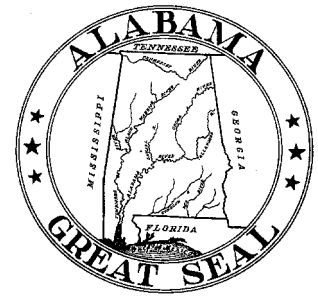


ALABAMA



“We have the technical know-how and we have the basic knowledge of preventative healthcare. What we do not have is the societal commitment for putting our collective noses to the grindstone and not budging until the changes we know need to be there are there.”

–Senator Ted Little, Lead Legislator

Southern Regional Project on Infant Mortality, July 22, 1985

According to the Department of Public Health’s Center for Health Statistics, the infant mortality rate for the state was 9.1 in 2002, or 538 total infant deaths, a drop from its two-year steady rate of 9.4. This is the lowest number recorded, yet it remains among the nation’s highest. Sumter County had the highest IMR (19.2) for the years 2000-2002 combined, while Coffee County had the lowest rate of 3.7. The counties with the lowest rates generally are in the northern part of the state. Counties with the highest rates are scattered throughout the middle and southern part of the state.

The decrease in infant mortality occurred despite several alarming trends: the rate of premature births increased from 13.8 in 1990, to 15.4 in 2001; the percent of low birth weight infants increased from 9.3 in 1999, to 9.6 in 2001; the percent of mothers receiving late or no prenatal care rose from 3.7 in 1999, to 3.9 in 2001; and multiple births rose from 3.0 percent of all births in 1999, to 3.5 percent in 2001. The total number of twin births also increased from 1,237 in 1980, to 1,923 in 2001; births of triplets increased from 20 in 1980, to 115 in 2001; and the number of quadruple births increased from zero in 1980, to 15 in 2001. In 2001, 4,094 infants were admitted to the neonatal intensive care units, a rising trend for the state in the last decade.³³

Although the infant mortality rate remains high, Alabama’s teenage pregnancy rate continues to decrease. The teenage birth rate declined from 62.8 in 1999, to 57.8 in 2001. This also was the lowest number of recorded births to teenagers in Alabama.³⁴

Improvement in survival has not been associated with equal improvement in morbidity. There has been an increase in the number of chronic lung diseases, sepsis, and poor growth outcomes among the infants born.¹⁸ Intensive medical treatment of preterm and low birth weight infants may result

State Facts 2001*

Infant Mortality Rate	9.4
Preterm Birth Rate	15.4
Low Birth Weight Infants	9.6
Prenatal Care in First Trimester	84.4
Pregnancy/Maternal Smoking	12.6
Teenage Birth Rate (age 15-19)	57.8
Birth Rate to Unmarried Women (age 15-44)	34.4

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

in future ill effects in adulthood including altered neurodevelopment and cognitive functions. In order to ensure positive results year after year, many programs were developed and expanded in Alabama to help reduce infant morbidity and mortality. Neonatal intensive care and regionalization of perinatal care emerged as early as the late 1970s. In an effort to confront the state’s high infant mortality rate, a group of physicians, other health-care providers, and interested citizens came together and became the impetus behind the passage of the Alabama Perinatal Health Act in 1980. This statute established the Alabama Perinatal Program and the mechanism for its operation under the direction of the State Board of Health.

The purpose of the Alabama Perinatal Program is to identify and recommend strategies that will effectively decrease infant morbidity and mortality. Additionally, there are several regional and community-based projects that have evolved throughout the state implementing specific strategies to target mothers and infants at risk. These are designed to strengthen statewide efforts to maximize perinatal health that will result in improved access to and quality of services for pregnant women, mothers, and infants.

Alabama is divided into five perinatal regions. Each region has its own perinatal nurse coordinator and a high-risk infant follow-up program. Though each region is comprised of different perinatal





programs, all have similar goals and targets with strong emphasis on improving maternal and infant health. There are several statewide programs and initiatives that influence perinatal issues in Alabama. Some of these include:

Alabama Abstinence-Only Education Program: funded since FY 1998 through Section 510 of Title V of the Social Security Act, the Program was established to help reduce sexual activity among adolescents 17 years of age and younger by providing abstinence-only-until-marriage education.

Smoking Cessation-Reduction in Pregnancy Trial (SCRIPT): a five-year (1997-2001) collaborative project between the University of Alabama at Birmingham (UAB) and the Department of Public Health (DPH). It was developed in an effort to reduce smoking among pregnant Medicaid patients. Based on 10 years of previous studies involving 2,000 DPH patients, the SCRIPT methods were found to be effective. The Bureau of Family Health Services, in collaboration with the UAB, developed a dissemination plan to train all DPH maternity care services staff to deliver the SCRIPT methods as part of routine care.

Alabama Tobacco Free Families Program: a four-year (2000-2004) community-based program using a campaign of media and policy change and a professional practice education component to reduce the smoking prevalence rate of pregnant women whose maternity care is supported by Medicaid, and all females of childbearing age (14-44) in the eight SCRIPT counties (Cullman, Calhoun, Covington, Jefferson, Houston, Lee, St. Clair, and Walker).

Alabama Unwed Pregnancy Prevention Program: established through a partnership with the DPH and the Department of Human Resources to reduce the incidence of unwed pregnancies by providing funding to local communities to develop strategies that will assist all women of childbearing ages to not engage in unprotected sexual activity,

provide information regarding health and social services, and increase public awareness about abstinence. Funding is made available through the federal program Temporary Assistance to Needy Families (TANF) funds.

ALL Kids Children's Insurance: a low cost or free children's health insurance program for uninsured children from birth to age 18. Benefits include regular check-ups and immunizations, sick child doctor visits, prescriptions, dental services, vision services, hospital and physician services, and limited mental health and substance abuse services.

Planfirst: a family health insurance program that helps low-income women plan for their pregnancies. Applicants must live in Alabama, be a U. S. citizen or resident, a female between the ages of 19 and 44, have not had surgery to prevent pregnancy, and meet income guidelines. Services include yearly family planning exam, care support from a social worker or nurse, birth control, tubal ligation for women 21 years or older, and pregnancy testing and lab work.

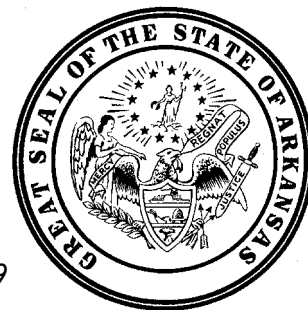
State Perinatal Advisory Council (SPAC): established in 1980 by the passage of the Alabama Perinatal Health Act (22-12A-4), its purpose is to advise the state health officer of the ADPH in the planning, organization, and evaluation of the Perinatal Program.

Alabama Child Death Review System: reviews unexpected and unexplained child deaths that occur in the state.

Uncompensated Maternity Care Project: initiated to encourage development through community-based coalitions of local healthcare networks to provide prenatal care and delivery services to pregnant women who are without private insurance and Medicaid. In FY 2002, Maternal and Child Health Block Grant funds were redirected to prenatal care programs in 21 counties that participated in the Uncompensated Maternity Care Project.



ARKANSAS



“We cannot afford to lose our next generation, the children who will become the future leaders, workers, parents, and innovators of our region and our nation.”

—Governor Bill Clinton, Lead Governor,
Southern Regional Project on Infant Mortality, 1989

The infant mortality rate continues to be on the decline for Arkansas (8.3 in 2001), yet it still remains higher than the national rate. With the contributing and risk factors in mind, several conclusions and explanations of these data may be drawn and linked to the state’s high infant death rate. Although Arkansas’ infant mortality rate is declining, data reveals that the health status and/or outcomes of the infants born have improved very little or not at all within the last decade. However, there have been improvements in preterm birth rates and low birth weight infants. Unfortunately, these changes have had little or no impact on the infant mortality rate.³⁵

Of the 37,454 live births in 2002, the birth rate to teenage mothers was 59.9 (compared to 64.2 in 2001); the birth rate to unmarried women was 49.0 (compared to 36.1 in 2001); 8.6 percent were low birth weight infants (compared to 8.8 percent in 2001); 574 were births that received no prenatal care (compared to 1,702 in 2001); the smoking rate among pregnant women was 18.6 (compared to 18.7 in 2001); and 22.2 percent were births to mothers with less than 12 years of education.³⁶

These statistics suggest that more education and interventions with preventative measures still are very much needed and considered crucial in order to increase the public’s awareness of the problem of infant mortality and morbidity and its enormous repercussions affecting not only the families, but the community as a whole. Having a maternal mortality rate of 10.6, compared to the nation’s rate of 9.9 in 2001, confirms that not only infant health, but also maternal health, should be considered as one of the state’s top priorities.³⁷

Arkansas is divided into five regions as guides for developing public health strategies by the Department of Health. One of the Department’s primary concerns is how to maintain a strong public health system that is able to meet the demands of the future. In November 2000, the people of Arkansas voted to implement the CHART (Coalition for a

State Facts 2001*

Infant Mortality Rate	8.3
Preterm Birth Rate	13.1
Low Birth Weight Infants	8.8
Prenatal Care in First Trimester	79.8
Pregnancy/Maternal Smoking	18.7
Teenage Birth Rate (age 15-19)	64.2
Birth Rate to Unmarried Women (age 15-44)	36.1

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

Healthy Arkansas Today) Plan, which will allocate an estimated \$60 million from the Tobacco Settlement funds to various healthcare activities such as the Tobacco Prevention and Cessation Program (Act 1572), of 2001, passed by the General Assembly.

The Department of Health is a centralized state agency that oversees public health operations in all 75 counties in the state through six bureaus, 10 regional area offices, and 95 local health units. There are several programs and services available through the various divisions of the Department of Health to help promote maternal and infant health and to prevent conditions and diseases that lead to disabilities or death.

Campaign for Healthier Babies: an information campaign operated under a statewide coalition that encourages women to get early and continuous prenatal care and provides general information and material distribution. This campaign is administered by the Technical/Support Services division.



Breastfeeding Program: operated under the Statewide Services Business Unit, promotes and supports breastfeeding through public education, education of health professionals, and individual counseling.

Family Planning Program: operated under the Statewide Services Business Unit, provides medical care, counseling, and contraceptive supplies to general clients including pap-smear results notification; specialized services may be offered to adolescent clients.

Teenage Pregnancy/Unwanted Birth Prevention Program: operated under the Statewide Services Business Unit, provides technical assistance and funding to local community coalitions involved in unwed teenage pregnancy prevention.

Abstinence Education Program: operated under the Statewide Services Business Unit, provides technical assistance and funding to community-based programs to implement abstinence-only education programs in an effort to reduce out-of-wedlock births and teenage pregnancy.

Mother/Infant Program: operated under the In-Home Services Division, provides skilled home nursing visits for first-time mothers and their infants to ensure that medical, social, and nutritional needs are met.

Maternity Program: operated under the Statewide Services Business Unit, provides prenatal and postpartum care including medical, nutritional, and social assessments and case management. Education on pregnancy, nutrition, labor and delivery, infant care, reproductive health, and parenting also are provided. High-risk women receive nutritional and social consultation and are referred to community high-risk providers where appropriate.

Stamp Out Smoking: a tobacco education and prevention program of the Department of Health, aims to eliminate tobacco use in children and pregnant women through public education, community programs, school programs, and supporting enforcement of laws prohibiting tobacco sales to minors.

Connect-Care: an outreach and education program administered by the Shared Services Business Unit as a provision of Medicaid, used to facilitate Medicaid enrollment, primary care physician selection, and use of preventative services. Services are provided through the media, printed materials, and a 24-hour toll-free telephone line.

Arkansas Safe Kids (ASK) Coalition: operated under the Statewide Services Business Unit and the Arkansas Children's Hospital as an injury prevention program for children from birth through age 14. The coalition includes more than 30 organizations working to reduce the number of fatal and non-fatal injuries to children. Members of the coalition also helped pass the Child Passenger Protection Act, requiring children under the age of 6 and weighing less than 60 pounds to be restrained in a child passenger safety seat, and every child under the age of 15 to be required to wear a seat belt.

Hometown Health Improvement (HHI) Project: began as a pilot in Boone County in 1999, and developed to improve the health and quality of life within the communities. It is designed to help communities identify their health problems, address their health needs, and implement actions that will result in positive outcomes. Currently, there are 55 HHI initiatives active in more than 22 counties.



FLORIDA



“The 1,600 children who are alive today because of our smart efforts to reduce infant mortality are proof that focusing on prevention truly works.”

–Governor Lawton Chiles, March 31, 1997

During the past decade, since the implementation of the Florida Healthy Start Program in 1992, Florida’s infant mortality rate has declined appreciably, particularly for non-white infants. Despite the decline, however, Florida continues to contend with a number of adverse factors affecting birth outcomes that are prevalent in the state. Florida has a very diverse population, made up of people from many different cultures. A large migrant population and many undocumented aliens make it more difficult to provide adequate prenatal care to pregnant women. According to the most recent census information, Florida’s minority population totals 3.2 million, or 18 percent of the total population. The health conditions vary from group to group with certain illnesses occurring more frequently in minority populations, including infant mortality and low birth weight. Rapid changes in society and extraordinary problems unique to the state make the provision of healthcare in Florida a challenge.

Florida’s infant mortality rate for 2002 (7.5) may be lower than for 1992 (8.8), but for all the years within the decade, the infant mortality rate has been somewhat static, even slightly on the incline. The 2002 IMR was the highest since 1995 (7.4) and has been steadily increasing since 1997.

The birth rate to unwed mothers in 2002 was 39.3, compared to 34.2 in 1992. The percentage of low birth weight infants, also uprising, was 8.4 percent in 2002, compared to 7.4 percent in 1992.³⁸

On a positive note, dropping from 2,190 in 1998, to 1,859 in 2002, was the number of births to mothers receiving no prenatal care. The percent of teenage births (18 years and under) also dropped from 14.7 percent in 1970, to 12.0 percent in 1980, to 8.7 percent in 1998, and to 7.0 percent in 2002. The number of women, however, with less than 12 years of education giving birth has been fluctuating year after year with little or no improvement. In 2002, there were 41,395 births to women with less than 12 year of education compared to 41,043 in 1996. Because the outcomes of the risk factors did

State Facts 2001*

Infant Mortality Rate	7.3
Preterm Birth Rate	12.7
Low Birth Weight Infants	8.2
Prenatal Care in First Trimester	84.1
Pregnancy/Maternal Smoking	10.3
Teenage Birth Rate (age 15-19)	49.3
Birth Rate to Unmarried Women (age 15-44)	39.0

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

not correlate with or directly link to one another, this again may prove that a decrease in mortality may not necessarily mean an improvement in morbidity.³⁹

The two minority groups that make up the largest portion of infant mortality in Florida are the Hispanic and black populations. Resident infants of Hispanic origin accounted for 15.1 percent of all infant deaths in 2002. Among the counties with the largest number of infant deaths within the Hispanic population in 2002 were Miami-Dade (192), Broward (133), and Hillsborough (133). Black infants accounted for 40.6 percent of all infant deaths for this same year. Counties with the largest number of black infant deaths also were Miami-Dade (92), Broward (73), and Duval (59). The leading causes of infant deaths among all groups were perinatal conditions, congenital anomalies, and Sudden Infant Death Syndrome. These causes accounted for 75.2 percent of all infant deaths that same year.⁴⁰

On June 4, 1991, Florida enacted the nation’s most comprehensive maternal and infant healthcare program, Florida’s Healthy Start initiative. Healthy



Start, operating under the Department of Health, Division of Family Health Services, continues today as a major public health initiative designed to improve the well-being of Florida's mothers and infants by ensuring access to maternal and child health services to all women and children in Florida. Implemented on April 1, 1992, the key components and program descriptions of Florida's Healthy Start include universal prenatal and infant risk screening; Healthy Start care coordination; community-based prenatal and infant Healthy Start coalitions; and high-risk obstetrical care.

Another major event that occurred in Florida was the ratification of the Closing the Gap Act. On June 8, 2000, Governor Bush signed HB 2339, the Patient Protection Act, into law. The 1999-2000 Legislature appropriated \$5 million to the Department of Health to implement and administer the Reducing Racial and Ethnic Health Disparities: Closing the Gap grant program. The program targets six priority health areas—cardiovascular diseases, cancer, diabetes, HIV/AIDS, adult and child immunizations, and maternal and infant mortality—in which racial and ethnic minorities currently experience serious disparities in access to care and health services. The Closing the Gap Act provides grants to local counties and organizations with the intent to increase community-based health promotion and disease prevention activities.

Florida has made great strides in improving health outcomes for mothers and children, and it is reasonable to conclude that Healthy Start has contributed to this success. It is important that there is local participation in the delivery of healthcare services, and Florida has made the expansion of local control a policy priority. A vital component of the Healthy Start program is the community-based Healthy Start Prenatal and Infant Health Care Coalitions. These local coalitions comprise business owners, political leaders, healthcare providers, educators, consumers, and other interested parties. The coalitions design and monitor local service delivery systems and advocate for improved maternal and infant healthcare services. Currently, there are 31 Healthy Start Prenatal and Infant Health Care Coalitions representing 65 counties in the state.

Like many other Southern states, Florida has made notable progress in reducing infant mortality rates. There are several initiatives and programs that have been implemented in an ongoing effort to improve the health and well-being of Florida's mothers and infants. These include the following:

Family Health Line: a toll-free hotline that promotes the importance of early and continuous prenatal and infant care. The hotline provides basic information on pregnancy and how to access prenatal care, infant care, family planning, WIC, drug abuse treatment, and other pregnancy-related services.

Florida's Statewide Birth Defects Surveillance System: established in 1997 under the Department of Health, Office of Maternal and Child Health, as a critical component in the effort to reduce the impact of birth defects on public health. The surveillance is necessary to detect the occurrence of birth defects, educate healthcare practitioners, investigate potential etiologic agents, disseminate information, plan and evaluate the effects of interventions, and ensure appropriate care for people in need of services.

Florida KidCare: signed into law during the 1998 legislative session as a program that offers low-cost health insurance for uninsured children from birth through the age of 18. The Department of Health was designated as the lead agency for designing and implementing outreach activities to promote participation in the program.

Shaken Baby Syndrome Campaign: a statewide campaign developed to educate the general public and healthcare providers about Shaken Baby Syndrome. The campaign is operated under the Department of Health's Healthy Start Coalitions.

Abstinence Education Program: administered by the Department of Health, Bureau of Family and Community Health, Office of Maternal and Child Health, as a program focusing on preventing teenage pregnancies and reducing unwed births among adolescents and preadolescents (ages 9 to 18 years).

Family Planning Program: provides, on a voluntary basis, the information and means to achieve child spacing and planned family size. All family planning clients are offered educational materials, initial counseling, laboratory tests, and physical examinations.

Clients also are given an overview of the available contraceptive methods. Additional health needs and economic services are provided to clients through referrals. Each of the 67 county health departments are actively involved in providing comprehensive family planning services, while nine private providers offer either comprehensive or specialized family planning services. All women and men of reproductive age are eligible for services.



Priority is placed on serving low-income women who are at risk of unwanted pregnancy. Women in need of family planning services are those ages 13 to 44, with incomes at or below 150 percent of the federal poverty level.

Florida's Transition Project: designed to train teams in local communities to enhance their ability to develop a community-wide system of transition to improve movement of young children between and among the agencies. The teams comprise representatives from agencies providing early intervention services and families with young children who participate in early intervention programs.

Volunteer Health Care Provider Program: created by the 1992 Legislature (Florida Health Care Access Act, section 766.1115) in an effort to increase healthcare access for indigent Floridians through volunteerism. Administered under the Department of Health, the program offers communities a means of recognizing and reporting existing healthcare volunteerism efforts and serves as a recruitment tool using the Liability Protection for Healthcare Providers against medical litigations as an incentive to increase the number of volunteers.

Ounce of Prevention Fund of Florida: a not-for-profit corporation founded in 1989 as a research and demonstration arm of public health, social services, and education. The activities of the Ounce of Prevention Fund are supported by public and private dollars. The goal of the corporation is to fund innovative programs and to test these program models through research and evaluation. Programs are designed to promote positive outcomes in children and families in maternal, child, and adolescent health; family functioning, stability, and safety; child and adolescent development; teen pregnancy prevention; and school performance of children and adolescents.

Children's Medical Services (CMS): provides children with special healthcare needs with a family-centered, managed system of care. Children with special healthcare needs are those children under age 21 whose serious or chronic physical and developmental conditions require extensive preventative and maintenance care. Most services are provided at or coordinated through CMS offices in local communities throughout the state. When necessary, children are referred to CMS affiliated medical centers. These centers provide many specialty programs with follow-up care provided at local CMS offices. CMS programs include Brain and Spinal Cord Injury Program; Child Protection Team; Children's Cardiac Program; Children's Multidisciplinary Assessment Team; CMS Network; Craniofacial/Cleft Lip and Cleft Palate Program; Diabetes/Endocrine Program; High-Risk Obstetrical Satellite Clinics; Infant Hearing and Screening Program; Infants and Toddlers Early Intervention Program; Liver Transplant Program; Medical Foster Care Program; Pediatric Hematology/Oncology Program; Pediatric HIV/AIDS Program; Primary Care Program; Regional Genetics Program; Regional Perinatal Intensive Care Centers; Telehealth Program; and Youth Transitions.

Comprehensive School Health Services Projects: operates in 46 counties to provide comprehensive school health to 253,468 students in 311 public schools. Due to the projects' coordinated aftercare and support services, 93 percent of females (6th to 12th graders) are able to return to school after giving birth to continue their education.





GEORGIA

“Even when faced with difficult budget circumstances, we must make every effort to keep our commitment to Georgia’s kids.”

—Governor Sonny Perdue, September 25, 2003

High infant mortality is considered to be more than a health problem in Georgia since it is an important indicator of the overall health status of the state’s women and children. Low birth weight and prematurity are the most common causes of infant deaths in Georgia, followed by congenital birth defects and SIDS. In 2002, 9.0 percent of live infant births were of low birth weight, an increase from 8.5 percent in 1998. The number of women beginning their prenatal care during the first trimester also dropped from 87.3 in 1999, to 84.7 in 2002.⁴¹ These factors illustrate the continued need for education and public awareness as a vital component in all pregnancy cases.

For the past decade, Georgia has had one of the highest infant mortality rates in the nation, even though the state’s rate of infant deaths has been declining steadily. There is serious concern about the racial disparity among black and white infant mortality rates, which also is the main contributor to Georgia’s poor national ranking. The infant mortality rate for white infants in 2001 was 6.2, compared to 13.2 for black infants.⁴²

Solutions to further reduce infant mortality and to improve maternal and child health in Georgia have included multi-faceted strategies that involve many sectors of society and collaborations among statewide community partners. Approximately one of every 10 children in Georgia is uninsured, and a stagnant economy is expected to increase this proportion. Physical access to appropriate services is a challenge—about one quarter of Georgians live in areas designated as Health Professional Shortage Areas. The percentage of reported cases of the AIDS virus also has been increasing among women in all groups, particularly among black women.

The Division of Public Health (DPH) is the lead agency with the ultimate responsibility for the health of communities and the entire population. At the state level, the DPH is divided into numerous branches, sections, programs, and offices that all work together to support maternal and child health. At the local level, the DPH functions via 19 health

State Facts 2001*

Infant Mortality Rate	8.5
Preterm Birth Rate	12.7
Low Birth Weight Infants	8.8
Prenatal Care in First Trimester	86.2
Pregnancy/Maternal Smoking	9.2
Teenage Birth Rate (age 15-19)	60.9
Birth Rate to Unmarried Women (age 15-44)	37.3

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

districts and 159 county health departments. The DPH is part of a larger state agency, the Georgia Department of Human Resources (DHR). The DHR is expanding and emphasizing various important risk reduction and prevention programs to improve the overall health status of mothers and their infants. Activities and programs that have produced positive results include improving the technologies in facilities treating extremely underweight newborns, increasing accessibility to prenatal care for pregnant women, and raising public awareness about SIDS. A sampling includes:

Babies Can’t Wait (BCW): Georgia’s statewide interagency service delivery system for families of infants and toddlers with developmental delays or disabilities. BCW, established by Part C of the federal Individuals with Disabilities Education Act (IDEA) of 1997, which guarantees all eligible children up to 3 years of age, regardless of their disability and income, access to services that will enhance their development. Babies Can’t Wait is administered through 19 district offices throughout the state. Through the 19 offices, children and families in every county in Georgia can access early intervention services. The DHR, Division of Public Health, is the lead agency administering the Babies Can’t Wait program.

Babies Born Healthy: a state-funded program, administered by the DHR, Division of Public Health, Family Health Branch, that has evolved to meet the changing needs of pregnant women not eligible for Medicaid, and whose family income is at or below 250 percent of federal poverty level.





Babies Born Healthy funds prenatal care, hospital delivery, (limited) newborn care, and case management services in each health district. Services are provided through partnerships with local providers, such as physicians, nurses, nurse midwives, nurse practitioners, nutritionists, social workers, and health educators. In FY 2003, there were 3,200 women served by Babies Born Healthy.

Children 1st: designed in 1992, provides family support for children between the ages of birth and 5 and addresses conditions in a child's environment that may have a negative impact on the child's health and development. Children 1st is the single point of entry to a statewide collaborative system of public health and other prevention-based programs and services. This system helps parents provide their young children with a healthy start in life. It allows children who are at high-risk for poor development to be identified early and gives them a chance to grow healthy and ready for school. Participation is voluntary and there are no financial requirements for enrollment into the system. During FY 2003, Children 1st identified 40,677 newborns and children needing medical or developmental services. Of those children identified, more than 18,000 children were linked to primary healthcare providers for continued assistance. More than 50,000 children were monitored for health and developmental status. For each one dollar invested in prevention and early identification, seven dollars could be saved in any future treatments. Children 1st is operated under the DHR, Division of Public Health.

Metropolitan Atlanta Congenital Defects Program: collects, analyzes, and interprets birth defects surveillance data since 1967. It was created by the CDC, National Center on Birth Defects and Developmental Disabilities, in the aftermath of the thalidomide tragedy to provide early warning of increases in the prevalence of defects at birth. The program monitors all major birth defects in five counties of the metropolitan Atlanta area (Clayton, Cobb,

DeKalb, Fulton, and Gwinnett) with approximately 50,000 annual births from a population of about 2.9 million. An estimated 3.3 percent of newborns each year has a major birth defect. The program provides the capacity to conduct epidemiologic studies to examine etiologic factors contributing to birth defects. The program acts as the model for many state-based programs and as a resource for the development of uniform methods and approaches to birth defect surveillance.

Perinatal Case Management: a partnership between the Department of Human Resources, Division of Public Health, and Department of Community Health, it is the only case management program for pregnant Medicaid women in Georgia. The Division of Public Health, Family Health Branch, provides policy development, training, and monitoring of the perinatal case management program in 19 health districts. Nurses and social workers provide pregnant women and their families with individual assessments and follow-up care throughout their pregnancies, linking them with prenatal care, Children 1st, and other medical and social services. In FY 2003, more than 48,000 women received Perinatal Case Management services.

Pregnancy Related Services: a Medicaid program focusing on reducing infant illness and death rate and improving the quality of life for new mothers and their infants. The program provides in-home health assessments and teaching for women who recently have delivered a baby. A physical assessment is done on both the mother and baby followed by education on breastfeeding, SIDS reduction and prevention, infant feeding, well-child routine care, and family planning. This program is operated under the DHR, Division of Public Health, Family Health Branch.

Regional Perinatal Centers: provides a system of comprehensive perinatal care services for pregnant women, their fetuses, and neonates in all risk categories. The centers, administered by the DHR, Division of Public Health, Family Health Branch, provide funding to six designated regional tertiary hospitals to provide high-risk perinatal services including transportation, prenatal care, delivery, postpartum care, and newborn care. All women and infants who are classified as high risk are accepted for services at the six regional tertiary hospitals without regard to income. Women and infants who meet program medical criteria (high risk), and whose incomes are below 250 percent of the federal poverty level, are eligible for funding. Services are provided statewide through the six designated tertiary care hospitals located in Atlanta,



Macon, Augusta, Columbus, Albany, and Savannah. In FY 2003, Regional Perinatal Centers provided care for 5,815 high-risk infants and 12,670 high-risk pregnant women.

High-Risk Infant Follow-Up Program: administered by the Division of Public Health, Family Health Branch, provides nursing services to infants, birth to age 1, who are at great risk for health and developmental problems due to their medical conditions at birth.

Children Medical Services (CMS): a state and federally funded Title V Children with Special Health Care Needs Program. Eligibility for the program includes medical and financial requirements. Children who are Medicaid/PeachCare enrolled, receive SSI, or are in foster care also are eligible for CMS services. CMS directly provides or coordinates specialty medical evaluations and treatment for eligible children (birth to age 21) with chronic medical conditions. CMS also provides or pays for comprehensive physical evaluations, diagnostic tests, inpatient and outpatient hospitalization, medications and other medical treatments, therapy, durable medical equipment, hearing aids, and dental care related to the child's CMS-eligible condition. Genetics services include diagnosis, counseling, and treatment for a wide variety of genetic conditions as a CMS service. CMS offers community-based services through Georgia's 19 public health districts. At each site, care coordinators provide outreach, referral, care coordination, education and follow-up for CMS clients and their families.

PeachCare for Kids: began in 1999, provides comprehensive healthcare to children through the age of 18 who do not qualify for Medicaid and live in households with incomes at or below 235 percent of the federal poverty level.



Adolescent Health and Youth Development Program: provides a network of community-based support to help adolescents succeed as they move into adulthood by focusing on the assets of individual youth and their families. The Adolescent Health and Youth Development-sponsored programs reinforce positive attitudes, healthy behaviors, and activities and reduce risk-taking behaviors, such as violence, substance abuse, poor school performance, and premarital sexual activity.

Governor's Council on Maternal and Infant Health: established in 1972 by the General Assembly, creates standards for maternal and infant healthcare services and aids state agencies in coordinating programs with local communities. The Council is composed of 17 persons appointed by the governor. Members include physicians, nurses, hospital administrators, educators, and consumers. The Council's recommendations have been embodied in state programs, as well as in legislation and regulations.

Family Planning Program: established in 1966 as the result of the General Assembly's passage of the Family Planning Services Act mandating that the Division of Public Health and Family and Children's Services work together to provide contraceptive services for any woman in Georgia who request these services. The program has developed and implemented strategies directed toward the reduction of unintended pregnancies, infant mortality, and improvement of birth outcomes. Family planning services are provided directly by county health departments and contracted agencies utilizing various combinations of federal, state, and locally supported staff. Approximately 354,498 visits were made to the Family Planning clinics in 2003 for family planning, counseling, treatment of common gynecological problems, and follow-up care. The majority of the clients were unmarried females over the age of 20 who had completed at least the 10th grade. The user population consisted of 77,393 black women, 62,677 white women, 26,763 Hispanic women, and 6,249 men of all races.

Resource Mothers: an outreach and education program administered by the DHR, Division of Public Health, Family Health Branch, and funded by Medicaid. The program connects experienced mothers with pregnant and parenting teenagers who need guidance and support. Resource Mothers volunteers and staff provide information on pregnancy, early prenatal care, parenting skills, child care, and health issues. This program educates and counsels pregnant and parenting teenagers to help reduce poor health outcomes for teen mothers



and their children. The Resource Mothers program is located in 17 counties (Fulton, DeKalb, Gwinnett, Clayton, Irwin, Richmond, Jefferson, Warren, Hancock, Lincoln, Columbia, Jenkins, Screven, Burke, McDuffie, Taliaferro, and Glascock). In FY 2003, Resource Mothers conducted 5,405 home visits.

Health Check: formerly known as Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT), as part of the Medicaid Program that was implemented in Georgia in 1972. The purpose of the Health Check program is to assure that children who are enrolled in Medicaid (birth to age 21) or PeachCare for Kids (birth to age 19) receive regular and age appropriate well-child check-ups. At each well-child visit, it is expected that health problems will be identified, diagnosed, and treated before they become more complex and costly. Health Check is operated under the DHR, Division of Public Health.

Healthy Child Care Georgia Project: a collaborative effort of the DHR, Division of Public Health, Family Health Branch, health professionals, child care providers, regulatory agencies, other organizations and families working in partnership to improve

the health and well-being of children from birth to 12 years of age in child care settings.

Tobacco Use Prevention Program: coordinates strategy in tobacco use prevention and control, provides assistance on policy development, and serves as a resource center for tobacco issues. The program collaborates with the Coalition for a Healthy And Responsible Georgia (CHARGE) and has adopted a national philosophy of changing environmental factors to reduce tobacco use. The Coalition serves as a forum for developing and carrying out strategies that focus on preventing tobacco use among youth and pregnant women, protecting children from secondhand smoke, and encouraging smoking cessation. The Tobacco Use Prevention Program provides support to the state coalition for tobacco use prevention and to local programs and coalitions in all 19 public health districts and is administered by the DHR, Division of Public Health.





KENTUCKY

“Kentucky has a number of serious health issues to confront....We must start addressing our health issues to help Kentucky move forward.”

– Governor Ernie Fletcher, July 23, 2004

The combined efforts of the state and local health departments and the state’s private practitioners have, and are continuing to produce, positive results in decreasing infant mortality (5.9 in 2001, compared to 7.3 in 1997), increasing child immunization rates, decreasing teenage pregnancy rates (51.4 in 2001, compared to 61.2 in 1996), and increasing first trimester prenatal care utilization (87.0 percent in 2002, compared to 86.6 percent in 1999). Like many Southern states, Kentucky is experiencing a decline in infant mortality rates, but there are other major risk factors contributing to infant deaths that have shown no improvement. The birth rate among unmarried women has been increasing for more than a decade (33.0 in 2002, compared to 28.5 in 1995). More and more infants are born with low birth weight (8.3 in 2001, compared to 7.6 in 1995). Kentucky’s high percentage of low-weight births is frequently the result of maternal smoking, alcohol consumption, and illicit drug use. Kentucky has the second highest smoking rate among pregnant women in the South (24.0 in 2002), next to West Virginia with the highest rate of 26.7.

The Department of Public Health (DPH) is the agency in Kentucky responsible for developing and operating all public health programs for the people of the Commonwealth. Kentucky Revised Statute 194.030 created the DPH to “develop and operate all programs of the cabinet that provide health services and all programs for the prevention, detection, care, and treatment of physical disability, illness, and disease.” Although somewhat successful, there still remains a critically high percentage of infants born with low birth weight and a high rate of smoking among the youth population. In 2000, the General Assembly authorized Governor Paul Patton’s early childhood development initiative, KIDS NOW, and appropriated funds for several population-based initiatives that will improve early childhood development, promote safety in child care settings, promote childhood immunizations, and help reduce incidence of congenital birth defects. During this same year, the first statewide public health effort also was authorized to encourage smoking cessation

State Facts 2001*

Infant Mortality Rate	5.9
Preterm Birth Rate	13.3
Low Birth Weight Infants	8.3
Prenatal Care in First Trimester	86.7
Pregnancy/Maternal Smoking	24.5
Teenage Birth Rate (age 15-19)	51.4
Birth Rate to Unmarried Women (age 15-44)	31.7

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

and to reduce exposure to secondhand smoke among different population groups.

There are six divisions of the Department of Public Health: Division of Adult and Child Health; Division of Epidemiology and Health Planning; Division of Laboratory Services; Division of Local Health Department Operations; Division of Public Health Protection and Safety; and Division of Resource Management. The Division of Adult and Child Health (ACH) promotes the health of mothers and children by developing systems of care that provide health and nutrition services to women, infants, and children. Programs and services are provided through ACH’s Maternal and Child Health Branch. The Branch oversees maternity and child health services provided by the local health departments with the goal of reducing maternal and infant mortality and decreasing the need for high-cost neonatal intensive care.

Another major component of the Kentucky public health system is the Cabinet for Health Services (CHS), an agency that administers programs to promote the mental and physical health of Kentuckians. The Cabinet consists of 10 agencies dedicated to achieving the Cabinet’s mission through administering a multitude of programs and services. Available maternal and child health programs and services administered by the DPH and the CHS include:

Kentucky Birth Surveillance Registry (KBSR): began in April of 1996, a state-mandated passive surveillance system designed to provide informa-



tion on incidence, prevalence, trends, and possible causes of stillbirths, birth defects, and disabling conditions. The KBSR collects information on children from birth to age 5. The system relies on existing data, primarily from vital statistics and hospital reporting. The KBSR is administered by the Cabinet for Health Services.

First Steps: an early intervention system serving children from birth to age 3 who have a developmental delay or a particular medical condition that is known to cause a developmental delay. First Steps services are provided statewide and coordinated by the lead agency, the Cabinet for Health Services.

Health Access and Nurturing Developing Services (HANDS) Program: administered by the ACH, Maternal and Child Health Branch, as a voluntary, intensive home visitation program designed to assist parents at critical developmental stages during their child's first two years of life. HANDS targets first-time parents, from the prenatal period to approximately three months after delivery. Its goal is to assist with child development, parenting skills, health services, and other needed resources.

Teen Pregnancy Prevention Initiatives: includes several programs that provide information on abstinence, contraception, family planning, and counseling. These initiatives include Reducing the Risk (RTR), Postponing Sexual Involvement (PSI), Statewide Media Campaign: "Get a Life First, Wait to Have Sex," the Resource Persons' Program, and community work groups and coalitions. Programs are administered by the ACH, Maternal and Child Health Branch.

Healthy Start in Child Care Program: implemented in July 2000, as a KIDS NOW Initiative to provide consultation on health, safety, and nutrition to child care providers. Trained Healthy Start child care consultants from the local health departments participate in joint activities with the resource and referral agencies in their area to ensure collaboration and coordination regarding the quality of child care. This program is administered by the ACH, Maternal and Child Health Branch.

Tobacco Use Prevention & Cessation Program: includes local and statewide initiatives aimed at preventing initiation of smoking in youth and pregnant women and helping those who wish to quit smoking to do so. This program is supported by funding from the Tobacco Master Settlement Agreement and by a grant from the CDC and is administered by the ACH, Chronic Disease Prevention and Control Branch.

Commission for Children with Special Health Care Needs: provides medical treatment to children with physically disabling conditions. Patients receive case management services from registered nurses who work with pediatric specialists to determine a plan of treatment and ensure that every child receives appropriate, state-of-the-art medical care. Care coordinators are committed to providing information and resources to patients and their families.

Any child under the age of 21 who is a resident of Kentucky may be eligible for services. The child must have a condition treated by a Commission clinic program and his or her family must meet financial guidelines based on income and family size. Cost of treatment is determined by a sliding fee scale based on family income, and financial eligibility is based on 200 percent of the federal poverty level. Children who have hemophilia are eligible for services regardless of age. The Commission is administered by the Cabinet for Health Services.

Office of Women's Physical and Mental Health: created in February 1998, the General Assembly passed the Women's Health Bill (HB 864) mandating the creation of an **Office of Women's Health** by the year 2000. Its purpose is to serve as a "repository for data and information affecting women's physical and mental health; analyze and communicate trends in women's health issues and mental health; recommend data elements affecting women's health and mental health that should be collected, analyzed, and reported; and administer a Women's Health Resource Center to focus on targeted preventative and comprehensive health education." The Office was officially opened on October 1, 2000.

Early Childhood Development Task Force: a 20-year plan created in 1999 by Governor Patton to help Kentucky children get the best start in life and reach their full potential. The Task Force proposed a comprehensive early childhood initiative which was approved unanimously by the 2000 General Assembly. The initiative is funded by 25 percent of Kentucky's Phase I Tobacco Settlement dollars. The Healthy Babies Campaign is part of this initiative. The Task Force is overseen by the Governor's Office of Early Childhood Development.





LOUISIANA

“I believe we are making progress in better educating our people, but we are not there yet. Education is the solution to every problem we have.”

–Senate President John J. Hainkel, Jr., July 16, 2001

In Louisiana, every 43 minutes a baby is born to a teenage mother, and every 24 minutes, a baby is born into poverty. Louisiana currently ranks 48th in the nation in children living in poverty. Infant mortality and low birth weight both have remained major public health issues in Louisiana. Maternal and child health has been identified, during the past 10 years, as one of the primary areas of concern for the state. Consistently, Louisiana ranks among the states with the highest rates for indicators such as low birth weight, infant mortality, perinatal mortality, and teen pregnancy.

In 2001, 10.4 percent (6,819) of total live births (65,193) were of low birth weight infants as compared to 10.0 percent (6,714) in 1999. Though the teenage birth rate is declining in Louisiana, it remains higher than the national average. In 2001, the birth rate to unmarried women was 46.3, compared to 43.9 in 1997, and has been increasing for almost a decade. These formidable trends have contributed to the state’s uprising infant death rates (9.8 in 2001, compared to 8.9 just a year ago and 9.1 in 1998).⁴³

The Office of Public Health (OPH) and the Department of Health and Hospitals have undertaken several initiatives to lower these indicators through a statewide process of evidence-based programs and interventions with strong involvement from the community. Programs and services offered through various sections of both departments include the following.

ChildNet: developed under Part C of the Individuals with Disabilities Education Act (IDEA) as an early intervention system that serves families, infants, and toddlers from birth to age 3 who have physical or mental conditions that result in developmental disabilities.

The system also serves infants and toddlers who, without a medical condition, are determined to be delayed in cognitive, physical, communication, social/emotional, or adaptive development. ChildNet is administered by the Department of Health and Hospitals.

State Facts 2001*

Infant Mortality Rate	9.8
Preterm Birth Rate	15.2
Low Birth Weight Infants	10.4
Prenatal Care in First Trimester	83.2
Pregnancy/Maternal Smoking	10.1
Teenage Birth Rate (age 15-19)	57.8
Birth Rate to Unmarried Women (age 15-44)	46.3

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

Genetics Clinical Services Program: established in 1981 through a federal grant and administered by the OPH, Center for Preventative Health, it ensures that genetic evaluation and counseling are available and accessible to individuals in all regions of the state through genetics clinics at eight OPH sites and five hospital sites in the southern region of the state.

Epidemiology, Assessment, & Evaluation (EAE) Program: began in 1996 with a grant from the CDC, which brought the first Maternal and Child Health (MCH) epidemiologist into the Office of Public Health. Members of the program are actively engaged in epidemiological analysis with specific regions of the state in an effort to reduce perinatal mortality rates. The EAE Program also provides teaching activities at the OPH and at different local universities. The Program leads and collaborates in the dissemination process of MCH information statewide.

Louisiana SIDS Counseling and Risk Reduction Program: formed in 1994 through a joint partnership between the OPH and Tulane University Department of Pediatrics, it provides comprehensive information about SIDS and counseling to families that had experienced a SIDS death, improves infant autopsy rate and standardization, and establishes a SIDS risk reduction program. The primary audiences of the program are females 15-29 years of age, in both urban and rural areas in Louisiana. The secondary audience which this program targets is those with day-to-day interaction with infants under one year of age, including healthcare professionals,



grandparents, babysitters, child care/family daycare providers, and general community.

Partners for Healthy Babies: begun in 1993 as an ongoing statewide social marketing project to promote prenatal care and healthy behaviors during pregnancy. The project was established in response to the high infant mortality and low birth weight rates, along with the high teen pregnancy rate in Louisiana. Project activities use a multimedia and multi-channel approach, including television, radio, billboard, and bus signage advertising and is operated under the OPH, Center for Preventative Health.

Family Planning Program: begun in September 1974 as part of the federal Title X Family Planning Program, aims to reduce infant mortality and morbidity and teen pregnancy by providing disease screening, health education, counseling and contraceptive methods. Individuals and families also are provided with information regarding reproductive health. Target populations are low-income, under-insured individuals and families. This program is administered by the OPH, Center for Preventative Health. The Family Planning Program served 62,841 clients in 2000, and 85 percent of those clients were below 100 percent of the federal poverty level. Proven to be fiscally effective, for every government dollar spent on family planning services in Louisiana, an average of \$4.40 is saved as a result of averting expenditures on medical services, welfare, and nutritional services, and an estimated \$12 also is saved in costs associated with unintended pregnancy.

Shots for Tots: created in 1992 in response to the low levels of immunizations among infants and children and the epidemic outbreak of measles in Louisiana. The Shots for Tots is a network of public and private entities working cooperatively to update and educate parents on the importance of childhood immunizations.

Louisiana Commodity Supplemental Food Program (CSFP): a USDA nutrition program designed to supplement the diets of low-income pregnant and postpartum women, children up to age 6, and seniors over the age of 60. One of 26 CSFP programs nationwide, Louisiana's CSFP is the second largest, with 76,000 participants in 2001, and currently is operated under the OPH, Center for Preventative Health.

Louisiana Birth Defects Monitoring Network: initiated in 1999, Senate Concurrent Resolution No. 29, created an 18-member task force to study

the feasibility of developing a birth defects registry in Louisiana. The purpose of the registry was "...to establish a system to collect, analyze, and disseminate data regarding birth defects in the state and to provide information to families of children born with birth defects regarding services available in their community and the development of appropriate prevention programs." On May 31, 2001, the Legislature passed Senate Bill 229 to create the Louisiana Birth Defects Surveillance System and advisory board, and the bill was signed into law by Governor Foster. This program is operated under OPH, Center for Preventative Health, Children's Special Health Services.

The Nurse-Family Partnership Program: established in March 1999, as a prenatal and early childhood intervention program designed to improve the health and social functioning of low-income, first-time mothers and their infants. Home visits by trained public health nurses begin before the 28th week of gestation and continue through the child's second birthday. The program currently is operating in four mostly rural, underserved areas of the state: the Lafayette Region (Region IV); the Monroe Region (Region VIII); the Lake Charles Region (Region V); and the Houma Region (Region III). The Nurse-Family Partnership Program is administered by OPH, Center for Preventative Health.

Healthy Families LA Paraprofessional Home Visiting Programs: a visitation program developed to lower Louisiana's high rates of infant mortality, low birth weight, and child maltreatment. Currently, there are four Paraprofessional Home Visitation Programs: 1) *Project Hope* serving first-time mothers and their babies in Quachita Parish; 2) *ETC ALPHA* serving high-risk pregnant and parenting teens and their babies in Calcasieu Parish; 3) *Healthy Kids* serving first-time and teen parents and their infants in Iberia Parish; and 4) *First Time Parents* serving high-risk, low-income parents and their infants in East Baton Rouge Parish. These programs are based on the Hawaii Healthy Start and Healthy Families



America Programs models and are administered by OPH, Center for Preventative Health.

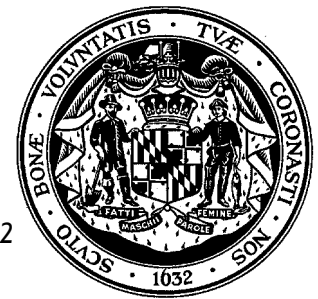
Children's Choice Waiver: established in February 24, 2001, by the Department of Health and Hospitals, Bureau of Community Supports and Services, and offers supplemental support to children with developmental disabilities who currently live at home with their families, or who will leave an institution to return home. The waiver provides services such as family support, family training, center-based respite, environmental accessibility adaptations, and diapers for children age 3 or older. This waiver has an annual service limit of \$15,000 per recipient. The Children's Choice Waiver is an option offered to children on the Mental Retardation and Developmental Disabilities (MR/DD) Request for Services Registry as funding permits.

Families choose to either apply for the Children's Choice Waiver or remain on the MR/DD Request for Services Registry.

SAFE KIDS: founded in 1994 by OPH and the Children's Hospital as a coalition of public, private, and voluntary organizations working to prevent unintentional injuries to children from birth to 14 years of age through a multifaceted approach by increasing public awareness, changing behavior through education and safety devices, advocating for public policy changes, and creating and supporting child safe communities. SAFE KIDS is administered by OPH, Center for Community Health.



MARYLAND



“I work toward the day when opportunities are available to all Maryland’s children, with an eye on continued improvements to healthcare.....”

–Senate President Thomas V. Mike Miller, Jr., October 31, 2002

Improving the health of pregnant women and infants is one of the toughest challenges for Southern states, but Maryland has managed to gain some successes. For 2002, Maryland’s infant mortality rate was 7.6 (compared to 8.8 in 1997), still higher than the national rate. Infant death rates in 2002 ranged from a low zero in Caroline County to a high of 31.8 in Kent County. Infant death rates declined significantly during the past decade in Montgomery, Prince George’s, and Worcester counties. The teenage birth rate dropped from 45.7 in 1999, to 38.2 in 2001, the lowest rate within the Southern region. More women also are seeking prenatal care within the first trimester of pregnancy. This progress is attributed to several factors and is the result of extensive work by many people in both the public and private sectors in their efforts to increase health services and access to insurance coverage for pregnant women and their infants.

Although Maryland has experienced much success, there are challenges associated with these gains. The birth rate among unmarried women continues to increase (34.8 in 2002, compared to 33.5 in 1997). The percent of births of infants of low birth weight has not improved in Maryland in over a decade (9.0 in 2001, among the South’s highest rates). Like many Southern states, health disparities between black and white infants continue to exist, but since there has been a greater decline in black and white infant mortality rates in recent years, the gap between black and white infant mortality rates has been narrowing. The IMR among white infants fell slightly from 5.5 in 2001, to 5.4 in 2002, while the IMR among black infants fell more substantially, from 13.6 in 2001, to 12.7 in 2002. In 2002, the three leading causes of infant death for all groups were disorders relating to short gestation and low birth weight, congenital malformations, and SIDS. Congenital malformations were the leading causes of death among white infants, while low birth weight was the leading cause among black infants. There has been a significant increase in overall infant deaths resulting from maternal complications of pregnancy due to a rise in the number of newborns affected by premature rupture of membranes.

State Facts 2001*

Infant Mortality Rate	7.9
Preterm Birth Rate	12.9
Low Birth Weight Infants	9.0
Prenatal Care in First Trimester	83.7
Pregnancy/Maternal Smoking	9.8
Teenage Birth Rate (age 15-19)	38.2
Birth Rate to Unmarried Women (age 15-44)	34.4

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

Joint efforts have been made and perinatal partnerships have been established among local health departments, academic institutions, perinatal organizations, hospitals, community groups, managed care organizations, and the Department of Health and Mental Hygiene (DHMH) in an attempt to improve the health of pregnant and infants. The Center for Maternal and Child Health, a part of the Department of Health and Mental Hygiene’s Family Health Administration, strives to strengthen and support the maternal and child health infrastructure and to assure the availability and accessibility of preventative and primary care services for women, infants, and children. Several programs are integrated to assure a holistic and coordinated life span approach to enhancing the health of Maryland’s mothers and their children. They are as follows:

Office for Genetics and Children with Special Health Care Needs (CSHCN): created in March of 2000 through the merger of the Office for Hereditary Disorders and the Children’s Medical Services (CMS), includes specialty services and care coordination for children with complex medical conditions. This Office comprises three divisions: Newborn Screening and Follow-up, including the Universal Infant Hearing Screening Program; Clinical Genetic Services; and Specialty Care and Regional Resource Development.

Children’s Medical Services (CMS): a state public health program for children with special healthcare needs. It currently serves CSHCN families whose income is less than or equal to 200 percent of the federal poverty level. As a result of the expansion





of health insurance coverage under the Medical Assistance program (Children's Health Program), many families historically served under CMS now have access to insurance coverage. The program funds specialty care services upon referral from primary care providers. Covered services include inpatient and outpatient medical care; occupational therapy; physical therapy; speech, language, and hearing services; medical equipment and supplies; nutrition services; and developmental and neurological assessments. Local health departments who offer clinical services charge on a sliding fee scale with third party payment accepted. No patient is refused service for inability to pay. This program also provides funds to local health departments for care coordination services for CSHCN who are uninsured and not eligible for other public benefit programs. Care coordinators provide outreach to ensure access to resource information and services. CMS is administered by the Family Health Administration, Division of Specialty Care and Regional Resources Development.

Early Intervention Coordination Program: administered by the Family Health Administration, Division for Specialty Care and Regional Resources Development, as part of the interagency collaboration with Maryland's Early Intervention System. Funding is provided to local jurisdictions for the delivery of evaluation and consultation services to children with complex needs and their families. Medical providers work with early intervention teams allowing for the integration of medical and developmental needs into the Individual Family Service Plans.

Child and Adolescent Health Program: responsible for developing policies and implementing primary prevention and early intervention strategies to improve the health of Maryland's children. Leadership, consultation, training, and technical assistance are provided in several program areas including school and adolescent health, care coordination and home visiting, environmental health, and

child fatality review. The program collaborates with numerous DHMH programs and other state agencies in the development of policies and programs. This program also oversees the child and adolescent health components of the Title V MCH Block Grant Program.

Maryland Birth Defects Reporting and Information System: established in 1982, collects data on the number of babies born with any of the 12 specific defects chosen by the World Health Organization (anencephaly, spina bifida, hydrocephalus, cleft lip with or without cleft palate, cleft palate, esophageal atresia/tracheo-esophageal fistula, rectal/anal atresia, hypospadias, lower reduction deformity, upper reduction deformity, congenital hip dislocation, and Down Syndrome). All infants with these disorders are eligible for information and referral services at no charge.

Advocates for Children and Youth, Inc. (ACY): founded in 1987 with the goals to ensure that all Maryland's children are healthy, safe, educated, and economically secure. Since 1997, ACY has been the organizing hub for a statewide movement for children. ACY also provides staff support to the Maryland Children's Action Network (MD CAN), a broad-based network of issue coalitions, organizations, and citizens mobilized to improve results for children, youth, and families.

Family Planning and Reproductive Health Programs: offers comprehensive clinic services, counseling regarding sexual decision-making; prevention of sexual coercion; abstinence; contraception; and other family planning options. All services place an emphasis on primary prevention and interventions that address the complex issue of teen pregnancy with the goal of improving the health of adolescents. More than 90 clinic sites throughout Maryland offer family planning services and many providers have special hours and clinic sessions for teens. In FY 2000, the programs served 26,000 persons under age 20. Current programs include the Colposcopy Program; the Preconception Health Program; Teen Pregnancy Prevention Program; and Three for Free Condom Distribution Program. The Family Planning Program is administered by the DHMH, Family Health Administration, Center for Maternal and Child Health.

Maryland State Child Fatality Review: created by the General Assembly in 1999 to prevent accidental or premature child deaths in the state of Maryland. Maryland law also requires the establishment of local teams composed of multi-agency and multi-disciplinary team members. Data collected from



Vital Statistics, Injury Prevention, Highway Safety, and local reviews are used to guide the state teams in making significant and purposeful recommendations to the General Assembly and to community action groups aimed at preventing child deaths. The teams also are required to submit annual reports to the governor.

WELL (Women Enjoying Life Longer) Project: a pilot program designed to improve access to comprehensive preventative health services for women enrolled at three eastern Baltimore County Maryland Family Planning Program sites. The Project operates under a three-year grant that began July 1, 2001, from the federal Health Resources and Services Administration.

Kids in Safety Seats (KISS) Program: begun in 1980 as the state's lead agency in child passenger safety. The goal of the program is to help reduce the number of accidental injuries and child deaths by educating the public on child passenger safety and to help people use safety seats correctly and properly each time a child rides in a car. KISS is administered by the Department of Health and Mental Hygiene and funded by the State Department of Transportation.

Medical Assistance Programs: an integral part of the DHMH, provides access to healthcare services for many of the state's low-income residents. Individuals may be eligible for services through the Medicaid Program, the Children's Health Program, or the Pharmacy Assistance Program, depending upon income and other factors. The *Children's Health Program*, begun in July 1998, uses federal and state funds to provide healthcare coverage to low-income children up to age 19 and pregnant women of any age who meet income guidelines.

Medical Day Care Centers: currently available at two locations, serves children age six weeks to 3 years with complex medical conditions whose needs cannot be met in traditional child/day care programs. The *Family, Infant and Childcare Center*, located in Montgomery County and, *Within My World*, in Baltimore County, provide childcare and skilled nursing services to infants and toddlers with challenged needs. In addition, support and training is offered to parents to maximize their skills and competencies in dealing with their child's special healthcare needs.





MISSISSIPPI

“It is the intent of the Legislature to foster the reduction of infant mortality and morbidity in Mississippi and to improve the health status of mothers and infants.”
–Speaker Tim Ford, December 8, 1997

Mississippi’s health officials have long recognized the unmet health-care needs of pregnant women and children that result from poverty, the influx of large minority groups, low education levels, and limited healthcare providers in rural areas. Infant mortality is a crude indicator of health status, but it also demonstrates how critical the disparities are for racial and ethnic minorities in Mississippi. Despite recent advances, infant mortality rates continue to remain two to three times higher for black infants than those of white infants. For the past 20 years, Mississippi’s infant mortality rates have been among the highest in the South. The state’s IMR was 10.4 in 2001, well above the national average.

During the 1900s, Mississippi’s health status improved significantly—infant mortality rates declined, healthcare became available to more people, and advances in medical knowledge and technology provided more effective management of many diseases. Today, many challenges remain for the state’s Department of Health. In 2002, 11.2 percent of all live births were to infants with low birth weight, compared to 10.7 in 2001 and 9.9 in 1996. For the past 20 years,

Mississippi has been plagued with the highest teenage birth rate and the highest birth rate to unmarried women in the South, which are key indicators for infant mortality.

In response to the problem of infant mortality with major ties to racial disparities, the Department of Health sponsors and supports many projects, at community and state levels, in an effort to improve the health status of pregnant women and children, especially those among minority populations. The Department of Health directly participates in state-wide programs advancing special health needs such as mobile services and rural health. It also administers state and federal programs for health initiatives such as tobacco prevention and primary care. The primary objectives of the Department of Health perinatal healthcare programs are to decrease infant

State Facts 2001*

Infant Mortality Rate	10.4
Preterm Birth Rate	17.0
Low Birth Weight Infants	10.7
Prenatal Care in First Trimester	82.7
Pregnancy/Maternal Smoking	12.6
Teenage Birth Rate (age 15-19)	66.7
Birth Rate to Unmarried Women (age 15-44)	46.3

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

mortality and low birth weight infants by providing healthcare to pregnant women. By increasing the number of women with access to prenatal care, the intended consequence is the reduction of infant mortality. A sampling of these programs includes the following:

Perinatal High-Risk Management Infant Service System: operates as a Medicaid provider for the Perinatal and Infant High-Risk Case Management Program. This program includes a multi-disciplinary range of preventative health services for pregnant women including physical exams; nutrition; social services; health screening; education; counseling; and referral services.

Born Free Program: a community-based consortium for pregnant and postpartum substance abusing women and their affected infants. It provides a



comprehensive, multi-organizational network of treatment resources and available services. Access to the Born Free network is through the Perinatal High Risk Management Program, which provides early identification of pregnant women who may be at risk and offers an entry point to case management services.

First Steps: an early intervention program that matches the unique needs of infants and toddlers who have developmental delays with professional resources available within the community. First Steps provides educational materials and other resources to help parents recognize and identify developmental problems as early as possible. Each eligible child receives an individual assessment, with parents and other relatives providing input. After evaluation, an assigned service coordinator develops an individualized family service plan to provide appropriate services to the child and family, using professional resources within the community.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program: provides Health check-ups for Medicaid-eligible children under age 21 with poor access to healthcare. EPSDT services are available statewide to children living at or below 185 percent of the non-farm poverty level. Services are basically preventative in nature and designed for early identification of crippling conditions.

Baby Steps Program: developed to encourage communities to become active in the wellness needs of their children. Through collaboration between local community and civic organizations, hospitals and providers of pediatric medical care, the program allows these groups to follow newborn infants for their immunizations during the first two years. Volunteer organizations and medical providers are supplied with training manuals, handouts, birthday, and immunization reminder cards, certificates of participation, and record keeping forms. Volunteers also make follow-up phone calls to the new mothers, encouraging them to have their babies immunized on time.

Family Planning Program: located in 102 clinics within local health departments throughout Mississippi's 82 counties, the program provides a wide range of confidential and professional family planning services to both men and women, regardless of income. Services include physical examinations; counseling; HIV and pregnancy testing; birth control supplies; sterilization; and care coordination. Clients may be eligible for free or reduced cost services based on a sliding fee scale.



Abstinence Education Program: developed to help reduce unintended pregnancies and out-of-wedlock births in youth ages 10 to 19 by expanding current abstinence education programs through contracts with local school systems, community-based, and faith-based organizations.

Children's Medical Program: provides medical and surgical care to children with chronic or disabling conditions. The service is available to state residents up to 20 years of age, based on family income, family size, and estimated cost of treatment. The program currently operates at 21 separate sites throughout the state to provide specialized care in the local communities in addition to a central multi-discipline clinic in Jackson at Blake Clinic for Children. Services include hospitalization, physician's services, appliances, and medications. The state matches federal funds targeted for the Children's Medical Program, and private industry, independent agencies, and individuals also contribute to this program.

Mississippi Community Planning Group for HIV Prevention: established in January 1994 as the state's only community planning body that addresses HIV (Human Immunodeficiency Virus). It is responsible for developing a comprehensive HIV prevention plan with other state and local agencies, non-governmental organizations, and representatives of communities and groups at risk for or infected with HIV, with special focus on youth and pregnant women or women of childbearing age.

Statewide Immunization Coalition: established in 1994 as a nonprofit corporation to improve childhood immunization. The goal of the coalition is to ensure that 90 percent of children age 2 and younger are completely immunized with all the required vaccines by the year 2000. On October 14, 1999, the Mississippi Statewide Immunization Coalition became a separate non-profit entity known as MSIC, Inc.



Mississippi Immunization Registry: established by the Mississippi Child Immunization Act of 1994 as a centralized registry operated by the Department of Health for healthcare providers to report all childhood immunizations given in the state. The goal of the program is to ensure that accurate and valid immunization data is available to healthcare providers, parents, and others who have a legitimate and tangible interest in immunization information.

Childhood Lead Poisoning Prevention Program: performs routine lead screenings for children ages 1 and 2 and for any child at risk from six months old to 6 years. The program also provides follow-up care, along with an inspection of homes for lead by a certified professional.

Early Intervention Resource Library: provides an array of early intervention and child health information to the general public, located inside the Jackson Medical Mall. The library does not offer medical advice. It makes available materials that will help inform parents on important child development topics. The resources include books, medical texts, newsletters, journals, magazines, informa-

tion sheets, audiotapes, videotapes, brochures, pamphlets, evaluation and assessment tools, and therapy toys and materials.

The Partnership for a Healthy Mississippi: a nonprofit organization formed as part of the Mississippi's Tobacco Pilot Program that has been instrumental in the development of prevention initiatives targeting youth over the past several years. The Pilot was initially a two-year program created in 2000 with funds the state received as a result of the Mississippi tobacco settlement. Through the use of carryover funds, the pilot program was extended for a third year. The program consists of four component areas for which the Department of Health was charged and funded to coordinate a comprehensive evaluation in the following areas: school health nursing; law enforcement; community intervention; and media/public awareness.

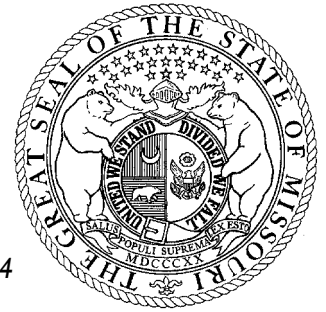
Car Seat Program: offers instructions on how to install a child safety restraint and also issues car seats through county health departments at no cost for those who are in need.



MISSOURI

“We’re pleased to see the improvement, but we still have a lot of work to do. Seventy-five thousand babies are born in Missouri every year, and every one of them needs to be protected.”

—Governor Bob Holden, August 2, 2004



In 2002, the infant mortality rate for Missouri was 8.5, a significant increase compared to 7.2 in 2000. Negative reproductive outcomes, such as prolonged hospitalization, premature birth, low birth weight, and infant mortality are significant and are of high prevalence in Missouri. Approximately one in four infant deaths resulted from a congenital birth defect. For 1996-2000, male infants had a 52 percent higher overall birth defect rate than females. The difference in rates reflects higher rates of genital and urinary organ defects among male infants. Male infants also had higher rates of hydrocephalus, circulatory and respiratory anomalies, cleft lip and cleft palate, pyloric stenosis, clubfoot, and skull and facial bone anomalies. Female infants had higher rates of microcephalus and congenital hip dislocation.⁴⁴ In 2001, 8.9 percent of all live births were of low birth weight, with higher rates noted within the state’s Eastern District. The low birth weight rate in Missouri showed slight fluctuations from 1992-2001.⁴⁵

Another major factor contributing to infant mortality in Missouri is prenatal tobacco, alcohol, and drug exposure. Between 1993 and 1997, the prevalence of alcohol and cocaine usage decreased 46 percent. The prevalence of tobacco usage showed no significant change (21.9 in 1993 to 21.0 percent in 1997), while the prevalence of marijuana, methamphetamines, and phencyclidine showed slight increases.⁴⁶ Missouri has one of the highest pregnant smoking rates in the South (18.3 percent in 2003). Health-related costs due to smoking during pregnancy run approximately \$15.8 million annually for more than 13,800 births in Missouri each year.

Having no prenatal care is one of the major indicators of whether a woman is using one or more (controlled) substances. In 1997, of those women not receiving prenatal care, one in 16 used alcohol; two in five smoked cigarettes; one in seven used marijuana; and one in five used cocaine during pregnancy. According to sections 191.725-745, RSMo, Missouri physicians are required to counsel pregnant patients on the effects of cigarettes, alcohol,

State Facts 2001*

Infant Mortality Rate	7.4
Preterm Birth Rate	12.7
Low Birth Weight Infants	7.6
Prenatal Care in First Trimester	87.7
Pregnancy/Maternal Smoking	18.3
Teenage Birth Rate (age 15-19)	46.1
Birth Rate to Unmarried Women (age 15-44)	34.8

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

and other controlled substances; obtain signatures from patients indicating that they have received counseling; maintain signatures in patients’ medical files; identify individuals with high-risk pregnancies for substance abuse; inform pregnant women using controlled substances about available intervention services; offer referrals for service coordination by the Department of Health and Senior Services to any pregnant patients at risk or using alcohol or controlled substances; identify infants showing signs and symptoms of prenatal drug exposure; and comply with the child abuse/neglect law (section 210.115, RSMo). Any physician or healthcare provider complying in good faith with these provisions shall have immunity from any civil liability.

Much progress has been made by the Department of Health and Senior Services (DHSS) to improve the health of women and children in Missouri despite these alarming trends. The breastfeeding initiation rate has been steadily increasing from 9.6 percent in 1993, to 25.3 percent in 2001. The proportion of women reported who begin prenatal care in the first trimester has consistently increased from 65.3 percent in 1994, to 87.7 percent in 2001. The proportion of women enrolled in the WIC program during their first trimester also have increased. Although the prevalence rate for self-reported smoking before pregnancy has increased, the rate for smoking during pregnancy decreased from 28.1 percent in 1994, to 18.3 percent in 2001. Common occurrences for smoking before pregnancy were among women ages 16-19 years, women with less than a high school education, and unmarried women.⁴⁷



In order to meet the national and state health objectives for maternal and child nutrition in low-income populations, prevention of teenage pregnancy, smoking cessation during pregnancy, decreased incidence of low birth weight, and decreased incidence of infant mortality, the DHSS has supported more efforts to strengthen the delivery of support services. Also, intervention strategies that target the reduction of risk factors among high-risk populations have been developed and implemented.

Family Care Safety Registry: established by law to protect children, elderly, and the physically or mentally disabled in the state and to promote family and community safety by providing background information on potential caregivers. This service is intended to provide information to help families and employers make informed decisions when hiring employees to work with children, elderly, or the physically or mentally disabled.

Baby Your Baby: a Web site (<http://www.health.state.mo.us/babyyourbaby/>) that promotes prenatal and well child care and provides useful information on all pregnancy and child care related topics.

Office on Women's Health: administratively established in 1999 by the DHSS. The next year, women members of the General Assembly sponsored legislation mandating the Office, and Governor Mel Carnahan signed that into law in July 2000. Duties of the Office include making recommendations to the director on ways to improve health and well-being of women of all ages; assessing women's health status; promoting integration and coordination of existing programs and services for women and families; and supporting the development of community leadership for women's health.

Special Health Care Needs Program: provides services for children and adults with disabilities, chronic illness, and birth defects. "HOPE," the Basset Hound, represents the hope that the program brings to families and children with special medical needs. The program is supported by state and federal funding.

Community Health Assistance Resource Team (CHART): developed in 1994 as a framework for community health improvement, provides technical assistance and workshops for communities striving to build skills in areas such as identifying local resources and needs; determining local risk factors; identifying intervention models; developing community-based strategic plans; and sustaining initiatives, leading to improved health outcomes.



Caring Communities Initiatives: a statewide effort created to increase the accountability of state agencies and communities for improving the lives of children and families. It works to change the way that decisions are made about what services are provided, how they are financed, and where they are delivered. The Family and Community Trust (FACT) Board of Directors, composed of the directors of eight state agencies and nine private sector members, directs this reform effort and serves as the bridge between state agencies and communities (the Family Investment Trust's name was changed to *The Family and Community Trust* on April 2, 2001 by Missouri Governor Bob Holden). There currently are 21 Caring Communities Partnerships across the local communities. Their overarching goals are to address the poor performance of children in school, the problems that disrupt and separate families, as well as barriers to children growing up healthy and safe.

Based on the directive in the Governor's Executive Order 01-07, issued April 2001, each Caring Community uses a standardized format to report to the governor, the General Assembly, and the public annually. The annual reports provide a succinct picture of a community's progress toward results, their success in generating additional resources, and their ability to identify and overcome barriers to effective service delivery.

Primary Care Resource Initiative for Missouri (PRIMO): provides help to people and communities to assure access to healthcare services to all Missourians. The focus on PRIMO is on building community-based systems of care across the state to work with their communities to make sure that health needs are met among the vulnerable populations such as pregnant women, children, and the elderly.

Child and Adult Care Food Program: assures that nutritious meals and snacks are served to children enrolled in child care programs by providing reim-



bursament for meals that meet minimum nutritional standards. The program requires that well-balanced meals be served and good eating habits taught. It also provides training and technical assistance on nutrition, food-service operations, program management, nutrition education and record keeping.

Missouri Commodity Supplemental Food Program: works to improve the health of participants by supplementing their diets with the U.S. Department of Agriculture (USDA) commodity foods. The program is funded by the USDA. The population served by this program is similar to that served by WIC, but it also serves older persons (age 60 and above), and provides food packages rather than the checks that WIC participants receive. Eligible women, infants and children cannot participate in both WIC and the Commodity Supplemental Food Program at the same time.





NORTH CAROLINA

“Our fight to reduce infant mortality and morbidity is far from over. Without the support, we will lose ground in our struggle to allow children to begin their lives healthy and full of promise.”

*—Representative Robert C. Hunter, Lead Legislator
Southern Regional Project on Infant Mortality, July 1991*

For both whites and minorities, North Carolina’s low birth weight and infant mortality rates have consistently exceeded national rates. Within the last 10 years, the state’s percentage of low weight births has risen, while the infant mortality rate has declined. The fall in the infant mortality rate reflects declining risk of death in all but the smallest birth weight category (under 500 grams) and substantial reductions in death from respiratory conditions, SIDS, and birth defects.⁴⁸ Great improvements have been made in reducing birth weight-specific infant mortality. However, the state’s worsening birth weight distribution is cause for concern. Increases in multiple births and maternal smoking have contributed to the increasing percentage of low birth weight infants in North Carolina. In 2001, the percent of low birth weight infants was 8.9, compared to 8.7 in 1996. The maternal smoking rate in 2002 was 14.0 percent, among the highest in the South. These disconcerting risk factors may be the result of the decrease in the number of pregnant women seeking prenatal care within the first trimester (84.4 percent in 2002, compared to 85.0 percent in 1999).

North Carolina has made substantial progress in reducing infant mortality, despite its national standing. In 1993, State Law, General Statute 143B-179.5 established the Governor’s Interagency Coordinating Council (NC-ICC). The NC-ICC met quarterly to advise and guide the Departments of Health and Human Services (DHHS), Environment and Natural Resources, the Public Schools of North Carolina, and other agencies regarding services for children with special needs from birth to age 5. In 2000, Governor Jim Hunt appropriated \$150,000 to the DHHS, Division of Public Health to help enhance its effort to promote the use of folic acid. That same year, the Division of Public Health also received a federal Healthy Start Baby Love Plus Grant. With annual funding of \$500,000, the focus was on minority infant mortality in Gates, Halifax, Hertford, Nash, and Northampton counties. On October 9, 2001, Governor Michael F. Easley signed Executive Order No. 13 appointing the Governor’s Task Force for Healthy Carolinians. The Task Force comprises 38 members representing health-

State Facts 2001*

Infant Mortality Rate	8.5
Preterm Birth Rate	13.5
Low Birth Weight Infants	8.9
Prenatal Care in First Trimester	84.4
Pregnancy/Maternal Smoking	14.3
Teenage Birth Rate (age 15-19)	55.2
Birth Rate to Unmarried Women (age 15-44)	34.3

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

care providers, businesses, academic institutions, religious organizations, councils, commissions, community groups, and legislators.

Another effort was on reducing the number of unintended pregnancies that often resulted in poor birth outcomes. Almost half of all pregnancies in North Carolina are unintended. In addition, almost 130,000 women between the ages of 19 and 44 are in families with incomes at or below 185 percent of the federal poverty level, ineligible for Medicaid, and at risk for unintended pregnancy.⁴⁹ North Carolina applied to the federal Medicaid agency to expand eligibility for family planning services to populations at high risk for unintended pregnancies and was approved by the General Assembly.

A wide range of programs and services are offered by various divisions of the DHHS in promoting maternal and infant health through local health departments. These programs and services



include all, but are not limited to, the following: the Child Fatality Task Force & Local Child Fatality Prevention Teams; Comprehensive Adolescent Health Care Projects; Parenting Education Services; Pediatric Primary Care Program; Medical Nutrition Therapy for Children and Adolescents; North Carolina Hemophilia Assistance Plan; Genetic Counseling Services; Maternal Serum Alpha Fetoprotein Screening; and Intensive Home Visiting Programs. Other available programs also include:

Baby Love Program: implemented in October 1987, designed to help reduce North Carolina's high infant mortality rate by improving access to health-care and the service delivery system for low-income pregnant women and children. Through Baby Love, pregnant women receive comprehensive care from the beginning stages of pregnancy through the postpartum period. Trained nurses and social workers known as Maternity Care Coordinators (MCC) are located in all 100 North Carolina counties to assist pregnant women in obtaining medical care and an array of social support services, such as transportation, housing, job training, and daycare. In FY 2001, MCC services were provided to 24,487 pregnant women. In addition to MCC services, Maternal Outreach Workers, special-trained home visitors, worked one-on-one with at-risk families to provide social support, encourage healthy behaviors, and ensure that families are linked with available community resources. Originally funded by the Kate B. Reynolds Healthcare Trust and Medicaid, the Baby Love Maternal Outreach Worker Program has expanded from 21 pilot projects to 58 programs located in various agencies across the state. The Division of Medical Assistance and the Division of Public Health, Women's and Children's Health Section, jointly administer the Baby Love Program in cooperation with the Office of Research, Demonstrations, and Rural Health Development.

Problem Pregnancy Services: administered by the Division of Social Services, Adult and Family Services Section, provides individuals with needed help and support in solving medical, social, educational, and psychological problems associated with unplanned pregnancies. Services include counseling and informing the client of voluntary choices available. Services also may include assistance in arranging for and utilizing other needed services, including residential care. The *State Maternity Home Fund*, a component of Problem Pregnancy Services, provides payment for up to six months of residential care and services. The fund pays for care and related medical services for any North Carolina resident expectant mother who is experiencing a difficult pregnancy. Funds may be provided regard-

less of age or marital status for the expectant mother who is unable to remain in her own home during the prenatal period.

Together We Grow: an early intervention program which comprises system of services provided by many different agencies and programs including the *Children's Developmental Services Agencies* and the *Family Support Network of North Carolina*, for children ages birth to 5 and their families. There are two parts of Together We Grow—the *Infant-Toddler Program*, for children ages birth to 3, and the *Preschool Program*, for children ages 3 to 5. The North Carolina Interagency Coordinating Council is an advisory group to both programs, and focuses on the birth to 5 age range. Together We Grow is administered by the DPH, Women's and Children's Health Section.

Adolescent Pregnancy Prevention Program (APPP): funds local, community-based teen pregnancy prevention projects throughout the state. Projects focus on preventing first and subsequent pregnancies among teens and are located in agencies such as health departments, schools, local councils on adolescent health, teen health clinics, churches, and other nonprofit agencies. The APPP usually funds about three to five new projects each year and is administered collaboratively by the DPH and the Division of Social Services.

Child and Adult Care Food Program (CACFP): began in 1990 as a federally funded program which is administered and funded by the USDA, Food and Nutrition Service (FNS). The CACFP provides reimbursement to qualified caregivers for meals and supplements served to participants. The types of facilities that are eligible for CACFP reimbursement are at-risk child care centers, family day care homes, at-risk after-school programs, homeless shelters, and adult day care centers. CACFP is administered by the DPH, Women's and Children's Health Section.

Pregnancy Nutrition Surveillance System (PNSS): supports the efforts of the DPH, Women's and Children's Health Section and the WIC program, by providing accurate and timely information on pregnancy risk factors and outcomes for low-income women. Through annual reports, PNSS data is made available for use by public health professionals and other interested groups in evaluating the health status of pregnant women, targeting high-risk groups, and planning interventions at both community and statewide levels. The PNSS also links data from the WIC program, public maternity clinics, birth certificates, and fetal death certificates



to the state of North Carolina and the Eastern Band of Cherokee Indians.

North Carolina Health Choice for Children Program: began October 1998 as North Carolina's new children's health insurance program available to children of families who are not eligible for Medicaid or who cannot afford health insurance. It provides the same coverage as that for children of state employees and teachers, plus vision, hearing, and dental benefits. Eligibility is determined by family income.

Public Health Task Force: established in 2003 to study public health in North Carolina and to devise an action plan to strengthen public health infrastructure, improve health outcomes, and eliminate health disparities. Membership on the Task Force includes legislators; community leaders; public health professionals from state agencies and universities; local health directors; other healthcare providers; and representatives from minority communities.

Tobacco Prevention and Control Branch: administered by the DPH, Chronic Disease and Injury Section, works to improve the health of North Carolinians and to reduce premature deaths and health problems due to tobacco use and second-hand smoke. Branch programs build capacity of diverse organizations and communities to carry out effective, culturally appropriate strategies. Ten local coalitions serving 23 counties are responsible for carrying out all of the following programs at the community level: Tobacco-Free Schools Programs; Preventing Youth Access to Tobacco Programs; Clean Indoor Air Programs; Programs to Support Tobacco Use Cessation; Media Literacy Programs; Spit Tobacco Use Prevention Initiative; Ethnic/Minority and Special Population Programs; and Youth Advocacy and Involvement Program.



OKLAHOMA



“Infant Mortality is part of every state’s agenda, a part of its programming, and a part of the work many legislators and governors aim to do while in office.”

–Governor David Walters, Lead Governor
Southern Governors’ Association, April 28, 1992

Annually, approximately 400 infants die before their first birthday in Oklahoma, an average of one infant death each day. Infant deaths in Oklahoma typically result from inadequate prenatal care. Other causes include poverty, maternal and infant neglect and abuse, injuries, accidents, and infections. Infant deaths also can be linked to premature deliveries, especially in young mothers. In 2001, 7,572 babies were born to females under the age of 20 in Oklahoma. Of those, 32 percent, or 2,427 babies, were born to females under the age of 17. Oklahoma ranked 9th highest in the nation in teenage birth rates to females between the ages 15-19 in 2001.⁵⁰ Although the state has several teen pregnancy prevention programs, very few provide an abstinence-only message. According to the *March of Dimes 2000 Perinatal Profiles*, in an average week in Oklahoma, 957 babies are born. Of those, 150 babies are born to teenage mothers, 129 are born to mothers who receive inadequate prenatal care, 71 are born with low birth weight, and 112 are born preterm.

Even though the infant mortality rate is declining in Oklahoma (a 12-percent drop between 1991 and 2001), several related risk indicators are on the rise. In 2002, the percent of mothers beginning prenatal care in the first trimester was 76.8, compared to 80.5 in 1999. The percent of low birth weight infants increased to 7.8 in 2001 from 7.4 in 1999. Between 1991 and 2000, the proportion of all babies born with low birth weights increased nearly 14 percent, and the percentage of all babies born preterm also increased more than 15 percent.⁵¹

Recognizing these challenges, the Department of Health is focusing on reducing the number of infant deaths by concentrating on early childhood care. Areas for improvement also include increasing support for public healthcare and decreasing the number of uninsured women and children. Numerous programs and services have been developed targeting risk populations. Health disparities among minority groups continue to exist, but is not considered significant when determining infant

State Facts 2001*

Infant Mortality Rate	8.0
Preterm Birth Rate	12.7
Low Birth Weight Infants	7.8
Prenatal Care in First Trimester	77.4
Pregnancy/Maternal Smoking	17.9
Teenage Birth Rate (age 15-19)	58.0
Birth Rate to Unmarried Women (age 15-44)	35.2

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

mortality rate. Oklahoma is slowly experiencing widespread improvements in the overall health of its citizens. This pace primarily is due to little improvement in the prevalence of smoking and a rise in the percentage of children in poverty.

Children First Program: operated under the Family Health Services, as a community-based voluntary family resource program, offers home visitation to families expecting to deliver and/or parent their first child. The program encourages early and continuous prenatal care, personal development, and the involvement of fathers, grandparents, and other supporting persons in parenting.

Child Care Program: helps to ensure that children and their parents have access to licensed and affordable quality child care. This is accomplished through the administration of the federal Child Care Development Fund and the statewide licensing program. Family Health Services has initiated several programs to improve the quality and quantity of child care. The programs include Reaching for the Stars, TEACH Oklahoma, Oklahoma Child Care Resource and Referral, Family Child Care Home Networks, and First Start.

Children with Special Health Needs Program: provides medical services to special needs children who are not eligible for Medicaid. Services may include food supplements, genetics testing and counseling, and grants to local programs serving community health needs. The program is operated under Family Health Services.





Early Childhood Comprehensive Systems Initiative: seeks to collaborate and create a statewide, multi-agency comprehensive statewide early childhood plan by 2006. This planning grant is funded by the MCH Bureau in an effort to support families and communities to foster the mental and physical development of toddlers and children upon school entry.

Oklahoma Toddler Survey (TOTS): surveys mothers who have participated in PRAMS (Pregnancy Risk Assessment Monitoring System) at the time the child reaches his/her second birthday. The goal is to assure quality healthcare for toddlers and to provide a longitudinal summary of characteristics prior to pregnancy and continuing through the first two years of a child's life.

Oklahoma Birth Defects Registry: provides statewide active surveillance to better understand the incidence, cause, impact, and prevention of birth defects in Oklahoma. Information regarding neural tube defects and resources for services also is provided to parents.

Children's Emergency Services: provides emergency shelters to children who are removed from their own homes due to abuse or neglect. The emergency shelters are located at the Pauline E. Mayer Center in Oklahoma City and the Laura Dester Center in Tulsa. Emergency foster care also is available to provide family foster home placement to children under age 10 in Tulsa and Oklahoma counties for up to 30 days.

Family Support Assistance Program: helps families care for children under the age of 18 who have developmental disabilities.

Family Support Services Program: offers family planning services including examinations and birth control methods to all Medicaid-eligible persons. The AFDC and Title XIX recipients are notified of the availability of the family planning services.

SoonerStart Program: an early intervention program that provides assistance and education to families who have children up to age 3 with developmental delays or physical or mental conditions associated with Down Syndrome, fetal alcohol syndrome, failure-to-thrive, or cerebral palsy. Services include diagnosis and evaluation, case management, family training, counseling, home visits, nursing and nutrition services, and occupational, physical, and speech-therapy. SoonerStart is a voluntary program, and there is no cost for services.

Teen Pregnancy Prevention Program: provides coordination, technical assistance, and evaluation of community-based teen pregnancy prevention projects located in 16 counties. The program implements teen pregnancy prevention strategies that address the identified unmet needs of specific populations of youth who are at high risk for pregnancy.

Youth Risk Behavior Survey: identifies the prevalence of high-risk behaviors among high school students that may lead to poor health outcomes. The six primary risk behavior target measures are tobacco and drug use; unintentional/intentional injuries; alcohol use; sexual behaviors; dietary behaviors; and physical activity. The data establishes a mechanism for communities and schools to work together in developing intervention strategies targeting teenagers who may be vulnerable to, or at high risk, for dangerous health behaviors.

Adolescent Health Program: provides contract monitoring and technical assistance to 10 community-based teen pregnancy prevention projects in 12 counties. These projects address teen pregnancy by implementing research-based curricula to young teens that target knowledge, attitude, and behavioral intention around early sexual involvement and providing education for parents of adolescents and teenagers on how to become the primary sex educators.

Oklahoma Commission on Children and Youth: created by the Legislature for the purpose of providing independent oversight of the children and youth service system, assisting local communities in the development of partnership boards to improve and increase needed services for children and their families, and providing leadership on children's issues through test models and demonstration projects.



Child Care Warmline (1-888-574-5437): offers free telephone consultation to child care providers on numerous topics of concern.

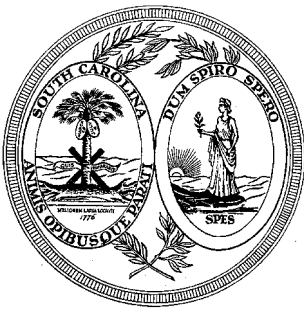
Oklahoma Abstinence Education Project: provides community-based, medically accurate, and age appropriate sexual abstinence-only projects to teenagers. The project aims at reducing the proportion of teenagers age 17 and younger who have engaged in sexual intercourse, lowering the pregnancy and birth rates, and reducing the incidence of sexually transmitted diseases among teenagers.

Early Childhood Development and Parent Education Program: provides education and consultation on child development, play and learning activities, and developmental assessments of children up to age 5.

Please Be Seated Program: initiated in 1992 to allow concerned citizens to report moving vehicles carrying unrestrained children. Patterned after a program in Virginia, the program allows motorists to carry Please Be Seated postcards in their vehicles and use them to report non-compliant drivers. The postcards request the tag number of the vehicle, date and time of reported offense, and number and ages of unrestrained children. The owner of the vehicle will then receive a packet with information on the importance of buckling up children and child passenger safety resources. Please Be Seated is solely educational, and drivers are not reported to law enforcement.

SAFE KIDS Buckle Up Program: provides child safety seat check-ups and child passenger safety training classes for professionals and other interested advocates in an effort to get more children properly restrained in vehicles.





SOUTH CAROLINA

“If we are to continue the progress of our Southern region, we must embrace prenatal and infant care as a fiscal imperative, assigning it a priority at the top of our state agendas.”

–Governor Richard Riley, Lead Governor

Southern Regional Task Force on Infant Mortality, February 24, 1985

South Carolina’s pregnant women and children face a variety of challenges. Both pregnancy and infancy represent critical points in life in terms of quality of life and economic consequences. South Carolina could save an estimated \$34 million by reducing low weight births from the current 9.3 percent (2002) to the national average of 7 percent. In addition, for every one dollar spent on providing adequate prenatal care to low-income women, \$3.38 could be saved from avoided direct medical care for a low birth weight baby during its first year of life.⁵²

There has been an overall decreasing trend in the number of live births to South Carolinians from 1990 to 2000 (a 4.2 percent drop during this 10-year period). However, live births began to increase in 1996, and the state has seen a 9.5 percent increase over the five-year period. This increase occurred the same time as the increase in the percentage of women who reported using no contraception. The unintended live birth rate for 1998 was 45.8 percent of all live births. Of those unintended births, 75.8 percent were to women less than age 20; 74.1 percent were to unmarried women; 67.4 percent were to women with less than a high school education; and 63.3 percent were to women enrolled in Medicaid. In 2002, the percent of mothers beginning prenatal care in the first trimester was 78.4, a drop from 80.7 in 1999. This declining trend may be linked to the increasing rates of low birth weight infants from 1998-2001. The counties having the lowest first trimester entry rates for the 1996-1998 combined periods were Allendale, Dillon, Fairfield, and Hampton.⁵³

The above indicators play major roles in contributing to the state’s rising infant mortality rate. Despite many downward trends, South Carolina has made great strides in reaching out to the communities to find individuals or families who need help getting into a system of healthcare. The Department of Health and Environmental Control (DHEC) has implemented several initiatives and programs to assist individuals and families in not only accessing healthcare, but in using available care appropriately.

State Facts 2001*

Infant Mortality Rate	8.9
Preterm Birth Rate	13.9
Low Birth Weight Infants	9.6
Prenatal Care in First Trimester	79.2
Pregnancy/Maternal Smoking	12.8
Teenage Birth Rate (age 15-19)	57.4
Birth Rate to Unmarried Women (age 15-44)	40.1

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

In 1997, the DHEC entered into a unique partnership with the Department of Health and Human Services to expand traditional outreach efforts. The DHEC assumed the responsibility of assisting the state Medicaid agency in identifying and recruiting potentially eligible individuals into the appropriate Medicaid program and increasing the number of primary care services providers (or medical home) by recruiting physician practices willing to enroll in the Medicaid program as providers. This served the Medicaid agency by increasing their network of providers. Most importantly, this arrangement benefited the clients by providing increased access to care provided through a partnership of medical and public health professionals.

As the result of this collaborative arrangement, the Medicaid agency has added more than 100,000 children to its expanded Children’s Health Insurance Program. This effort received national recognition for its strong partnership among the private medical community, public health agency, and the Medicaid agency. Private/public partnerships promoting medical homes for children have grown from four in 1993, to 54 in 1997, to 90 in 2000. More than 100 new physicians have become providers under Medicaid. The percent of Medicaid children from birth to age 3 who have seen a primary care provider in the last year also has increased from 45 percent in 1990, to over 84 percent in 1998.

Education has been a focus of prevention in South Carolina, especially targeted toward families with children. Based on the *1999 Youth Risk*



Behavior Survey, two out of every three high school students (58 percent) have had sexual intercourse, and one out of every four (22 percent) students has had sexual intercourse with four or more people. These high frequencies leave teenagers at high risk for teen pregnancy, HIV infection, and other sexually transmitted diseases. In 1998, the DHEC family planning clinics revealed 12.1 percent of 1,000 teenage girls between the ages 15-19 were infected with Chlamydia. Importantly, the rates for teenage pregnancy have declined in the last decade. This may be due, in part, to many available programs that address teen pregnancy prevention. Many education programs throughout the state cover a range of topics from abstinence, STD/HIV prevention programs, parenting programs, and programs that promote maternal and infant health.

The DHEC, through its Bureau of Maternal and Child Health, promotes the health of women, children, and their families in all 46 counties of South Carolina. Personal and preventative health services are provided by county health departments statewide. These hands-on services are provided to maintain and improve health outcomes for children and adults.

Partners for Healthy Children Program: authorized under Title XXI of the Social Security Act, provides Medicaid coverage for children whose families' incomes are at or below 150 percent of the federal poverty level.

Katie Beckett-TEFRA Children Program: created January 1, 1995, under Section 143 of the Tax Equity and Fiscal Responsibility Act of 1982, which allowed South Carolina to make Medicaid benefits available to disabled children under age 18 who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of their parents' incomes or resources. This program is operated under the Bureau of Beneficiary and Systems Support.

Postpartum Newborn Home Visitation Program: provides home visits to newborn babies and their mothers 48 to 72 hours after hospital discharge. Services include a comprehensive head-to-toe physical assessment of the newborn, a partial physical assessment of the mother, an environment assessment, and education regarding safety, feeding, routine bathing, and infant stimulation to promote brain and cognitive development.

Children with Special Health Care Needs Division: administered by the Bureau of Maternal and Child Health, operates a variety of programs

for individuals with disabilities, chronic illnesses, or severe developmental delays. The *Children's Rehabilitation Services* serves children and young adults from birth to 21 years of age for a variety of medical conditions. *BabyNet* serves children from birth to age 3 with developmental delays. The *Orthodontia* program assists children under age 21 with services for craniofacial anomalies. The *Hearing Aid* program provides batteries for hearing aid devices for children from birth to age 21 who are Medicaid eligible or are below 100 percent of federal poverty guidelines. *First Sound*, the universal newborn hearing screening and intervention program, ensures that all infants are screened at birth and prior to hospital discharge to identify any hearing problems.

Care Line (1-800-868-0404): provides assistance, support, and information to callers about prenatal care, infant and child healthcare, transportation to medical appointments, family planning, well child check-ups, immunizations, services for children with special healthcare needs, and BabyNet.

SC BIBS Program (South Carolina Black Infants Better Survival): dedicated to reducing the infant mortality rate among the black communities by helping parents access information and resources to ensure better health outcomes for their children. SC BIBS is operated under the Bureau of Maternal and Child Health.

Perinatal Regionalization: administered by the Bureau of Maternal and Child Health as a comprehensive, coordinated, and geographically structured approach used to assure risk-appropriate care for all mothers and infants with a goal of improving perinatal outcomes and reducing infant mortality. Key elements of the system include early-risk assessment and referral to appropriate care; designation of care as Basic (level I), Specialty (level II and IIE), and Subspecialty (level III); coordination and communication between hospitals and community providers; monitoring of systems through data; and assuring access to services from preconception through the baby's first year of life.

Family Support Services: available through the local public health departments to enhance and support primary medical care and preventative health behaviors. Service teams include public health nurses, licensed social workers, registered dietitians and nutritionists, health educators, and public health assistants.



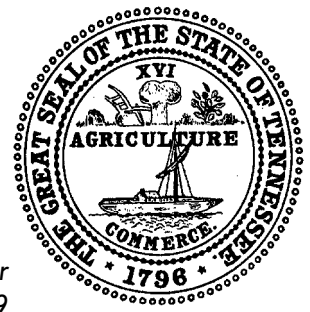
Maternity/Prenatal Care Services: available in all 46 counties and 100 clinic sites. These services are provided as a continuing effort to improve pregnancy outcomes. Several levels of care are available depending on the client's request for services, her risk status (i.e., diabetes, high blood pressure, STDs, etc.), and arrangements for provision of services within each county. The county health department acts as the client's advocate to see that all pregnant women who apply for services receive risk-appropriate care. It provides both supportive services and complete services to women. Supportive services are for those women who receive their prenatal care elsewhere and only come to the health department for WIC. Private physicians (obstetricians or family practitioners) provide the actual medical care. Complete services are provided for those women who receive their prenatal care and postpartum services at the health department. Currently, only two counties in South Carolina (Lee and Pickens) provide complete prenatal care. All other counties in the state have been able to partner with private physicians for the medical care.

Migrant Health Program (MHP): established in 1977, ensures the provision of culturally competent healthcare and health-related services to migrant and seasonal farm workers and their families. Program services are provided directly, or through contractual arrangements, and are targeted to areas with large concentrations of farm workers, or where there are no community health center sites. MHP services and activities include provision of primary care; dental and pharmacy services; specialty referrals; outreach services; health screening; health education; translation and interpretation; transportation; and case management. Staffing includes the administrative management team, a part-time clinical director/M.D., part-time seasonal nurses, outreach workers, and lay health promoters. MHP is administered by the Office of Minority Health.

Good Health Begins With You Campaign: operated under the Office of Minority Health, promotes healthy behaviors and lifestyles among South Carolina's communities of color. The campaign makes use of radio and print media outlets, and promotional items such as the annual "*Good Health Begins With You Calendar*," to support the effective promotion of health among South Carolina's minorities.



TENNESSEE



“As long as babies are dying in the South or being born with disabling conditions that could have been prevented, we must continue to push for programming for the children of tomorrow.”

–Senator Douglas Henry, Lead Legislator
Southern Regional Task Force on Infant Mortality, 1989

As in many Southern states, Tennessee’s infant mortality rates have been rising over recent years (9.4 in 2002 vs. 8.1 in 2001 vs. 7.4 in 2000). This may be linked to the declining number of mothers seeking prenatal care within the first trimester of pregnancy (82.8 in 2002, compared to 84.3 in 1999). The rates of infants born with a low birth weight remained steady from 1999 to 2002, with no significant improvements. Though the teen pregnancy rate has dropped from 74.0 in 2000, to 64.9 in 2002, it continues to be high. In 1999, one in every 1,000 teenage girls aged 15-17 became pregnant and, by age 21, one out of every five required treatment for sexually transmitted diseases. Haywood County had the highest rate for teenage pregnancy at 28.9, followed by McNairy County at 26.9, and Hardeman County at 26.3.⁵⁴

In an effort to address out-of-wedlock births and infant mortality, the Department of Health has established several programs and initiatives that are geared toward communities and populations at risk for adverse health outcomes to help improve the overall well-being of children and their families. In 2000, the Department of Health funded 18 community-based, abstinence-only education projects across the state. They were charged with providing curricula and activities focusing on abstinence until marriage and life skills. Programming targeted 10-17 year-olds with a focus on 10-14 year-olds. Projects included a hospital district, the Boys and Girls Club, a Girl Scout troop, crisis pregnancy support centers, and school-based programs. The goal is to reduce premature death, disease, and disability through a combination of programs, wellness initiatives, and chronic disease interventions. Prevention efforts comprise innovative techniques to inform the public and promote the adoption of healthy lifestyles.

Child Care Resource Centers: available across the state to help child care providers and professionals improve the quality of child care. The Centers are the result of a collaborative project involving the Department of Human Services, Department of

State Facts 2001*

Infant Mortality Rate	8.1
Preterm Birth Rate	14.0
Low Birth Weight Infants	9.2
Prenatal Care in First Trimester	82.8
Pregnancy/Maternal Smoking	17.1
Teenage Birth Rate (age 15-19)	58.4
Birth Rate to Unmarried Women (age 15-44)	35.7

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

Health, and the Developmental Disabilities Council. There currently are 11 Child Care Resource Centers across the state serving 95 counties.

Healthy Start: an intensive home visiting program for first time parents. Its goals are health promotion and child abuse prevention. Eligible families may begin the program during the time period of the third trimester of pregnancy through the child turning four months of age. Families may remain in the program until the child is 5 years of age.

Parents Encouraging Parents (P.E.P.): a state-wide parent-to-parent network established to offer support and information to parents of children with mental, physical, or developmental disabilities, chronic illnesses, or special needs. *Support parents*—trained volunteers who have developed effective coping skills and strategies in parenting a child with special needs—are matched with *referred parents*—parents with a child who is newly diagnosed, in crisis or transition, or simply in need of support and information. Parents are matched as closely as possible based on the child’s diagnosis, family structure, and cultural, racial, or religious factors. The frequency and duration of contacts are determined by the referred parents’ needs and preferences. All information is kept confidential. P.E.P. provides practical advice and information, as well as emotional support and encouragement.



Children's Special Services (CSS): provides services to eligible children with special healthcare needs. CSS has three components: medical services, care coordination, and the P.E.P. program.

Family Planning Program: provides education and counseling, medical examinations, laboratory tests, and contraceptive supplies for any person of reproductive age. Services are available in all 95 counties at 129 clinic sites, which include all local health departments, planned parenthood clinics, some student health clinics, and primary care clinics.

Prenatal Care Program: provides basic prenatal care services at all local health department clinics, including pregnancy testing, education, presumptive eligibility and TennCare enrollment, referral for WIC, and referral for obstetric medical management. Selected counties across the state provide full service obstetrical care for pregnant women.

Perinatal Regionalization Program: established to provide diagnosis and treatment of certain life-threatening conditions of pregnant women and newborn infants. The five regional perinatal centers across the state have made this specialized care available by providing a statewide mechanism to healthcare providers for consultation and referral of high-risk patients; transport of these patients, if necessary; personnel skilled in high-risk perinatal care; post-graduate education for physicians, nurses, and other medical personnel; and site visits to local hospitals.

Tennessee Adolescent Pregnancy Prevention Program (TAPPP): promotes community awareness and involvement in adolescent pregnancy and parenting issues; facilitates collaboration among various sectors of the community to enhance and increase prevention efforts; coordinates, improves and expands services available to pregnant and parenting adolescents. There are 13 regional and metro TAPPP coordinators in the state.

Help Us Grow Successfully (HUGS) Program: assists pregnant women, postpartum women for up to two years, and infants and children up to age 6 in gaining access to medical, social, and educational services. HUGS services are available in all 95 counties.

Child Health and Development (CHAD) Program: available in 23 counties for pregnant women and children from birth to age 6. CHAD helps prevent or reduce abuse, neglect and developmental delays by providing parent support and education services.

Child Fatality Prevention Teams: created through the Child Fatality Review and Prevention Act of 1995, as multi-discipline, multi-agency local teams to review all deaths of children 17 years of age or younger in the 31 judicial districts. The state Child Fatality Prevention Teams review the reports from the local teams, analyze statistics of the incidence and causes of child deaths, and make recommendations to the governor and General Assembly to promote the safety and well being of children. Tennessee is part of a national movement to identify why children are dying and what preventative measures can be taken.

TennCare: provides a system of healthcare/managed healthcare program to children and adults who are Medicaid eligible or who lack access to health insurance. Currently, the state is moving toward a plan that will stop short of returning to traditional Medicaid by preserving full coverage for children, and limiting benefits and reducing enrollment for adults. The plan for "Basic TennCare" will preserve full coverage for all 612,000 children currently on the program and maintains a reasonable level of benefits for 396,000 adults who are eligible for Medicaid. As many as 323,000 adults who are not eligible for Medicaid will lose TennCare coverage—although 24 percent of those enrollees will continue to be covered under Medicare. The conversion to Basic TennCare is expected to be substantially complete by 2006.⁵⁵

TennCare began in January 1994 as an experiment to expand Tennessee's Medicaid program to deliver healthcare to a larger number of people for the same amount of money. But the program was beset by problems and cost overruns, especially by rising healthcare and prescription drug costs. TennCare's \$7.1 billion annual budget now accounts for nearly one in three dollars the state spends. For example, TennCare's pharmacy benefit in recent years has grown at a rate of 26 percent annually versus average growth of 17 percent in neighboring states' healthcare plans. The total cost of TennCare's pharmacy benefit (\$2.11 billion) now is greater than the cost of Tennessee's higher education system (\$1.89 billion).⁵⁶



TEXAS



“Texas has many health assets and opportunities, but it also has some critical health challenges that must be addressed.”

—Eduardo J. Sanchez, M.D., M.P.H.,
Texas Commissioner of Health, December 22, 2003

Texas has made great progress, but it continues to face many obstacles. Despite the strong role individual behaviors can play in promoting the state’s health, there are factors that cannot easily be changed by individuals such as economic factors; environmental problems; an inadequate health infrastructure; and poor quality health education. According to the *2002 Health of Texans Report*, many public and private entities do crucial work in addressing the health of Texans, and examples of these coordination and collaboration efforts exist. However, Texas generally lacks a coordinated approach to establishing health goals, having individual organizations take responsibility for reaching those goals, measuring the impact of coordinated efforts, and making adjustments over time.

Efforts have been made by the Department of Health to identify and target the behaviors that result in poor health outcomes as well as poor health status. According to the United Health Foundation’s 2003 State Health Rankings, Texas was 38th in the combined measures of risk factors and 27th for its combined measures of outcomes. Without changes, the future health of Texans may be jeopardized or compromised if this trend continues.

The rate of infants born with a low birth weight has been rising for the past decade. In 2001, the rate of low birth weight infants born was 7.6, compared to 6.0 in 1990. Though more women are beginning their prenatal care early, within the first trimester, the infant morbidity rates have not much improved. The 14 counties bordering Mexico consistently have experienced exceptionally high rates of neural tube defects, with anencephaly rates as high as 26 per 10,000 live births. In 2002, 6.5 percent of Texas mothers reported smoking during pregnancy, compared to 6.4 in 2000. Pregnancy complications due to smoking cost Texas an estimated \$17.7 million annually. Children under age 18 accounted for 28 percent of the state’s population in 2000, but accounted for about 42 percent of the population living in poverty.⁵⁷ Many Texans continue to struggle with the consequences of inadequate care

State Facts 2001*

Infant Mortality Rate	6.0
Preterm Birth Rate	9.8
Low Birth Weight Infants	7.6
Prenatal Care in First Trimester	80.3
Pregnancy/Maternal Smoking	6.4
Teenage Birth Rate (age 15-19)	66.5
Birth Rate to Unmarried Women (age 15-44)	31.0

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

and barriers to healthcare including language or cultural differences, fear of the medical system, lack of awareness of the pregnancy, lack of money or insurance, absence of services within the community, or problems related to transportation.

Texas is a large and diverse state. The seven largest metropolitan counties—Bexar, Dallas, El Paso, Harris, Hidalgo, Tarrant, and Travis—together account for half of the total population. In 1990, approximately 83 percent of the population lived in metropolitan areas. By 2010, a projected 86 percent of the population will live in the 58 counties currently designated as metropolitan. In Harris County, Texas’ largest, of the 313,900 teenage residents aged 13-18, more than 5,000 had given birth in 2001; 4,184 contracted sexually transmitted diseases; 41 infant deaths were recorded; 442 were classified as low birth weight; 1,781 mothers received inadequate prenatal care; 18.1 percent of teenage births were repeated births; 2,844 dropped out of school; and 55,739 lived below the poverty level. In 2001, Medicaid paid for 173,226 deliveries in Texas, at a total cost of \$420 million. Approximately 10 percent of these deliveries were to teen mothers aged 13-17, at a cost of \$41 million.²⁶

With one large metropolitan area comes one larger rural area. Some parts of Texas still lack hospital services. Of 254 counties, 63 lack an acute care hospital and 124 have only one acute care hospital. In addition, 47 counties (41 rural) with acute care hospitals do not provide obstetrics services, and 56 counties (37 rural) with acute care hospitals do not provide certified trauma services. There are 88



counties with only minimal emergency medical services (EMS) capability and two counties with no EMS coverage. Most rural counties and all sparsely populated counties in Texas rely on volunteer EMS systems, and there has been an increasing shortage of rural EMS volunteers.⁵⁹ Because of Texas' high poverty levels, its many sparsely populated areas, and its chronic shortages of health professionals in rural and some inner city areas, it is the incumbent upon the state and federal governments to work together to identify these shortfalls and to develop programs and initiatives that target the population groups at risk for poor health outcomes. Current programs available through the Department of Health are as follow.

Texas Birth Defects Monitoring Division: established in 1993, collects data on births occurring throughout the state. It identifies and describes patterns of birth defects, finds the causes, and works toward their prevention.

Child Wellness Division: provides statewide leadership in identifying and addressing conditions which contribute to childhood morbidity and mortality, or compromise a child's potential to become a healthy and productive adult through prevention, early identification, and remediation.

Children with Special Health Care Needs Division: comprises several programs that provide services to children with extraordinary medical needs, disabilities, and chronic health conditions. Its medical healthcare benefits program pays for medical care, family support services, and related services for children not covered by Medicaid, CHIP, or private insurance. The program also contracts with agencies throughout the state to provide an array of clinical and support services to children with special healthcare needs and their families, and it assists children and their families by supporting case management at the Department of Health's regional offices throughout the state.

Texas Primary Care Office: through a cooperative agreement with the Health Resources and Services Administration and a partnership with the Texas Association of Community Health Centers, works with healthcare providers and communities to improve access to care for the underserved populations by recruiting and retaining providers to practice in federally designated shortage areas.

Parenting and Postpartum Counseling Information: passed by the Legislature as HB 341 in the 78th Regular Legislative Session (2003), requires physicians, midwives, hospitals and birthing centers



which provide prenatal care to a pregnant woman during gestation or at delivery to provide the woman with a current resource list of professional organizations that provide postpartum counseling and assistance to parents. The list is maintained by the Department of Health. In addition, it must be documented in the client's chart that she received this information, and the documentation must be retained for a minimum of three years.

Abstinence Education Program: provides abstinence education information to children, adolescents, and parents across the state and to programs to promote abstinence from sexual activity with a focus on those groups which are most likely to bear children out-of-wedlock. Currently, there are 41 programs.

Adolescent Health Program: protects and promotes the health of adolescents. Services include helpline telephone numbers, vision and hearing screening, eating disorders support, and school health.

Audiology Services Program for Amplification for Children of Texas (PACT): serves Texas children from birth through 20 years of age who have hearing losses that cause a problem in school.

Childhood Lead Poisoning Prevention Program: advocates and promotes the health of children in Texas who have or are at high risk for having an elevated lead level and to increase awareness of iron anemia and the associated long-term effects.

Family Health Services Information & Referral Hotline (1-800-422-2956): a toll-free information and referral service for women and children in Texas.

Perinatal and Women's Health Program: works to improve health outcomes for the women and infants of Texas through the facilitation of systems



and collaborative approaches. Several areas are encompassed in this program. The *Texas Comprehensive Women's Health Initiative (TxCWHI)* is a three-year, Health Resources and Services Administration (HRSA)-funded project that is working in two Texas public health regions to facilitate the development of collaboration and strategic planning of women's health systems. The *Women's Health Network (WHN)*, part of the TxCWHI, is an internal Department of Health Workgroup that is charged with the task of developing a collaborative approach to women's health issues within the agency. *Perinatal Systems* focuses on the facilitation of perinatal systems across Texas. The *Perinatal Systems Workgroup* brings together healthcare providers, community-based organizations, healthcare administrators, consumers and other stakeholders to give input to perinatal issues that impact Texas.

Texas Health Steps (THSteps): a service under Medicaid, provides medical and dental check-ups and care to children from birth to age 21 who are enrolled in Medicaid. THSteps expands client awareness of existing health services, recruits and retains a qualified provider pool, makes comprehensive services available through public and private providers so that eligible young people in the Texas Health Steps client population can receive medical and dental care before health problems become chronic and irreversible.

Family Planning Program: serves the 11 Public Health Regions within the state. Services are provided directly by the Department of Health's regional health facilities and through contracts with a variety of organizations including local health departments, medical schools, hospitals, private non-profit agencies, and community and rural health centers. Medicaid-eligible individuals may also receive family planning services through physicians in private practice, advanced practice nurses, federally qualified health centers, and rural health clinics. No state or federal family planning funds are used to pay for abortions.

Region VI Infertility Prevention Project: a collaborative effort of the Sexually Transmitted Diseases/Family Planning programs and Public Health Laboratories in Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. The overall purpose of this project is to reduce the prevalence of *Chlamydia trachomatis* (Ct) infections and their sequelae through screening, treatment, and follow-up services.





VIRGINIA

“We must have a climate that promotes adequate healthcare resources and provides the necessary safety net for those who can’t access healthcare on their own.”

—President Pro Tem John H. Chichester, October 20, 2003

Maternal and infant health progress has been slow but continuous for the Commonwealth of Virginia. The state’s infant mortality rates gradually have been decreasing until most recent years. The 2001 infant mortality rate was 7.4, compared to 6.8 for the previous year. Although teenage birth rates have been declining, induced terminations, birth rates to unmarried women, the percent of low birth weight infants, and percent of women beginning prenatal care in the first trimester have begun to rise. A low teenage birth rate may be linked to the rise of the induced terminations rate. More babies are being born, 99,235 total live births in 2002 versus 91,871 in 1995, and more are becoming victims of infirmity. Births to unmarried women and to women enrolled in Medicaid accounted for the overall increase of low birth weight infants. In 2002, there were 30,223 non-marital births, compared to 26,961 in 1995.⁶⁰

Several efforts have been made by the Department of Health in promoting education on prenatal care, parenting issues, and children’s health within the communities, including schools, healthcare facilities, daycare centers, private businesses, and the media. Local health departments continue to offer prenatal care in most areas. Twenty-nine out of 35 health districts provide some prenatal care at 105 locations. The Richmond City district contracts its care with the Medical College of Virginia, a university-based hospital. Health departments also provide varying degrees of services based on community need and availability of resources. Some follow patients for the entire pregnancy, while others conduct initial exams and assessments and then link patients to private physicians. An additional 11 districts work collaboratively with local private providers by using per diem services or sharing staff. In 30 communities, the health departments are the only provider of prenatal care. In 2002, health departments served approximately 14,000 prenatal patients, and three out of 10 were teenage mothers.⁶¹ Additional maternal and child health programs and initiatives available through the VDH, Office of Family Health Services include the following:

State Facts 2001*

Infant Mortality Rate	7.4
Preterm Birth Rate	11.7
Low Birth Weight Infants	7.9
Prenatal Care in First Trimester	85.1
Pregnancy/Maternal Smoking	9.0
Teenage Birth Rate (age 15-19)	39.4
Birth Rate to Unmarried Women (age 15-44)	30.3

*All rates per 1,000 live births in specified group except prenatal care, pregnancy smoking, and low birth weight, which are in percent.

Pediatric Screening and Genetics Services: a statewide system works to reduce unnecessary morbidity from potential or existing genetic conditions by assuring access to the appropriate education, testing, counseling, and treatment to residents of the Commonwealth. The Program includes the following components: Virginia Newborn Screening Services; Metabolic Treatment Services/Phenylketonuria (PKU) Management; Virginia Congenital Anomalies Reporting and Education System (VaCARES); Regional Genetic Centers; and Virginia Genetics Advisory Committee.

BabyCare Program: provides pregnant women who are Medicaid recipients with the support and services they need through intensive case management and coordination of care. The program aims to improve birth outcomes by ensuring pregnant women and infants receive all the services they need. BabyCare is provided in more than 30 of the local health district offices and a small number of private community organizations.

Resource Mothers Program: uses lay community mentors to provide intensive home visiting services to young pregnant women and mothers through the infant’s first birthday. Currently, there are 26 programs across the state, located in health departments and private nonprofit agencies serving more than 84 counties. The goals of the program are to decrease infant mortality and morbidity; decrease the rate of low birth weight infants born each year; delay and/or prevent repeat pregnancy; keep teen mothers in school; and involve the infant’s father in the parenting process.



Regional Perinatal Councils: improves perinatal health by providing resource and referral information and education on preconception, pregnancy, childbirth and infancy. Services include bereavement support, infant mortality reviews, and supporting the coordination and linkage of perinatal health services in each region.

Family Planning Program: provides comprehensive family planning services to low-income citizens to help reduce the occurrences of unintended pregnancies.

Virginia Healthy Start Initiative and Richmond City Healthy Start: two federal grant programs that work to improve the health of pregnant women and infants in communities with high infant mortality. Through involvement of community leaders, healthcare providers and consumers, both programs foster change in the healthcare systems and health behaviors that prevent infant mortality. The cities where the maternal and infant populations are at risk or vulnerable to adverse health outcomes are Norfolk, Petersburg, Portsmouth, Richmond City, and Westmoreland.

Loving Steps: a Healthy Start public education campaign informing pregnant women, their families, healthcare professionals, community leaders, churches, educators, and others about what they can do to prevent infant mortality and to give their babies a healthy start.



Partners in Prevention Program (PIP): aims to reduce non-marital childbearing by increasing public awareness of its causes and consequences and mobilizing the development of community-based strategies and solutions. PIP employs creative strategies using media campaigns, direct intervention, and public forums targeting young adults aged 20-29. For fiscal year 2004, 15 coalitions were awarded funding to engage in Partners in Prevention activities within their communities. These coalitions represent 42 counties and cities.

Tobacco Use Control Project: provides training, information, materials and other support to help Virginians choose and maintain tobacco-free lifestyles. The program's main focus is on projects designed to prevent youth tobacco use. The staff works closely with 17 volunteer coalitions, school districts, and volunteer partners. Funding is provided through a grant from the Centers for Disease Control and Prevention.

Virginia Abstinence Education Initiative: established to address adolescent sexual risk-taking behavior and its consequences by promoting sexual abstinence. This is done by supporting abstinence education programs for school-aged youth, involving major youth influencers (parents, peers, educators, health professionals, faith community, and youth services providers) as partners in encouraging and supporting abstinence decisions, and developing relevant training and resources for educators and others committed to teaching and promoting abstinence. The program targets youth from age 10 to 17.

Child Development Services Program: a specialized program for children and adolescents suspected of having disorders such as developmental delays, developmental disorders associated with sensory or physical disabilities, disorders of attention and hyperactivity, learning disabilities, emotional and behavioral concerns, and mental retardation. A professional team consisting of a pediatrician, nurse, social worker, educational consultant, and psychologist provides these services. Core services include diagnostic assessment and care planning, follow-up care coordination, and referral.

Childhood Lead Poisoning Prevention: provides screening for children under age 6 for elevated blood lead levels. The mission of the program is to eliminate lead poisoning in children by the year 2010. In 2003, over 50,000 children were screened, with 1,048 having an elevated blood lead levels. The program funds high-risk localities in Richmond and



Norfolk to perform case management and environmental follow-up.

Healthy Child Care Virginia: works to promote safe and healthy daycare sites. More than 100 public health nurses have been trained as child care health consultants to offer training and assistance to daycare providers including assessing daily health status of children; ensuring good nutrition; preventing injuries; monitoring immunization schedules; and recognizing child abuse and/or neglect.

Care Connection for Children: a statewide network of centers for children with special healthcare needs that provide medical services, care coordination, medical insurance benefits evaluation and coordination, family-to-family support, and training and consultation with community providers on issues for children with special health needs. One of the goals of the centers is to help adolescents transition from a pediatric to an adult healthcare system and to help adolescents reach their full physical, developmental, educational, and career potential.

Better Beginnings Coalitions: established to help reduce adolescent pregnancy through the cooperative efforts of community coalitions comprised of public agencies, private organizations, community groups, and individual volunteers. The program's goals are to increase community awareness of the problem of teen pregnancy, support and promote local programs that seek to reduce teen pregnancy through youth development approaches, and advocate educational and health services to prevent teen pregnancy and parenthood. The 19 Better Beginnings Coalitions provide a variety of services and programs that vary from one community to another but generally include direct services to youth and families, media campaigns and public education, and training and technical assistance to adolescent service providers, such as teachers, counselors, and community service agencies.

Teen Pregnancy Prevention Program: established in 1993, provides funds for seven legislatively designated sites throughout Virginia to offer community-based programs to reduce unplanned pregnancies for teens. Youth targeted for this program range in age from 10 to 19.

Bright Futures: begun in 1990, a vision and philosophy of healthcare based on the principle that every child deserves to be healthy and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community. The mission of Bright Futures is to promote and improve the health, education, and well-being of infants, children, adolescents, families, and communities. Bright Futures materials incorporate national guidelines for child health and are consistent with American Academy of Pediatrics guidelines.

Girls Empowered to Make Success Program (GEMS): a youth development program for girls ages 9-15 who are the younger siblings or close relatives of older teens who are pregnant. The objectives of this program are to encourage these girls to delay sexual activity, stay in school, and avoid drugs, smoking, and alcohol and to become involved in the community through volunteer projects.

Virginia Breastfeeding Task Force: a forum opened to all interested citizens or organizations to develop and implement effective breastfeeding promotion strategies. Its goals are to improve infant and family health by making breastfeeding the cultural norm and to improve the rates of breastfeeding initiation and duration to meet the National Healthy People 2010 Breastfeeding Objective.

Sudden Unexpected Infant Death Referral and Notification Program: provides follow-up care and offers bereavement services to families who have experienced infant death. The Regional Perinatal Council staff work closely with the regional medical examiners to contact families of infants who have died unexpectedly. Data is collected and analyzed to assess the circumstances of those deaths.



WEST VIRGINIA



“We must have the courage.....even if we are uncertain of the outcome. To do nothing would be disastrous.”

—Senate President Earl Ray Tomblin, January 8, 2003

Between 1996-2000, more West Virginians died than were born. In 2000, 267 West Virginians died as a result of natural decrease, the excess of deaths over births. The rate of natural decrease was 0.15 persons per 1,000. Results from the 2000 Census showed an overall increase (approximately 0.8 percent) in the state’s population since 1990, from 1,793,477 to 1,808,344. This increase was the result of an overall natural increase and an excess of immigration over outmigration during the entire decade.⁶²

The geography of West Virginia contributes significantly to the problems of access to quality healthcare. The surface elevation of West Virginia is extremely uneven. It ranges from a low of 240 feet in the Valley of the Potomac to a high of 4,862 feet at Spruce Knob in Pendleton County. West Virginia’s mountains often are steep and rugged, rising and falling in successive waves of ranges. Non-interstate travel through West Virginia also can be treacherous. During the months of late December through early April, poor weather conditions add more time or prevent driving altogether.⁶³

West Virginia, along with the rest of the nation, recognizes the need to reduce the infant mortality rate and decrease the number of low and very low birth weight babies. There are several barriers that have made it difficult for low-income women to access early care including lack of transportation, obstetrical providers in their community, payment mechanisms, and an understanding of the importance of early prenatal care. The children of indigent families also experience similar difficulties in obtaining healthcare, and rural communities remain isolated from larger towns with medical centers, leaving many families cut off from healthcare facilities. West Virginia is the second most rural state in the nation, with 64 percent of its population living in communities of fewer than 2,500.⁶⁴ Forty-five of 55 counties are designated as rural or non-metropolitan as defined by the Bureau of the Census.

In an average week in West Virginia, 52 babies are born preterm and 33 are born with a low birth weight. In 2001, there were 2,690 preterm births,

State Facts 2001*

Infant Mortality Rate	7.3
Preterm Birth Rate	13.2
Low Birth Weight Infants	8.5
Prenatal Care in First Trimester	86.3
Pregnancy/Maternal Smoking	26.1
Teenage Birth Rate (age 15-19)	45.5
Birth Rate to Unmarried Women (age 15-44)	32.5

*Rates are calculated per 1,000 live births, except for low birth weight, prenatal care, and maternal smoking, which are calculated in percent.

representing 13.2 percent of live births. Between 1991 and 2001, the rate of infants born preterm increased by nearly 31 percent. Total charges for hospital stays for infants with any diagnosis related to premature births were estimated at \$13.6 billion in 2001.⁶⁵

The Department of Health and Human Resources (DHHR), Bureau for Public Health (BPH), has responded to the fluctuations in the health status of its mothers and infants by placing a greater emphasis on preventative medicine through promoting more healthful behaviors. Preventative approaches that hold the greatest promise for changing behaviors are community-based efforts that focus on both individual and societal influences. The BPH, Office of Maternal, Child, and Family Health, is the lead agency for numerous services, networks, and programs aimed at improving infant morbidity and mortality and increasing the capacity of local community groups to help promote the overall health of its citizens. A sampling of these include the following:

Birth to Three Program: a statewide system of services and supports for children under age 3 who have a delay in their development, or may be at risk of having a delay, and their family. A team of professionals works with the family based on each family’s concerns and priorities for their child. Teams include people who can provide the family knowledge about possible areas of concern with the child’s development. If a child is found to be eligible for Birth to Three, the family chooses whether they want to participate and receive services.



Early Childhood Resource Lending Library: contains numerous resources such as books, brochures, videotapes, training manuals, workbooks, curriculum guides, assessment tools, and self-study modules. Also available for loan are environmental controls, adapted toys and software.

Right from the Start Program: provides comprehensive maternity care for women whose income is at or below 185 percent of the federal poverty level. These services are provided in collaboration with Medicaid and Title V. Medical case management for high-risk women and infants is provided to facilitate entry into, and receipt of, appropriate healthcare for populations who, because of medical conditions/predilections, might otherwise not have appropriate or available care.

HealthCheck: West Virginia's E.P.S.D.T. Program ensures that Medicaid-eligible children under age 21 receive a comprehensive range of preventative and primary health services. This program provides periodic, comprehensive health examinations, vision, dental and hearing assessments, immunizations, and treatment follow-up of conditions found through the health examination.

Genetics Project: provides clinical genetic services for patients at five satellite locations throughout West Virginia. Services include diagnosis, counseling and management of genetically determined diseases, prenatal counseling, and evaluation of teratogen exposure. The Project is operated by the West Virginia University Department of Pediatrics and is supported by MCH Title V funds.

Adolescent Pregnancy Prevention Initiative: provides development, oversight and coordination of adolescent pregnancy prevention activities. Adolescent Pregnancy Prevention is a focus area of the Family Planning Program, targeted to reduce the number of pregnancies among adolescents through improved decision making skills, abstinence, or access to contraceptive services.

Family Planning Program: contracts with over 150 county health departments, primary care and rural health centers, college and university student health clinics, hospitals, and private medical practices to deliver clinical family planning services to eligible individuals.

West Virginia Abstinence Education Project: a preventative program educating youth and parents about the health benefits gained through positive lifestyle choices. AEP promotes primary prevention of sexual activity before marriage and related high-

risk behaviors in youth ages 10 to 14. The Project promotes an abstinence-until-marriage philosophy, targets the reduction of teen pregnancy rates, and seeks to reduce teen sexual activity in future generations.

Adolescent Health Initiative: designed as a complement to HealthCheck programming with the expressed 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.

Access to Rural Transportation Project (ART): began in 1991, allows government-sponsored patients (Medicaid/Title V), pregnant women, and infants up to 1 year of age, in need of medical care, to receive monies in advance to cover transportation to medically necessary services. This advance travel payment system was a collaboration between the Office of Maternal and Child Health and the Non-Emergency Medical Transportation, administered by the Office of Family Support. The Project operates in concert with the Right From the Start program to reduce barriers experienced by government-sponsored patients who reported transportation to be the major obstacle often preventing them from seeking early and continuous care. The advance monies are distributed through a network of community-based service providers who complete the necessary paperwork, which ultimately reduces the demand placed on local DHHR offices for transportation assistance, while improving patient access. Services currently are available in 54 counties.

West Virginia Rural Hospital Flexibility Program: often referred to as the Critical Access Hospital Program or the Flex Program, resulted from a major national initiative to strengthen rural healthcare by allowing small hospitals the flexibility to reconfigure their operations, particularly for acute inpatient care at Critical Access Hospitals (CAHs); offering cost-based reimbursement for Medicare acute inpatient, swing bed services and outpatient services (the Bureau for Medical Services supports the program by also offering cost-based reimbursement for Medicaid patients); encouraging the development of rural health networks; and offering grants to hospitals to strengthen the rural healthcare infrastructure.

Toll-Free Hotline Services (1-800-642-8522 or 1-800-642-9704): staffed by a registered nurse or licensed social worker who will serve as the initial service coordinator for children, families, and professionals about available services offered by the Office of Maternal, Child, and Family Health.

