For any state, children are a priceless “natural resource.” They are not only today’s youngest citizens—they’re also tomorrow’s workforce, leaders, policy-makers, and parents. They will control the future.

That’s why West Virginia would be smart to optimize its children’s health, to shape policies and practices that will help kids develop to their fullest potential.

It’s not happening.
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Trustees, Officers, and Staff
The Claude Worthington Benedum Foundation is an independent foundation established in 1944 by Michael and Sarah Benedum, natives respectively of Bridgeport and Blacksville, West Virginia. The Foundation’s policy is to allocate no less than five percent of the market value of its assets each year in support of its charitable activities, including the grants program. The Foundation’s assets at year-end 2004 totaled $357,798,543. Since its inception in 1944, the Foundation has made over 6,600 grants totaling almost $285,000,000.
Is it possible for a state with a difficult economy to help its kids to better health?

Yes.

And West Virginia has a number of advantages not available elsewhere. For example:
The entire State has only about 400,000 children—and only about 20,000 are born each year. Those are comprehensible, manageable numbers.

The vast majority of West Virginia’s children (92%) already have health insurance coverage.

About 65% of those kids are covered by one of the three public payors: Medicaid, the Children’s Health Insurance Program (CHIP), and the Public Employees Insurance Agency (PEIA). That gives State leaders a huge “captive audience” for implementing sound policy.

69.6% of West Virginia’s private pediatricians accept Medicaid patients—far above the national average of 54.6%; that means access isn’t as great a problem as it is elsewhere.

While some of the problems in children’s health will require spending more money, many will not; they will instead require reprioritizing, focus, and coordination of existing resources.

What does all this mean? It means that West Virginia has a remarkable opportunity—right now—to improve the health of its children. To some degree, that’s beginning to happen. There’s a very long way to go—but, with a major investment of will and work, West Virginia could even become a national leader in pediatric health.
issues:

Pregnancy and birth
Immunizations
Obesity
Oral health
Teen violent deaths
Asthma
Mental health
Poverty
A California study is providing a powerful rationale for considering emotional as well as physical factors when looking at children’s health.

The Adverse Childhood Experiences (ACE) Study, a collaboration between Kaiser Permanente in San Diego and the Centers for Disease Control and Prevention (CDC), examined the childhoods of more than 17,000 middle-aged, middle-class Kaiser patients. The Study (www.acestudy.org) revealed a strong—even startling—relationship between negative emotional experiences in childhood and physical and mental health later in life.

Participants were asked whether, as children, they had lived in households with recurrent physical abuse; recurrent emotional abuse; sexual abuse; an alcohol or drug abuser; an incarcerated household member; someone who is chronically depressed, suicidal, institutionalized, or mentally ill; a mother being treated violently; one or no parents; and/or emotional or physical neglect.

More than 50% of participants reported Adverse Childhood Experiences (ACEs), and one in 14 reported four or more categories. Researchers note that ACEs tend to occur in groups—where there is one, there are often multiples.

Then the researchers looked at the correlation between ACEs and participants’ health-related risk behaviors—for example, cigarette smoking, heavy alcohol use, overeating, promiscuity, and injected drug use. They found that the higher the number of categories of ACEs, the higher the number of adult risk behaviors and ensuing health-related problems.

How does that happen? Apparently adverse childhood experiences produce a cascade effect, starting with early alterations in brain development. Says Dr. Rob Anda, a CDC senior scientist and co-principal investigator of the ACE Study, “Neurobiology and neurobiochemistry are showing us that, when a child undergoes these experiences, both the structure and the chemistry of the developing brain are changed. The long-term effects on emotions, judgment, and behaviors appear to be profound.

“This suggests strongly that childhood abuse and family dysfunction lead—even decades later—to the development of the chronic diseases that are the leading causes of death and disability in this country, including heart disease, stroke, diabetes, and more.”

Risk Behaviors: A Way of Coping?
The researchers theorize that people with strong backgrounds of adverse childhood experiences may not only be more susceptible to risk behaviors; they may in fact use those behaviors as a way of coping. Dr. Vincent J. Felitti, the study’s other co-principal investigator, is a physician in Kaiser Permanente’s Department of Preventive Medicine, which he
founded 28 years ago. He says, “This is an entirely new way of looking at what we've always perceived to be public health problems—but which may in fact be expressions of a single issue: a way of coping later in life with adverse childhood experiences. The thing that presents as a public health problem often turns out also to be the person's solution to problems well concealed by time, shame, and social taboo.”

The ACE Study is continuing to follow participants; researchers believe that, sadly, they may see increased early deaths as the ultimate consequence of adverse childhood experiences.

Meanwhile, how to put to use the information developed by the study? For health professionals treating adult patients, the ACE Study offers new insight into causes—and therefore treatment—of risk behaviors and the health problems they cause.

For children, the study indicates that society would be wise to think more broadly about what “health” means. “We need policies and practices that promote a far wider understanding of child development,” says Renate Pore, Ph.D., Co-Chair of the West Virginia Healthy Kids & Families Coalition. “Every one of us needs to understand what a vulnerable time the first years are in the life of a human being—and that we ignore that fact at our peril.”

Screening pediatric patients for adverse childhood experiences, and dealing with those experiences early, may be one way health professionals can help short-circuit the later development of a host of risk behaviors and ensuing illnesses. Dr. Felitti says, “It's not easy in a busy medical practice to make the time to look carefully at what your patients are experiencing, and it's not always comfortable. But it is feasible—and it can make a world of difference.”
Because understanding a problem is the first step toward addressing it, a few of the issues are briefly described here. Although some of the numbers may seem daunting, it’s worth remembering that, while they represent challenges, they also represent opportunities.

Pregnancy and birth There’s some good news here. In one recent year, 79.1% of West Virginia mothers had adequate prenatal care; the national figure was 74.7%. While laudable, the West Virginia figure is also puzzling—because, among public and private insurances and monies from the State’s Maternal, Child and Family Health program, there are payment mechanisms available for all pregnancies.

There’s also not-so-good news around pregnancy and birth: the number of low birth-weight babies (less than 5.5 pounds) is high—and rising. Such babies are at increased risk of dying in the first year of life and of experiencing developmental problems. In one recent year, 8.8% of West Virginia babies were low birth-weight; the national rate is 7.8%.

Infant mortality is also high in the State—7.9 per 1,000 live births vs. 7.0 nationally.

And too many pregnant women still smoke, even though smoking contributes to problems for both mother and baby. Nationally, 12% of mothers-to-be light up—but in West Virginia, nearly 25% do. That figure rises to approximately 45% among pregnant women with less than a high school education.

Immunizations More than one-quarter (25.4%) of West Virginia’s two-year-olds are not fully immunized, leaving them vulnerable to serious illnesses including mumps, measles, rubella, diphtheria, polio, hepatitis B, whooping cough, and more. All insurances cover such immunizations, and free immunizations are available through local health departments—so there are no financial barriers to full immunization.
Obesity  West Virginia’s children are overweight to an alarming degree. Nearly half of fifth-grade students and one-third of kindergarten children screened are at or above the 85th percentile for body mass index (BMI)—just about double the national average.

The health implications aren’t good: these kids are at high risk for the development of cardiovascular disease and diabetes, with all their ensuing heartache and negative economic impact. In the nearer term, research shows that children who are overweight increasingly suffer from depression and social anxiety.

Oral health  In West Virginia, 41.9% of adults have lost six or more teeth due to decay; the national average is 21.2%. Too many of the State’s kids are heading in that direction: 33% of 15-year-olds have untreated tooth decay, which can lead not only to tooth loss but to infections that cause kids to miss school.

The high rate of decay is puzzling because West Virginia has one of the highest water fluoridation rates in the country, and 89% of the State’s dentists accept Medicaid patients. But only 35.5% of the State’s children have anti-decay sealants on their teeth (sealant application is covered by all public insurances).

Teen violent deaths  The rate of violent deaths among the State’s teens is improving—but still tragic. The national rate is 50.0 deaths per 100,000 teens age 15–19; in West Virginia, the rate is 67.5, down from 77.2 in 1990.

Asthma  Asthma is the leading serious chronic disease among children, and West Virginia’s pediatric asthma rate is the fourth highest in the country, with 11.1% of children diagnosed with asthma. The national average is 8.9%. No one is sure why the State ranks so high; the high rate of smoking may be a factor because secondhand smoke is an asthma trigger.

Mental health  Emotional and behavioral disorders among young people are major problems everywhere—and West Virginia is no exception. But the Department of Health and Human Resources estimates that only about 30% of the State’s severely emotionally disturbed children receive help. A 2001 survey by the Centers for Disease Control and Prevention found that 32% of West Virginia’s high school students had “felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities”; 20% had considered suicide. West Virginia’s teen suicide rate closely tracks the national rate: among 15-to-19-year-olds, it’s slightly better than the national rate (10.5 suicides per 100,000 vs. 10.7), and among 10-to-14-year-olds, it’s slightly worse (1.8 vs. 1.6).

Poverty  While poverty is not itself an illness, it is absolutely a children’s health issue—and 29% of West Virginia’s children under age 5 live in poverty. (The national rate is 19%.)

Poor children are 3.6 times more likely than more affluent children to have health that is poor or just fair; they are also twice as likely to die from birth defects and five times more likely to die from infectious diseases. Furthermore, recent studies indicate that the physical well-being of students has a direct impact on their ability to achieve academically.

“Poverty is often associated with conditions that put children’s health at risk,” says Renate Pore, Ph.D., a children’s health policy expert who directed the Governor’s Cabinet on Children and Families and who now co-chairs the Healthy Kids & Families Coalition. “Examples might be single-parent families with limited time to attend to nutrition and preventive health care; transportation and schedule issues that keep children from receiving care; and stress levels high enough to have a negative impact on health.”

Broadening the definition  Other not-so-obvious factors can have a profound effect on children’s health. Children are pure potential, and whether and how that potential blossoms depends on much more than vital signs. It is a function of how well adults meet each child’s needs, not just physical but also emotional, cognitive, and social—starting before birth with good prenatal care, expanding during the early years when the rapidly developing brain is (or is not) helped to make the synaptic connections that optimize intelligence, and continuing throughout childhood and adolescence. (Please see the ACE Study story.)

The “bottom line” question: with only 20,000 children born in West Virginia each year, can the State afford not to make the most of every one of them?
After the shot
Two contrasting issues show what can happen when West Virginia focuses on a health issue—and when it does not.

A “full-court press” against obesity...
On one recent day, Googling the words “obesity West Virginia” produced 795,000 results: some describe the problem, but, significantly, many describe what’s being done about it. Obesity—both adult and child—is getting a full-court press in the State, with major effort in both the public and private sectors. Happily, there are too many initiatives to list, but a few representative examples include:

Calling in the CDC Normally, the CDC (Centers for Disease Control and Prevention) helps states with infectious disease outbreaks, not chronic diseases or lifestyle issues like obesity. But when West Virginia’s Department of Health and Human Resources (DHHR) Bureau of Public Health contacted the CDC and described the seriousness of the State’s obesity problem, the CDC sent an expert team for three weeks of intensive investigation. The team and DHHR looked at how environmental supports—everything from “walkability” to restaurant offerings to school programs—enhance or inhibit healthy weight. Results were not available as this report went to press, but the CDC says it plans to deploy widely the tools and techniques it pioneered in West Virginia.

Legislation The Healthy West Virginia Act of 2005 created the Office of Healthy Lifestyles within DHHR, and, among other things, established a clinical advisory committee and enhanced requirements for physical education and nutrition in schools.

Coalition-building The West Virginia Healthy Lifestyle Coalition includes educators, healthcare providers, nonprofit and faith-based organizations, businesses, and state government. With a major focus on reducing and preventing obesity and on coordinating existing initiatives, the Coalition is a valued advisor on health issues. Its website, www.healthywv.com (co-sponsored by the West Virginia Medical Foundation) is a useful compendium of information and resources about communities, schools, workplaces, and more. The Benedum Foundation is a supporter of the Coalition.

Schools Through both legislation and West Virginia Board of Education policy, the State’s schools are fighting obesity. West Virginia is one of only 18 states to limit the availability of

11.1
Percentage of West Virginia children diagnosed with asthma (the national rate is 8.9)
When it's 3 a.m. and the baby is crying and feverish, many parents believe a trip to the emergency room is the only option. That trip may be unnecessary—and it can lead to delayed treatment for minor illnesses, a diminished sense of parental effectiveness and control, and higher health care costs.

A new West Virginia program helps parents decide whether emergency care is necessary, and deal competently and confidently with their children’s minor medical needs.

“What to Do When Your Child Gets Sick” is modeled on a UCLA pilot program and funded by the Robert Wood Johnson Foundation through the Center for Health Care Strategies. It’s a project of the West Virginia Healthy Kids and Families Coalition and the Parents As Teachers (PAT) Program, formerly housed at the United Way of Central West Virginia in Charleston and now part of Regional Education Service Agency (RESA) III. PAT is an in-home parent education program in which paraprofessionals work regularly with families to create and implement individual learning plans for each child.

‘We Wish We Knew More…’

The Coalition and PAT enrolled 128 families with young children in the program. Beverly Bolles, Ed.D, formerly the United Way’s Early Childhood Initiative Director and now with RESA III, recalls, “Parents told us, ‘We wish we knew more about how to help our kids when they're sick’; but it was clear that many simply didn't know much about coping with a sick child when their regular health care sources weren’t available.”

PAT in-home educators brought each enrolled family the book after which the program was named. What to Do When Your Child Gets Sick uses clear language and abundant illustrations to help parents manage more than 50 common childhood health problems. The book also discusses over-the-counter medications, child safety tips, and more. Over several months, the PAT educators included discussion about the book at every home visit.

The project’s results, which mirror those of the original UCLA study, were assessed through pre- and post-intervention surveys—and they’re impressive:

• Emergency room use declined, from 37% to 26.1%.

• Before the project, only 2.3% of parents said they'd consult a health book; afterward, half said they’d do so before seeking help.

• Parents were significantly more confident in their ability to deal with their children's minor medical problems.
Well-child checkups actually increased; the researchers theorize that’s because the parents became more knowledgeable in general about children’s health, including the benefits of preventive care.

Potential Savings in the Millions

While the West Virginia project didn’t measure cost savings, the UCLA study predicted $200 annual per-child savings in avoided unnecessary clinic and emergency room visits. Even when extrapolated only to West Virginia’s pediatric Medicaid population, those savings would total $40 million per year.

“This is truly a ‘win–win’ situation,” says Dr. Bolles. “Children get the appropriate and timely care, parents tell us they feel good about what they’re doing, and money is saved.”

Two additional “When Your Child Gets Sick” projects have launched: one through New River Health Center in Fayette County and the other at the Nicholas County Starting Points Center. They’re supported by the Benedum Foundation, with the Children’s Health Insurance Program (CHIP) providing the books.
“competitive foods” (foods—often of the “junk” variety—outside the federally sponsored school meal program), and one of only four states to set nutritional standards for competitive foods. To varying degrees, access to soft drinks is limited: sales are tightly controlled in elementary and middle schools, but the soft drink industry and schools’ desire for vending machine revenues have kept the sugar-laden beverages available in many high schools.

**An insurer initiative** The Public Employees Insurance Association (PEIA), which provides health care coverage to 215,000 state, municipal, and other government employees, says obesity claims cost it $77 million last year—so, with West Virginia University and some public schools, PEIA is offering a number of anti-obesity programs. A highlight: the “Dance Dance Revolution” research project, which is investigating whether providing kids with the high-octane Japanese dancing game will be enough to get them moving—and losing weight.

Overall, West Virginia’s response to the obesity issue is a model of energetic collaboration across the board, and it’s being recognized: the University of Baltimore’s Obesity Report Card, which measures the effectiveness of states’ responses to the issue, last year gave West Virginia an F; this year, the State received a B.

**...But not yet with mental health**

Describing mental health systems across America, a report by the New Freedom Commission on Mental Health said “… the mental health delivery system is fragmented and in disarray, leading to unnecessary and costly disability, homelessness, school failure, and incarceration.” West Virginia’s system is no exception.

The way the State is dealing with children’s mental health—an enormous problem—stands in sharp contrast with the obesity issue, because, in short, not much is happening. There are pockets of responsiveness and innovation—but there are far more gaps and inadequacies.
Among the issues...

**Identification of the problem**

Too often, health care professionals treating children simply don’t recognize the presence of emotional problems. *Pediatrics in Review* says that “clinical judgment identifies fewer than 50% of children who have serious emotional and behavioral disturbances.” Further, about 40% of parents say they have concerns but don’t share them with their child’s clinicians. That argues for thorough screening—which often doesn’t happen, despite the availability of effective and efficient screening tools. One example: Medicaid’s EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) program is in some ways the “gold standard” for comprehensive screening; however, while it’s excellent for physical health, there are more thorough (and still easily administered) screens available for pediatric mental health. DHHR says it’s working to improve the situation; however, some people are concerned that the basic EPSDT program may be compromised in the process.

**A shortage of resources**

In the United States, there are 28.4 clinically trained professionals (psychiatrists, psychologists, social workers, and psychiatric nurses) per 100,000 “civilians”; in West Virginia, the figure is 9.9. Joan Phillips, M.D., a pediatrician and child advocate who is president of the West Virginia Chapter of the American Academy of Pediatrics, says, “Unless a child is in extreme crisis and needs an acute care facility immediately, the wait to see a mental health professional is often so long that urgency and motivation can subside by the time an appointment is available—but inevitably the issue comes around again, and it’s usually worse.”

Many people expect school counselors to deal with kids’ mental health issues—but there simply aren’t enough counselors: the American School Counselor Association recommends one counselor for every 250 students, and West Virginia is nowhere near that. Individual counties have to make difficult choices with limited staffing dollars, and counselor slots can go unfilled, especially at the elementary and middle school levels. Stories abound about schools desperate to get help for kids struggling with mental health problems.

**The public system**

In West Virginia, the Division of Children’s Mental Health Services in DHHR’s Bureau of Behavioral Health administers about $4 million in federal and state dollars; the monies go to grantees statewide, targeting primarily prevention and community supports for kids with serious emotional disturbances, and for their families. “We have pockets of good services but not a comprehensive continuum of care and no State plan coordinating services,” says Division Director David Majic. “We need to develop some consensus on how to work together, and on where we want this system to go.” He cites the New Mexico model, in which an inter-agency consortium agreed on goals and then integrated resources to meet them.

West Virginia is beginning to address the issues—a federal grant allowed DHHR to model a continuum of care in 12 counties; the model seems to be working, serving 600 children well for $1.7 million. In contrast, lacking in-State resources to deal with extremely disturbed children, West Virginia had outplaced 37 such kids from the same 12-county area to facilities across the country—at a cost of $3.4 million. The situation sparked the legislative creation of a commission chaired by the new DHHR Secretary, Martha Yeager Walker, who says, “We’ll deliver our report this winter—and that will be just the beginning of our work on improving the overall system.”

9.9

Number of clinically trained mental health professionals per 100,000 West Virginia residents (the national number is 28.4)
With many crucial children’s health issues, there’s no need to break new ground: proven models exist, sometimes elsewhere in the country and sometimes in-State.

It’s important to note that these issues are not completely unaddressed; in most cases, good (and sometimes excellent) work is being done—but usually in small pockets, by individual entities, and with limited financial support. There is not yet a critical mass of focus, will, and energy—and that’s what’s needed. A few examples:

- A Virginia initiative operated by a Medicaid managed care provider targeted women at risk for premature births and low birth-weight babies, working to manage the risk factors. In just 21 months, the initiative reduced admissions to neonatal intensive care units, saved Medicaid $6.3 million—and avoided untold anguish and lifelong medical problems. Each year, more than 55% of births in West Virginia are to mothers enrolled in Medicaid. WVU’s Ann Dacey, a former nurse practitioner with extensive experience in women’s and perinatal health, says, “The State’s First Lady recently challenged us to look into how West Virginia might apply proven concepts more widely—because the statistics show that what we’re doing for pregnant women simply isn’t enough. There are people working hard and well—but a more concerted focus is needed.”

- West Virginia’s preschool children receive recommended eye screenings in multiple settings. But too often the screenings—even those in pediatricians’ offices—are performed in ways that miss amblyopia, a condition that affects up to 1 in 20 children. Amblyopia can cause permanent vision loss if not treated early, ideally before the school years. While the consequences can be dire, treatment is relatively simple, usually involving the use of an eye patch. Geoffrey Bradford, M.D., a pediatric ophthalmologist at WVU’s Robert C. Byrd Health Sciences Center, founded the Vision Initiative for Children to deal with undiagnosed amblyopia by training childhood vision screeners across the State. Since 2001, Initiative-trained screeners have performed 15,000 eye exams—but Dr. Bradford says the program’s ultimate goal is to have 40,000 preschool children appropriately screened each year.
Physical education
Perhaps the most striking example of a proven model is the School-Based Health Center system. West Virginia’s school nurses, whose numbers fall far short of recommended levels, are hard-pressed to meet even the most urgent health care needs of students—so, in 1994, a system of fourteen School-Based Health Centers (SBHCs) was launched. Independent entities operated by nearby primary care facilities or hospitals, the centers are full-service in-school health operations available to all students (with parental permission). The centers bill families’ public and private insurers for their services; uninsured families pay on a sliding scale.

The centers are a resounding success. One study elsewhere of children covered by Medicaid and enrolled in SBHCs showed that the children have significantly lower inpatient, drug, and emergency department expenses than non-enrolled kids. And the SBHCs represent excellent public/private collaboration in both their operation and their support sources: they’re funded by reimbursement, DHHR’s Bureau for Public Health, the Sisters of St. Joseph Health and Wellness Foundation, and the Benedum Foundation.

So what’s the problem? After taking a national leadership position in the development of SBHCs, West Virginia’s effort slowed dramatically—and today there are only 37 SBHCs serving 47 schools in 18 counties; only 9% of the State’s public school students have an SBHC available.

**Rx: practice prevention, concentrate on quality**

Adopting and expanding proven models is one potentially productive approach to children’s health. But more is needed—so how can West Virginia begin to get its collective mind and will around the issue?

A mindset shift is a good way to begin: moving from a “treatment” focus to a “prevention” orientation. Many of the health issues affecting the State’s children are preventable—and childhood presents a never-again-available opportunity to short-circuit the disease development process.

Overlapping with prevention is an equally important focus: quality. It’s easy to think that, because the United States offers the best health care in the world, quality of care isn’t an issue. That’s a mistake. Thankfully, life-saving techniques and technologies are available—but today’s health care too often falls short when it comes to the non-heroic, low-tech, everyday measures on which good health so often depends. Ensuring (and measuring) the excellence of everyday care, including preventive care, is a critical aspect of quality.

Whose responsibilities are prevention and quality? There’s a role for every player. A few examples…

**Public payors: combined clout—potentially**

Together, West Virginia’s three public payors—Medicaid, CHIP (the Children’s Health Insurance Program), and PEIA (the Public Employees Insurance Agency) provide health insurance for about two-thirds of the State’s children.

Medicaid is by far the largest entity of the three. Over the course of a year, it insures nearly 200,000 children, most of them among the State’s poorest. A $2.2 billion program in 2005, Medicaid receives approximately three federal dollars for every state dollar invested. CHIP, which over a year covers about 37,000 children (primarily from low-income working families), is a newer program with a slightly higher federal-to-state funding ratio—approximately 4:1. PEIA, for government employees and their families, is funded 80% by government and 20% by insurees; it insures 39,390 children.

All three insurers cover comprehensive health care, including preventive services—but it’s difficult to quantify and compare how much the services are being used.

**Quantifying quality**

For many insurers, a set of measurements called HEDIS (Health Plan Employer Data and Information Set) indicators is the preferred way to measure the quality of care, including whether recommended services are delivered to patients. HEDIS indicators allow apples-to-apples comparison of, for example, how many insureds receive well-child checkups, immunizations, or any other service.
In West Virginia, CHIP is the only public insurer to consistently use HEDIS measures. PEIA says it data-mines when it wants specific information, but doesn’t quantify usage of most individual services. For most of its programs, Medicaid uses only those measures required by the federal Centers for Medicare & Medicaid Services, and the measures don’t deal with many preventive services. (Additionally, an IT problem kept the State’s Medicaid system from compiling even the basic numbers this year.) Medicaid’s managed care programs, however, which cover about 40% of enrollees, will be required to use HEDIS measures for the first time this year.

The import: it’s impossible for policymakers to know and compare to what degree West Virginia’s publicly insured children are using the health services available to them. The statistics about children’s health status seem to indicate that usage isn’t what it should be—if preventive services were well used, children would probably be healthier—but to what degree most services are used is an unanswerable question, except with CHIP.

Richard “Mort” Wasserman, M.D., pediatrics professor at the University of Vermont College of Medicine and one of the founders of the National Initiative for Children’s Healthcare Quality (NICHQ), says, “The role of payors in promoting quality care, including prevention, could be enormous. For example, with reliable, comparable quality measurement, they could consider instituting ‘pay for performance,’ which Medicare is now considering and which involves incentivizing physicians for making sure their patients are—for instance—fully immunized, or receiving appropriate asthma management. And with good quality measures, policymakers could see which insurers are successful in helping improve kids’ health.”

What else could public insurers do to help the State’s children to better health? Some people suggest that combining forces might produce good results. The payors do talk occasionally about issues of mutual interest, but so far those conversations have centered on cost-related measures like drug formularies.

A modest proposal
A few years ago, CHIP Director Sharon Carte floated an idea that wasn’t adopted, but she wonders if the time might now be right: “What if the three public insurers were to join forces to help make sure that, each year, every 4-year-old in the State receives the type of comprehensive preventive checkup physicians recommend for preschoolers? That would be an excellent way to catch problems early, when they’re more amenable to treatment.”

A first step, she suggests, could be for CHIP, Medicaid, and PEIA to commit to making sure that all of their enrolled 4-year-olds receive such a screening. The additional cost for that, plus the cost to the State for screening all uninsured 4-year-olds, would total only about $400,000. A parallel step would be to bring all the State’s commercial/private insurers on board with an equal commitment; it’s likely that most of their insured children already receive yearly checkups, so the incremental cost might not be a significant barrier. Along the way, involvement by and coordination with other stakeholders and policymakers—for example, the legislature and private physicians—would also be needed, so making universal preschool screening a reality would be at least a minor challenge.

But the reward would be great: West Virginia’s kids would be healthier, and the State would be propelled into a leadership position in preventive care for children.

L. Clark Hansbarger, M.D., a pediatrician who is former director of the State’s Department of Health (before it was DHHR) and who is now dean of the WVU School of Medicine’s Charleston campus, says, “I’m proud of what West Virginia has done with insuring children. The problem is that the system isn’t yet polished enough to work together to manage children’s health needs successfully. It’s one thing to be insured, and another to make sure the money invested in insurance produces results.”

State government: fragmentation—for now
Although federal regulations guide much of the public insurers’ work, the insurers answer in great measure to the state government—as, of course, do all the cabinet-level departments that have a hand in children’s health.

A Commonwealth Fund issue brief says, “State governments, which license qualified providers, set standards, and enforce laws and regulations, have unique opportunities to directly affect quality of care for children. As purchasers, states can also powerfully influence quality by defining expectations and incentives for improvement and by rewarding performance that meets these expectations.”
Nutrition class
A beehive—but uncoordinated

The organizational structure of the Department of Health and Human Services may be an issue. With 6,000 employees; multiple bureaus, divisions, offices, and units; and responsibilities for administering Medicaid and much more, the Department is a beehive of activity—but, unfortunately, much of the work around children’s health is dispersed and uncoordinated; nor is it coordinated with the child-oriented efforts of other departments within the State system.

DHHR’s structure was shaped over the years in response to federal funding streams—but that may be changing. Martha Yeager Walker, DHHR Secretary since early 2005 (and a former legislator and former chair of the Senate Health and Human Resources Committee), says, “We’re currently doing a program review to see where there are holes and overlaps, and how we can consolidate funding and administration to direct more resources to needed services. We’re too fragmented now, and we shouldn’t be: a child is a child is a child, and we want to address that more effectively. That’s a directive coming right from Governor Manchin.”

DHHR is also piloting electronic health records (EHRs) in some of the primary care centers it funds; if the pilot is successful, EHRs will be more widely used as resources allow. That could be a significant step toward administrative efficiency and effective quality measurement.

What else might the State consider doing? One possibility: requiring of its three public insurers a common system of quality measurement (such as HEDIS measures), making those measures publicly known, and then working to improve them.

Physicians: working hard in “the last 19th-century industry”

Pediatricians and family practitioners as a group are known for their hard work. Schedules are stressed by heavy patient loads and onerous paperwork, and practices with large numbers of Medicaid-insured kids receive relatively low reimbursement. Most practices aren’t yet computerized, so reviewing paper records is the only way to determine which services have been delivered.

The upshot? In the whirlwind of daily practice, immunization rates and other quality measures are often not where they should be. Prevention and early intervention take a back seat to urgent care, ear infections, and sports physicals.

Dr. Mort Wasserman, the Vermont pediatrician and quality improvement expert, says, “In many ways, health care is the last 19th-century industry. Pediatricians have studied hard; they know a lot and they work hard—and most believe they’re doing a good job.

Dependent on old-fashioned systems

“In many senses they are—but they’re dependent on old-fashioned systems that don’t allow them to know, for instance, what their practice’s immunization rate is... or that they’re often not doing vision screenings that are timely and high-quality... or what proportion of their patients with persistent asthma are on controller medications. Unintended variability and deficiencies in pediatric preventive care are well documented.”

Dr. Wasserman helped create the Vermont Child Health Improvement Program (VCHIP), a practice-based quality improvement collaboration among the University of Vermont, primary care practitioners, and Vermont state government.

VCHIP applies the kinds of quality improvement tools proven productive in the business sector. In one major project, private pediatric practices significantly ratcheted up their performance against goals like increasing immunizations.

“The process takes a lot of internal resources—some from the physician and more from the staff,” says Dr. Wasserman. “It’s not easy. And in fact there’s no ‘business case’ for quality in an individual practice, no financial return on investment because doctors aren’t paid for performance. But it’s the right thing to do; it’s good health care.”

While West Virginia hasn’t implemented VCHIP-style quality improvements for pediatrics practices, there is some focus on quality.

Dr. Joan Phillips, the pediatrician who heads the State’s American Academy of Pediatrics chapter, is also Clinical Director for Children’s Services at the Charleston Area Medical Center’s Women & Children’s Hospital. She says, “One of our priorities is to test and identify best practices and then help physicians implement them; we’ve done that with initiatives in asthma, flu prevention, and attention deficit disorder, and we’re continuing...
Program Finds WV Kids At High Risk For Heart Disease

America's largest public health surveillance program is operating in West Virginia, uncovering significant cardiovascular risk factors in the State's children—and doing something about it.

The Coronary Artery Risk Detection In Appalachian Communities (CARDIAC) program was founded in 1998 by Dr. William A. Neal, Chief of the Section of Pediatric Cardiology and Professor of Pediatrics at the WVU School of Medicine. "Many parents were unaware that children can have high cholesterol," he says, “and my colleagues and I thought that screening kids in school for risk factors might be an effective way to help raise awareness and get a handle on the actual numbers."

CARDIAC (www.cardiacwv.org) began in three counties, with support from the Benedum Foundation, and the program has grown quickly. Now every fifth-grade student in every West Virginia county is eligible for screening; about 10,000 are screened each year. The process includes age-adjusted Body Mass Index (BMI) calculation, blood pressure, and a cholesterol check.

33% Have Abnormal Lipid Profiles

The results of the screenings are worrisome and, says Dr. Neal, "somewhat surprising":

- 47% of the fifth graders screened are at least overweight (above the 85th percentile for BMI), including 29% who are frankly overweight (above the 95th percentile). Dr. Neal explains that the CDC has stopped using the emotionally charged word “obese” to describe children’s BMI above the 95th percentile.
- 14% have high blood pressure.
- 33% have abnormal lipid profiles—including low HDL, high LDL, high total cholesterol, and/or high triglycerides.
- 6% have signs of insulin resistance, an indication that diabetes may be developing.

Results are sent to parents, who are also invited to be screened. Because some risk factors are genetic, the parents as well as the children will have them; others are lifestyle-related, but families tend to eat and live similarly, so when a child has those risk factors, the parents probably will, too. More than half the parents screened have abnormal results, some significantly.
Raising awareness and producing quality data were original goals of the program, and those goals are certainly being met—but, with data showing so many kids headed for cardiovascular trouble, the CARDIAC team decided to implement some interventions. Among them:

- The Healthy Hearts project, an interactive web-based instructional module for fifth- and sixth-grade students. Research shows that kids using the module make significant changes in their levels of physical activity.

- A new program in which a CARDIAC nurse will work with school nurses around the State to develop individualized programs for students found to be at high risk for cardiovascular disease.

- Children’s lipid clinics, to which parents can bring their at-risk kids for information and treatment, conducted across the State.

- A Familial Hypercholesterolemia targeted screening program designed to identify and refer for treatment children and adults with exceptionally high, genetically based cholesterol levels; in the relatively short term, this program alone could significantly reduce early heart attack deaths.

CARDIAC, which is expanding its research efforts to assess younger and older children, is a remarkable—and remarkably successful—program. It sets the standard for surveillance and early intervention, but, at least as importantly, it’s a model for both public/private sector cooperation and inter- and intra-agency collaboration. Funding comes from multiple departments within the State government as well as from private and federal sources.

“CARDIAC seems to be stimulating stakeholders within and beyond the State to work effectively on the problem; there’s a great deal of interdisciplinary interest and action,” says Dr. Neal. “I think people understand that, unaddressed, these cardiovascular risk issues in our kids will ultimately create not only health problems for individuals but a workforce that can’t compete in the global economy.”

Body mass index (BMI) is a calculation that estimates weight status. A BMI at or above the 85th percentile is considered overweight; BMI at or above the 95th percentile is considered obese (although the CDC no longer uses that term for children). For adults, BMI measurement is based only on height and weight; for children, the calculation is adjusted for age. Age-adjusted BMI tables are available at www.cdc.gov.
in other areas. We think pay for performance will soon be a reality, and we need to be ready to quantify our quality.”

**Medical home: a route to quality?**

Another potential route to quality care is the “medical home” concept. A medical home is a health care resource—often a physician’s office—that coordinates all the medically related needs of a child, including community-based services for the child and family. The rationale is that the medical home staff knows the family’s situation well, and is able—for example—to help arrange services ranging from specialist appointments to transportation for a family unable to get to a doctor.

The medical home is a comprehensive, and potentially enormously helpful, approach to health care—particularly for families lacking resources, and particularly for children with special needs, because those kids often require coordinated care from multiple sources. Dr. Renate Pore of the Healthy Kids & Families Coalition says, “The challenge is to get the medical community behind the health and well-being of the ‘whole child,’ and the medical home concept responds to that.”

One West Virginia pediatrician is a medical home pioneer. Neurodevelopmental disability specialist Jim Lewis, M.D., has a Marshall University–based practice in Huntington. He’s the West Virginia coordinator for the Medical Home Learning Collaborative, a project of the federal Maternal and Child Health (MCH) program, the New Hampshire–based Center for Medical Home Improvement, and Dr. Mort Wasserman’s NICHQ, with support from DHHR. The American Academy of Pediatrics—nationally and in West Virginia—supports the medical home concept.

The Collaborative is working on multiple strategies around the concept, including simplified health records parents can carry with them to various specialist physicians, and, if necessary, to emergency department visits. Additionally, the Collaborative is working to streamline communication among treating physicians and emergency departments to avoid gaps, overlaps, and delays in treatment.

A medical home, Dr. Lewis explains, has special staffing requirements. “A care coordinator who’s skillful at communicating with families and at knowing what resources are
School nurse
available is a necessity,” he says. “In our practice, it works well to have two people share that job—they’re both moms who have kids with special needs. Other parents are comfortable talking with them and more apt to open up about family situations that can ultimately affect their children’s health.”

Dr. Lewis’s care coordinator position is underwritten by the West Virginia Developmental Disabilities Council; insurances don’t reimburse medical homes for the added staff and services. Dr. Lewis says, “The Collaborative is looking at the economics now; eventually we may be able to document that the medical home saves money—in decreased emergency room visits, hospitalizations, and days lost from work or school.

“Twenty years ago, insurers wouldn’t pay for well-baby care,” he recalls. “But eventually they saw the light. I think that will happen with the medical home concept.”

Families: sociocultural issues
In a state with poor health statistics, good insurance coverage, and the great majority of physicians willing to accept public health insurances, it’s impossible not to wonder why parents aren’t taking more advantage of covered health services for their kids.

There are apparently several reasons, particularly for low-income families.

Beverly Bolles, Ed.D., Early Childhood Initiative Coordinator for Regional Education Service Agency (RESA) III, says, “Parents who don’t have health insurance themselves often just don’t think about it; it’s not part of their mindset. So, even when their kids have coverage, it simply doesn’t occur to them, especially when the kids don’t have an immediate health problem.”

Richard Crespo, Ph.D., a professor in the Marshall University School of Medicine’s Department of Family and Community Health, believes that additional issues can come into play: “Transportation is often a problem, as are work schedules. It’s difficult for parents in some jobs to take several hours off for their children’s medical appointments—especially for a well-child visit when there’s not an urgent problem.”

Additionally, he says, there are cultural barriers to leaving a rural area—for example, to go to an urban medical center for specialist care. “I hear this over and over again,” he recalls. “People are insecure when they leave their environment. They’ll usually do it for their kids, but working up to it may take a while.”

Those same cultural issues can play a role in parents’ nutritional choices, for themselves and for their children. “There is an Appalachian diet, and it’s high in starch and fat,” says Dr. Crespo. “Add to that the fact that small rural stores may not offer a great range of fresh fruits and vegetables, and culture and habit are reinforced.”

Acceptance, even resignation
Dr. Crespo also believes that a certain acceptance, even resignation, can be a factor in the Appalachian culture: “I can only speculate about this,” he says, “but when life is hard, sometimes people think that illness is just part of the package, and not necessarily something to be actively dealt with or managed.”

The biggest question, of course, is how West Virginia can begin to address these sociocultural issues.

Social marketing—the “selling” of a culture-altering value or idea—may play a role, and Marshall University is piloting social marketing tools coupled with behavior change materials. Working with adults, the University developed effective ways to identify people ready to make healthful changes in their lives—and then to help them make those changes. Now similar tools are being developed for kids; with Benedum Foundation support, they’ll be used in School-Based Health Centers. If the tools are effective in those settings, they’ll be shared widely.

“Our materials optimize individuals’ control and choice,” says Dr. Crespo, “and words and images are carefully tailored to the users. We have reason to believe they’ll be useful in helping people make positive health-related changes.”
What else needs to happen in order for West Virginia to help its children to better health? Combining ideas contributed by multiple stakeholders produces this broad-brush “to do” list:

- Communicate the issues to help build a widely shared sense of responsibility for children’s health
- Develop a consensus vision of what children’s health should be in West Virginia, and what the priorities are
- Identify issues influencing children’s health in the State, and research the best practices to deal with those issues
- Shape policies that respond directly to children’s health needs, and develop benchmarks and evaluations that can measure progress and effectiveness
- Implement the policies and be flexible enough to adjust them as needed

Where would leadership and responsibility reside for a major push in children’s health? That’s an open question. The Commonwealth Fund’s issue brief on the role of states in improving health care for children says that, in most states, “There is no obvious mechanism for coordinating activities that influence health care for children, making it difficult to align resources—both dollars and people—across agencies and programs.” That is certainly true in West Virginia. Dr. Hansbarger of the WVU School of Medicine adds, “Children don’t vote, and they don’t object if responsibility for them is scattered and diluted. Imagine what we could do for children if resources were coordinated.”

One collaborative effort is working to coordinate at least some available resources. The School Health Partnership is a group of public and private health and education organizations meeting regularly to work toward helping West Virginia’s kids be healthy and optimally ready to learn. “The Partnership aims to create a system where people are talking to each other at the state level and at the local level, and then link the two levels together,” says Dr. Renate Pore, coordinator of the Benedum-
Any amount of child abuse is too much—but in West Virginia the problem seems considerably greater than elsewhere. At 22.7 documented cases per 1,000 children, West Virginia’s rate of child maltreatment is nearly twice the national rate.

Abuse, of course, is not simply a problem of childhood: it’s an issue that reverberates throughout life. It can destroy peace of mind, manifest as physical and mental illness, and—in addition to the toll on individuals—cost society enormous amounts of money in health care, the legal system, and lost productivity.

Why so much in West Virginia?

Why is there so much child maltreatment in West Virginia? The stresses of poverty and isolation are certainly factors—but child abuse and neglect occur across the socioeconomic spectrum, and often relate to how parents were treated in their own childhoods. Julie Pratt, State Coordinator for Prevent Child Abuse West Virginia, says, “If people don’t have an understanding of child development, they’re apt to fall back on how their parents raised them. If they were well treated, they and their children are lucky. If not, they may be more likely to mistreat their own children.”

Helping families to be safe and healthy is the goal of Prevent Child Abuse West Virginia (PCAWV), which was founded by Laurie McKeown; she is Executive Director of TEAM for West Virginia Children, a Huntington-based nonprofit operating programs that support and strengthen families.

The centerpiece of PCAWV (www.preventchildabusewv.org) is Partners in Prevention, a mini-grant program that funds nearly two dozen initiatives across the State. The programs vary based on local needs; some, for example, focus on public awareness, while others involve school-based work with children, parent education, parent support, home visiting, respite care, and other approaches.

“There aren’t enough social workers in the world…”

All are deeply rooted in their communities, all are based on research that indicates their approaches are productive, and all work to engage people outside the professional sphere.

“I think that kind of engagement fills a void,” says Julie Pratt. “I’m a social worker and I know that professionals have an important role in child abuse prevention—but there aren’t enough social workers in the world to keep children safe.

We have to stop viewing child abuse as solely a professional concern, and realize that every person has a role in helping kids in our own communities.

“Our programs do that—we involve local citizens, businesses, and faith groups in our efforts, and they contribute enormously to better outcomes for children’s lives.”
In addition to the mini-grant program, Partners in Prevention offers educational opportunities to grantees and professionals who might encounter child abuse in their work. One example: a partnership with the West Virginia chapter of the American Academy of Pediatrics. The partnership works to help pediatricians and family practitioners learn more about supporting families in ways that will prevent abuse, and about recognizing and dealing with potentially abusive situations.

Is the two-year-old Partners in Prevention initiative working? “It wouldn’t be honest to make claims yet,” says Julie Pratt. “But we believe it’s likely that abuse is prevented through the programs we fund, because they’re based on national research and grounded in community experience. We’re moving ahead with the most promising strategy we’ve found: working locally to strengthen the protective factors that promote healthy families and healthy development in their children.”

Funding for Prevent Child Abuse West Virginia is provided by the West Virginia Children’s Trust Fund, the State’s Department of Health and Human Resources, and the Benedum Foundation.
supported effort. “Each has a different piece of the puzzle, and nobody knows everything—so we’re listening to each other.” The group is preparing a report, to be issued this winter, that will identify strengths, gaps, and disparities across the State, and lay out goals that can realistically be accomplished within three to five years.

Meanwhile, the First Annual Children’s Health Conference planned for this winter in Charleston is convening children’s health stakeholders from multiple sectors to begin working toward a consensus agenda that stresses prevention and quality.

The Conference is chaired by Dr. Joan Phillips and First Lady Gayle Manchin, who says, “I am absolutely confident that we West Virginians can help our children to better health. The problems didn’t develop overnight, and we won’t solve them overnight—but with some attitude adjustment and hard work, I believe we can make dramatic gains.”

Dr. Hansharger agrees, and has a cautionary word for any who think such an effort might be too costly: “I know there’ll be people who say this is too expensive, too labor-intensive,” he says.

“Here’s my response to that: what’s the cost of not doing it? What’s the cost of all the future medical problems, the cost to the quality of tomorrow’s workforce? This is the right thing to do for kids, but it’s also an economic development issue. We simply can’t afford not to improve the health of our children.”

Among American states, West Virginia’s rank in overall well-being of children
Healthy food cart
Mission
To encourage human development in West Virginia and Southwestern Pennsylvania through strategically placed charitable resources.

Guiding Principles
The following principles guide the Foundation’s grants programs in those regions:

• We honor Michael and Sarah Benedum’s belief in “helping people help themselves,” and we seek opportunities to cultivate the creativity of people and communities.

• We nurture leadership within the communities we serve, and we participate in leadership when it adds value.

• We encourage planning, projects, and programs that cross geographical and political boundaries so that access to services and economic growth is maximized.

• We expect collaboration among the public, private, and nonprofit sectors in order to leverage the resources that each can bring to common concerns.

• We strive to advance innovative practices that demonstrate measurable and sustainable benefit.

• We seek projects that contribute to advancement in public policy.

The Foundation’s Role
In seeking to achieve our mission and acknowledging lessons learned in over 50 years of grantmaking, the Foundation has identified its role as follows:

“The Foundation largely takes on the agenda of the people we serve. Our business is to help people help themselves. This is not intended to suggest that the Foundation’s role is passive. To the contrary, we go out into the field and listen closely. We build strong and supportive relationships with grantees. We provide technical assistance. We broker ideas and institutions. We create partnerships. We undertake analyses of issues and problems, and we promote public awareness of them. We help to build broad consensus for change. We seek to empower people to develop their own capacity and the capacity of their institutions to succeed. We leverage not only funds but interest, involvement, and commitment.”

Excerpted from In the Company of Extraordinary People: A Special Report upon the Occasion of the 50th Anniversary of the Claude Worthington Benedum Foundation, 1994

Philanthropic Programs
In keeping with the wishes of its donors, the Claude Worthington Benedum Foundation is a regional philanthropy focusing on West Virginia and Southwestern Pennsylvania. The Foundation generally spends about two-thirds of its grant dollars in West Virginia and one-third in Southwestern Pennsylvania.

West Virginia Grants Program

Geographic Focus
The geographic area for this program encompasses the state of West Virginia, and we strive to improve the social and economic conditions of all West Virginians. In pursuit of that goal, the Foundation seeks to help build the capacity of West Virginians to meet their needs as they see them. For that reason, the Foundation typically supports only West Virginia–based organizations.

West Virginia is a predominantly rural state. Throughout its history, the Foundation has maintained a special focus on the needs of rural West Virginians, particularly the rural poor and other vulnerable populations. We have found that the problems of rural people and their communities often require unique approaches and strategies.
The Foundation favors human services programs that integrate health, education, and social services. Current efforts focus on child well-being—helping to give the most vulnerable children in West Virginia the best chance for success through:

• **Support for Intermediaries.** Helping statewide groups provide technical assistance to nonprofit agencies, stimulate collaboration, and promote volunteerism.
• **Research.** Investigating and analyzing social issues and informing public policy development.
• **Social Service Innovation.** Helping local community groups find new ways of addressing the problems of high-risk populations.

**Programmatic Focus**

Because of limited philanthropic resources in West Virginia, this agenda is designed to respond to a range of social needs. The following program categories represent the scope of issues and initiatives included in the West Virginia Grants Program.

**Education**

Education is the most important vehicle for enabling people of all ages to reach their full potential. Therefore, the Foundation takes a broad approach to education that currently focuses on the following efforts:

• **Improved Student Learning.** Raising student achievement through: curriculum innovation; improved school administration; educational enrichment outside of school; partnerships with businesses, nonprofits, parents, and community leaders; family literacy and early childhood development; and arts education, particularly through partnerships with community-based arts organizations.
• **Teacher Quality.** Improving teacher preparation and professional development of practicing teachers.
• **Workforce Development.** Supporting customized job training and career education efforts that are responsive to employer demand and linked to economic development.
• **Higher Education.** Improving the capacity of public and private institutions of higher education to better prepare West Virginia’s workforce.

**Health**

The Foundation is committed to working with others in making comprehensive, high-quality, and affordable health care available to all West Virginians. Current efforts focus on primary care and prevention for children, rural health care access, and end-of-life care through:

• **Rural Health Policy.** Supporting collaborative research, issue analysis, and public education to improve health care.
• **Rural Health Care Delivery.** Fostering new and more efficient systems of care to improve access.
• **Health Professions Education.** Encouraging health careers in rural areas and advancing the skills of health care professionals to better serve rural communities.
• **Community-Based Initiatives.** Encouraging organizations to undertake health promotion programs.

**Community Development**

The Foundation supports efforts that cultivate leadership and strengthen communities to create an environment in which economic development is likely to occur through:

• **Community Capacity Building.** Increasing the ability of communities, and the nonprofit organizations that serve them, to engage in community and economic development.
• **Leadership Development.** Increasing the capacity of individuals and groups to improve their communities.
• **Affordable Housing.** Providing adequate shelter as a necessary prerequisite for decent living, family stability, and full engagement in education and employment.

**Economic Development**

The Foundation’s primary interest is the preservation and growth of businesses and jobs, with value placed on those initiatives that balance economic benefit with environmental responsibility. Current efforts focus on:

• **Business Development.** Supporting economic development research and planning; projects of substantial statewide, regional, or community impact; access to capital for business growth; and entrepreneurial activities that build on the strengths of West Virginia’s human, natural, technical, financial, and other resources.
Southwestern Pennsylvania Grants Program

Geographic Focus
The Foundation’s Southwestern Pennsylvania Grants Program focuses on Allegheny, Fayette, Greene, and Washington Counties. This area is a natural connector between Pittsburgh and West Virginia, and the outlying counties of Fayette, Greene, and Washington contain rural communities that may benefit from the Benedum Foundation’s experiences in serving West Virginia. The Foundation also encourages projects that cross state lines so that resources and ideas originating either in West Virginia or Pennsylvania may benefit both.

Programmatic Focus
The West Virginia grants program is broadly focused, in part because philanthropic resources are sparse in West Virginia. We face a different challenge in Southwestern Pennsylvania. Because of the large number of locally based foundations, we have adopted a more targeted focus that supports regional agendas and seeks to apply the knowledge gained from work in West Virginia to address the needs of underserved rural communities in Southwestern Pennsylvania.

Education
The Foundation strives to improve the educational outcomes for students in grades K–12 to give young people the broadest possible range of options upon graduation; and to support career education that is linked to workforce demand and economic growth. Preference is given to the rural communities of Southwestern Pennsylvania and initiatives that focus on:

- **Improved Student Learning.** Raising student achievement through curriculum innovation; improved school administration; educational enrichment outside of school; and partnerships with businesses, nonprofits, parents, and community leaders.

- **Teacher Quality.** Improving teacher preparation and professional development of practicing teachers.

- **Workforce Development.** Supporting customized job training and career education efforts that are responsive to employer demand and linked to economic development.

Economic Development
The Foundation encourages economic vitality through the growth of jobs and businesses and through initiatives that contribute to an environment attractive to business growth. Current efforts are directed at:

- **Regional Initiatives.** Supporting multi-county initiatives that contribute to the economic vitality of Southwestern Pennsylvania, and metropolitan Pittsburgh initiatives that have clear regional impact.

- **Rural Business Development.** Encouraging the start-up or expansion of businesses in the counties of Fayette, Greene, and Washington.

Pittsburgh Cultural District
The Foundation supports certain arts organizations within the Cultural District to strengthen the District as a major asset to the region.

Promotion of Philanthropy
The Foundation believes that one of the best ways to advance Michael and Sarah Benedum’s philosophy of “helping people help themselves” is to assist communities in raising their own charitable resources. The Promotion of Philanthropy Initiative in both West Virginia and Southwestern Pennsylvania seeks to increase the capacity of local communities to address their social needs through higher levels of charitable giving and greater local decision-making. The Foundation strives to grow the assets of community foundations and United Ways—two critical networks capable of harnessing local leadership and wealth for charitable purposes. The Foundation also strives to improve the quality of philanthropy by supporting foundation affinity group and resource centers.
How to Apply for a Grant

Before applying for a grant, applicants should carefully review the Foundation’s Mission and Guiding Principles, and its Philanthropic Programs on the preceding pages. Seeking a grant from the Benedum Foundation is a highly competitive process. Each year, the Foundation receives applications for many more worthwhile projects than it can possibly support. Despite their individual merit, the majority must be declined.

Restrictions

The Foundation generally does not make grants in support of:

- Organizations located outside West Virginia or Southwestern Pennsylvania
- Individuals
- Organizations not exempt from taxation under Internal Revenue Code Section 501(c)(3)
- Student aid, fellowships, or travel
- Ongoing operating expenses
- National organizations
- Biomedical research
- Religious organizations for religious purposes
- Individual elementary and secondary schools
- Annual appeals or membership drives
- Conferences, films, books, and audio-visual productions, unless an integral part of a Foundation-supported program

Proposal

Grant applicants should make initial contact with the Benedum Foundation by sending a brief Proposal. The Proposal should be no longer than five pages and should include:

- short description of organization
- organization address (including telephone, fax, and e-mail addresses)
- name of contact person
- one-sentence summary of the project
- clear, concise description of the project and expected outcomes for which funding is sought
- total project costs, other funding sources, and the specific amount that will be requested from Benedum
- plan for continuance or self-sufficiency of program at the conclusion of proposed grant
- anticipated time frame (start time and project duration)
- copy of evidence of organization’s tax-exempt status with the IRS

Proposals may be sent to the Foundation year-round. Proposals sent via fax or e-mail will not be accepted.

Send one copy of your proposal to:

William P. Getty, President
Claude Worthington Benedum Foundation
1400 Benedum-Trees Building
223 Fourth Avenue
Pittsburgh, PA 15222

You may expect to receive a response to your Proposal within 60 days, at which time you will be notified:

- if your project is not one the Foundation can consider, or
- if you should submit additional information requested by a program officer.
2004 Grants

Although some of our grants have impact in both West Virginia and Southwestern Pennsylvania, for ease of reference grants authorized in 2004 are listed below alphabetically by region of primary benefit. Grants in support of Promotion of Philanthropy are listed separately.

Readers, especially grant seekers, should be aware that the emphasis of the Foundation’s grants program evolves over time and that grants as reported may not be indicative of the Foundation’s future program emphasis.

West Virginia Grants Program

The Alliance for Children Inc.
Charleston, WV
Continued support of Care Access & Resource Enhancement project to improve services for children requiring out-of-home placement
$225,000

Arts Monongahela Inc.
Morgantown, WV
Research and planning to grow and sustain arts in the community
$35,000

Berea College
Berea, KY
Brushy Fork Institute’s leadership development program in West Virginia, participation in Community Collaborative, and involvement by alumni in leadership program redesign and evaluation
$32,500

BIDCO Foundation Inc.
Charleston, WV
On behalf of Advantage Valley, Inc., implementation of the Entrepreneurial League System in the greater Huntington and Charleston areas to develop entrepreneurial talent and build sustainable companies (over two years)
$350,000

On behalf of the Mid-Atlantic Technology Research and Innovation Center (MATRIC) for start-up funding, including staffing
$250,000

Big Brothers Big Sisters of the Northern Panhandle Inc.
Wheeling, WV
Expansion of school-based mentoring into 21 counties in the State
$176,500

Bluefield State College Foundation, Incorporated
Bluefield, WV
Support for Partnerships for Teacher Quality Initiative to develop a Professional Development School model of teacher preparation at public institutions in the State
$7,000

Cabell Wayne Family Resource Network, Inc.
Huntington, WV
Development of a Child Advocacy Center serving Cabell, Lincoln, Mason, and Wayne Counties
$50,000

Camcare Health Education and Research Institute Inc.
Charleston, WV
Start-up costs for the West Virginia Nursing Leadership Institute, a collaboration with West Virginia University–Charleston Division School of Nursing
$125,000

Carnegie Institute
Pittsburgh, PA
Initiation of a distance learning program linking new dinosaur exhibit to K–12 classrooms in West Virginia and southwestern Pennsylvania
$180,000

Center for the Arts and Sciences of West Virginia, Inc.
Charleston, WV
First year operations in the Performance Hall and audience development
$300,000

The Center for Rural Health Development, Inc.
Dunbar, WV
Matching grant for the West Virginia Rural Health Access Program that includes a loan fund, rural health networking, recruitment and retention, leadership development, and technical assistance
$260,000

2004 West Virginia Rural Health Conference
$15,000

West Virginia Rural Health Infrastructure Loan Fund designed to improve access to capital for rural providers
$250,000

ChildLaw Services Inc.
Princeton, WV
Development of the West Virginia Child Advocacy Network as a state chapter of the National Children’s Alliance
$7,500

Community Collaborative, Inc.
Charleston, WV
2004–05 sustainable coordination of West Virginia Communities Training Program and the coordination of West Virginia Leadership Network
$55,000

Community Loan Fund of Southwestern Pennsylvania Inc.
Pittsburgh, PA
On behalf of The Hopewell Fund, Inc., as a match to support start-up/operational costs to provide lending and technical assistance to businesses in the northern and Ohio River Valley region of West Virginia
$115,000

CommunityWorks in West Virginia Inc.
Elkview, WV
Continued operating and program support in 2004 for low-income housing initiatives
$35,000

Comprehensive Women’s Service Council, Inc.
Beckley, WV
Developmental support for Fayette Just for Kids, Inc., a Child Advocacy Center
$24,000

Concord University Foundation, Inc.
Athens, WV
Support for Partnerships for Teacher Quality Initiative to develop a Professional Development School model of teacher preparation at public institutions in the State
$30,000

DreamHome Community Development Corporation
Grantsville, WV
Operating support for low-income housing initiatives
$100,000

The Education Alliance—Business and Community For Public Schools, Inc.
Charleston, WV
Third year matching funds for Public Education Network Teaching Quality initiative, expansion of the Results-Based Partnership program to include 25 schools statewide, and support for research on critical issues
$185,000

EdVenture Group Inc.
Morgantown, WV
Demonstration project to match high-end employer training needs with two- and four-year colleges (over two years)
$120,000
Energy Village, Inc.  
Morgantown, WV  
Implementation of strategic plan to develop a statewide economic development strategy to cultivate the energy and environmental technology sector  
$125,000

Fairmont State University Foundation Inc.  
Fairmont, WV  
Support for Partnerships for Teacher Quality Initiative to develop a Professional Development School model of teacher preparation at public institutions in the State  
$15,000

Federation of Appalachian Housing Enterprises, Inc.  
Berea, KY  
Continued operating support for low-income housing initiatives  
$50,000

Federation of Appalachian Housing Enterprises, Inc.  
Berea, KY  
Contribution to the West Virginia Affordable Home Loan Fund to increase funds available to low-income home buyers  
$100,000

First Commitment Foundation Inc.  
Wheeling, WV  
Board training and development program targeting West Virginia’s nonprofit organizations  
$30,000

First Commitment Foundation Inc.  
Wheeling, WV  
Technical assistance and evaluation services for West Virginia School-Based Health Centers with emphasis on improving quality of preventive health services in 47 centers  
$165,000

The Francis Foundation for the Arts d.b.a. The Appalachian Education Initiative Foundation  
Morgantown, WV  
Assessment of the status of arts education in all West Virginia school districts, piloting of a community planning process in selected schools, and hosting of a four-state symposium on arts education advocacy  
$119,000

Glenville State College  
Glenville, WV  
Support for Partnerships for Teacher Quality Initiative to develop a Professional Development School model of teacher preparation at public institutions in the State  
$20,000

Habitat for Humanity of West Virginia—Charleston  
Charleston, WV  
Blueprint WV project to ensure sustainability of the planned statewide support organization and increase the number of Habitat homes in West Virginia  
$80,000

iNetworks  
Pittsburgh, PA  
Program-related investment to create a Community Development Venture Capital fund in West Virginia and western Pennsylvania  
$250,000

Lightstone Community Development Corporation  
Moyers, WV  
Matching funds for Community Development Financial Institute and Small Business Administration funding to provide technical assistance, loan loss reserve, and investment capital  
$200,000

The Marshall University Foundation, Inc.  
Huntington, WV  
Support for Partnerships for Teacher Quality Initiative to develop a Professional Development School model of teacher preparation at public institutions in the State  
$20,000

Marshall University Research Corporation  
Huntington, WV  
Assessment of the economic importance of early childhood education and participation in policy development in West Virginia  
$50,000

Mission West Virginia Inc.  
St. Albans, WV  
Development of Wellspring Center to enhance and expand the capacity of faith-based and nonprofit organizations working with disenfranchised and underserved individuals and families in ten counties  
$50,000

Monongalia County Commission  
Morgantown, WV  
Start-up support for Child Advocacy Center in Monongalia County  
$50,000

Monongalia County Schools Foundation, Inc.  
Morgantown, WV  
Pilot of math and reading instructional methods for after-school staff and volunteers (over two years)  
$114,000

Mountaineer Food Bank, Inc.  
Gassaway, WV  
Initiation of a statewide food buying program to enable 430 local programs to purchase food and personal care items at wholesale prices directly from the Food Bank  
$225,000

Natural Capital Investment Fund Inc.  
Shepherdstown, WV  
Increase the amount and availability of investment capital for business investment in West Virginia, especially in rural and most distressed communities  
$200,000

New River Health Association, Inc.  
Scarbo, WV  
Development of Statewide Teaching Communication Skills Initiative for health professions students (over three years)  
$150,000

North Central West Virginia Community Action Association, Inc.  
Fairmont, WV  
As part of the local match needed by Group Work Camp, Inc. to repair homes in Randolph and Tucker counties  
$8,500

As part of the local match needed by Group Work Camp Inc. to repair homes in Pocahontas County  
$8,500

Oglebay Foundation Inc.  
Wheeling, WV  
Support of development expenses related to capital campaign  
$200,000

Pittsburgh Gateways Corporation  
Pittsburgh, PA  
Continued support of economic development relationships and business opportunities in West Virginia and western Pennsylvania  
$110,000

Preservation Alliance of West Virginia, Inc.  
Charleston, WV  
Continued development of the West Virginia Heritage Tourism Program in cooperation with the West Virginia Development Office  
$195,300

The Progress Fund  
Dawson, PA  
Leverage for public and private funding for investment capital to be used for business start-ups and expansion in West Virginia  
$150,000
Randolph County Children’s Advocacy Center Inc.
Elkins, WV
Implementation costs for a Child Advocacy Center
$35,000

Regional Education Service Agency (RESA I)
Beckley, WV
Development of a viable distance education model serving middle and high schools in southeast West Virginia through Marshall University and West Liberty State College
$250,000

Regional Family Resource Network, Inc.
Charleston, WV
Establishment of a Child Advocacy Center serving Boone County
$35,000

Safe Housing and Economic Development Inc.
Welch, WV
Operating support and staffing to increase availability of affordable housing in rural West Virginia
$100,000

Shepherd University Foundation Inc.
Shepherdstown, WV
Support for Partnerships for Teacher Quality Initiative to develop a Professional Development School model of teacher preparation at public institutions in the State
$7,000

Southern Appalachian Labor School Foundation, Incorporated
Kincaid, WV
Matching grant to purchase building materials for two group work camps to repair homes in Fayette and western Kanawha Counties
$19,000
Matching grant to purchase building materials for group work camps to repair homes in Fayette County in 2005
$19,000
Continued administrative support for low-income affordable housing initiatives in 2004
$40,000
Continued administrative support for low-income affordable housing initiatives in 2005
$50,000

Southern West Virginia Community and Technical College
Mount Gay, WV
Continued support for and expansion of the APPALREAD family literacy program in Logan, Lincoln, Mingo, McDowell, Wyoming, and Boone Counties
$50,000

Tamarack Foundation Inc.
Beckley, WV
Continued support for the start-up of artisan-entrepreneur business development programs
$100,000

Team for West Virginia Children, Inc.
Huntington, WV
For the Prevent Child Abuse West Virginia program to promote and coordinate efforts statewide to reduce child abuse and neglect
$175,000

Tucker County Commission
Parsons, WV
Development of a Child Advocacy Center serving Tucker County
$20,000

United Way of Central West Virginia
d.b.a. LifeBridge
Charleston, WV
Development of Success By Six programming through five Regional United Ways
$100,000

Upshur County Family Resource Network
Buckhannon, WV
Development of Child Advocacy Center in Upshur County
$35,000

West Liberty State College Foundation, Inc.
West Liberty, WV
Program to increase the number of National Board Certified Teachers in underserved areas of West Virginia
$147,000
Support for Partnerships for Teacher Quality Initiative to develop a Professional Development School model of teacher preparation at public institutions in the State
$30,000

West Virginia Community Development Partnership Inc.
Charleston, WV
Organizational development, programming, and evaluation of statewide organizations to build the capacity of grassroots community economic development organizations
$150,000
On behalf of the Alliance of Champion Communities, for assistance in providing start-up organizational and program support
$30,000

West Virginia Department of Education
Charleston, WV
Implementation of Carnegie Learning’s Cognitive Tutor Math I Curriculum in ten additional high schools in West Virginia
$190,000
Establishment of a coordinator for Entrepreneurship Education and advancement of a K–Adult entrepreneurship education strategy in West Virginia schools (over three years)
$225,000

West Virginia Department of Education and the Arts
Charleston, WV
Higher education financial assistance awareness campaign for parents and high school students to increase West Virginia’s college-going rate
$67,000
Support for the Governor’s Minority Students Strategies Council, a parent and community support structure to assist efforts to close student achievement gap
$105,000

West Virginia Development Office
Charleston, WV
Development of a database of job demand by industry and region to be used as a planning tool for Workforce Investment Boards and other workforce development organizations
$106,000

West Virginia Division of Culture and History
Charleston, WV
Industry of Culture Initiative to plan and develop a strategy to maximize economic impact of cultural assets in West Virginia
$20,000

West Virginia Economic Development Foundation, Inc.
Charleston, WV
Matching funds for the Appalachian Regional Commission Flex-E-Grant program providing grants to organizations in distressed counties for capacity-building and leadership development activities
$141,000
Continued operating support for West Virginia: A Vision Shared!, the State’s economic development plan
$280,000

West Virginia Entrepreneurs Forum, Inc.
Charleston, WV
Entrepreneurial educational activities specifically targeting development of capital-ready business proposals
$50,000
West Virginia Family Grief Center, Inc.
Morgantown, WV
Development of a grief counseling program for children ages 3–18 and their families
$30,000

West Virginia Health Right, Inc.
Charleston, WV
Telemedicine project to link free clinic serving uninsured and underinsured patients to West Virginia University for clinical care
$4,000

West Virginia High Technology Consortium Foundation
Fairmont, WV
Statewide technology awareness and education program for small and medium-size businesses, as well as economic development professionals and organizations
$100,000

West Virginia Hospital Research and Education Foundation
Charleston, WV
Project Vision: a planning model to develop and implement a common vision and plan for a rational acute health care delivery system in West Virginia
$100,000

West Virginia Housing Development Fund
Charleston, WV
Provision of training and technical assistance for nonprofit housing organizations (over two years)
$70,000

West Virginia Kids Count Fund, Inc.
Charleston, WV
Birth-to-Three Early Literacy and Learning Community Partnerships Project, a community-focused public awareness campaign about the importance of early literacy
$60,000
Second year support for Birth-to-Three Early Literacy and Learning Community Partnerships Project
$120,000

West Virginia Laubach Literacy, Inc.
Dunbar, WV
Mini-grants to local literacy programs and GED preparation through Workforce WV employment centers
$150,000

West Virginia Medical Foundation
Charleston, WV
West Virginia on the Move, a statewide weight gain prevention initiative
$225,000
Development of the West Virginia Healthy Communities Designation Initiative
$100,000
Second year support for West Virginia Healthy Lifestyles Coalition working to address the problem of overweight and obesity in West Virginia
$75,000

West Virginia Ministry of Advocacy and Workcamps, Inc.
Charleston, WV
Operating expenses in 2005 to support home repairs by work groups for needy families
$32,345

West Virginia State University Foundation, Inc.
Institute, WV
Support for Partnerships for Teacher Quality Initiative to develop a Professional Development School model of teacher preparation at public institutions in the State
$20,000
On most of the following grants, West Virginia University collaborates with one or more organizations in providing regional or statewide services.

West Virginia University Foundation, Inc.
Morgantown, WV
Coordinator position working on integration of CARDIAC and Rural Health Education Partnership (over two years)
$100,000
Expansion of student internship program at Entrepreneurship Center to serve WVU Business Incubator and other locations providing students with hands-on entrepreneurial experience and promoting economic development in the State by supporting commercialization efforts
$75,000
Expansion of the Vision Initiative for Children
$100,000
Support for Partnerships for Teacher Quality Initiative to develop a Professional Development School model of teacher preparation at public institutions in the State
$121,000

Summer engineering camp and web-based school curriculum to improve math scores of African-American high school students
$155,000

Continued support for building clinical capacities in End-of-Life Care and the West Virginia Pediatric Palliative Care Team and Network
$160,000
 Development of distance learning professional development program for K–12 art teachers in West Virginia and southwestern Pennsylvania
$84,100
Third year support for college liaison coordinator for the Health Sciences Technology Academy
$50,000

Wheeling Health Right, Inc.
Wheeling, WV
Development of clinic facility to provide primary health care services and medications to uninsured and underinsured residents of the Northern Panhandle of West Virginia
$50,000

Wheeling Jesuit University
Wheeling, WV
Development of a career exploration component for a distance learning science curriculum
$60,000

WV Welfare Reform Coalition, Inc.
Charleston, WV
Asset Building Initiative that encompasses the Earned Income Tax Credit Outreach Campaign and the Individual Development Account Program
$40,000
Additional support for statewide Asset Building Initiative
$25,000

WVU at Parkersburg Foundation, Inc.
Parkersburg, WV
Development of a cross-skill technical curriculum for flexible job placement
$86,000
Support for Partnerships for Teacher Quality Initiative to develop a Professional Development School model of teacher preparation at public institutions in the State
$30,000
Southwestern Pennsylvania
Grants Program

Allegheny Conference on Community Development
Pittsburgh, PA
Support of the Agenda Development Fund in 2004
$85,000

Development of a regional report card of school performance and school readiness efforts as part of the Conference’s education agenda
$100,000

Internal planning and assessment process
$15,250

County of Allegheny
Pittsburgh, PA
Matching support for a grants fund to aid small businesses affected by the flood of September 17, 2004
$200,000

Carnegie Institute
Pittsburgh, PA
Continued support for the 2004 Three Rivers Arts Festival and First Night 2004
$25,000

Expansion of professional development services to arts educators in Washington, Greene, and Fayette Counties
$165,000

Carnegie Mellon University
Pittsburgh, PA
Business plan to create a service learning institute for area colleges
$12,000

Catalyst Connection
Pittsburgh, PA
Partnership with EdVenture to train K–12 teachers in technology integration and curriculum development
$70,000

Community Foundation of Greene County
Pennsylvania
Waynesburg, PA
Establishment of a fund to support the Greene County Comprehensive Economic Development Plan
$200,000

The Downtown Management Organization
Pittsburgh, PA
Operating support
$50,000

Planning for downtown residential development in Pittsburgh
$25,000

The Education Policy and Leadership Center
Harrisburg, PA
Continued support for research, leadership, and advocacy activities to improve student learning in grades K–12
$25,000

Health Careers Futures
Pittsburgh, PA
Addition of a health career counselor and organized health career clubs in Fayette County schools to promote post-secondary training in high-demand health jobs
$120,000

Intermediate Unit 1
Coal Center, PA
Introduction of a robotics curriculum to eighth-grade math and science classes in southwestern Pennsylvania and northern panhandle of West Virginia, in partnership with Carnegie Mellon University
$171,000

Program to enhance teacher quality and meet state requirements of teacher assessment in partnership with Point Park University
$185,000

 Provision of technical assistance to underperforming districts and creation of a peer learning network of Intermediate Unit 1 principals, in partnership with The University of Pittsburgh Principals Academy
$75,000

Local Workforce Investment Board for the Westmoreland-Fayette Workforce Investment Area
Youngwood, PA
Development of an emergency medical technician and nursing training program for rural emergency and health care providers
$50,000

Manchester-Bidwell Corporation
Pittsburgh, PA
Planning for a greenhouse and horticulture training center in the Mon Valley
$83,000

The Mon Valley Initiative
Homestead, PA
Continued support for workforce development satellite office in Washington County
$50,000

National Board for Professional Teaching Standards, Inc.
Arlington, VA
Support to increase the numbers of National Board Certified Teachers in Fayette, Greene, and Washington Counties
$130,000

Pennsylvania Economy League, Inc.
Pittsburgh, PA
Development of the Washington County Comprehensive Plan for economic development
$100,000

Support Tri-County Airport Partnership and development of industrial sites in airport market area
$44,000

The Pennsylvania State University
Monaca, PA
Project to improve reading comprehension of students in 5th through 12th grades in Washington, Fayette, and Greene County schools using a web-based tutoring program
$161,500

Pittsburgh Ballet Theatre, Inc.
Pittsburgh, PA
Season support for the 2004–05 year
$75,000

Pittsburgh Opera, Inc.
Pittsburgh, PA
Season support for the 2004–05 year
$75,000

Pittsburgh Public Theater Corporation
Pittsburgh, PA
Season support for the 2004–05 year
$75,000

Pittsburgh Symphony Society
Pittsburgh, PA
Season support for the 2004–05 year
$100,000

Pittsburgh Tissue Engineering Initiative, Inc.
Pittsburgh, PA
Support for working capital fund
$75,000
The Pittsburgh Trust for Cultural Resources  
Philadelphia, PA  
Season support for the 2004–05 year of the Pittsburgh Dance Council, Inc.  
$30,000

University of Pittsburgh  
Philadelphia, PA  
Expansion of staffing for the Greene County Business Assistance Center  
$60,000

Pilot phase of the Greene County Education Master Plan implementation  
$48,000

The Progress Fund  
Dawson, PA  
Loan fund and staffing to promote tourism-related businesses in Fayette and Greene Counties  
$225,000

Three Rivers Employment Services  
Philadelphia, PA  
Demonstration of two-way video conferencing of job readiness and technical training between the City of Pittsburgh and Fayette County  
$150,000

Tides Center—Western Pennsylvania  
Philadelphia, PA  
Operating and program support for The Sprout Fund  
$100,000

United Way of Westmoreland County  
Greensburg, PA  
Development of school readiness transition team in the Connellsville School District (Fayette County) to help children entering school to succeed in the early grades (over two years)  
$100,000

Promotion of Philanthropy

The Foundation Center  
New York, NY  
Public education services in 2004  
$6,000

The Grantmakers of Western Pennsylvania  
Philadelphia, PA  
Operating and program support in 2004  
$17,425

Parkersburg Community Foundation  
Parkersburg, WV  
Staff for affiliate offices in Jackson, Ritchie, and Doddridge Counties, plus two new affiliates serving Mason and Wirt/Callhoun Counties  
$68,000

United Way of Jefferson County WV  
Charles Town, WV  
Challenge grant to encourage $10,000 donors to annual United Way campaigns in Jefferson, Berkeley, Morgan, Kanawha, Wood, and Harrison Counties  
$125,000
**Financial Summary**

The Foundation’s fiscal year corresponds to the calendar year. At the end of 2004, the market value of the Foundation’s investments, including cash, was $362,598,989. Grants authorized during the year totaled $14,093,045.* The Foundation makes multi-year commitments, with payments scheduled over as many as five years. At year-end 2004, outstanding grant commitments totaled $2,243,000,* and unfunded program-related investments were $250,000.

The following indicates invested assets, and authorizations and payments of grants and program-related investments over the last five years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Investments Including Cash</th>
<th>Authorized: Grants and Program-Related Investments*</th>
<th>Payments: Grant and Program-Related Investment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>$340,326,800</td>
<td>$19,135,860</td>
<td>$16,725,885</td>
</tr>
<tr>
<td>2001</td>
<td>$321,072,595</td>
<td>$12,786,272</td>
<td>$14,433,564</td>
</tr>
<tr>
<td>2002</td>
<td>$285,658,768</td>
<td>$12,224,847</td>
<td>$13,552,403</td>
</tr>
<tr>
<td>2003</td>
<td>$333,631,173</td>
<td>$11,452,558</td>
<td>$15,422,831</td>
</tr>
<tr>
<td>2004</td>
<td>$362,598,989</td>
<td>$14,093,045</td>
<td>$15,449,436</td>
</tr>
</tbody>
</table>

*Includes contingent grants.

The Foundation maintains a diverse portfolio. The following table summarizes the cost and fair value of the Foundation’s investments as of December 31, 2004. In its audited financial statements and for the federal tax return, the Foundation reports investments at fair value:

<table>
<thead>
<tr>
<th>2004</th>
<th>Cost</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term investments</td>
<td>$2,560,563</td>
<td>$2,568,901</td>
</tr>
<tr>
<td>Common and preferred stocks</td>
<td>88,487,614</td>
<td>121,533,811</td>
</tr>
<tr>
<td>Tactical asset allocation funds</td>
<td>33,731,431</td>
<td>42,325,439</td>
</tr>
<tr>
<td>U.S. Government and agency obligations and corporate debt obligations</td>
<td>46,465,459</td>
<td>46,037,783</td>
</tr>
<tr>
<td>Private limited partnerships</td>
<td>91,166,434</td>
<td>110,508,534</td>
</tr>
<tr>
<td></td>
<td>262,411,501</td>
<td>322,974,468</td>
</tr>
<tr>
<td>Program-related investments</td>
<td>5,539,787</td>
<td>5,539,787</td>
</tr>
<tr>
<td></td>
<td>267,951,288</td>
<td>328,514,255</td>
</tr>
<tr>
<td>Cash</td>
<td>34,084,734</td>
<td>34,084,734</td>
</tr>
<tr>
<td></td>
<td>$302,036,022</td>
<td>$362,598,989</td>
</tr>
</tbody>
</table>
## Assets, Liabilities, and Unrestricted Net Assets
### December 31, 2004 and 2003

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td>$328,514,255</td>
<td>$328,392,535</td>
</tr>
<tr>
<td>Cash and equivalents</td>
<td>34,084,734</td>
<td>5,238,638</td>
</tr>
<tr>
<td>Other assets</td>
<td>290</td>
<td>533,206</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>332,247</td>
<td>776,732</td>
</tr>
<tr>
<td>Receivable from private</td>
<td>–</td>
<td>908,719</td>
</tr>
<tr>
<td>limited partnerships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property and equipment,</td>
<td>612,240</td>
<td>654,462</td>
</tr>
<tr>
<td>net of depreciation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>$363,543,766</td>
<td>$336,504,292</td>
</tr>
<tr>
<td><strong>Liabilities and</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unrestricted net assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants payable</td>
<td>$2,063,000</td>
<td>$3,074,391</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>–</td>
<td>224,569</td>
</tr>
<tr>
<td>Accrued federal excise</td>
<td>382,439</td>
<td>–</td>
</tr>
<tr>
<td>tax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted net assets</td>
<td>361,098,327</td>
<td>333,205,332</td>
</tr>
<tr>
<td><strong>Total liabilities and</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>unrestricted net assets</strong></td>
<td>$363,543,766</td>
<td>$336,504,292</td>
</tr>
</tbody>
</table>

### Change in Unrestricted Net Assets

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividends</td>
<td>$3,547,113</td>
<td>$3,057,888</td>
</tr>
<tr>
<td>Interest</td>
<td>2,557,285</td>
<td>2,598,805</td>
</tr>
<tr>
<td>Net gain on investments</td>
<td>10,862,535</td>
<td>51,677,395</td>
</tr>
<tr>
<td>Partnership income</td>
<td>29,715,526</td>
<td>5,053,912</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>$46,682,459</td>
<td>$62,388,000</td>
</tr>
<tr>
<td><strong>Grants and Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants (net of refunds)</td>
<td>$14,521,892</td>
<td>$11,423,109</td>
</tr>
<tr>
<td>Investment management and custodial fees</td>
<td>1,898,509</td>
<td>1,814,490</td>
</tr>
<tr>
<td>Grant administration</td>
<td>1,280,436</td>
<td>1,280,226</td>
</tr>
<tr>
<td>Other administration</td>
<td>496,720</td>
<td>498,867</td>
</tr>
<tr>
<td>Federal excise tax</td>
<td>591,907</td>
<td>210,569</td>
</tr>
<tr>
<td><strong>Total grants and expenses</strong></td>
<td>$18,789,464</td>
<td>$15,227,261</td>
</tr>
<tr>
<td><strong>Increase in Unrestricted Net Assets</strong></td>
<td>$27,892,995</td>
<td>$47,160,739</td>
</tr>
</tbody>
</table>

This information is summarized from the books and records of the Foundation. Copies of audited financial statements are available upon request.
Excerpts from the Fifth Codicil to the Last Will & Testament of Michael L. Benedum

The disposition of a not inconsiderable estate is never an easy assignment.

It has been a thorny & laborious problem for me because, recognizing my frailty & inadequacy, I have not been able to lose sight of the awesome responsibility involved.

If I could have looked upon my material goods as personal property, belonging to me alone, my task would have been immeasurably lighter. But I have never regarded my possessions in that light. Providence gives no fee simple title to such possessions. As I have seen it, all of the elements of the earth belong to the Creator of all things, and He has, as a part of the Divine Purpose, distributed them unevenly among His children, holding each relatively accountable for their wise use and disposition.

I have always felt that I have been only a trustee for such material wealth as Providence has placed in my hands. This trusteeship has weighed heavily upon me. In carrying out this final responsibility of my stewardship, I have sought to utilize such wisdom and understanding of equity as the Creator has given me. No one with any regard for his responsibility to his God and his fellow man should do less. No one can do more.

As I have seen it, life is but a proving ground where Providence tests the character and mettle of those He places upon the earth. The whole course of mortal existence is a series of problems, sorrows & difficulties. If that existence be rightly conducted, it becomes a progress towards the fulfillment of human destiny. We must pass through darkness to reach the light.

Throughout my adult life, day by day & year by year, I have been instilled with the conviction that wealth cannot be measured in terms of money, stocks, bonds, broad acres or by ownership of mine and mill. These cannot bear testimony to the staple of real excellence of man or woman. Those who use a material yardstick to appraise their wealth and foolishly imagine themselves to be rich are objects of pity. In their ignorance and misanthropic isolation, they suffer from shrinkage of the soul.

All of us aspire to a higher and better life beyond this, but I feel that the individual who seeks to climb the ladder alone will never find the way to Paradise. Only those who sustain the faltering ones on the rungs above and extend a helping hand to the less fortunate on the rungs below, can approach the end with the strength of sublime faith and confidence.
At the end of life each of us must face the great teacher that we call death. Stern, cold & irresistible, it walks the earth in dread mystery and lays its hands upon all. The wealth of empires cannot stay its approach. As I near my rendezvous with this common leveler of mankind, which takes prince and pauper alike to the democracy of the grave, I do so with resignation to the will of God, and with faith in His eternal justice.

Life has been sweet to me…sweet in the loved ones that have been mine, sweet in the friends who have surrounded me & rewarding in the opportunities that have come my way. I could not leave this earth with any degree of happiness and satisfaction if I felt that I had not tried to bring some of these joys to those less fortunate than I have been.

We know not where seed may sprout. In the poorest and most unregarded child who seems to be abandoned to ignorance and evil, there may slumber virtue, intellect and genius. It is our duty to sow and to nurture, leaving it to others to harvest the fruits of our efforts.

While I am conscious that my love for the land that gave me birth has been an influence in guiding the disposition of my estate, there are other practical reasons why I have favored my native state of West Virginia. It is not that I am unmindful or unappreciative of my adopted home of Pennsylvania, but rather that I have sought to appraise and balance the needs of each and the available potential for supplying those needs.

I cannot close my eyes to the realistic consideration that Pittsburgh and Pennsylvania abound in riches, having a citizenship in which men of great wealth are more common than rare. West Virginia is in a less fortunate position. There can be no question but that its needs are much greater than those of my adopted home. Consequently, in making specific provisions for West Virginia institutions, I have done so in good conscience, with a sense of equity & with recognition of a responsibility to distribute my estate in a way that will bring the greatest good to the greatest number. This decision was not made lightly or impetuously.

Conscious that in this Codicil to my Last Will & Testament, I am figuratively speaking from the grave, and that the great book of my account with the Creator has been closed beyond change or amendment, I submit my soul to His tender mercy, and my memory to the generosity & compassion of my fellow man.

Signed by Michael L. Benedum
on the 15th day of June 1957
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