide care in accordance with American College of Obstetrics and Gynecology (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.*

In 2007, 66 West Virginia teens ages nineteen and under had at least a portion of their obstetrical care funded through the RFTS Maternity Services. The teens had no other resources with which to fund their obstetrical care.

In 2007, 7,299 unduplicated clients received care coordination services through the RFTS Project. There were 3,590 prenatal clients and 3,396 infant clients who received a total of 20,366 home visits and 22,416 other contacts. Client encounters included contact at office and clinic sites, by phone and at other miscellaneous locations. The average number of contacts for prenatal clients was 5.34 and the average for infant clients was 6.96. //2009//

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)
<u>ANNUAL DATA LINKAGES</u> 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	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	2	No
Annual birth defects surveillance system	3	Yes

Survey of recent mothers at least every two years (like PRAMS)	3	Yes
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Notes - 2009

Narrative:

The Division of Research, Evaluation and Planning has access to both birth and death files on a regular basis from Vital Statistics, newborn metabolic screening from the State Laboratory and also houses the following data sets and Projects:

The Birth Defects Surveillance System (CARESS - Congenital Anomalies 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 relies upon them to submit monthly reports which include 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.

Newborn hearing screening data originates on the Birth Score card from WVU and is sent to OMCFH weekly. Infants who fail or were not screened are followed by nurses/social workers with the Right From the Start Project who receive a direct referral from the Birth Score Office.

The Childhood Lead Poisoning is financed through a CDC grant and the OMCFH maintains screening and confirmatory results. A social worker and/or nurse will follow-up with any child who has a positive result greater than or equal to 10mcg/dl.

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 - 2009

2007 YRBS

Narrative:

/2009/ The 2007 Youth Risk Behavior Survey (YRBS) was completed by 1,393 students in 34 public high schools in West Virginia during the spring of 2007. The results are representative of all students in grades 9-12.

The weighted demographic characteristics of the sample are as follows:

Males 51.1% Females 48.9%

9th grade 28.6% 10th grade 25.6% 11th grade 23.4% 12th grade 22.0%

White 93.8%

African American 4.5%

Hispanic/Latino 0.7%

All other races 0.5%

Multiple races 0.5%

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.**

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 = 27.6% overall; 26.7% for males and 28.4% for females; 25.4% of ninth graders; 27.0% of tenth graders; 29.9% of eleventh graders; and 27.7% of twelfth graders.

Percentage of students who used chewing tobacco, snuff, or dip on one or more of the past 30 days = 14.8% overall; 27.0% for males; 2.2% for females; 16.4% for ninth graders; 15.5% for tenth graders; 14.7% for eleventh graders; and 12.0% for twelfth graders.

Percentage of students who ever smoked cigarettes daily, at least one cigarette every day for 30 days = 19.5% overall; 19.1% for males; 20.1% for females; 16.2% for ninth graders; 18.0% for tenth graders; 25.1% for eleventh graders; and 19.5% for twelfth graders. //2009//

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. 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.

//2009/ Causes of infant death, low birthweight and maternal smoking must be continued to 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 developmental specialists and other professionals must become a priority. //2009//

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 accommodate the purchase of generic treatment medications and contraceptives. These pharmaceuticals are purchased en masse 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 improve capacity. 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 may be used to pay for their care.

The West Virginia five year needs assessment is a work in progress throughout the year, every year. In order to ensure that adequate health care is available 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 to include the 29 nationally recommended tests

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 are 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) Decrease smoking among pregnant women.

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 medical 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 support STD screening in Family Planning clinics to assure early identification of patients in need of treatment.

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	2003	2004	2005	2006	2007
Annual Performance Objective	99.5	100	100	100	100
Annual Indicator	99.1	100.0	100.0	100.0	100.0
Numerator	21280	19	18	25	27
Denominator	21480	19	18	25	27
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2006

from state lab

Notes - 2005

from State Lab

a. Last Year's Accomplishments

The West Virginia Newborn Screening Program, housed within the Office of Maternal, Child, and Family Health within the Bureau for Public Health, is in the process of expanding newborn screening to include twenty-nine (29) disorders in order to adhere to national standards recommended by the United States Department of Health and Human Services Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases.

During the 2007 Legislative Session, a mandate to increase the number of newborn metabolic disorders screened was passed. Beginning July 1, 2007 screening for biotinidase deficiency was

implemented. On November 1, 2007 screening for congenital adrenal hyperplasia was started and screening for cystic fibrosis started March 3, 2008. Phase II, which is slated to begin January 1, 2009, increases screening for the remainder of the 29 recommended newborn disorders.

In 2007, 99% 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 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, in the past reimbursed the State Lab for all newborn screening specimens. With the passage of the Newborn Screening Rules during the 2008 Legislative session, the Bureau for Public Health is now able to bill the hospitals for every infant who receives a screen. The cost of the newborn screening system is included in this charge.

The Genetics Program at West Virginia University provides genetic clinics at 6 strategic locations throughout the state, offering diagnosis, treatment and counseling and was historically funded using Title V dollars. The Genetics Program costs are now included in the system charges.

Staff routinely visit 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 to reduce the number of specimens submitted to the laboratory which fail to meet criteria established for a satisfactory specimen. Such failure results in compromised or no test results, making a repeat blood collection necessary, which is an inconvenience to the patient, and a repeat test, which is time consuming and expensive for the system. The two principal reasons for repeat testing are (1) inadequacy of the specimen, and (2) collection of the initial specimen too soon after birth.

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 assists 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 creates efficiency.				X
7. State Legislature mandated increase to 29 tests to screen for metabolic disorders during 2007 session.				X
8. Formal relationships have been developed with Schools of Medicine to assure availability of medical experts.				X
9. The 2008 Legislature approved newborn screening rules mandating insurance companies to pay				X

10. WV currently screens for 10 disorders with expansion to 29 slated for January 2009			X	
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b. Current Activities

Of the twenty-nine (29) recommended disorders, West Virginia currently screens for seven (10): three (3) hemoglobinopathies, phenylketonuria (PKU), galactosemia, congenital hypothyroidism, biotinidase deficiency, congenital adrenal hyperplasia, cystic fibrosis and hearing. Newborn hearing screening is a separate Program that began universally screening all newborns in West Virginia in 2000 before discharge from the hospital. The cost of newborn hearing screening is captured under the hospital's maternity DRG charge that is paid for by the insurance companies. Newborn hearing data is collected on the Birth Score instrument which also is used for risk assessment for post neonatal health in the first year of life and developmental delay.

Renovations to upgrade the electrical system at the State Lab are currently underway to accommodate the Tandem Mass Spectrometry. Courier service, using UPS, to pick up specimen at the hospital and deliver to the State Lab daily, is being piloted in the northern part of the State and is expected to go Statewide in August, 2008.

Educational information on the additional disorders is currently being developed for use by physicians and families.

The Newborn Screening website is continually updated to include progress on expansion efforts and information on disorders as well as establishing links to supportive information.

A training tape, to be used at the hospitals, on specimen collection technique is also being developed by the State Lab.

c. Plan for the Coming Year

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

Phase II, which is slated to begin January 1, 2009, increases screening for the remainder of the 29 recommended newborn disorders. To prepare for the larger expansion, this involves: leasing the tandem mass spectrometry; training staff to use the new equipment; validating the screening process for the added disorders; expanding courier service Statewide that will deliver the specimen from the birthing facilities to the State laboratory where newborn screening lab analysis is performed; improving genetic services capacity i.e. counseling, medical expertise and nutritional services; increasing the availability of medically necessary supplements; continual updating of the WV Newborn Screening Program web site to reflect specialty medical expertise available within our borders and across the country; explore the use of telemedicine to eliminate geographical barriers to care for and assure linkage between specialists and the primary care provider; improve capacity for tracking and follow-up within the Office of Maternal, Child, and Family Health for all children diagnosed with a disorder; develop educational resources to be used by physicians and families; and complete the training tape on specimen collection to be used by the hospitals to reduce non-useable specimen and reduce repeat screening.

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	2003	2004	2005	2006	2007
Annual Performance Objective	65	75	60	65	56.1
Annual Indicator	56.1	56.1	56.1	56.1	59.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	65	65	65	65	65

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 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.

Birth To Three, WV's Part C/IDEA system for infants and toddlers with developmental disabilities, assures that families have a choice of credentialed practitioners to provide services agreed upon during the Individual Family Service Plan (care plan) development. Families also have access to other families who have similar experiences and can provide support and resource information. These parent to parent resources are available statewide with a parent coordinator assigned a specific geographic region of the state. Eight parent to parent coordinators are paid by BTT. In addition, families are seated on the Interagency Coordinating Council/ICC alongside other stakeholders. The ICC is charged with providing advise and guidance to the state Part C system administered by MCFH (Title V).

Care plans for children under age 18 participating in CSHCN Program are developed along with their parents to assure that medical, social and appropriate developmental issues are accommodated. The CSHCN Program, using Title V funds continues to support the Parent Network, administered in partnership with the Center for Excellence in Developmental Disabilities (UAP) at WVU, although staff are strategically located throughout the state. These Parent Network Specialists assist families with making informed choices about healthcare to promote treatment

options, community resources, and conduct outreach activities to families, healthcare professionals and other appropriate groups.

Families are also represented on the Newborn Metabolic, Newborn Hearing and Childhood Lead advisory bodies. These crossovers have assisted WV by serving as credential community voices, and with public and professional informing.

All of the above facilitate parent input on products, processes and workgroup recommendations. To facilitate parent involvement in all facets of MCFH, we need to identify barriers to full participation such as the use of acronyms. To ensure State staff are "doing our part" we've participated in the WV Developmental Disabilities Council training "Project Trust."

During CY 2007, 436 CSHCN Program patient care plans were completed and 2,515 updates were done to assure a continuum of comprehensive medical care and transition to adult care when appropriate. Plans are updated when change in treatment or medical care is recommended or an additional client/family need is identified. The client/family then reviews and signs the care plan with each update and is provided with a copy for their file. Transition services also involve parents, education specialists and other interested parties. Transition screening tools for middle adolescents and young adults were completed by the client/family and used by the care coordinator in providing resources and transition services, 1,334 transition services were provided to youth, ages 14 to 21 years of age.

In reponse to the results of the CSHCN Family Survey completed in 2006, greater emphasis was placed on the comprehensive approach to the entire family and their medical and social service needs. Educating families as to what care coordination is and how they can benefit from those services became a priority in 2007. Informational material, including pamphlets and posters, were developed and distributed informing families and the public about the components of care coordination and how to access services from the CSHCN Program.

To support the CSHCN staff in their commitment to provide care coordination to the families they serve, a statewide staff conference was held in October 2007. Topics included an overview of services offered by state and federal programs as well as a presentation by a CSHCN participant and her parents on the challenges of living with a disability.

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 in Developmental Disabilities 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 in Part C and CSHCN Programs.		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 8 Birth To Three Regions are available to families, and 5 Parent Network Specialists.				X
10. All BTT participants self select practitioner offering services.		X		

b. Current Activities

The CSHCN Medical Advisory Board met in January 2008. The membership of the Board includes the Director of Infant, Child and Adolescent Health, the Director of the CSHCN Program, the administrative team from the CSHCN Program, and physicians that provide services in clinics and act as medical consultants for the CSHCN Program. The Medical Advisory discussed goals and objectives for the coming year including clinic services offered by the program and the relationship between the CSHCN Program and community based clinics held in the tertiary care centers throughout the state.

Partnering with 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. PNS, in cooperation with the CSHCN Program, continued the process of updating the care notebooks including the resource contact section to assure clients/families receive current and accurate information to assist them in finding needed resources.

The CSHCN Program also developed a resource library which is accessible to all staff members through the shared computer system. Included are numerous topics addressing the medical, social and educational services available to families throughout the state. Sharing this information allows the staff to provide comprehensive care coordination to the families they serve.

c. Plan for the Coming Year

During FY 2007, patient/family assessments and care plans were completed or updated for all program-enrolled children through home visits, clinic visits and/or other face-to-face contacts. Priority is 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. Continual 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 Program will continue to explore the possibility of developing a transition team to enhance transition services offered to children and families. The team would include a nurse, social worker, parent representative and an office assistant which will work in concert with the CSHCN staff to define and develop specific transition services.

The plans for the coming year include an all staff meeting covering important issues facing clients/families. Presentations on wellness and nutrition for children with special health care needs, language and transition services are among topics to be included.

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	2003	2004	2005	2006	2007
Annual Performance Objective			60	60	60
Annual Indicator	56.9	56.9	56.9	56.9	56.9
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	58	58	60	60	65

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

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

a. Last Year's Accomplishments

Information about a child's primary care provider (medical home) is collected by the Systems Point of Entry Unit(SPE) during initial intake, and by CSHCN Program staff each time a child presents for service. During CY 2007, 1,743 children who received CSHCN Program services had an identified primary care practitioner. This represents 91% of children enrolled and in pending status with CSHCN. SPE service coordinators link children without an identified primary care practitioner to the state's expansion network of community health centers and to primary practicing clinicians for medical care. All children receiving benefits through the WV Medicaid Program, including those participating in the CSHCN Program, are assigned a primary care physician. Children, diagnosed with mental health needs, ie; socially emotionally disturbed (SED) etc., are managed by Child Protective Services and the Bureau for Behavioral Health and Health Facilities within DHHR.

Following the Public Employees' Insurance Agency's lead, WVCHIP adopted a voluntary medical home program for its members on March 1,2007. Under this program, members agree to utilize one physician for all their primary care needs selected from a directory of qualified physicians specializing mostly in pediatric or family medicine. In exchange, co-payments for all visits to a member's designated medical home are waived. Providers receive full payment for services from WVCHIP. No formal referral process to specialists or other care outside the medical home is required by providers.

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

Progress reports related to Part C/Birth To Three are also shared with the child's medical home

with parental consent.

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

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. State CSHCN Program provides extensive care coordination		X		
3. Medicaid, CHIP, Public Employees Ins. and commercial carriers are requiring use of a medical home				X
4. The U.S. Scorecard ranked WV number 8 for percent of children who have a medical home			X	
5. The U.S. Scorecard ranked WV number 1 for percent of children whose personal doctor or nurse follows up after receive specialty care			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Efforts are made to coordinate the CSHCN Program specialty care provided with the child's medical home to keep the primary care physician informed of treatment plans. CSHCN Program 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 at 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/family 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 14 years. Through the patient/family assessment and patient/family care plan development process families are linked to supportive, educational, and community-based services.

c. Plan for the Coming Year

CSHCN will continue to work with the WV Medicaid Managed Care, and other insurers 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, debilitating 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, paid for by Title V, lose funding for these medically necessary prescribed supplements when the young adult transitions from CSHCN at age 21 years. The WVU Center for Excellence in Disabilities (WVUCED) 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	2003	2004	2005	2006	2007
Annual Performance Objective			65	65	65
Annual Indicator	59.8	59.8	59.8	59.8	64.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	65	65	65	65	65

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

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

a. Last Year's Accomplishments

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

During CY 2007, 85.9% 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 is done through receipt of a written notice given to the family and/or by accessing RAPIDS, the Medicaid eligibility data system. Information submitted to the DHHR office during this process is also used as the determinant of a child's financial eligibility for 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, Private carrier)		X		
2. CSHCN requires Medicaid and CHIP applications, to ensure Title V resources are last resort				X
3. Coordination between CSHCN and Social Security Administration facilitates access to SSI		X		
4. CHIP expanded eligibility to 220%FPL with plans for expansion to 300%FPL in yearly 20% increments				X
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 within the EPSDT Program, 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.

The CSHCN Program has instituted policy changes related 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 may be 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.

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.

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	2003	2004	2005	2006	2007
Annual Performance Objective			75	75	75
Annual Indicator	73.1	73.1	73.1	73.1	89.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	90	90	90	90	90

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

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

a. Last Year's Accomplishments

In CY 2007 an informational pamphlet was developed and given to each family at the time of enrollment. The pamphlet provided information about CSHCN Program, eligibility criteria for continued service, services offered including aspects of care coordination and a listing of the patient/family rights and responsibilities.

Also in CY 2007 the development of Regional Specialty Care Centers (RSCC) became more of a reality when the CSHCN Program worked in collaboration with Charleston Area Medical Center (CAMC) - Women & Children's Hospital to see patients diagnosed with cystic fibrosis in the clinic

setting. Medical management and genetic counseling was provided by CAMC while the CSHCN Program supplied the nursing and social service components including care coordination.

The Director of the Cystic Fibrosis Care Center, housed at CAMC, Dr. Robert Kaslovsky, is an active participant of the Newborn Screening Advisory Committee. WV began screening for cystic fibrosis November 1, 2007.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

The CSHCN quality assurance component was strengthened by continuation of an internal process designed to monitor staff documentation in enrolled patient records. Each month the CSHCN Director of Nursing and the Director of Social Services review a portion of each of their assigned staff's work using an Internal Chart Review form, which identifies important elements in care management and case recording. The CSHCN Policy Coordinator also completes chart reviews on enrolled patients as well as those patients in pending status waiting to complete the enrollment process. This process identifies areas that need improvement and serves as a basis to identify staff training needs and evaluation. The system serves to augment the periodic clinic/field office site visits completed by the CSHCN Director of Nursing, the Director of Social Services and Policy Coordinator. 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 track their response times from the time of inquiry, to the time of authorization and then to the delivery of patient equipment or services.

c. Plan for the Coming Year

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

The PNS will continue to provide resource information, support families in dealing with educational issues, and plan regional workshops to include information on transition services. The PNS will also work towards the development of parent support groups in their assigned areas.

The development of the Regional Specialty Care Centers continued in 2008 with the collaboration between the CSHCN Program and the Physician Office Center, West Virginia University (WVU) School of Medicine in Morgantown. The CSHCN Program provides the nursing and social service components, while the medical management of the clinic patients has been turned over to our partners at WVU. Exploring this type of collaborative effort with the other medical schools in West Virginia will continue in 2008 and 2009.

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	2003	2004	2005	2006	2007
Annual Performance Objective			6	6	6
Annual Indicator	5.8	5.8	5.8	5.8	41.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	41.3	42	43	43	43

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

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

a. Last Year's Accomplishments

It is estimated that 4.5 million children and adults in the U.S. have developmental disabilities. Working to assure that individuals with developmental disabilities and their families have the opportunity to actually participate in the design of community-based programs and have access to community services, individualized supports, and other forms of assistance that promote and create opportunities for independence, productivity, and self-determination is a goal of the Office of Maternal, Child and Family Health.

In January 2006, the West Virginia Division of Rehabilitation Services (WVDRS) was awarded a

Comprehensive Employment Systems Infrastructure Development Grant (CES-ID Grant) from the U.S. Centers for Medicare and Medicaid Services (CMS.) The CES-ID Grant was initiated collaboratively by WVDRS and the Center for Excellence in Disabilities at West Virginia University (CED) in cooperation with the Bureau for Medical Services (BMS), i.e., the state Medicaid agency within the WV Department of Health and Human Resources (DHHR). CED secured the Center for Entrepreneurial Studies and Development, Inc. (CESD) for technical assistance to develop a strategic map with the objective of describing the employment landscape for West Virginians with disabilities and identifying their needs.

Transition services are included as part of the development of the Patient Care Plan completed with youth enrolled in the CSHCN Program. During CY 2007, 1,334 separate transition services were provided to youth, age 14 to 21. The Division has 51 staff who are dedicated to transition planning for children with disabilities, within 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 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.

Longstanding collaborative and financial relationships exist between the CED and the OMCFH. CED provides interdisciplinary training to students and professionals, offers direct nutrition supports at CSHCN Program clinics, and makes available five part-time Parent Network Specialists to offer input on public policy as well as parent-to-parent support and advocacy. Additional information on transition services is included for this section.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN offers transition services to all program participants beginning at age 14.		X		
2. WVU Center for Excellence in Disabilities has a transition advisory.		X		
3. Marshall University School of Medicine is collaborating with Title V on transition programming.		X		
4. Participants are encouraged to access VR counseling in schools.		X		
5. WV established required certification for interpreters.				X
6. Division of Rehabilitation Services has Cooperative agreements with all 55 county school systems				X
7. Throughout WV, 63 rehabilitation counselors are assigned to work with public and private schools		X		
8. These counselors assisted 876 students with disabilities in developing individualized plans for employment		X		
9. Fifty-two percent of the case closures with rehabilitation services were employed		X		
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.

The PNS participated in community health fairs and shared medical and educational transition information with young adults and their families. They developed a Medical Transition Plan which was included in the Care Notebook distributed to each family.

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

c. Plan for the Coming Year

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

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

To enhance transition services offered to patients and families, the CSHCN Program is exploring the development of a transition team. To ensure parent involvement the team would include a full time parent position along with a nurse, social worker and office assistant. The transition team would work with the CSHCN staff to define and develop specific transition services for patients 14-21 years of age.

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

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

Varieties of assessments across different groups continue to be completed. The voices heard

within the state from a wide audience (education, business, advocates and people with disabilities and their families) provides positives, challenges and ideas for improvement.

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	2003	2004	2005	2006	2007
Annual Performance Objective	90	90	85	95	95
Annual Indicator	81.8	93.5	93.5	90.3	93.3
Numerator	50700	58000	58000	56000	57850
Denominator	62000	62000	62000	62000	62000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	95	95	96	96	96

Notes - 2007

WV Immunization Program 2007...numbers were provided for individual immunizations (DTaP: 86.2%, Polio: 94.5%, MMR: 95.1%, Hib: 96.1%, Hep B: 94.7%)...numbers were added together and divided by total number for overall percentage

Notes - 2006

WV Immunization Program as of June 2006...numbers were provided for individual immunizations...numbers were added together and divided by total number for percentage

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.

a. Last Year's Accomplishments

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.

Immunization data for 2007: 86.2% had been immunized for DTaP-4, 94.5% for IPV-3, 95.1% for MMR-1, 96.1% for Hib-3 and 94.7% for Hep B-3. All of these individual vaccines have risen since 2005.

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 state Immunization Program and the statewide immunization coalition, West Virginia Immunization Network (WIN) collaborated to implement the "Take Your Best Shot" campaign targeting adolescents for HPV, MCV, Tdap, chickenpox and Hep b vaccinations. WVCHIP provided matching funds to Raleigh County to implement the "Take Your Best Shot" adolescent campaign, which began in October 2007.

The Immunization Program worked with the WV Higher Education Policy Commission to develop a list of recommended immunizations for college enterers.

WVCHIP materials were included in the State's Immunization Program packets to new mothers through the Right From The Start Coordinators.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Need for immunizations is promoted by RFTS, WIC and other public health programs.		X		
2. The EPSDT/HealthCheck 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 before leaving the birthing facility.				X
6. WV does not allow non-medical exemptions for immunizations.				X
7. In 2006, WV was 35th in the Nation for completion of regularly scheduled immunizations on children up to 36 months of age.			X	
8. Partnered with West Virginia's Immunization Network(WIN) to promote adolescent immunizations.		X		
9.				
10.				

b. Current Activities

The West Virginia Immunization Program is working to increase the number of providers who regularly report to the Immunization Registry. Of the 380 providers of immunizations, all are enrolled and have reported at least once to the registry, but only 80-85% report regularly to 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.

The West Virginia Immunization Network, the State's Immunization Program and WVCHIP continue working on strategies to implement an immunization campaign targeting adolescents.

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.

The state immunization registry, West Virginia Statewide Immunization Information System (WVSIS) has developed a consent authorization form for public schools to distribute to guardians of new school enterers in the K-12 school system which would authorize the Department of Education to share the immunization records of new school enterers with the WVSIS database.

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	2003	2004	2005	2006	2007
Annual Performance Objective	20	20	19	19	19
Annual Indicator	20.1	20.1	20.0	20.9	19.8
Numerator	711	712	707	739	700
Denominator	35411	35411	35411	35411	35411
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	19	19	18	18	17

Notes - 2007

Based upon 2006 Vital Statistics

Notes - 2006

2006 Vital Statistics

Notes - 2005

a. Last Year's Accomplishments

Family Planning:

148 sites of the publicly funded Family Planning Program clinical network provided contraceptive care to 56,800 women and men -- including 15,804 sexually active teenagers in CY 2007. (56% of all women in need of publicly supported contraceptive services and 60% of the teenagers in need). These publicly funded clinics help women prevent 13,800 unintended pregnancies each year.

Adolescent Pregnancy Prevention Initiative (APPI):

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

- Processed 67 requests for educational literature, in addition to resource materials distributed during classroom trainings
- Conducted 349 school presentations, addressing student populations on the topic of teen pregnancy prevention
- Completed 128 school visits to introduce the Adolescent Pregnancy Prevention Initiative and APPI Specialists
- Mailed out 331 informational packets to WV schools
- Completed 5 community presentations
- Conducted 4 parent workshops
- Participated in 10 FP Program site visits to introduce clinical service providers to APPI
- Displayed APPI information at 50 events
- Completed 6 college/university campus visits

National Teen Pregnancy Prevention Month

The Adolescent Pregnancy Prevention Initiative actively promoted participation in the National Day to Prevent Teen Pregnancy in May 2007. The National Day To Prevent Teen Pregnancy was created to get teens to stop, think, and take action. By taking the on-line interactive quiz, teens review real-life scenarios and decide how they would react in certain risky situations

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Adolescent Pregnancy Prevention Specialist conducted numerous community education and outreach activities on a regional/local level.				X
2. Provided confidential contraceptive services through the FP Program to 15,804 sexually active teens in 2007.			X	
3. Recognized and promoted "National Teen Pregnancy Prevention Month" (May 2007).			X	
4. Conducted 349 school presentations at WV schools and 5 community presentations and 4 parent workshops on the topic of teen pregnancy.				X
5.				
6.				
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 four (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 148 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 adolescents regarding the importance of family involvement in sexual decision-making.

c. Plan for the Coming Year

APPI will continue to design and conduct community education and outreach activities to increase public awareness of adolescent pregnancy prevention and related issues targeting community groups, schools, health care professionals, parent groups, or businesses. Adolescent pregnancy prevention will be addressed on a state-wide level stressing the following: access to adolescent pregnancy prevention services; confidentiality; transportation, financial or other identified barriers; and local availability of pregnancy prevention services. Maintenance of existing and establishing new partnerships with entities serving populations of adolescents will ensure ongoing growth on the initiative.

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	2003	2004	2005	2006	2007
Annual Performance Objective	50	50	33	35	38
Annual Indicator	21.3	30.0	33.3	37.5	28.1
Numerator	514	1039	1416	1309	1050
Denominator	2413	3466	4256	3488	3736
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	30	30	31	31	32

Notes - 2006

The Children's Dentistry Project covers 45 of WV's 55 counties and is being used as representative for the state's 3rd graders.

Notes - 2005

2005 data from Children's Dentistry Project
National Survey of Children's Health

a. Last Year's Accomplishments

Almost 55% of the State's children ages 6-9 who are Medicaid eligible received a dental service in FFY 07. Forty-eight point six percent (48.6%) of all Medicaid eligible children ages 3-20 received a dental service. In CY 2006, ninety-seven point five percent (97.5%) of children eligible for WVCHIP ages 4-6 had a dental check-up and 95.84% of children and youth eligible for WVCHIP ages 4-18 had a dental checkup.

The Children's Dentistry Project (CDP) currently has 29 contracts with local health departments, primary care facilities, and individuals to offer oral health education to students in public schools in all 55 West Virginia Counties. Educators offer information about dental hygiene, the need for preventive dental visits, and the dangers of tobacco use. The list of oral health educators on contract with the OMCFH Oral Health Program (OHP) is now available on the OHP's website.

The CDP, in partnership with county school systems, Head Start agencies, WIC, 4-H, and other community children's programs, are working together to offer a sealant and fluoride rinse program within schools. The CDP contracts with local primary care centers 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. This project was initially provided only to students in Lincoln County but the OHP is working to expand this service to students in Mason and Mingo Counties.

Beginning January 2007, the OHP staff talked via conference call with Susan Walters of the Shenandoah Valley Medical Systems about school-based services through that facility. The OHP staff then met with Valley Health Systems, and representatives from the Eastern Panhandle to coordinate school-based dental services and oral health education in Berkeley, Jefferson, and Morgan Counties. The OHP provided portable dental equipment to Eastern Area Health Education Center/WVU so they could begin services summer 2007.

The OHP has provided portable dental equipment to primary care facilities for the purpose of offering school-based dental services in Calhoun, Fayette, Jackson, Lincoln, Marshall, Nicholas, Ohio and Ritchie Counties.

The CDP worked to increase the effectiveness of the existing infrastructure to improve the oral health status of its youth and adolescents by providing funds for the 4 WVU Services 4-H Project to purchase 4-H planners and oral health education materials/information to teach practical oral health skills during 4-H club monthly meetings. The 4-H planners included a component on the importance of making and keeping dental appointments.

The CDP collaborated with a local primary care center and other stakeholders to provide funding for billboards and posters to promote the WV Rush-2-Brush (R2B) campaign to reinforce the message to WV Adults and children on the importance of proper dental hygiene and preventive dental services. The R2B campaign was financed by the primary care center in part with funding from the Claude Worthington Benedum Foundation.

The OHP collaborated with Head Start Association staff and other members of the Head Start Oral Health Initiative to develop an oral health DVD with tool kit to promote good oral hygiene and to encourage Head Start parents to make and keep dental appointments. The Clay County oral health educator accepted the task of creating the tool kit. The CDP Coordinator collaborated with the Clay County oral health educator to form a focus group consisting of six additional oral health educators. This focus group reviewed the tool kit information then met to discuss their recommendations. This oral health DVD has also been made available to all OHP oral health educators.

The Oral Health Program (OHP) was provided water fluoridation equipment to the Town of Clay Water System, the Clay-Roane PSD, Prociuous District, and the Town of Wayne water treatment plant so they could provide fluoridated water to their citizens.

The OHP provided all licensed West Virginia dentists a PowerPoint presentation on CD showing the 53 most common oral lesions. This CD was created by Dr. Jerry Bouquot for dental professionals and oral pathologists, etc.

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	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CDP currently has 29 contracts/agreements with local health departments, primary care centers and individuals to offer oral health education to students in public schools in all 55 WV counties. 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 the schools.

The CDP continues to partner with a community health center network to offer school-based dental services and oral health education to students in Berkeley, Calhoun, Fayette, Jackson, Jefferson, Lincoln, Marshall, Morgan, Nicholas, Ohio and Ritchie Counties.

The CDP continues to work in conjunction with Valley Health Systems (VHS) to provide sealants to elementary students in Lincoln County. The Lincoln County school nurse is involved in obtaining parental permission and scheduling on-site visits. The VHS staff travel to the schools and complete screenings on all students with parental permission.

The CDP Coordinator has participated over the past two (2) years in the Wilson/Martino Free Dental Days. Wendy Boyce, Director of Marketing for Wilmar Management sent a letter to the CDP staff appreciating the support and information provided to the patients.

c. Plan for the Coming Year

The CDP continues to work in conjunction with Valley Health Systems to provide sealants to elementary students in Lincoln County. Plans are being discussed to expand these services to Mason and Mingo Counties for the 2008-2009 school year.

The CDP Coordinator will work closely with the Early Childcare Coordinator to learn more about what can be done to improve dental health services to WV children.

The CDP will assist two community water systems in obtaining fluoridation equipment in 2008. The Office of Environmental Health Services has been approached as a non-funding partner and is willing 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.

OMCFH has been charged with convening an expanded Oral Health Advisory to study policy and procedures necessary to improve oral health access and utilization in West Virginia. This charge by the Legislature is complicated by the fact that the assignment is population-based, and so many West Virginia adults (and some children) lack access to dental health service financing/insurance. For example, West Virginia Medicaid does not provide dental coverage to adult beneficiaries except to alleviate pain and suffering, i.e., extraction. There is no special coverage extended to pregnant Medicaid beneficiaries, although there has been discussion around pregnancy, periodontal disease and preterm labor. WV Medicaid and WVCHIP provides dental coverage to children beneficiaries.

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	2003	2004	2005	2006	2007
Annual Performance Objective	4	3.5	3.5	3	3.3
Annual Indicator	4.6	6.1	3.6	4.6	3.9
Numerator	15	20	12	15	13
Denominator	329137	329137	329137	329137	329137
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	3.9	3.8	3.5	3.5	3.5

Notes - 2007

Based upon 2006 Vital Statistics

Notes - 2006

2006 Vital Stats

Notes - 2005

2005 Vital Stats

a. Last Year's Accomplishments

Collectively, highway related deaths and injuries are a significant public health concern. Highway crashes continue to be the leading cause of death in children and young adults. In 2006 410 people died on WV highways. Nationally in 2006, 1,794 children age 14 and younger were killed in motor vehicle crashes. Of those 1,794 fatalities, 306 (17%) occurred in alcohol-impaired driving crashes. In WV, 15 children died in motor vehicles accidents who were age 14 or less.

In 2005, seatbelt use nationwide was 82% according to the National Highway Traffic Safety Administration (NHTSA). In West Virginia, the 2006 Scientific Survey of seat belt usage revealed an 88.5% usage rate. This was a dramatic increase from the pre-2001 rates which were in the high 40 to low 50 percentile range. Although West Virginia passed a secondary enforcement Seat Belt law in 1993, no significant increases in belt use occurred until WV adopted the "Click it or Ticket" model. After the law passed, there was a substantial reduction in fatalities and serious injuries, which has been sustained. Based on the 2005 Safety Belt Survey, NHTSA estimates that if WV were to pass a primary law, usage would rise by an estimated 6 percentage points. This would potentially prevent 18 fatalities, 188 serious injuries, and save \$36.9 million dollars in economic loss annually.

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 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 affecting change.

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. This program includes: 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.

c. Plan for the Coming Year

Work continues with the Transportation and Traffic Safety to develop materials that are directed to youth. We also use our existing workforce and partnership network for distribution of this anticipatory guidance.

Partnerships 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.

The Division of Highways will lead the development of implementation plans to execute the initiatives in the Strategic Highway Safety Plan. While extensive work is currently underway to implement many initiatives outlined in the Plan, a coordinated effort continues to devise both emphasis area implementation plans and an overall detailed management plan for the Strategic Highway Safety Plan.

To be effective, a plan cannot rest upon a shelf. It must be refined over time to address changing conditions. The Strategic Highway Safety Plan is viewed as a dynamic document and will continue to evolve as West Virginia evaluates its outcomes.

Performance Measure 11: *The percent of mothers who breastfed 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	2003	2004	2005	2006	2007
Annual Performance Objective				35	35
Annual Indicator			32.0	56.0	57.1
Numerator			6700	11730	12000
Denominator			20920	20931	21000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	60	60	60	60	60

Notes - 2007

based upon 2006 PRAMS data

Notes - 2006

PRAMS data - mothers who initiated and breastfed for any period of time

Notes - 2005

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

a. Last Year's Accomplishments

While the latest data on breastfeeding indicates that a low percentage of women choose to breastfeed their infants, this should not be taken as an indication of little effort on the part of the State's Bureau for Public Health or, in particular, the Office of Maternal, Child and Family Health (OMCFH). All pregnant women participating in the RFTS 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 postpartum and to breastfeeding mothers of eligible infants until their infant reaches age one year. Educational tools such as videos, DVDs, brochures, The Pregnancy Workshop and medical models were available to RFTS DCCs for use on home visits to promote breastfeeding. A DVD player was used by each RFTS DCC in order to more effectively provide client education in their homes.

As revealed by data below, RFTS Project participants have experienced a steady increase in the number of moms who choose to breastfeed their infants at hospital discharge and those who continue to breastfeed at case closure.

	2003	2004	2005	2006	2007
Chose to breastfeed at hospital discharge	19%	20%	32%	37%	40%
Still breast feeding at case closure	3%	9%	14%	16%	18%

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All women participants in the RFTS 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. WIC goals include providing additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physicians practices in order to keep mothers breastfeeding longer.				X
7.				
8.				
9.				
10.				

b. Current Activities

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

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

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

The RFTS Project encourages collaboration with WIC offices statewide to ensure participants continue to receive breastfeeding education and support after case closure. In 2007, the Project was involved with WV WIC in a collaborative strategic planning effort to develop a cross-referral system for service integration and coordination. It was decided that the most logical system to use statewide would be SPOE.

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 promote breastfeeding with each prenatal participant and provide support and referrals as needed. RFTS will continue to train DCCs on the benefits of breastfeeding and how to encourage participants to try breastfeeding as their choice for infant feeding.

RFTS DCCs have access to the use of standardized step-by-step prenatal curriculum which includes education on breastfeeding. The curriculum is entitled "The Pregnancy Workshop" and is available to each DCC at no cost for use and/or reproduction of the educational materials through the RCC.

RFTS 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.

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

Since each RFTS Project DCC is now assigned a DVD player to use for client/family education during home visits, the Project is in the process of purchasing educational DVDs that effectively promote breastfeeding.

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	2003	2004	2005	2006	2007
Annual Performance Objective	97	98	98.5	99	99
Annual Indicator	97.7	90.2	93.7	91.9	93.2
Numerator	20993	18868	19526	19431	20500
Denominator	21480	20911	20834	21137	22000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	99	99	99	99	99

Notes - 2007

2007 preliminary data - based upon 2006 Birth Score Office data

Notes - 2006

2006 WVU Birth Score Data - infants screened before hospital discharge

Notes - 2005

data from 2005 WVU Birth Score

a. Last Year's Accomplishments

The Newborn Hearing Screening (NHS) Project partners with West Virginia University to collect the NHS result on the Birth Score card, an assessment tool that is intended to identify infants at risk of developmental delay or death within the first year of life. In 2006, improvements in the database allowed for enhanced data collection by linking newborn hearing screening follow-up data collected by the NHS Project and the Birth Score card data. This was an important step in improving the data system and identifying issues needing attention. In 2007, continued efforts were aimed at cleaning the database and outlining processes within a flow chart that was shared with the State's perinatal program's staff, a homevisiting program that follows-up on infants who either were not screened or failed the hearing screen before discharge from the hospital. The perinatal home visiting program is called Right From The Start (RFTS).

Interlacing Birth Score and NHS follow-up information has significantly reduced the risk of human error as well as time involved in completing forms with duplicate information. In January 2007, the Birth Score Office (BSO), NBHS and Vital Statistics staff met to discuss the BSO receiving timely current birth information in order to identify those infants for whom a Birth Score card had not been completed, and identify hearing screen data.

The entire referral and follow-up process has been streamlined and allows the database to be a supportive monitoring tool for quick reporting on specific practitioner performances for those charged with follow-up. This helps assure project protocols are completed, as well as providing information to the NHS Project.

West Virginia birthing facilities are concerned with the number of newborn hearing screens and Birth Score cards not being completed before discharge and are providing opportunities to screen infants who are missed after discharge. Equipment failure at birthing facilities is a common reason cited for missed screens which prompted the use of NHS Project money to purchase loaner equipment.

To help reduce the number of lost referrals in 2007, Designated Care Coordinators (DCCs) who are licensed nurses or social workers in RFTS provider agencies, send an introductory letter and brochures discussing the need for hearing follow-up services, and other health/social service offerings, when initial phone contact cannot be made.

Four regional trainings were held statewide in the fall of 2007 to update RFTS staff on Newborn Hearing Screening Program policies, procedures and other relevant information. One hundred twenty-five participants traveled to the four sessions and evaluations showed that, overall, seventy-three percent (73%) of the participants found the sessions to be excellent.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
------------	--------------------------

	DHC	ES	PBS	IB
1. All WV birthing facilities are required to screen infants for hearing loss before discharge.			X	
2. Infants identified with a hearing loss are referred to the CSHCN Program.		X		
3. OMCFH maintains loaner equipment and shared hospital home equipment for care.				X
4. OMCFH purchased diagnostic equipment to assure access/availability.				X
5. Redesigned monitoring tool to better meet Program needs.				X
6. Redesigned and updated 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 the percentage on infants screened before discharge and access to timely audiological diagnosis and intervention. Four regional diagnostic centers have been provided with state-of-the-art equipment. Services that are 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, resource guides and NHS brochures continue to be distributed to providers and audiologists in order to assist practitioners in directing infants and their families to appropriate hearing evaluation and intervention. Informative brochures are sent to parents of infants who were not screened in the hospital or those who were screened and failed. Referrals are sent to CSHCN and Early Intervention for those infants with diagnosed hearing loss.

Data is shared between the NBS and the Birth Score Office. With detailed data collection and information sharing, follow-up of infants who either failed or were not screened has been improved. Further, the data is being used as an oversight tool.

c. Plan for the Coming Year

The NHS Project focuses on undetected hearing loss, which delays speech, language and cognitive development. West Virginia has greatly improved timely, appropriate follow-up diagnostic service and intervention and continues to refine and implement statewide data management and program evaluation.

The administrative functions and activities of the NHS Project are funded with a HRSA grant. The grant focus changed this past year and a new grant was submitted addressing the new focus. Following are the goals for the NHS Project for this coming year:

Goal 1: Screen 100% of newborns born in WV prior to discharge or within the first month of age, minimizing missed infants and decreasing rates of cases referred to RFTS for follow-up services as well as those infants and families lost to follow-up services.

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.

Goal 3: 100% of infants referred for screening will receive follow-up and an audiological evaluation by a qualified provider.

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.

Goal 5: Continue to provide monitoring, evaluation and quality assurance reports.

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	2003	2004	2005	2006	2007
Annual Performance Objective	5	5	5	4	5.7
Annual Indicator	6.1	5.6	5.8	5.7	4.5
Numerator	26011	24025	24664	24500	19057
Denominator	427879	427879	427879	427879	427879
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	4.3	4.2	4	4	3.5

Notes - 2007

2007 CHIP Annual Report - data for fiscal year ended June 30, 2007

Notes - 2005

From CHIP

a. Last Year's Accomplishments

During the 2006 Legislative session, House Bill 4021 passed authorizing WVCHIP to adopt a higher income limit of 300% for program eligibility. In implementing this legislation, the Board adopted premium payments for those children with family incomes above 200%FPL. The Bill also extended the "waiting period" for children to be uninsured, from the six-month requirement for the regular WVCHIP program, to twelve months for children eligible under the expanded program. After much deliberation, the Board, at the request of the Governor, adopted a higher income limit of 220%, with planned annual expansions in 20% increments, until the full 300% limit is adopted. On January 1, 2007, WVCHIP implemented the higher income limit for program eligibility of 220%FPL. This expanded program was named WVCHIP Premium. In addition, the Board approved a full medical and drug benefit package, with higher co-payments, a limited dental package, and no vision coverage.

CHIP enrollment, as of June, 2007, now covers 24,950 children. The goal is to cover an additional 400 children believed to be eligible for CHIP which will increase the percentage of children covered under insurance to 97%.

Following the Public Employees' Insurance Agency's lead, WVCHIP adopted a voluntary medical home program for its members on March 1, 2007. Under this program, members agree to utilize one physician for all their primary care needs selected from a directory of qualified physicians specializing mostly in pediatric or family medicine. In exchange, co-payments for all visits to a member's designated medical home are waived. Providers receive full payment for services from WVCHIP.

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. Currently WVCHIPs eligibility is 220%FPL. This will increase by 20% a year until 300% is achieved.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Governor Manchin charged an interdepartmental team with working on a goal of assuring that every child starts school healthy and ready to learn. In an initiative called Kids First, the strategy to reach this goal is to assure that every child has had an opportunity for a comprehensive wellness exam by a physician prior to entering Kindergarten. WVCHIP played a key part in this strategy this year by seeking approval of a State Plan change that would permit the program to reimburse providers rendering wellness exams to uninsured children as a special public health or preventive measure. Since West Virginia now has health coverage in a public or private form for 95% of its children, federal approval would mean that the remaining 5% with no insurance (or about 1,100 children of Kindergarten age) could receive such a wellness exam. This project will go forward in 2008 pending federal approval.

The Director of the WVOMCFH has been an active member of the Governor's planning committee for the Kids First Initiative.

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.

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

c. Plan for the Coming Year

West Virginia has become one of the most successful states in enrolling children in CHIP and Medicaid. More than 95% of the state's children now have health coverage. The increase in enrollment of children in both CHIP and Medicaid has been the result, in part, of the efforts of a public/private partnership between the WV Healthy Kids Coalition, primary care centers, Family Resource Networks, state government, and private and public funds. For the last four years, the

WV Healthy Kids Coalition has conducted community-based outreach for CHIP and Medicaid through the placement of outreach coordinators who serve each of the state's 55 counties from 49 locations. Since the inception of this program, more than 40,000 children have been enrolled in CHIP and more than 5,000 children have been enrolled in Medicaid via the CHIP application. To maintain and even improve upon this high level of enrollment 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.

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	2003	2004	2005	2006	2007
Annual Performance Objective				25	24
Annual Indicator			27.2	25.0	24.0
Numerator			6488	5899	4938
Denominator			23861	23611	20556
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	23	23	22	22	22

Notes - 2007

2007 WIC data

Notes - 2006

2006 WIC data

Notes - 2005

Data from WV WIC sources

a. Last Year's Accomplishments

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 \$25,900 a year and be considered eligible for WIC services; for other household sizes, add \$6,600 for each additional family member. This eligibility expansion will allow more pregnant, breastfeeding and postpartum women to take advantage of the program as well as infants and children up to age 5. Families can purchase certain healthy groceries including milk, eggs, dried beans, peanut butter, natural cheese, iron fortified cereals and infant formula, as well as Vitamin C-rich natural juices.

WIC has had a statewide caseload growth of 2.45% thus far in FY 2008.

There has also been a formation of the WIC Outreach Partners Strategic Planning Committee to develop a Memorandum of Understanding between all Bureau for Public Health Programs serving the maternal and child population as well as staff development strategies to ensure cross referral systems are utilized to their fullest potential.

In FY 2007/08, the WV WIC Program continued partnership with State Nutrition Action Plan Nutrition Network. WV WIC will provide recipes and snack ideas to WIC participants to promote fruit and vegetables consumption. Public Service Announcements will be provided in partnership with SNAP initiatives.

Healthy Times, a six-part television series scheduled to begin airing in 2007 on the West Virginia Public Broadcasting Station (PBS), dedicated one segment to the WV WIC Program and Farmers' Market Nutrition Program.

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

WIC participates in the Americans Helping American's Teddy Bear Buddies Program. The Teddy Bear Buddies program is used to provide teddy bears to children in Appalachia during frightening times, such as, during illness, injury, immunizations, and health care visits.

As well as being a leader in the field of nutrition, the WV WIC Program continually promotes early literacy by:

The WV WIC Program received over 35,000 free books from First Book National Book Bank. These books are given to WIC participants on their 1st, 2nd, 3rd and 4th birthday to support early literacy.

Read Aloud events in Head Start centers, preschools and daycare centers using nutrition-themed storybooks remain at the forefront of WV WIC's community and faith-based initiatives.

WV WIC partners with the Bureau for Education and the Arts to encourage early literacy in children birth to five. Registered children in McDowell, Lincoln, Clay and Barbour Counties will receive a storybook each month until their fifth birthday.

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 women and children over 2 years. This will continue to be done with parents in individual counseling and nutrition education classes.

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

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	2003	2004	2005	2006	2007
Annual Performance Objective				25	27
Annual Indicator			25.3	29.0	28.6
Numerator			5225	6075	6000
Denominator			20630	20931	21000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	26	26	25	25	25

Notes - 2007

based upon 2006 PRAMS data

Notes - 2006

2006 PRAMS data

Notes - 2005

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

a. Last Year's Accomplishments

West Virginia Vital Statistics data show the highest smoking rate for pregnant women in the United States. The 2005 rate was 26.4% and the 2006 rate was 27.2% compared to the National rate of 10.7% (2005 last available).

Data from the RFTS Project show the following quit rates among pregnant participants:

2003 = 23%; 2004 = 22%; 2005 = 26%; 2006 = 27%; 2007 = 22%

Pregnant RFTS clients have a high incidence of smoking during pregnancy. According to 2007 data collected by the Project 42% of pregnant participants were self reported smokers. In response WV continued to provide an intense smoking cessation initiative, The WV RFTS SCRIPT (Smoking Cessation/Reduction in Pregnancy Treatment), implemented statewide in 2002 through the Office of Maternal, Child, and Family Health. Using the existing RFTS home visitation network, Registered Nurses and Licensed Social Workers, Designated Care Coordinators (DCCs), provided services to pregnant women and infants throughout WV.

Educational tools such as videos, CO monitors, smoking cessation guides, medical models and smoking cessation incentives were available for use on home visits. Additional CO monitors and supplies along with smoking cessation DVDs were purchased using WV Division of Tobacco Prevention grant funding in 2007. A DVD player was assigned to each DCC to use to provide more effective client education.

The Right From The Start (RFTS) Project in collaboration with the Office of Maternal, Child and Family Health (OMCFH) Newborn Hearing Screening and SIDS Projects conducted four statewide mandatory Designated Care Coordinators' (DCC) training sessions in 2007. Topics included Sudden Infant Death Syndrome, Newborn Hearing Screening and RFTS Updates. Participant evaluations reported the training as overall "Excellent".

When new RFTS providers were trained, each completed a virtual training CD, "Smoking Cessation for Pregnancy and Beyond: Learn Proven Strategies to Help Your Patients Quit", which was purchased in 2006. RCCs and DCCs used the virtual training CD to practice skills on a regular basis.

Teleconferences with the National Partnership to Help Pregnant Smokers Quit provided by the Centers For Disease Control were accessed by RFTS and provided free resources.

According to the WV SIDS Project there were forty-four (44) Sudden Unexplained Infant Deaths (SUID) in West Virginia in 2006. All infants were less than seven (7) months of age, 73% of the infant deaths involved co-sleeping, 86% involved hazardous bedding and 59% involved maternal smoking during pregnancy. Because co-sleeping and maternal smoking during pregnancy were identified in these deaths, they were not labeled Sudden Infant Death Syndrome (SIDS).

RFTS DCCs were reminded of the importance of providing anticipatory guidance to participating families on the risks of co-sleeping, of placing infants on their back to sleep, smoking cessation during pregnancy and creating a smoke free environment. DCCs were instructed on how to document this information and all on-site observation. A statewide mandatory training for RFTS providers was conducted in 2007 which concentrated on critical documentation of delivery of anticipatory guidance.

Data collection improved with monitoring of reporting systems and procedures following implementation of the new RFTS EDS June 1, 2007. Deadlines for data entry and submission were given to RFTS providers. Reports have been created which allow State staff to closely monitor client service delivery and implement changes as needed.

The WV Quitline did not serve PEIA clients in 2007 and only served Medicaid clients from October-December. During that period Quitline data indicated 1,923 users, 16 (.8%) who were pregnant compared to 2006, when there were 5,364 users, 153 (3%) who were pregnant.

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 RFTS smokers/former smokers are offered CO Testing.			X	
7. State government maintains Quit Line.				X
8.				
9.				
10.				

b. Current Activities

Statewide WV RFTS SCRIPT education to participating providers continues in 2007-2008. All RFTS Regional Care Coordinators (RCCs) receive monthly training and updates and then provide quarterly mandatory group and/or individual training sessions with DCCs.

The virtual training CD, "Smoking Cessation for Pregnancy and Beyond - Learn Proven Strategies to Help Your Patients Quit", has been distributed to and completed by the RCCs and DCCs statewide, either individually or in a group setting during a quarterly DCC meeting who continue using the tool for ongoing education.

The 2007 RFTS Client Satisfaction Surveys show thirty-eight percent (38%) of the women reported they received smoking cessation education from DCCs. These surveys were not only completed by smokers/former smokers but also by women who never smoked.

The RFTS Project works closely with the WV Tobacco Quitline operated by the Division of Tobacco Prevention. All pregnant women who are smoking at RFTS case closure or who relapse postpartum are referred to the Quitline. The Quitline may be used while she is participating in RFTS services if the pregnant woman chooses both interventions.

c. Plan for the Coming Year

Dr. Richard Windsor, MS, PhD, MPH, Professor, Department of Prevention and Community Health, School of Public Health and Health Services, George Washington University Medical Center, Washington, D.C., received notification in October 2007 of a grant award from the National Cancer Institute for 2008-2011. The George Washington University Institutional Review Board has approved the project and will use West Virginia RFTS as a model of an entire system of care for evidenced based interventions for pregnant Medicaid smokers. One of the primary objectives of the grant is to institutionalize the intervention with staff during/after the grant and evaluation is completed.

This award reflects the hard work over the past 3 years, under the joint leadership, of Dr. Windsor, Jeannie Clark, the RFTS RCC's and DCC's, and colleagues at GWU through the WV Right From The Start (RFTS)-Smoking Cessation and Reduction In Pregnancy Treatment (SCRIPT) Dissemination Program.

The GWU NIH Internal Review Board (IRB), in its critique of the proposal, acknowledged the RFTS progress between 2004-06 in disseminating a nationally recognized, evidence based SCRIPT Program, and also acknowledged the high quality of the Project's process, impact and cost evaluations.

The grant allows The Right From The Start Project to hire a full time, Master's prepared coordinator and a part time data support person to coordinate the expanded smoking cessation in pregnancy initiative.

The foundation has been laid in WV for an effective statewide initiative to continue reductions in the number of pregnant smokers. Although The WV RFTS SCRIPT provides smoking cessation

education to numerous low income pregnant women and their families, more than half of WV pregnant women are eligible for this support and for public assistance.

The RFTS Project plans to continue to provide smoking cessation education and support to pregnant women and their families on the dangers of smoking during pregnancy and the importance of maintaining a smoke free environment. Providers will continue to use the 5 A's best practice method and a carbon monoxide monitor to provide a visual message of the dangers of smoking during pregnancy.

Database revisions have been completed which will allow more accurate data collection for the Project. Data from 2007 RFTS Client Satisfaction Surveys show thirty-eight percent (38%) reported they received smoking cessation education from DCCs. The survey will continue to be mailed at case closure and data collected by the RFTS Project.

RFTS DCCs will receive continuing education on proper method of using tools to enhance, support and facilitate therapeutic relationships between provider and client for mothers desiring to quit or reduce smoking.

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	2003	2004	2005	2006	2007
Annual Performance Objective	7	6	6	5	7
Annual Indicator	7.2	9.6	8.0	11.1	8.0
Numerator	9	12	10	14	10
Denominator	125578	125578	125578	125578	125578
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	7.5	7.5	7	7	7

Notes - 2007

Based upon 2006 Vital Statistics

Notes - 2006

2006 Vital Statistics

Notes - 2005

estimated based on 2004 WV Vital Statistics

a. Last Year's Accomplishments

In March of 2006, the West Virginia Council for the Prevention of Suicide contracted with the Mental Health Association in New York City to provide statewide suicide prevention services through the National Suicide Prevention Lifeline, 1-800-273-TALK. Callers from anywhere within West Virginia who call that toll-free number are automatically routed to the Crisis Intervention Specialists at Valley HealthCare System in Morgantown, WV. Based upon the severity of the call,

emergency dispatchers may be notified, callers may be referred for inpatient treatment, referred for outpatient treatment, or provided with supportive counseling over the telephone. Valley HealthCare System was chosen as the site for this service due to the availability of trained professionals 24 hours a day seven days a week, the availability of necessary equipment, and the fact that both the Executive Director and the Suicide Prevention Coordinator of the Council are both located at Valley HealthCare System.

The Council is currently providing workshops on Suicide across the Lifespan at various locations across the state. This year the Council has presented five workshops and has two more planned following our summer conference in June. Response to these workshops has been overwhelmingly positive. The council is also making preparations for our next summer conference which will take place in June 2008. The conference will feature both national speakers and state experts on suicide and depression. The Council also has had 4 suicide assessment instruments published in the book "Innovations in Clinical Practice". The Council collaborated with Dr. William Fremouw to establish an assessment instrument for each age group, and will continue to offer trainings on the assessments in the coming year. In October of 2007, the Council sponsored the first Out of Darkness Walk for Suicide Prevention in Huntington, WV. This is the first event of its kind to be held in West Virginia, and was attended by over 200 people.

In April the Council Board held a board retreat and completed a strategic plan for the coming year. Some of the goals identified for the coming year were to target community awareness of suicide prevention to police officers, firemen, children, parents, and older Americans. The Council also identified the need to get legislation passed regarding training school teachers on the early signs of suicide. This year the Council also purchased posters, magnets, and bracelets that have the National Suicide LifeLine number on them. The Council has been distributing these throughout the state over the last year. The Council also purchased screen time at several movie theaters in West Virginia to raise awareness of the National Suicide LifeLine and the Council's website www.wvsuicidecouncil.org. The Council also purchased an additional web portal this year, www.preventsuicidewv.org. This website features warning signs of suicide and depression, as well as a suicide risk questionnaire. The Council held a Suicide Awareness day at the Capitol on June 24th. The Council has also established two Survivor's of Suicide groups in the State, one in Morgantown, WV and one in Charleston, WV. The groups in Morgantown are held on a monthly basis at Valley HealthCare System, and weekly in Charleston at 910 Quarrier Street. Council staff also presented at the Kentucky and West Virginia Older Person's Conference on August 27th and 28th, and at the Governors Summit on Aging on September 18-20th. In July Council staff attended the Suicide Prevention Action Network's conference in Washington DC. While at the conference staff met with representatives from Robert Byrd's and Jay Rockefeller's offices to discuss the continuation of the Garrett Lee Smith Memorial Act, which provides funding for the ASPEN project in Kanawha County, West Virginia. Council staff also attended the National Suicide Prevention LifeLine Conference in New Orleans.

Table 4a, National Performance Measures Summary Sheet

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

published in the book "Innovations in Clinical Practice".				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The West Virginia Council for the Prevention of Suicide believes education and prevention will assist our state in saving lives of our citizens. Knowing the early signs of depression and suicidal behaviors is paramount in saving someone from their first suicide attempt. The West Virginia Council for the Prevention of Suicide workshops will inform the workshop participants on how to recognize the early signs of depression and then where to go for assistance. The workshops will also explain the early signs of suicidal behaviors and again where to go for assistance. The Council also gives out crisis numbers for every county in West Virginia which has a provider that operates 24 hours, 7 days a week crisis lines.

The Council is currently providing workshops on Suicide across the Lifespan at various locations across the state. This year the Council has presented five workshops and has two more planned following our summer conference in June. Response to these workshops has been overwhelmingly positive.

The Council continues to provide oversight to ASPEN, West Virginia's Garrett Lee Smith Memorial Act grant. The grant has been funded since October 2006. Since it began serving kids in February 2007, the grant has served over 100 suicidal youth within Kanawha County. Grant staff have provided numerous educational presentations within the community, including awareness trainings to school staff, parents, church groups, and peer mentors.

c. Plan for the Coming Year

The Council is making preparations for the summer conference which will take place in June 2008. The conference will feature both national speakers and state experts on suicide and depression. The Council has completed a five year strategic plan for suicide prevention in WV. The Council also has had 4 suicide assessment instruments published in the book "Innovations in Clinical Practice". The Council collaborated with Dr. William Fremouw to establish an assessment instrument for each age group, and will continue to offer trainings on the assessments in the coming year.

Suicide prevention efforts are mainly administered through the Office of Behavioral Health Services within the Department of Health and Human Resources. The Office is located in the same building as the Office of Maternal, Child and Family Health. The Division of Infant, Child and Adolescent Health located within the OMCFH works closely with Behavioral Health Services in designing education efforts targeted for teens.

Several goals of the Council include: 1) Establish activities to decrease prejudice toward receiving services for mental health or substance abuse issues, reduce ready access to self-destructive materials, and assure supports for families and friends of persons who commit suicide, 2) Develop broad-based support for suicide prevention among providers of behavioral health and health care services, 3) Promote public and professional awareness that suicide is a public health problem that is preventable, and 4) Assure that health care, behavioral health, social service providers, and the general public are aware of the latest information concerning suicide and suicide prevention.

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	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	85	98	98
Annual Indicator	84.0	96.5	97.3	84.9	95.4
Numerator	242	248	250	258	290
Denominator	288	257	257	304	304
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	98	98	98	98	99

Notes - 2005

estimated based on 2004 Vital Statistics

a. Last Year's Accomplishments

Although the RFTS Project provides care coordination for a high risk population the following data were collected regarding infant birth weight:

	2005	2006	2007
Average RFTS infant birth weight	7.2 pounds	7.2 pounds	6.96 pounds

Most West Virginia OBs now complete the Prenatal Risk Screening Instrument (PRSI) and submit referrals for potential clients to RFTS. RCCs continue to make site visits to the OB providers to encourage completion of the PRSI and obtain client referrals. A Power Point presentation, RFTS posters, and free literature were given to providers. The providers were advised that RFTS care coordinators can reinforce client education and provide additional support for their clients in the client's homes.

High risk infants are referred to RFTS by the WVU, Birth Score Program, which is financed by the MCFH resources. The Birth Score Developmental Risk/Newborn Hearing Screen Instrument is a population-based assessment designed to identify infants at birth that may be at risk for developmental delay or death within the first year of life.

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

By December 31, 2007 there were 908 active primary care providers (681 private physicians and 227 clinics) accepting Birth Score referrals. There were thirty-five (35) new physicians added in CY 2007.

The Birth Score Office, in collaboration with the WV School of Dentistry developed and distributed an oral health brochure which is distributed by birthing hospitals to parents of infants born in West Virginia. A total of 70,000 brochures were printed: 24,000 were distributed to the WV Dental

Association for distribution to dentists across the State, 20,000 were forwarded to OMCFH/ Right From the Start Project, and 500 were distributed to WVU School of Dentistry-Oral Health Promotion during Pregnancy Project.

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 patients 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 screening and referral.				X
4. The WV RFTS 'SCRIPT' educates, supports, and assists pregnant women to quit or lower number of 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. Patients are provided info on detection of preterm labor.		X		
8.				
9.				
10.				

b. Current Activities

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

RFTS DCCs are highly trained, Registered Nurses and Licensed Social Workers with community health experience, and have access to resources which enable them to recognize and provide intervention for families who are at risk for poor birth outcomes. 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. A 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.

Each client's individually designed service care plan is shared with their medical provider and the DCC collaborates with the provider to facilitate client compliance with obtaining early and adequate access to health care and enhancements to medical care.

c. Plan for the Coming Year

Improvement in the health of WV'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. This WV partnership will continue for 2008.

One of the main goals of the RFTS Project is to empower RFTS participants to be able to have the tools and knowledge to access adequate health care and needed services after being discharged from care coordination. The primary goal of RFTS services is not to serve as a "crutch" for the families served but to provide education and support so that the families learn how to function on their own without outside intervention after discharge from the Project.

West Virginia DHHR local offices continue to request RFTS training and the benefits provided to pregnant women by contacting the Director of Perinatal Programs and the RCCs. Power Point presentations which will provide education on the components of the RFTS Project and how the DHHR local offices can refer clients to RFTS for services are scheduled for 2008.

The Project DCCs and RCCs will continue to screen participants for risks that could result in poor birth outcomes such as preterm and low birth weight births. The DCCs will provide intervention and referral to community resources as needed for issues such as access to care, depression, smoking, use of harmful substances, and domestic violence. Issues affecting each client will be shared with the medical provider using the service care plan which will be updated on a regular basis.

The WV Birth Score Office, WV Office of Vital Statistics and The Right From The Start Project Electronic Data System are now able to match and share data on birth outcomes. This will allow the RFTS Project to identify areas of the State which need additional education and intervention through home visiting care coordination services in order to improve birth outcomes.

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	2003	2004	2005	2006	2007
Annual Performance Objective	87	88	88	89	89
Annual Indicator	85.8	83.0	85.0	83.6	88.1
Numerator	17474	17350	17700	17500	18500
Denominator	20368	20911	20834	20931	21000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	90	90	90	90	90

Notes - 2007

Based upon 2006 PRAMS data

Notes - 2006

2006 PRAMS data

Notes - 2005

2005RAMS data

a. Last Year's Accomplishments

Since the RFTS Project was first initiated in 1989, access to first trimester prenatal care overall has shown improvement from 69.7% to 83.6% in 2006 (latest available). This correlates with intense care coordination and support provided by Right From The Start staff to families in rural West Virginia.

In 2006, the RFTS Project initiated an automated system of sending out invitation letters to all Medicaid eligible pregnant women and infants and this continued in 2007. The reason for this process is to assure that all eligible pregnant women and infants receive an invitation letter and have the opportunity to access early health care through the support of the RFTS Project provider network that has existed in WV since 1989.

The WV OMCFH continues to support early identification of pregnant women using the state's family planning provider network. Calls from patients who wish to continue pregnancy, but need health care financing and physician care, are supported by the OMCFH toll-free line professional staff.

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 shortage areas.				X
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 referral of pregnant women who are denied Medicaid coverage for obstetrical care services.		X		
9. RFTS receives a monthly print out sent electronically from Medicaid of those women who were denied Medicaid coverage during pregnancy. RFTS notifies the person by phone and/or letter of OMCFH services available.		X		
10.				

b. Current Activities

The RFTS Project continues to use the automated system of sending invitation letters to all Medicaid eligible pregnant women and infants. The reason for this process is to assure that all

eligible pregnant women and infants receive an invitation letter and have the opportunity to access early health care through the support of the RFTS Project provider network.

Right From The Start provides direct financial assistance for obstetrical care for some WV pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. Pregnant women may qualify for assistance with prenatal care through a program entitled Maternity Services if they are a WV resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V funded service, through Presumptive Eligibility, 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 the first visit.

The WV Director of Perinatal Programs and RFTS RCCs provide training and education to local DHHR office staff and other community agencies statewide on Maternity Services coverage and how to make a referral to the Project. Staff are advised to refer all women who are denied Medicaid coverage to the OMCFH for eligibility determination for Maternity Services coverage.

c. Plan for the Coming Year

The RFTS Project will continue to work collaboratively with OB providers, March of Dimes, WIC, American Lung Association, WV Perinatal Partnership, and many other groups to educate women on the health consequences of unplanned births and the importance of prenatal care.

The RFTS Project will continue to provide intense education for participants promoting the importance of access to early and adequate prenatal care, and will continue to be the statewide network through which the March of Dimes provides education, literature to residents and medical providers.

RFTS RCCs will continue to make site visits to OB providers to encourage referral to OMCFH for casemanagement support to obtain access to health care financing. The medical community will continue to offer prenatal care to medically indigent patients, with OMCFH guaranteeing payment (presumptive eligibility) for initial visit, lab work and ultrasound.

Information regarding eligibility for OMCFH services is available on the web site and continues to be updated as necessary.

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	2003	2004	2005	2006	2007
Annual Performance Objective				12	12
Annual Indicator	13.7	13.0	14.5	14.0	14.7
Numerator	17204	16325	18250	17600	18400
Denominator	125578	125578	125578	125578	125578
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	12	12	11	11	10

Notes - 2007

2007 YRBS

Notes - 2006

Based upon 2005 YRBS

Notes - 2005

2005 YRBS

a. Last Year's Accomplishments

The data available on the problem of overweight among West Virginia youth are limited. The latest statistics are from the 2007 Youth Risk Behavior Survey. Overall, 14.7% of West Virginia high school students in grades 9 through 12 were overweight (17.6% of males and 11.7% of females). Seventeen percent (17.0%) of students were at risk of overweight, 15.0% of males and 19.0% of females. Questions on daily diets revealed that 19.8% of students ate five or more servings of fruits and vegetables each day and those who drank three or more glasses of milk were only 16.7%.

In the school year 2006-2007, the CARDIAC project reported that 27.7% of fifth-graders were obese and this number has dropped during this school year to 25.8%. The percentage of both overweight and obese students in the other grades screened by the project also declined from last year. An aggressive approach to informing parents about the dangers of obesity, coupled with a statewide promotion of healthy lifestyles, has started to pay off.

The West Virginia Games for Health project is a broad based collaborative project, which utilizes the interactive video game Dance Dance Revolution (DDR) as a physical activity intervention with children and youth. In 2007, WVCHIP financially contributed \$150,000 to the project to complete implementation of DDR in all high schools and a portion of the elementary schools in West Virginia. This contribution added on to a program already underway through contributions from the Public Employees Insurance Agency. All participating schools are provided a full set of equipment, lesson plan strategies, and extracurricular models with a full day's training. DDR is used with Physical Education curriculum, in before school and after school activities, and in DDR clubs. WVCHIP participates in a state-wide advisory team for establishing goals and monitoring progress of the project.

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. West Virginia has a strategic highway safety plan				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Bureau for Public Health uses 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.

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.

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.

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.

c. Plan for the Coming Year

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.

To this end, West Virginia plans to continue to try everything from dance-related video games in schools to increasing the amount of time spent in physical education classes, all aimed at combating a problem that costs state health plans more than \$200 million annually.

Medicaid Managed Care organizations are offering counseling for high risk populations for weight control and healthy eating habits.

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	2003	2004	2005	2006	2007
Annual Performance Objective				19	18.5
Annual Indicator	21.5	21.5	19.3	19.0	19.5
Numerator	26999	26999	24236	23800	24500
Denominator	125578	125578	125578	125578	125578
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	18	17.5	17	16.5	16

Notes - 2007

2007 YRBS

Notes - 2006

Based upon 2005 YRBS

Notes - 2005
2005 YRBS

a. Last Year's Accomplishments

The 2007 YRBS shows that the percentage of students who ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days has increased slightly to 19.5%

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

Raze Crews, groups of teens making a difference, are in over 140 schools and communities in West Virginia.

TAC (Teen Advisory Council) members get a chance to be in charge of a number of important duties for Raze. TAC members meet once a month either in person or by conference call. TAC plans, organizes and implements a number of various trainings and commotions. They also provide feedback on Raze issues such as ads, gear, etc.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WV DHHR and Department of Education have strong anti-tobacco programs which include a brand and promotional campaign designed in advice from youth in this age group.			X	
2. The Adolescent Health Initiative warns of the dangers of tobacco use.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

Among the current strategies to meet 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.

West Virginia's Youth Tobacco Prevention Program's goal is to prevent WV's youth from using tobacco products, even trying them, and to assist the youth who are using tobacco products in reducing the amount they use or quitting. The Youth Program works closely with the WV Department of Education (WVDE) on tobacco related issues including policy and enforcement. The Regional Tobacco Prevention Specialist (RTPS) Network is facilitated and managed through the Office of Healthy Schools, WVDE and the Division of Tobacco Prevention, WVDHHR. The Youth Program also collaborates with the American Lung Association of WV (ALA) to address the community needs of the state and provide facilitation for both schools and communities. The WVDE and the ALA work with the Youth Program and The Arnold Agency to support Raze. Raze is West Virginia's teen led anti-tobacco movement. For more information go the Raze website at www.razewv.com

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	2003	2004	2005	2006	2007
Annual Performance Objective				24	23
Annual Indicator	73.6	27.0	32.0	29.0	26.2
Numerator	15322	5650	6670	6070	5500
Denominator	20830	20911	20834	20931	21000
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	22	21	20	20	20

Notes - 2007

based upon 2006 PRAMS data

Notes - 2006

2006 PRAMS data

Notes - 2005

2005 PRAMS data

a. Last Year's Accomplishments

According to West Virginia Vital Statistics, WV has the highest smoking rate for pregnant women in the United States. The rate of smoking during pregnancy in WV for 2006 was 27.2%, compared to the U.S. rate of 10.7% for 2005 (last data available).

In 2007, The RFTS Project obtained data from the Birth Score Office which shows that many counties in WV have a self-reported rate of 30% to 57% among Medicaid mothers who smoked during pregnancy. 2007 data derived from the new RFTS Electronic Data System reveals a self reported rate of 42% smoking during pregnancy among Project participants. This creates an enormous health problem for the State of WV which not only effects the developing infant but the pregnant woman, her children, and other exposed family and friends, as well as the health care community. To address this issue, RFTS adopted an intense smoking cessation initiative. The program was developed by Dr. Richard Windsor of George Washington University Medical Center, Department of Prevention and Community Health, who successfully implemented the program in Alabama.

A smoking cessation program was implemented in West Virginia in January 2002, through the OMCFH. It was incorporated as protocol into the RFTS Project in October 2003, known as The WV RFTS SCRIPT (Smoking Cessation/Reduction in Pregnancy Treatment). The WV RFTS SCRIPT uses the existing home visitation network and protocols established in the RFTS Project. Registered Nurses and Licensed Social Workers, Designated Care Coordinators (DCCs) provide services to pregnant women and infants throughout West Virginia.

In 2007, RFTS DCCs received additional training in the tobacco dependence effort to provide pregnant women with best practice smoking cessation methods. RFTS Regional Care Coordinators (RCCs) provide SCRIPT education to providers who provide obstetrical services in each region and encourage them to refer their pregnant smokers for home based tobacco dependence treatment.

Data from the RFTS Project show the following quit rates among pregnant participants: 2003 = 23%; 2004 = 22%; 2005 = 26%; 2006 = 27%; 2007 = 22%

Data from SCRIPT document how pregnant smokers and their families respond to intense statewide efforts. DCC documentation of intervention through CO testing has saved the lives of WV families.

Data from 2007 RFTS Client Satisfaction Surveys show 38% of Project participants reported they received smoking cessation education from DCCs. The Project would like to increase that percentage.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented the Smoking Cessation Program (SCRIPT) developed by Dr. Richard Windsor in January, 2002 and is ongoing.				X
2. The WV SCRIPT uses the existing home visitation network and protocols in the RFTS Project.		X		
3. 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				X

Screening databases.				
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 continue with Dr. Richard Windsor, the WV RFTS SCRIPT consultant, and WV agencies who have an interest in smoking cessation among pregnant women. Dr. Windsor received notification in October 2007 of a grant award from the National Cancer Institute for 2008-2011. The George Washington University Institutional Review Board has approved the project and will use West Virginia RFTS as a model of an entire system of care for evidenced based interventions for pregnant Medicaid smokers. One of the primary objectives of the grant is to institutionalize the intervention with staff during/after the grant and evaluation is completed.

The RFTS Project works closely with the WV Tobacco Quit Line. If the pregnant smoker chooses both interventions she may participate in both. However all women who are smoking at RFTS case closure or who relapse postpartum are referred to the Quitline. Two staff persons from the WV Tobacco Quitline have agreed to serve on the SCRIPT Policy and Management Committee which was formed in 2007.

SCRIPT education to all RFTS providers continued in 2007. A virtual training CD, "Smoking Cessation for Pregnancy and Beyond...." is used for continuing education.

c. Plan for the Coming Year

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

West Virginia Medicaid provides reimbursement for both pharmaceutical products and behavioral modification services to promote the discontinuation of tobacco products by eligible recipients. Pregnant females are eligible for an additional course(s) of treatment if needed. In 2007, the WV Tobacco Quitline made services and NRTs available free of charge to family members of pregnant participants and this will continue in 2008.

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

Data collection will continue on all pregnant smokers participating in the RFTS Project. The RFTS web-based electronic data system launched June 1, 2007 and allows for more accurate data collection for the Project.

A primary goal of the RFTS Project is to continue to reduce the rate of WV pregnant smokers through the statewide efforts of the expanded SCRIPT initiative.

The grant from the National Cancer Institute received by the OMCFH in 2007 will allow the RFTS

Project to hire a full-time coordinator and a part-time data support person to coordinate the expanded smoking cessation pregnancy initiative.

Through funding provided by the Tobacco Prevention grant, standardized research-based educational materials and best practice curriculum proven to be effective in assisting with smoking cessation, will be purchased. 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 weight rates.

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	2003	2004	2005	2006	2007
Annual Performance Objective				37	38
Annual Indicator	26.2	30.0	22.0	56.0	57.1
Numerator	5500	6270	4580	11730	12000
Denominator	20986	20911	20834	20931	21000
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	57	57	58	58	59

Notes - 2007

based upon 2006 PRAMS data

Notes - 2006

2006 PRAMS data - women who initiated and breastfed for any amount of time

Notes - 2005

2005 PRAMS Data

a. Last Year's Accomplishments

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 Right From The Start Project (RFTS) 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.

As revealed by the data below, RFTS Project participants have experienced a steady increase in the number of moms who choose to breastfeed their infants at hospital discharge and those who continue to breastfeed at case closure.

	2003	2004	2005	2006	2007
Chose to breastfeed at hospital discharge	19%	20%	32%	37%	40%
Still breastfeeding at case closure	3%	9%	14%	16%	18%

The RFTS Project encourages collaboration with local WIC offices statewide to ensure that participants continue to receive breastfeeding education and support after case closure. After learning of ineffective community collaboration between RFTS and West Virginia WIC providers, the Director of Perinatal Programs voiced concerns regarding this matter to the Director of the

Office of Nutrition Services. RFTS DCCs report that collaborative efforts have improved. This improvement provided RFTS participants with better continuity of care and resulted in an increase in the number of pregnant women referred to RFTS for care coordination. This in turn provided an opportunity for more breastfeeding education and support and is evidenced by the steady increase in breastfeeding rates of RFTS Project participants reported above.

In 2007, The RFTS Project was involved in a collaborative strategic planning effort to develop a cross-referral system for service integration and coordination. It was decided that the most logical system to use statewide would be Systems Point of Entry which is housed within OMCFH.

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 breastfeeding.				X
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. WIC goals include providing additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physicians practices in order to keep mothers breastfeeding longer.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Project participants are encouraged to breastfeed and educated on health and socioeconomic benefits to mother and infant. Some long-term benefits discussed regarding breastfeeding are reduced childhood obesity, reduced risk of some chronic diseases, decreased risk of allergies, improved neurological development, higher IQs, better eyesight, increased jaw strength and straighter teeth as a direct result of suckling at the breast.

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

The social and economic benefits of breastfeeding are emphasized to show families that they can potentially save money when comparing the cost of breastfeeding to the cost of using formula. Breastfeeding is convenient and safer because breast milk is always available at the correct temperature, is sterile, and requires no mixing.

The RFTS Project continues to encourage collaboration with local WIC offices statewide to ensure that participants receive breastfeeding education and support after case closure.

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 promote breastfeeding with each prenatal participant and provide support and referrals as needed. RFTS will continue to train DCCs on the benefits of breastfeeding and how to encourage participants to try breastfeeding as their first 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 with March of Dimes grant funding in 2004 is entitled "The Pregnancy Workshop" and is available to each DCC at no cost for use and/or reproduction of the educational materials through the Regional Care Coordinator.

Since each RFTS Project DCC is now assigned a DVD player to use for client/family education during home visits, the RFTS plans to purchase educational DVDs that will more effectively promote breastfeeding.

RFTS 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.

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

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	2003	2004	2005	2006	2007
Annual Performance Objective				10	10
Annual Indicator	12.0	12.0	10.6	10.4	10.0
Numerator	15069	15069	13300	13000	12500
Denominator	125578	125578	125578	125578	125578
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	9.5	9	8.5	8	8

Notes - 2007

2007 YRBS

Notes - 2006

Based on 2005 YRBS

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.

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.

The 2007 YRBS states that 10.0% 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 warehouse, 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.

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.

WV developed a West Virginia Strategic Highway Safety Plan (SHSP) in accordance with requirements of 23 USC Section 148, under the oversight of the Highway Safety Management Taskforce which has numerous stakeholders from various agencies throughout local, state and federal governments. This is a far-reaching plan incorporating numerous emphasis areas with the overall goal to reduce the number of lives lost on WV highways as a result of motor vehicle crashes.

In 2006 410 people died on WV highways. Although WV has experienced decreases below 400 in years 2003 and 2005, in the last seven years there is a relatively flat fatality trend line between 2000 and 2006.

The goal for West Virginia is to reduce highway related fatalities to zero. WV has a goal of "Zero Fatalities...Saving One Life at a Time" with an interim goal of no more than 300 highway fatalities annually by 2010.

Between 2002 and 2005, 36% of all fatalities due to car crashes were related to alcohol.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Students Against Destructive Decisions (SADD) works with communities to establish local chapters.		X		
2. Adolescent Health Initiative promotes healthy decision making.			X	
3. State alcohol distribution policy protects youth.				X
4.				
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

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.

Several initiatives from the WV Strategic Highway Safety Plan include: Expand SADD and MADD

to improve education at the family and school levels; develop a designated driver program; conduct comprehensive law enforcement training; create stigma for DUI through improving public awareness of convictions; expand Interlock program to make it mandatory for first time offenders; require mandatory enrollment in alcohol and drug treatment program and rewrite criminal DUI law.

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	2003	2004	2005	2006	2007
Annual Performance Objective				15	14.5
Annual Indicator	15.2	15.2	15.2	15.0	16.6
Numerator	19087	19087	19087	18800	20800
Denominator	125578	125578	125578	125578	125578
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	14	13.5	13	12.5	12

Notes - 2007

2007 YRBS

Notes - 2006

Based on 2005 YRBS

Notes - 2005

2005 YRBS

a. Last Year's Accomplishments

West Virginia's efforts to encourage motorists to buckle up have paid off. The U.S. Department of Transportation awarded a \$5 million grant to the Governor's Highway Safety Program in May 2008 because the state has one of the highest seat belt usage rates in the nation. West Virginia was among five states with a seat belt usage rate of at least 85 percent for two years. The state's usage rate was 88.5 percent in 2006 and 89.5 percent in 2007.

The grant will be used to buy electronic reporting equipment, to fund driver behavior programs and develop educational materials targeting impaired driving prevention efforts.

Table 4b, State Performance Measures Summary Sheet

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

6.				
7.				
8.				
9.				
10.				

b. Current Activities

Since September 1993 and the implementation of West Virginia State Code 17C-15-49, wearing your safety belt in a motor vehicle is mandatory and not just during the annual statewide Click It or Ticket campaigns.

- All drivers must wear a seat belt.
- All passengers in the front must wear a seat belt.
- All passengers in the back under the age of 18 must wear a seat belt.
- Violators can be fined up to \$25.

c. Plan for the Coming Year

It is the goal of the West Virginia Strategic Highway Safety Plan to increase seatbelt usage to 94% by 2010. Part of this plan includes evaluating the feasibility of a "ride the school bus program" for students who now use personal vehicles.

Also planned are:

1. enact primary seatbelt law before July 2008
2. upgrade existing seatbelt law to include all seating positions and to call for minimum fine of \$25
3. enact legislation that prohibits riding in the back of pick-up trucks
4. enact legislation which requires the use of a helmet for all ATV riders
5. oppose any attempt to repeal the Motorcycle Helmet Law

Another goal is a 20% reduction of fatalities in each of the driver categories/user groups:

Younger Drivers:

1. enhance law enforcement training on Graduated Driver Licensing
2. improve crash form to include Graduated Driver License gradients

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)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				90	90
Annual Indicator		87.8	88.2	88.7	89.6
Numerator		199564	200354	232500	233427
Denominator		227222	227222	262222	260614
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	90	92	92	92	93

a. Last Year's Accomplishments

Of the children enrolled in WVCHIP for the entire calendar year 2006, 100% of the children ages less than or equal to 15 months had a well child visit with a physician. Of the children ages 0 through 6 years of age 94.73% enrolled in WVCHIP had a well child check-up. Eighty-three percent (83%) of children enrolled in WVCHIP ages 12 to 21 years had a well visit with a

physician.

For FFY 2007, of the 13,905 children less than one year old eligible for Medicaid, 13,807 (99.29%) received at least one initial or periodic screen. The participation rate for children ages 1-2 was 65.53%, ages 3-5 was 49.15%, ages 6-9 was 57.82%, ages 10-14 was 28.94%, ages 15-18 was 20.83% and for ages 19-20 it was 9.05%. Overall participation rate was 45.31%.

West Virginia is ahead of most other states when it comes to getting children access to health care, according to a recent study. A report released by The Commonwealth Fund ranks West Virginia in the top quartile overall. The Mountain State also has the highest ranking in providing specialty care to children. West Virginia provides public health insurance for many of its children partly through agencies like Medicaid and the State Children's Health Insurance Program.

In May 2006, West Virginia received CMS approval to move forward on plans to redesign its Medicaid program. Taking advantage of the flexibility outlined in the DRA, West Virginia utilized the state plan amendment process. A four-year, phased in implementation began in July 2006. The West Virginia reform streamlines eligibility and moves healthy children and parents into one of two plans:

Basic Plan: The plan covers all mandatory and some optional services, but benefits are more limited than the state's previous Medicaid benefits package. Children continue to receive services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Enrollees can access additional benefits covered by the Enhanced Plan by signing a member agreement.

Enhanced Plan: For individuals who have signed a member agreement, this plan covers all the services included in the Basic Plan plus mental health services, diabetes care, and prescription drugs above the four-drug limit in the Basic Plan. The Enhanced Plan is comparable to the state's previous Medicaid benefits package.

The cornerstone of West Virginia's plan is the member agreement and the Healthy Rewards pilot program. Enrollees who sign a member agreement, a 'personal responsibility contract,' are enrolled in the Enhanced Plan and receive a fixed amount of credits per quarter in a Healthy Rewards account. The credits can be used to cover medical and pharmaceutical co-pays and bonus credits are added for meeting health goals. Individuals who do not meet their responsibilities are moved to the more limited Basic Plan.

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 and handouts from HealthCheck advising them of the EPSDT services and how to access those services.

EPSDT utilization remains at 50%. EPSDT Family Outreach Workers, located in nine regions of the State, inform parents and care-takers of Medicaid eligible children not enrolled in Medicaid managed care 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.

The OMCFH HealthCheck staff only does outreach for EPSDT members not assigned to an HMO. Forty-four counties are covered 100% by HMOs and another 5 counties are covered by one HMO and PAAS. HealthCheck only serves 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.

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. Promote routine health care utilization via Healthy Schools			X	
4. Promote the Governor's Kid First Initiative to screen kindergarten kids			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

WVCHIP continues to partner 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 a healthy lifestyle. Collaborations are important to allow multiple agencies and entities inside and outside state government to integrate efforts related to a statewide mission for the health of West Virginia's children. WVCHIP has embarked on several health intervention and prevention initiatives that have involved the Infant, Child, and Adolescent Division within OMCFH as well as other Offices within the Bureau for Public Health.

Currently, WVCHIP is focusing on educating families on the importance of well-child visits, immunizations, reducing unnecessary emergency room visits, child development and asthma and diabetes case-management.

Several groups and coalitions have asked Medicaid to revise its newly redesigned Medicaid plan. They contend that the redesign will not get the intended results. Findings showed that in Clay and Lincoln counties, participation in the enhanced plan hovered around 10%, while it reached 20% in Upshur County. These were the three pilot counties.

The Kids First Screening Initiative was launched this year with the support of WV Governor, Joe Manchin. Kids First's Healthcheck is a comprehensive screening that includes hearing, speech, language, and growth and development. Beginning the school year 2008-09, all children enrolling in kindergarten will receive this exam.

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.

The health care reform bill 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 expansion. The CHIP expansion is projected to achieve a 97% rate of children who have health insurance.

WVCHIP will continue partnerships with several State agencies and community health programs and focus on healthy lifestyles and prevention efforts.

The West Virginia Small Business Plan will continue to allow small businesses access to the buying power of the Public Employees Insurance Agency (PEIA). Through a private-public partnership between the West Virginia Public Employees Insurance Agency (PEIA) and insurance companies that choose to offer the plan, the West Virginia Small Business Plan allows participating carriers to access PEIA's reimbursement rates, enabling the new small business coverage cost to be reduced significantly. PEIA is the largest self-insured plan in the state, providing insurance to public employees in state agencies, state universities, and colleges, as well as county boards of education. The Small Business Plan has similar goals to group purchasing arrangements because it builds on the buying power of a large group. Program enrollment began in January 2005 and, as of the Fall of 2006, more than 1,200 were enrolled, representing 300 businesses.

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	2003	2004	2005	2006	2007
Annual Performance Objective				68	69
Annual Indicator	66.3	66.3	63.7	65.0	42.8
Numerator	83258	83258	79993	81600	53700
Denominator	125578	125578	125578	125578	125578
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	50	50	55	55	60

Notes - 2007

2007 YRBS - question is actually stated as percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days.

Notes - 2006

Based on 2005 YRBS

Notes - 2005

2005 YRBS

a. Last Year's Accomplishments

Throughout the 2006-07 school year, 762 schools in all 55 counties administered the FITNESSGRAM(r). Physical education teachers report grade level FITNESSGRAM(r) results through the West Virginia Education Information System (WVEIS) Tenth Month Report. For each test category, teachers report the number of students tested and the number of students performing in the "healthy zone" as defined by the FITNESSGRAM(r). Tested and reported categories include: aerobic capacity, body composition, curl-up, upper body strength, flexibility and trunk lift.

The 2006-2007 FITNESSGRAM(r) results indicate that a majority of students are performing in the Healthy Fitness Zone. However there is room for improvement and physical education teachers need technical assistance in data analysis so that they can design their physical education programs to address the areas of greatest need for their students.

Passed March 11, 2006; in effect ninety days from passage:

An act to amend and reenact SS18-2-7a of the Code of West Virginia, 1931, as amended, relating to requirements for physical education in public schools; additional condition authorizing development of alternative programs to meet requirements; grouping requirements by programmatic rather than grade levels; and requiring state board rule on collection, use and reporting body mass index data.

Every school is encouraged to develop schedules that meet or exceed the requirements. However, a provision 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-approved 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.

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

For the 2007 YRBS this question was modified and now states: percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days.

The CARDIAC Project provides health screenings to elementary school children in all 55 West Virginia counties. Data from the CARDIAC Project for the latest school year show declines in unhealthy weights throughout the elementary school-age population. In the 2006-07 school year, the project reported that 27.7 percent of fifth-graders were obese, based on their body mass index. That has dropped in the current school year to 25.8 percent. The percentage of both overweight and obese students in the other grades screened by the project also declined from last year. The biggest declines were among obese kindergartners, falling from nearly 20 percent to about 17 percent, and overweight second-graders, a drop from 19 percent to 15 percent. Still, about 21 percent of all West Virginia children are obese according to the Trust for American's Health. Nationally, the rate is about 17 percent.

West Virginia has tried everything from dance-related video games in schools to increasing the amount of time spent in physical education classes, all aimed at combating a problem that costs state health plans more than \$200 million annually.

Some schools have tried locally developed initiatives with successful results.

c. Plan for the Coming Year

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 expectations and encouraged county boards to prepare, adopt and implement a comprehensive nutrition and physical activity plan that included specific standards.

E. Health Status Indicators

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.

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, **//2009/ 148 publicly funded family planning clinics provide contraceptive care to 56,800 women -- including 15,804 sexually active teenagers. //2009//** 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 site. Among the 50 states and the District of Columbia, West Virginia ranked 6th in service availability in 2006. The publicly funded family planning network 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.

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 days postpartum and care coordination for Medicaid eligible infants up to one 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 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 West Virginia counties, the HAPI Project has been expanded to eight 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 2004, 2005 and 2006 the percentage has remained between 83-84%.

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. More than 50% of West Virginia births are paid for by Medicaid. Due to declining economic circumstances in West Virginia, the percentage of Medicaid eligible families has continued between 50-60%

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 83%, 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% and has leveled off at 83%. However, between 1995 and 2006, 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 tertiary care facilities providing fertility care and treatment services. Multiple births represent 3% of live births in West Virginia.

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., 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 (27.2%) of the 20,931 births in 2006 were to mothers who smoked during their pregnancies, while 0.3% of births were to women who used alcohol.

Because West Virginia has a high rate of 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 (2006) 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 (2006) showed that 65.1% 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. ***//2009/ In 2006, 43% of women living in West Virginia and delivering a live infant reported their pregnancies to be unintended, representing a slight increase in the number of unintended pregnancies from 42% in 2005. //2009//***

Many conditions such as maternal death or ill health decrease when women have births that are

adequately spaced giving their bodies' sufficient time to restore. 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.

Motor vehicle accidents are the leading cause of death for West Virginia children ages 15 through 19. ***//2009/ Of the 101 adolescents who died in 2006 in this age group, 49(48.5%) were due to motor vehicle accidents. //2009//*** In 2004, West Virginia implemented one of the most visible Click It or Ticket enforcement and media efforts 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 speeding 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 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 successful 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. ***//2009/ The percentage of seat belt useage rose to 88.5% in 2006 and to 89.5% in 2007. //2009//***

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.

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.

//2009/ West Virginia's efforts to encourage motorists to buckle up have paid off. The U.S.

Department of Transportation awarded a \$5 million grant to the Governor's Highway Safety Program because the state has one of the highest seat belt usage rates in the nation. West Virginia was among five states with a seat belt usage rate of at least 85 percent for two years. The state's usage rate was 88.5 percent in 2006 and 89.5 percent in 2007. The grant will be used to buy electronic reporting equipment and to fund driver behavior programs and impaired driving prevention efforts.

Since September 1993 and the implementation of West Virginia State Code 17C-15-49, wearing your safety belt in a motor vehicle is mandatory and not just during the annual statewide Click It or Ticket campaigns.

•All drivers must wear a seat belt.

•All passengers in the front must wear a seat belt.

•All passengers in the back under the age of 18 must wear a seat belt.

•Violators can be fined up to \$25. //2009//

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, for children not enrolled in an HMO, 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 additional services. 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 85.9%. 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 preconceptional 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. Because Medicaid mandated enrollment of clients into HMOs, the WV EPSDT Program called HealthCheck is serving fewer and fewer clients.

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 through EPSDT.

Cervical cancer is one of the leading causes of cancer-related death among West Virginia women aged 25-44 years. The 2004 age-adjusted invasive cervical cancer incidence rate is 9.6 per 100,000. The opportunity to provide cervical cancer screening through the WVBCCSPP is part of our effort to improve the quality of life for West Virginians. Women who meet certain clinical guidelines may also be eligible to receive a human papillomavirus (HPV) test through the WVBCCSPP. This data is monitored through the WVBCCSPP's surveillance system. Women diagnosed with invasive cervical cancer can also receive case management services and a Medicaid card through a partnership with the Office of Maternal, Child, and Family Health and the West Virginia Bureau for Medical Services if they are medically indigent.

/2009/

•Federal guidelines mandate that all NBCCEDP grantees have a never or rarely screened rate of > than or equal to 20%. Never or rarely screened is defined as a woman who has never had a Pap test or has had one, but it was five or more years ago. The WVBCCSPP has increased the percentage of serving never or rarely screened women from 4.5% in 2002 to 41.4% in 2007.

•In October 2006, the WVBCCSPP published, "Assessing Awareness and Knowledge of Breast and Cervical Cancer Among Appalachian Women" in the peer-reviewed CDC e-journal Preventing Chronic Disease.

•The WVBCCSPP is increasing the number of women aged 50-64 receiving mammograms through the Program. The proportion of mammograms provided to women 50-64 years of age has increased from 64.9% in 2002 to 86.8% in 2007.

•Over the past several years, the WVBCCSPP has participated in several studies including: the CDC's MDE Validation Project and NBCCEDP Cost Effectiveness Study; the federal Government Accountability Office's Access to Mammography Study, and George Washington University's Breast and Cervical Cancer Prevention and Treatment Act Study.

•During October 2007, 75 activities were conducted by the WVBCCSPP as part of Breast Cancer Awareness Month.

•Nineteen Walks for Women were conducted in 2007 to raise awareness about breast cancer.

•During FY 2006-2007, 50 free screening clinics were conducted. A total of 1,032 women were screened and 640 were enrolled.

•A new vendor was awarded the cytology contract for the WVBCCSPP and Family Planning Program effective November 1, 2006. The new vendor is Cytology Services of Maryland (CSM).

•The WVBCSP transitioned from conventional Pap testing to liquid-based Pap testing during FY 2007-2008. //2009//

G. Technical Assistance

//2009/ West Virginia would like technical assistance to examine our systems and identify strategies to positively impact the low birthweight incidence. In 2006, there were a total of 2,020 low birthweight babies (those weighing less than 2,500 grams or 5 1/2 pounds) born to West Virginia residents, representing 9.7% of all births. Of the 2,020 low birthweight infants with known gestational age, 1,363 or 67.7% were preterm babies born before 37 weeks of gestation. (Of all 2006 resident births with a known gestational, 12.4% were preterm babies.) Over one-fourth (27.4%) of the 20,929 births were to a mother who smoked during her pregnancy. Over the years smoking mothers while pregnant has increased as well. Eighty-one percent (81.5%) of West Virginia mothers with known prenatal care began their care during the first trimester of pregnancy, compared to 86.1% of mothers nationwide (2005). 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. //2009//

V. Budget Narrative

A. Expenditures

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

B. Budget

The Office of Maternal, Child and Family Health has done a good job of leveraging resources. The Block Grant Title V, serves as the foundation but the Office also administers Title X Family Planning; Title XV Breast and Cervical Cancer Screening Program; Part C/IDEA; 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 referred to CSHCN. The CSHCN Program, financed under Medicaid and Title V, not only serves children who have diagnosed chronic and debilitating conditions but arranges assessment for children referred by their primary care/medical home. All of these efforts are 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 ambitious 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 tenets of Part C and to obtain financing necessary to support the system. This system is designed to serve children who are developmentally delayed or at risk of developmental delay, but the many programs administered by the Office 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.