

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **SC**

APPLICATION YEAR: **2005**

I. General Requirements

[A. Letter of Transmittal](#)

[B. Face Sheet](#)

[C. Assurances and Certifications](#)

[D. Table of Contents](#)

[E. Public Input](#)

II. Needs Assessment

III. State Overview

[A. Overview](#)

[B. Agency Capacity](#)

[C. Organizational Structure](#)

[D. Other MCH Capacity](#)

[E. State Agency Coordination](#)

[F. Health Systems Capacity Indicators](#)

IV. Priorities, Performance and Program Activities

[A. Background and Overview](#)

[B. State Priorities](#)

[C. National Performance Measures](#)

[D. State Performance Measures](#)

[E. Other Program Activities](#)

[F. Technical Assistance](#)

V. Budget Narrative

[A. Expenditures](#)

[B. Budget](#)

VI. Reporting Forms-General Information

VII. Performance and Outcome Measure Detail Sheets

VIII. Glossary

IX. Technical Notes

X. Appendices and State Supporting documents

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

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

B. FACE SHEET

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

C. ASSURANCES AND CERTIFICATIONS

//2004/ An electronic version of the state's Assurances and Certifications related to federal grants is attached as a file.

//2005/ An electronic version of the state's Assurances and Certifications related to federal grants is attached as a file. //2005//

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

//2005// Public input was requested via the MCH Bureau web page that includes brief instructions on how to review the current state (FFY'04) MCH Block Grant narrative and data, a link to the MCHB National web site, and a request for comments electronically by June 15.

A flyer was created that contained the same information and also stated that a hard copy was available for review and comments at the MCH Bureau, 1751 Calhoun Street, Mills Building, Room O-425, Columbia, SC, 29204. Comments could be submitted via the Internet, by mail or in person. Comments were received up to June 15, 2003.

The flyer was distributed in May to members of the Commissioner's Obstetrical Task Force and other advocate organizations encouraging review and input into the process, as well as requesting assistance with further distribution to their staff, advisory committee members and advocates. Members of the committee did distribute it widely.

Comments were received and incorporated from:

No newspaper public notices were purchased this year due to no inquiries or input received as a result of this expenditure for at least the past 5 years.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

/2005/ The leading economic, health, education and behavioral indicators that measure well-being are frustratingly low for SC, a small and poor state with many of the problems associated with low socio-economic status. Poverty is a major threat to children in SC. Based on the 2000 census, thirty three percent of the state's total population verses forty three percent of the children live below 200% of poverty. Almost a third of the children in the state live in single parent families. In 2000, 66.1% of mothers with children under 6 and 73.1% with children 6 - 17 were in the labor force. The scores of SC students rank among the worst in the nation on standardized education tests. Although SC ranks well in some indicators measuring economic growth and development, sharp disparities between whites and minority races and populations are evident. Employment may be readily available in areas where tourism is a major industry, but the jobs filled by minorities are more likely to be low wage and not offer health insurance benefits. Unemployment rates are higher for minorities, especially in rural counties and in areas without a diversified industrial base.

SC scores very poorly on many indicators of maternal and child health status. The rate of very low birth weight, early prematurity, and infant mortality of black and other mothers are over 2.5 times those of whites. The larger racial disparities persist at comparable levels of maternal age, education, income and marital status. The gap between black (and other races) and white populations for many health indicators is not improving.

Sixty-four percent (64%) of pregnant women in the state are living below 185% of poverty. Twenty-one percent, or about 1/5 of women delivering a live birth in SC in 2001 had not completed high school. Almost half (48.2) of all births in 2001 resulted from pregnancies that were unintended, far above the Healthy People 2010 goal of 30. The births to teens rate (15-17 years old) continues to decrease, 28.7 in 2002 verses 29.9 in 2001.

The state is far below the Healthy People 2010 goals of 90% for first trimester entry into prenatal care and 90% of women receiving adequate prenatal care. In SC, the number of women beginning prenatal care in the first trimester has shown a continuing decline since 1999, 79.4% in 1999, 78.6% in 2000, 78.5% in 2001 and 77.7% in 2002. The gap between black and white women entering into prenatal care has continued but seems to be closing. The percentage of white women who entered prenatal care early decreased slightly last year, 82.0% in 2002 verses 83.8% in 2001. However, the percentage of black women who entered prenatal care early increased slightly to 69.6% in 2002 from 68.7% in 2001.

In 2002, a small increase was seen in the percent of pregnant women who received adequate prenatal care (Kotelchuck index), however, there is still a racial gap, 76.8% for all women, 79.9% for white and 71.3% for black women. The greatest improvement was seen among black women, 69.5% in 2001 to 71.3 % in 2002. The percentage of white women basically remained the same, 79.5% in 2001 verses 79.9% in 2002.

The number and percentage of births whose mothers were of Hispanic origin have increased dramatically since 1997. In 1997, the number of Hispanic births was 1,147 or 2.2% verses 3,188 or 5.85% in 2002.

The 2002 infant mortality rate increased slightly to 9.3 per 1,000 live births compared to 8.9 in 2001 and 8.7 in 2000. For the third year in a row, disorders relating to premature births and low birth weight are still among the leading causes of infant deaths. DHEC statistics showed 52,746 live births in 2002. Of that number, 507 babies died before their first birthday, compared to 496 of 55,748 in 2001. The infant mortality rate for black infants at 15.9 per 1,000 live births continues to be more than twice and almost three times that of white infants at 5.9. SC remains far above the national infant mortality rate of 6.8 (in 2001) and above the 2010 Healthy People goal of 4.5 deaths per 1,000 live births.

SC's rate of births less than 32 weeks gestation has been increasing since 2000, 21.26 in 2000, 21.45 in 2001 and 21.69 in 2002. The disparity by race is present and dramatic, almost twice for black births than white births, a rate of 34.49 for black births versus 15.11 for white births in 2002. The rate for white births increased from 14.11 in 2001 while the rate for black births decreased from 36.11 in 2001.

The percentage of low birth weight babies is not declining, but has actually shown some increase in 2002 to 10 from 9.6. The percent of black babies with a low birth weight (14.5) is almost twice that of whites (7.5) in 2002. Nationally, black mothers in every age category --not just teens--have a greater risk of losing their babies than white mothers of similar age. According to the 2004 SC Kids Count report, the cost of hospitalization for each low birth-weight baby in the state in 1999 - 2001 was \$13,731 and \$91,517 for each very low birth-weight baby, compared with \$1,933.14 for a baby of normal birth-weight. The result was excess cost in the state of \$99,501,765 for all low birth-weight babies, of which \$69,516,776 was for very low birth-weight babies.

Major providers of health care services for maternal and child populations in SC include physicians and dentists in private practice, for-profit and not-for-profit hospitals, federal health clinics, state public health agencies, and county health departments. In addition to these components of the service delivery system, numerous foundations, professional organizations, and universities focus on promoting maternal and child health through research, educational campaigns and materials, development of practice standards, and legislative advocacy. Some linkages exist between parts of this system of care, i.e., hospital transportation and back-transport for very low birth weight deliveries; statewide immunization information system for county health departments; medical home service coordination through health departments and private medical providers; and coordination of early intervention services through BabyNet (Part C). However, routine coordination between components of the overall system is not in place.

The role of the Department of Health and Environmental Control (DHEC--state and county health agency) at state, district and county health department levels is moving toward more involvement in building, supporting and facilitating community health care systems through core public health assessment, assurance and policy development functions. More communities are looking at health care systems in a comprehensive manner and community assessment initiatives are active in over half of the counties in the state. DHEC districts are encouraged to provide and support leadership in county and community coalitions, develop public and private partnerships, strengthen infrastructure building, and transition staff to provide more family support services. The role of DHEC is changing from being a primary provider of medical services to indigent clients, to coordinating private/public partnerships and providing wrap-around family support services (public health nursing, health education, nutrition, social work and paraprofessional services) to complement the medical services provided by other partners. Numerous pediatric partnerships for medical homes, obstetric partnerships for prenatal care, agreements with dentists for referrals, partnerships with schools for nurse placement, and community coalition partnerships, e.g., First Steps to School Readiness, are in place. Partnerships with dental providers to provide Medicaid funded dental services in school-based programs have been a successful addition in 2003.

Access to comprehensive, high-quality health care services is a continuing health care delivery system problem. Long-term barriers that decrease availability of services and access for low-income families of all races include:

-Insufficient number of physicians and dentists enrolled in the Medicaid program and providing services to low income families.

-Lack of health care providers in rural areas.

-Low Medicaid reimbursement rates for physicians providing prenatal care and child care, especially for subspecialty physicians caring for children with special health care needs.

-Disproportionate distribution of Medicaid patients to physicians in many locations.

- Disproportionate distribution of Medicaid patients to dentists in many locations.
- Number of children and youth not enrolled in Medicaid, although eligible for enrollment.
- Growing number of permanent Hispanic residents without legal status, who are therefore not eligible for Medicaid enrollment.
- Growing number of working poor families that have too much income for Medicaid eligibility but receive no health insurance through their employer.
- Intense and persistent pressure from some hospitals to weaken the state's perinatal regionalization system.
- Insufficient or inadequate transportation for patients and families.
- Disparity of utilization of health care services by minority groups. Functionally illiterate young families may not access programs designed to benefit them because paperwork and processes are too complex.

Medicaid continues to be a major payer for deliveries; however the percentage paid for by Medicaid has dropped to 37.2 percent of all deliveries. Factors that may have contributed to this drop may be due to the fact that there have been changes in the Medicaid eligibility and outreach process. With recent budget constraints, the Medicaid eligibility process has been compromised. There are fewer out-stationed workers in provider areas, especially in local health departments and the agency has developed a very cumbersome application process. Although the application can be mailed in, it is so complex that many clients are not able to complete the application. Last year, the EPSDT administrative outreach contract that DHEC had with DHHS was cancelled. Therefore, while evaluation data regarding children whose care is provided in public/private partnerships demonstrates improved utilization in partnership practices, the Medicaid overall data system has been changed and evaluating the relationship between screenings by provider by county is no longer available. Additionally, screenings provided in the managed care arena are only partially captured.

Increased Medicaid reimbursement for dental services in 2000 provided an incentive for more dentists to enroll as providers in the Medicaid program, resulting in increased numbers of children receiving dental health services. Over 1000 dentists are now enrolled as Medicaid providers (over 50 percent of all dentists in the state), compared with less than 600 in 1999. Program modifications in December 2001 identified and maintained improved funding for medically necessary pediatric dental services. These program changes have continued the increase in the number of eligible children receiving a dental service while reducing program expenditures. The number of children receiving dental services continues to increase substantially.

Over the past 4 State Fiscal Years (2001-04), the Agency has experienced a cumulative state budget cut of 33.96% of state funds (2001-10%, 2002-6.5%, 2003-8.73%, 2004-8.73%). The Agency budget projection for next year (2005) seems to have improved with level funding expected.

These budget cuts have had an impact on the ability of the Agency and the Bureau to perform its responsibilities and provide services to clients. Positions have been held vacant requiring staff to take on additional duties without additional compensation and the workload has not diminished. Since 2000, Health Services has decreased from 4,102 to 3,446 full time positions, a loss of 756 positions or 16%; and decreased clinic sites by 15 or 14% going from 110 to 95 clinic sites statewide. These figures do not include the bioterrorism positions that Health Services has acquired during this period. The budget impact can also be seen below by the 22.8% decrease in the number of clients seen by MCH staff:

Number of Clients Served 2003 2000
Pregnant Women 19,212 18,722
Infants 26,632 18,006
Children 116,748 208,695
Children with Special Health Care Needs 10,944 11,914

Others 116,748 114,044

Total 290,284 371,381

To assist with this budget and staffing decrease, the staff and leadership of the Agency and the Bureau have developed priorities and begun extensive reviews of existing programs, processes and staffing patterns in order to improve the efficiency and effectiveness of what, why, how and who of service provision and support the Agency and Health Services continues to provide.

The state Medicaid agency has also experienced difficult budget years over the past three years. However, during the two past legislative sessions (2003 and 2004), the Medicaid agency maintained their funding levels with no significant budget cuts. However with the increasing costs and demands for services, it has implemented several actions to decrease expenditures. During 2004, the Medicaid Agency implemented co-pays (MCH services exempt), and an active client re-determination process. It has also developed a list of over thirty possible actions that could be implemented if expenses exceed revenues.

The Medicaid Agency is aggressively pursuing and implementing several managed care options. During 2004, it plans to implement Disease Management programs for individuals suffering with asthma, hypertension and diabetes. It plans to implement a Primary Care Case Management (PCCM) program for children in three upstate counties in July 2004. DHEC is working internally and with Medicaid to develop the public health component of this new managed care program for children. The PCCM program is being designed to support the primary physician provider and the medical home concept. //2005//

MCH Bureau

Title V provided invaluable guidance as well as funding during the changes and transition that occurred in South Carolina in the past few years. The MCH Pyramid of Health Services offers a concept and framework for building stronger health care delivery systems. The MCH Pyramid is included as an attached file. Title V funding is the foundation for maternal and child health programs in SC. Development of a web of inter-connecting health care delivery systems at local, district and state levels to improve the health status of women, children, youth and families, including families with children with special health care needs, is an ongoing, continuous process toward an ideal goal. Title V funding enabled the infrastructure building to take place for an MCH Pyramid of Health Services especially designed for this state.

The MCH Bureau provides a coordinated focus for the Public Health Services Deputy area and the agency for priority setting, planning, policy development, and administration of programs for maternal and child health populations. The Bureau works with Health Services management to establish priorities; assure consistency in messages affecting MCH populations, i.e., assessments, problem statements, planning, evaluations, service delivery, program implementation; assures integration of efforts across Health Services program areas; and enables creative thinking to improve health outcomes and achieve state and national objectives for all women, children, youth and adolescents.

Several policy and planning initiatives to examine health services for mothers, infants, children and youth are currently ongoing and provide an opportunity to build a more comprehensive health care service delivery system for all children and youth in the state. These initiatives include:

- Implementation of a single Health Services Operational Plan (HSOP) for all districts and central office divisions that is based on the agency's strategic plan and long term outcomes. All MCH Title V Block Grant performance measures are incorporated into the HSOP;
- Interagency "Front End Services" initiative to promote preventive services, led by DHHS, the Medicaid agency;
- Medical Homes for CSHCN, led by the American Academy of Pediatrics;
- Creation of a state oral health advisory council to oversee the implementation of the state Oral Health Plan.
- Expansion of the existing Children's Oral Health Coalition to cover the lifespan.

In addition to the Title V block grant, other major funded programs within the Bureau include the Title X Family Planning Program and the CDC funded Childhood Lead Poisoning Prevention Program, both located in the Division of Women and Children's Services; BabyNet, the early intervention program for infants and toddlers, funded through P.L. 102-119 of IDEA, and located in the Division of Children with Special Health Care Needs; and the USDA funded Special Supplemental Food Program for Women, Infants and Children administered in the Division of WIC Services.

//2005/ During 2003 and 2004, the Oral Health capacity of the state has increased dramatically through three new funding opportunities. More Smiling Faces in Beautiful Places is a Robert Wood Johnson Foundation funded oral health program targeting children from birth to six years as well as children and adolescents with special health care needs, and is dedicated to linking medical homes to dental homes through case management, education of medical and dental providers, education of the public, and empowering families to manage oral health. The state dental disease prevention program is a CDC funded program to strengthen the state's ability to conduct oral health surveillance, expand school-based and school-linked dental sealant programs, and expand community water fluoridation. The HRSA Systems Development grant currently funds community based public education and oral health improvement programs. The HRSA SOHCS grant supports community based initiatives to convene partners and create plans to address oral health needs of Head Start students. //2005//

B. AGENCY CAPACITY

DHEC is the primary advisor to the state in matters pertaining to public health. It has the authority to make and enforce rules and regulations for the protection of public health and the environment. The rules and regulations enacted by DHEC have the force of law and affect many aspects of the daily life of citizens. A broad range of health and environmental responsibilities are specifically assigned to DHEC by law. Central operations of DHEC are located in Columbia, the state capitol of SC.

Statutory Authority:

The SC General Assembly established the State Board of Health in 1878. The SC Department of Health and Environmental Control (DHEC) was formed in 1973, when the Board of Health was merged with the Pollution Control Authority. Statutory authority for the department is primarily provided in Titles 44 and 48 of the SC Code, 1976. The department operates under the supervision of a seven member Board of Health and Environmental Control, one member from each congressional district and one at-large member. The Governor with advice and consent of the Senate appoints board members. The chairman of the board is the at-large member and serves at the pleasure of the governor. The commissioner is hired by and serves at the pleasure of the board. DHEC is managed through five major organizational areas, each headed by a deputy commissioner: 1) Environmental Quality Control, 2) Health Services, 3) Ocean and Coastal Resources, 4) Health Regulations and 5) Administration. State level responsibilities for Title V rests within the Health Services Deputy Commissioner area.

Legislative and Congressional Statutes:

In addition to the responsibilities mandated by the State, the Department performs a wide range of activities under Federal authority, in accordance with Federal laws and regulations. Among the programs operated under Federal and State authority are chronic disease, communicable disease, maternal and child health, family planning, health education and risk reduction, environmental sanitation, air quality control, radiological health, hazardous wastes, water pollution control, water supply, emergency medical services, home health, personal care services and primary care. The legislative and congressional statutes providing authority for MCH programs follows:

A. Title V (Federal) Social Security Act: To provide for (1) health services for mothers and children to

reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, (2) rehabilitative services for blind and disabled children under the age of 16, and (3) treatment and care of crippled children.

B. Title X (Federal) Public Health Service Act (FAMILY PLANNING): To make comprehensive, voluntary family planning services readily available to all persons desiring such services.

//2005/ Section 44-37-30, S.C. Code of Laws, As Amended, (Newborn Screening): Promulgate regulations for screening of metabolic disorders in infants. 2003 amendment related to storage and use of blood specimens collected, forms, documentation, confidentiality of information, improve clarity and readability as well as strengthen, improve and codify standards and terminology to be consistent with national and medical standards. //2005//

D. Section 17 (Federal) (Child Nutrition Act - WIC): Provide supplemental foods, breastfeeding promotion and nutrition education to pregnant, postpartum and breastfeeding women, infants and young children.

E. Section 44-33-10, S.C. Code of Laws, As Amended, Section 39.7, Appropriations Act (1989-90): Provide education, voluntary screening, genetic counseling and referral services to children and adults with Sickle Cell disease, Cystic Fibrosis and Hemophilia.

F. Public Law 105-17, Part C, Individuals with Disabilities Education Act, State Law 114 (BABYNET): To develop and implement a statewide, comprehensive, coordinated, multi disciplinary, interagency program of early intervention services for infants and toddlers with developmental delay and their families.

G. Public Law 89-97, Formerly Social Security Act, (Federal) Title XIX, (EPSDT): Preventive (well) health services to Medicaid eligible children from birth to age 21.

H. Lead Poisoning and Control Act (State) (Lead Screening and Follow-up): DHEC was mandated to establish a program for early diagnosis of cases of lead poisoning and identification and reduction of sources of lead. Local health departments provide screening tests through the EPSDT, Comprehensive Child Health and WIC programs.

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//2005/ I. Preventive Dental Services (State): Section 40-15-110, SC Code of Laws, As Amended Grants the Department the ability to target preventive dental services in a public health setting to underserved populations using the services of dental hygienists performing under general supervision without a prior patient exam by a licensed dentist. This legislation also defined the service dental assistants may perform through the Department.

J. Birth Defects Act (State): Legislation was adopted that establishes a birth defects program within SC DHEC. An active system for monitoring will be developed and include surveillance from prenatal through age two. No funding was provided to establish the program and the implementation is contingent upon the availability of funding. This program will be developed within the Division of Perinatal Systems.

K. Fetal Death Certificates (State): Requires SC DHEC to issue fetal death certificates for deliveries resulting in a live still birth for births of 20 completed weeks or more or a weight of 350 grams or more.

2004 Legislative Issues discussed but not passed:

H. 4971 To establish the SC Commission on Health Care to report and provide recommendations by 2007 related to the high number of uninsured citizens in the state, particularly working adults of small businesses.

S.356 Primary seat belt enforcement

S.381 School nurses in all elementary schools

S.415 150 minutes minimum PE/health p/week for grades K-8

S.416 Public schools, food and drink; must comply with certain dietary requirements

S.972 Gun Law for Domestic Violent Offenders

H.3084 Youth Access to Tobacco Prevention Act

H.3978 Ensuring Developmentally Appropriate Discipline in Child Care

S. 387 Prohibits placing foster care children with an unmarried couple

S 604 Allows school districts to allow asthma, allergy, and diabetes self-medication

S.1002 Liability insurance for childcare homes

S.1084 Moving childcare from Department of Social Services to Health and Human Services Agency (Medicaid)

S.1112 Equalized Education Finance Act of 2004

S. 1156 Immunization Registry Act (an electronic repository of vaccination records to be used in aiding childhood disease prevention and control)

S.1198 Putting Parents in Charge Act -Tax credits for sending children to private school

H. 4399 Amend the Childhood Lead Poisoning Prevention and Control Act //2005//

Title V Capacity:

Title V capacity in South Carolina has been adversely affected by the state budget cuts over the past three years and the changing environment of other pending issues, such as Bioterrorism and Emergency Preparedness. However, MCH staff continue to provide services, prioritize initiatives, and search for efficiencies that can maximize and target resources. Following are descriptions of MCH programs and services in SC paid for in part or whole by Title V, or programs that through their participation on MCH issues are increasing their coordination with the MCH Bureau and vice-versa. Where eligibility requires payment for services, the Family Planning sliding fee scale provided in the FY 1996 application is still in use.

Women and Children's Services Division

The Women and Children's Services Division is organized into three general program areas and several special projects to allow for the best utilization of expert staff and to increase efficiency. All activities are targeted toward improving access to risk appropriate care for pregnant women, infants and children and low-income women seeking family planning services. These programs function with the support of an administrative staff and utilization of a multi disciplinary team of consultants (Health Education, Nursing, Nutrition, and Social Work).

1) Family Support Services (FSS): Services provided to mothers and children in SC have been enhanced through the implementation of a Medicaid contract to provide risk appropriate Family Support Services to all Medicaid eligible populations. FSS may be provided in the clinic, home, school, or day care setting. Services include follow-up for missed appointments, coordination and reinforcement for the primary/acute care, linkage to medical and/or dental homes where available, social work assessment and treatment, nutritional counseling, and parent/child education relative to developmental, safety and environmental issues. These services are key to the ongoing promotion of private public partnerships. Providing these core traditional supportive services enhance the ability of the primary care providers to serve as medical and dental homes for families in the state.

During FY 2003, FSS was revised to allow considerable flexibility in the provision of these services. Documentation requirements have been simplified to some degree and the language relative to "medical necessity" has been expanded to include "developmental and psychosocial" risk factors. These changes have made it easier for staff to continue to serve women and children even in the current budgetary environment.

2) Family Planning: Services are provided statewide according to the regulations and guidelines of Title X of the U.S. Public Health Service Act and include the following: physical examination, contraceptive of choice with counseling, and other services. SC has a Family Planning waiver in place, which extends eligibility for services to include coverage for all women up to 185% of poverty regardless of their childbearing status. Family Planning outreach efforts are fully operational and ongoing outreach is provided to teens and patients whose prenatal care was provided in either the public or private sector.

//2005/ The waiver is scheduled to end December 31, 2004. The Medicaid agency has submitted a request to CMS for a renewal of the wavier.

3) Low Risk Maternity Program: This program offers an array of interdisciplinary services including primary prenatal care in areas where other care is not available, and FSS.

Comprehensive prenatal care is offered in only two small counties one of which will transition out of prenatal care in August 2004 leaving only one county providing prenatal care. //2005//

4) Child Health Services (CHS): These services are provided for non-Medicaid children who use the Health Department as their primary care provider. These children receive limited or comprehensive services depending on need. Medicaid children are provided the same services through the EPSDT program and all children are risk assessed for educational, nutritional and psychosocial need for FSS.

5) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) DHEC is one of many providers

of EPSDT services in the state. Services are the same as those described in comprehensive child health services. . DHEC provides follow-up through the provision of FSS.

//2005/ 6) Partnership Development: To accomplish the MCH goals for women and children there is continued focus on the development of private/public partnerships in which local physician practices provide the medical care and the health department provides preventive and supportive, core public health enabling services based on the unique needs of the local community. Although the maintenance and expansion of partnerships is a bureau priority, statewide staff losses have made this priority a challenge. In 2000 we had reported over 100 partnerships but in 2003 we had only 50 formal partnerships across the state. In the next fiscal year and with ongoing negotiations with Medicaid, we are hoping to assist districts in providing a more targeted approach to serving clients in partnerships. //2005//

8) Postpartum/Newborn Home Visits: All infants born to women who are on Medicaid are eligible for a postpartum newborn home visit. During the visit, the mother and infant's health status are evaluated. Infants receive a thorough physical appraisal, weight check, and are enrolled in WIC, and a "two week" clinic visit is planned. Mothers are encouraged to have a primary care provider and to maintain routine well care and immunizations for the infant. Health education and referral to community resources are provided as needed. The physical environment is assessed to determine if problems exist that would be detrimental to the health of the infant. A follow-up visit or referral for FSS is made if the assessment indicates a need. DHEC continues to maintain a long-range goal of making this visit available to all newborns in the state.

//2005/ 8) Lead Screening and Follow-Up: The central office maintains a statewide registry of cases of child lead poisoning, and monitors and classifies all test results analyzed in DHEC and private laboratories. Other services include coordination of follow-up testing and educational interventions, contractual arrangements with the Bureau of Environmental Health for environmental investigation for sources of lead, and provision of specialty medical consultation for private providers. As of January 1, 2004, blood lead screening responsibility was transferred to the EPSDT provider. Local health departments provide testing and follow-up services to approximately 350 children ages 1-6 years of age annually. Environmental investigations and technical assistance regarding abatement procedures are also provided for cases of lead poisoning with levels high enough to meet established protocol.

9) Newborn Screening: Women and Children's Services maintains a statewide registry of patients with phenylketonuria (PKU), congenital hypothyroidism, galactosemia, congenital adrenal hyperplasia (CAH), medium chain acyl co-A dehydrogenase deficiency (MCADD), and hemoglobinopathies; monitors laboratory tests; and reports results to providers with recommendations for follow-up. Local health departments and Children's Rehabilitative Services (CRS) clinics provide linkages to specialty medical care, and distribute special formula for patients with PKU and other inborn errors of metabolism. During the fall of 2004, the state will expand the test panel to include screening for cystic fibrosis, biotinidase deficiency and additional disorders of fatty acid, amino acid and organic acid metabolism. The expansion will require the implementation of a new data system for newborn screening. This new system will allow infant newborn screening results to eventually be linked with the electronic birth certificate. //2005//

10) Day Care Screening: Child development centers licensed by the Department of Social Services can receive Social Services Block Grant funds for health screening children in the centers. These centers can contract with local health departments to do the screening. Health screening services are the same as those provided through CHS and EPSDT.

11) Sudden Infant Death Syndrome (SIDS) Follow-Up: Grief counseling is offered statewide by specially trained and licensed social workers, and referrals to support groups are made for families who experience SIDS. In addition, training for first responders are available, public awareness is conducted about SIDS and the need for autopsies is promoted.

//2005/ 12) School Health: An innovative school health partnership between the State Medicaid agency, the State Department of Education (SDE) and DHEC to designate school districts as Title V providers was implemented in September, 2003. The Title V designation allows school nurses to bill for services provided to Medicaid children, not just to Medicaid children with Individual Education Plans. In 2004 there were some issues raised regarding the position of CMS on this exemption to the "free care rule". However, lacking specific direction from CMS,

the contracts for Title V designation will be renewed for the 2004-2005 school year.

School efforts continue under the leadership of the school nurse program consultant's leadership. The annual school nurse conference was held with over 500 nurses attending and 63 new nurses have received orientation. WCS also employs an MSW who is partly funded by the Department of Education and who provides support training and partnerships to increase the number of social workers in schools. //2005//

Division of Children with Special Health Care Needs:

/2005/ The Division houses several programs and initiatives directed at services for CYSHCN: 1) Title V CSHCN-CRS Program: The CRS Program serves over 10,000 children in S.C. between the ages of birth through 20 whose family income is less than 250 percent of poverty. The program provides diagnostic and treatment services including inpatient care, for the following conditions (but not limited to) for children with disabilities and chronic illness: diseases of the bones and joints; congenital anomalies; cardiac defects; rheumatic fever; hearing disorders; epilepsy/seizure disorders; hemophilia; cleft lip/palate; other craniofacial anomalies; cerebral palsy; residuals of trauma; sickle cell disease, and other central nervous system disorders. The goal of CRS is to provide multidisciplinary rehabilitative and early intervention services to help achieve the greatest potential for CYSHCN and to decrease secondary morbidities.

Application for the CRS Program and service coordination is made through county health departments or public health district offices. Services purchased outside of DHEC must be pre-authorized by the CRS clinic. The following services are offered: 1) Clinic services for evaluation, diagnosis, or treatment; interdisciplinary clinics such as craniofacial and tube feeding clinics 2) Durable medical equipment and hearing aids 3) Physician visits 4) Pharmaceuticals, including metabolic and special formulas 5) Speech, occupational, physical, and audiology therapy 6) Coordination of Care 7) In and outpatient surgery/hospitalization 8) Corrective and restorative dentistry, including orthodontics 9) Family Support Services 10) Nutritional therapy 11) Social Work 12) Nursing and health education 13) Parent to parent support.

Specialty care is available around the state through the community-based system of CRS interdisciplinary clinics and specialty partnership clinics and through six tertiary level hospitals and two proximate out- of-state centers (Charlotte, NC and Augusta, GA). Pediatric subspecialty physicians from the Medical University of South Carolina, the University of South Carolina, and Greenville Hospital Systems, travel to several local communities to hold clinics that decrease transportation concerns for CRS families. Subspecialty health care needs of these children are assessed in clinics and followed-up through development of treatment plans and coordination of care.

2) Medical Homes for CSHCN: South Carolina was one of 12 states chosen to participate in the National Medical Home Initiative for Children with Special Health Care Needs. This is a partnership between MCHB and the American Academy of Pediatrics. South Carolina has a medical home team composed of representatives from Title V, the American Academy of Pediatrics, Family Connections, and DHHS (the Medicaid agency). South Carolina also applied for and received one of the MCHB Community Integrated Service Grants for Medical Homes, which began in April 2002. A partnership with ETV through the Sound Partners Grant resulted in the making of a Video directed at Physicians and Families of CSHCN on the importance of a Medical Home. Individual copies of the video are being used to train physicians, families and other interested organizations. Five mentor medical home pilots were established last year. Both of these use a case management model to assist families of CSHCN to coordinate services. There is a strong evaluation component for the Medical Home initiative and the data will be used to help recruit other physicians and providers to participate in the medical home initiative. The current president of the State Chapter of the AAP and the Medical Consultant from CRS continue to make numerous presentations to physician groups around the State on the Medical Home for CSHCN model to increase the number of mentor medical home in the

coming year as well as increase the participation of families who are utilizing a medical home. Efforts are being made to incorporate medical home into residency training.

3) **Parent Program:** The CSHCN Parent liaison coordinates parent efforts for both CRS and BabyNet (early intervention). The Parent Advisory Council has expanded to include several initiatives important to parents including development of a: Personal History Folder - a medical record that the parent can keep on their special needs child; Family Information Packet to be given to new families entering CRS services; parent satisfaction surveys and a parent newsletter called "Children Are Special" and the medical home training. Council members are active at the state and local level in addition to providing support to state committees addressing SSI, transition, policy, and health care reform issues for CSHCN. Additionally, these individuals are active in helping parents understand their right to advocate for their child. Training to help parents develop support systems has been conducted in all 12-health districts. Additionally, Parent Resource Specialists are employed in all 12-health districts and staff the Parent Advisory Council. In 2004 the CRS Program has created a permanent position for a Parent Liaison who staffs the Parent Advisory Council, edits the CRS newsletter, and mentors parent resource specialists. The parents work closely with the SC Medical Home Team to develop the medical home training including the video Special Children, Special Care. Parents have been employed in each medical home site. In addition parents have developed resource books for tube feeding and newborn hearing screening and an emergency plan folder. All parents work closely with BabyNet through the ICC and local care coordination teams. CRS, BabyNet, the Department of Disabilities and Special Needs (DDSN) and Family Connection (family partners) work together in a statewide initiative to make sure that there is at least one general support group and an active parent network of support in each health district clinic and catchment area (12).

4) **Systems Development:** In addition to local specialty care clinics, CRS has developed several partnerships with medical homes and tertiary specialty clinics: neurology, cystic fibrosis, nephrology, endocrine/metabolic, and cardiology. CRS staff are housed in these clinics to provide outreach, child find, appropriate triage and linkage, and coordinated/continuous care. Currently, CRS maintains 70 partnerships and is planning additional medical home partnerships for 2004.

5) **Child and Adolescent Service System Program (CASSP) and Transition Coordination:** Through a signed Memorandum of Agreement with S.C. Vocational Rehabilitation, cross training of service staff, coordinated care and provision of collaborative services and treatment plans are conducted, where appropriate. In addition, CRS has hired a transition coordinator who is responsible for working across agencies to effectively develop systems for transitioning CSHCN into the community, including BabyNet transition. The CSHCN Program has developed a transition system, which includes a plan for transitioning CSHCN through various stages from birth to 21; transition criteria and; resources and information needed by families to transition successfully to services in the community. The Program has developed transition criteria and initiated an effort with the Parent Advisory Council and the Transition focus group to develop information needed by families. Through the year 2004, the priority will be to maintain and enhance this transition system of care.

6) **Camp Burnt Gin:** CRS operates a summer camp for CYSHCN sponsored by state appropriations and Title V funding. Since 1945, the camp, located in Sumter County, has been offering recreational opportunities for children with physical disabilities. Camp Burnt Gin attempts to provide the kinds of experiences and stimulation that will help develop physical, social, and emotional growth in its campers. It celebrated its 50th anniversary in 1996. Camp Burnt Gin has developed special adolescent and young sessions with a unique curriculum. Camp Burnt Gin has also provided additional camping opportunities for children who are HIV positive and for children served by the Muscular Dystrophy Association. The camp continues to take more children with higher acuity since there are limited opportunities for camping. The full time camp director works with camps throughout the state to promote inclusion.

7) **Cultural Sensitivity:** CRS and BabyNet provide access to interpreters for individuals whose native language is not English, or for sign language interpretation for the deaf.

8) **Supplemental Security Income/Disabled Children's Program (SSI/DCP):** The Amendment of Title XVI of the Social Security Act of 1976 (PL 94?566) established a program for children

receiving Supplemental Security Income (SSI) to receive appropriate medical, educational, developmental, rehabilitative, counseling and social services through coordination with other state agencies. The Governor designated DHEC as the state agency to coordinate activities. This effort has now been incorporated into CRS utilizing Title V Block Grant funds; SSI recipients are also eligible for Medicaid benefits. CRS triages all referrals to local CRS clinics and other appropriate agencies.

9) Hemophilia Assistance: The State Legislature has appropriated recurring state funds for individuals with hemophilia to receive certain services, which are provided through the CSHCN division. Guidelines for services are as follows: Individuals with hemophilia with incomes at or below 250 percent of federal poverty can receive blood products and supplies at no cost. The legislature provided increased recurring state dollars to the Hemophilia program for FFY 2005 to assure services could continue at the current level.

10) Adult Sickle Cell Disease: A Sickle Cell Workgroup operates at the state level comprised of representatives from the four sickle cell community based non-profit organizations in this state; CRS the state Title V program; Newborn Screening; and DHHS. The group serves as a forum where information is shared, concerns are addressed and funding mechanisms are coordinated. Some key outcomes from the group include: development of a Strategic Plan for services; purchase and statewide placement of billboards about sickle cell disorders and development of several educational materials. A program director works closely with the Sickle Cell Foundations and the teaching hospitals to enhance the system of care for Sickle Cell patients in the state. The director is in the process of developing a statewide registry with all involved tertiary hospitals and the Sickle Cell Foundations. In FY 2004, the state legislature increased the amount of recurring state dollars for the Sickle Cell program for FFY 2004.

11) Genetic Disease Testing and Counseling: Federal funds are channeled through CRS to support three (3) Regional Genetic Centers in South Carolina. These centers provide genetic evaluations and counseling to children needing this service with incomes less than 150% of the federal poverty level.

12) Newborn Hearing Screening: Through "First Sound," South Carolina's Early Hearing Detection and Intervention Program (EHDI), all 49 birthing hospitals in South Carolina are screening more than 98 percent of infants statewide during birth admission and are submitting screening data, via a web-based system to DHEC. South Carolina was one of 9 states rated "exemplary" by the World Council on Hearing Health for keeping screen rates between 95 and 98 percent with less than 50 percent of the program funding from temporary federal grants.

The statewide referral rate for audiological follow-up is approximately 3 percent; a rate that falls below the less than 4 percent recommended by the American Academy of Pediatrics. Hospital to audiologist referrals have resulted in the identification of 200 infants (year to date) in South Carolina with hearing loss. This is a prevalence rate of approximately 1.5 infants with a hearing loss per 1,000 live births that falls in the 1 to 3 per 1000, predicted nationally.

Tasked with tracking all infants who refer on inpatient screen and following those infants until an outcome is determined, DHEC's First Sound Program coordinates/collaborates with community based systems including: hospitals, participating audiologists, Family Support Services, BabyNet, and Medical Homes. Our goal, adopted from the American Academy of Pediatrics (AAP) and the Joint Committee on Infant Hearing (JCIH) guidelines, is to ensure that all infants with hearing loss in South Carolina receive appropriate early intervention by 6 months of age. The processes for tracking and follow up and entry into services are continuously being examined and revised with assistance from the First Sound Advisory Council. The Council is made up of representatives from community systems, professionals, parents, and systems within DHEC's Health Services. Infants referred into the early intervention system by 6 months of age have increased from 39 percent in FY 2001 to 86 percent in FY 2003.

Lost to follow up continues to be an issue nationally. South Carolina's lost to follow up rate hovers between 40 and 50 percent. First Sound Staff participates on committees that examine strategies for integrating systems that link and track clients. Integration of systems will

improve the ability to contact clients, decreasing the number of clients lost to follow up.
13) BabyNet (Part C of IDEA) System of Early Intervention Services: BabyNet is South Carolina's System of early intervention services for infants and toddlers with developmental delays or conditions associated with a high probability of delays, and their families. BabyNet, in accordance with Federal Law 105-17 provides a comprehensive, coordinated interdisciplinary multi-agency system of services. To the maximum extent possible, services are provided in the child's natural environments. Depending upon the needs of the child and family, BabyNet services may include: evaluations and assessments, audiology and vision services, speech therapy, physical therapy, occupational therapy, nursing, health services, nutrition, social work, assistive devices, transportation, psychological services, and special instruction.

DHEC serves as the Lead Agency for BabyNet as appointed by the Governor of South Carolina. The South Carolina Interagency Coordinating Council (SC-ICC) advises and assists BabyNet with policy, resources, personnel, and services development. The SC-ICC is comprised of representatives from participating state agencies, private providers, and family members. Additional information can be accessed through the BabyNet website at www.scdhec.net/babynet.

Planning for all children, including those with special health care needs has been fully integrated into the DHEC operational plan. During the annual planning process across MCH services, Districts are asked to report the number and type of specialty clinics being offered each month to assure that adequate access to specialty care is available at the local level. Districts are also asked to describe their discharge planning activities to assure linkages back to community systems and to describe all partnership initiatives. Districts report all data using the Six National Performance Measures as a baseline. //2005//

This section was too long, therefore it is continued in attachment III. B..

C. ORGANIZATIONAL STRUCTURE

/2004/ State level responsibilities for Title V rests within the Health Services Deputy Commissioner area. Since 2002, Health Services has been led by Dr. Lisa Waddell and is managed through two Assistant Deputy Commissioner areas: 1) Public Health Services, 2) District and Professional Services, and the Director of Health Services Administration. Implementation and coordination of maternal and child health programs occurs within the Public Health Services area in conjunction with the District and Professional Services area, where the professional discipline offices for nursing, nutrition, social work and health education as well as the thirteen public health districts are located. Financial monitoring of the Title V Block Grant is within Health Services Administration. *//2004//*

The Public Health Services Assistant Deputy Commissioner area now includes six bureaus: 1) Maternal and Child Health, 2) Disease Control, 3) Home Health and Long Term Care, 4) Chronic Disease Prevention and Control 5) Environmental Health, and 6) Epidemiology. All the Bureaus serve maternal and child populations and the Bureau of Maternal and Child Health coordinates with other Bureaus on issues that are broader than a given Bureau area, i.e., HIV/STD (Disease Control); home visits (Home Health); schools (Chronic Disease Prevention and Control); lead poisoning (Environmental Health); and data analysis (Epidemiology).

/2005/ Health Services now has only five Bureaus, the Bureau of Epidemiology was deleted in 2004. //2005//

/2004/ Included in the Appendix are two organizational charts that illustrate the general Agency, Health Services, and Bureau structures. The two charts are: 1) The structure of DHEC from the Governor down to the Bureau level within Health Services; 2) The structure of the MCH Bureau and

its Divisions. //2004//

//2005/ The Bureau of Maternal and Child Health (MCH) has primary responsibility and oversight of Title V programs in the state Sara Balcerek, MSN, was appointed Director in February 2003. Five divisions and one Unit are located within the Bureau. The Divisions are: 1) Women and Children's Services, 2) Children with Special Health Care Needs, 3) Women, Infants and Children (WIC) Services, 4) Perinatal Systems, and 5) Oral Health. The MCH Epidemiology Unit was recently recreated back within the MCH Bureau and is responsible for needs assessment, data, surveillance, and evaluation responsibilities. //2005//

Key Leaders:

Following are brief biographies of key leaders within MCH in DHEC:

//2004/ Sara Balcerek, MSN: Director, Bureau of Maternal and Child Health. Mrs. Balcerek has over 28 years experience with DHEC as a nurse midwife, Director of Family Planning, Director of Maternal Health Services, and most recently, Deputy Commissioner for Health Services.

Linda Price: Director, Division of Children with Special Health Care Needs. Linda Price has over 20 years experience working with maternal and child health programs, in her present position for thirteen years. Previous responsibilities include Acting Bureau Director and Administrator for the Bureau of Maternal and Child Health.

//2005/ Ms. Price retired July 2004. Mr. Kevin Smith, MPH, has been designated as the Interim Director for the CSHCN Division. The Bureau anticipates recruiting and hiring a permanent Director during the early fall of 2004. //2005//

Candace Jones, RD, MPH.: Joined the Bureau in 2002 as Assistant to the Bureau Director and has been assigned the responsibilities of the Title V MCH Block. Candace Jones came to DHEC in 1994 from Georgia where she was the Deputy Director of the Governor's Commission on Health Care. Upon arrival in South Carolina, Candace joined the Bureau of MCH as Director of Community Systems Development. In 1995, Candace became District Health Director of the Lower Savannah Health District. She returned to central office in 1997. She has worked in the WIC program in both Georgia and South Carolina. ***//2005/ Ms. Jones has also been assigned the responsibilities of the SSDI grant and serves as the Project Director for this grant. //2005//***

Sarah Cooper, RN, MN, CS: Director, Division of Women and Children's Services. Sarah Cooper has over 25 years experience with DHEC, with positions at county, district, and state levels. She is the agency team leader for Preventive and Rehabilitative Family Support Services for Primary Care Enhancement, the statewide, interagency program with an interdisciplinary effort to support families through primary care and practice of healthy behaviors.

//2005/ Ms. Cooper is the lead for the new Medicaid managed care product entitled 'Primary Care Case Management (PCCM)' pilot program. //2005//

Janet Sheridan, MA: Director, Family Planning Program. Janet Sheridan has been with DHEC over 20 years. She previously served as Division Administrator, returning to the Division of WCS in 2000 as Family Planning Director. She has a broad background in fiscal operations and contract development and auditing and holds the designation as a Certified Public Manager. Her MA is in Conflict Resolution, and she is called upon frequently to apply her skills both internally and externally.

Burnese Walker, MS, RD: Director, WIC Program. Burnese Walker has over 20 years experience working with WIC programs in two states (Georgia and South Carolina). She has also worked with School Food Services at the SC Department of Education.

Luanne Miles, MSW: Director, Division of Perinatal Services. Luanne Miles has worked with maternal and child health programs at DHEC for the past 9 years. Previously, she worked as a clinical social worker with children and families for 11 years in both private and public health agencies. She is president-elect for the SC Perinatal Association. ***//2005/ Mrs. Miles now has over 10 years***

experience. //2005//

Raymond F. Lala, DDS: State Dental Coordinator. Dr. Lala is a HRSA/MCHB and US Public Health Service Commissioned Corps assignee to South Carolina to strengthen oral health infrastructure within the state. He has extensive experience in dental public health issues related to community fluoridation, sealant programs, oral health surveys, coalitions, clinical experience in both private and public settings, as well as emergency response.

//2005/ Dr. Lala will be assuming another HRSA assignment in August of 2004. The Bureau anticipates interviewing and hiring a new Oral Health Director by the fall of 2004.

Jianli Kan, Dr PH, MPH: MCH Epidemiologist. Dr. Kan joined the MCH Bureau in March 2004. He received his medical degree in China, his masters and doctorate degrees in public health from UCLA. Dr. Kan has over 9 years experience working in MCH Epidemiology positions in both New York City and Michigan State Health Departments. //2005//

Joe Kyle, MPH: Senior Planner. Joe Kyle has been with DHEC since 1997, providing direct oversight of the Health Services Operational Plan implementation and assists the MCH Bureau to integrate MCH goals, outcomes, activities and data with Agency planning processes. Previous experience includes eight years with the Peace Corps in Central America managing development projects and 2 years at a county health department in east Texas.

//2005/ Mr. Kyle has recently been promoted to the Director of Office of Performance Management. //2005//

Other staff playing important roles in partnership with the MCH Bureau:

Robert Carlton, MSW. Director of Youth Development and MCH Adolescent Health Coordinator. Robert Carlton devotes 50 percent of his time to MCH and 50 percent to the Office of Social Work.

Sandra Jeter, LISW. Lead contact for youth suicide prevention and domestic violence, and serves as DHEC's representative on the CDC's Healthy Schools Infrastructure Grant. Sandra Jeter is located in the Bureau of Chronic Disease Prevention and Control.

13 CRS Parent Advisory Council members (one per District) are employed part time (16-20 hours per week).

Staff Resources and Leadership

//2004/A listing of FTE positions (not all are slotted FTEs) within Health Services central office that work with the MCH population is provided below:

Managerial/administrative/budget: 32.3, of which 4.83 are in Administrative Health Services

Administrative Support 18

Program Director/ Manager 15

Nutritionists: 2

Social Workers 1

Health Educator 3 Nurses: 6

Data and Research Managers 14, of which 1 is in Administrative Health Services

Total: 91.3, of which 5.83 are in Administrative Health Services. //2004//

//2005/ A listing of FTE positions (not all are slotted FTEs) within Health Services central office that work with the MCH population is provided below:

Managerial/administrative/budget: 45.38

Administrative Support: 22

Program Director/ Manager: 11

Nutritionists: 3
Social Workers: 2
Health Educators: 2.8
Nurses: 6.45
Data and Research Managers: 10.93

Total: 103.56 //2005//

D. OTHER MCH CAPACITY

/2005/ Bureau of Chronic Disease Prevention and Health Promotion

This Bureau deals with a variety of chronic diseases and health risks that affect the citizens and communities within SC, in particularly women. Areas of primary prevention emphasis include:

Office of Healthy Schools

This Office serves as the focal point within DHEC's Health Services Deputy area for coordinated school health and maintains a strong collaborative partnership with the State Department of Education (SDE), the MCH Bureau, as well as other bureau areas within Health Services. The Program uses an approach that focuses on building capacity and infrastructure that leads to an established collaborative organizational pattern through ongoing communication, coordination and collaboration and cooperation within SC DHEC, between the SDE, other state, regional and local agencies interested in the health and academic success of our children.

The Office promotes a coordinated school health model that addresses risk behaviors in children and youth and is framed around the interrelated components of health education; physical education; nutrition; guidance, psychological counseling, and social services; a healthy school environment; staff wellness; and family and community involvement. This approach is vital if we want to effectively improve the lives of children and reduce the prevalence of chronic disease and disability for the citizens of our state.

Division of Injury Prevention

The focus of this Division is to prevent and reduce the occurrence of injuries and disabilities that impact upon the quality of life of all citizens of SC. Coordination of DHEC Injury and Violence Prevention (IVP) activities and the development of partnerships with state and local agencies and organizations that are essential for achieving this mission are major activities carried out in the Division. Programs include: 1) Child Passenger Safety Program 2) Traumatic Brain Injury Surveillance (TBI) 3) Residential Fire Injury Prevention Program 4) State Child Fatality Advisory Committee. 5) Disabilities and Health Initiative 6) South Carolina Violent Death Reporting System (related to mothers).

Division of Cancer Prevention and Control

The SC Breast and Cervical Cancer Early Detection Program/Best Chance Network (BCN) provides comprehensive screening and follow-up services at no-cost to eligible women (age 47-64, uninsured or have hospitalization coverage only, below 200% of federal poverty level) through contracts with over 200 private physicians, federally-funded community health care centers, hospitals, laboratories, and radiology centers to deliver these services. In addition, the SCDHEC maintains oversight of the overall program administration and management, quality assurance, case management, data management, surveillance. The BCN entered into a unique public/private partnership with the American Cancer Society (ACS), South-Atlantic Division. ACS is responsible for public education (recruitment) and professional education,

and provider service coordination in South Carolina. The BCN has initiated strategies to build infrastructure to support services to Hispanic & physically disabled women. The Division staffs and coordinates the Cancer Control Advisory Committee, consisting of cancer experts, appointed by DHEC's Commissioner, that advises the DHEC Board and staff on professional and programmatic issues pertaining to cancer prevention, care, and surveillance. The SC Cancer Alliance, staffed by the Division, is a registered non-profit organization, with 700 members to date, that addresses the burden of cancer in the state through five key sectors: Research, Prevention, Early Detection, Patient Care, and Advocacy/Policy. The rising treatment costs, coupled with level annual allocations, has irreversibly diluted the ability of the State Aid Program to address the needs of our citizens, resulting in the ending of this program. The Division also collaborates in a CDC-funded research project in partnership with the University of South Carolina Prevention Research Center. The purpose is to investigate why some women with abnormal Pap tests within the BCN do not obtain follow-up care in a timely manner, and what differences exist in follow-up care between African-American and European-American participants.

Division of Cardiovascular Health (CVH)

The Division of Cardiovascular Health's mission is to prevent and reduce heart disease and stroke in South Carolina through the development and promotion of policy and environmental changes. The division, in collaboration with its partners, is implementing a plan of action to address the challenges of this disease. The plan includes a variety of activities that support efforts to: (1) Promote healthy behaviors among all South Carolinians to prevent or reduce cardiovascular diseases (CVD)-with a focus on reducing health disparities, (2) promote early detection, treatment and control of risk factors for CVD (high blood pressure, high cholesterol, obesity and diabetes) and the early detection of CVD and (3) promote early and aggressive treatment of CVD.

Division of Diabetes Prevention and Control

Working collaboratively with partners to maintain a statewide structure to support diabetes prevention and control is the mission of this division. The primary goal of the division is to reduce health disparities among high-risk and disproportionately affected populations, i.e., African Americans, Hispanics, elderly, the underinsured and uninsured, etc. The division uses a three- (3) pronged approach to include: 1) monitoring the burden of diabetes through a statewide surveillance system, providing ongoing epidemiological information and surveillance of medical costs, and determining the impact of diabetes and its complications, 2) working to improve access to quality care in office-based practices in medically underserved areas, and 3) mobilizing communities through coalition building and programs such as Diabetes 101 to strengthen their ability to promote awareness, decrease risk reduction behavior, and seek early detection.

Division of Obesity/Physical Activity and Nutrition

This division is charged with increasing state capacity to address obesity by establishing a statewide partnership comprised of public and private partners. The partnership will develop a comprehensive strategic plan to maximize resources, coordinate efforts, and evaluate efforts primarily focused on policy and environmental supports. Nutrition and Physical Activity State level consultants closely support these activities through staffing of various committee and work groups, (e.g., the SC Governor's Council on Physical Fitness), providing ongoing consultation and technical assistance to local health department staff, working with state-wide partners, and coordinating special programmatic efforts, such as: Walk to School events, the Governor's Conference on Physical Activity, and the " Five a Day" program.

Division of Tobacco Use Prevention

This division focuses on reducing the incidence and prevalence of tobacco use among youth and adults through policy and environmental change, and providing resources to a network of community based coalitions and organizations. These coalitions and organizations provide services to address tobacco use in a variety of community settings, including schools, work

sites, health care facilities, places of worship, media and other community environments. Division staff continue to provide training, consultation, and technical assistance to organizations to promote tobacco control. The division's partners include the SC Tobacco Collaborative, local tobacco coalitions, the SC Departments of Education and Alcohol and Other Drug Abuse Services, and the SC African-American Tobacco Control Network. The division's public health media efforts include the Rage Against the Haze campaign, a social marketing effort targeting adolescents. Key components of this effort include an inter-active web-based recruitment, peer education through specialized training curricula, and localized youth-lead programming.

Division of STD/HIV

This Division provides services to prevent the spread of sexually transmitted diseases (STDs) and HIV infection and to provide care and support resources for persons with HIV disease. Prevention services are provided by state and local health departments and through contracts with community based organizations. Services are targeted to persons at increased risk for STDs and HIV infection.

African American women account for a steadily increasing proportion of HIV disease in South Carolina, representing 30% of new cases diagnosed in 2003 (verses 20% in 1990). This impacts our children: more than 8 of every 10 babies/children who are infected with HIV from their mothers are African American. One of our greatest successes in HIV prevention is reducing mother to baby transmission. MCH, STD/HIV and other program staff collaborate closely to offer provider education, training and joint services. Routine screening of pregnant women and treatment for those infected continues to confine the proportion of infants born to HIV infected mothers who become infected to 3% in 2001 and 2002, compared to 14% in 1994. Women are being screened and diagnosed earlier for HIV, with 100% before or during pregnancy in the past 2 years, compared to 77% in 2004. In 2004, DHEC plans to participate in a CDC assessment of prenatal screening practices through medical chart review in eligible birthing hospitals to determine the proportion of pregnant women/infants receiving screening for HIV, syphilis, chlamydia, hepatitis B, Group B Streptococcus and rubella.

Division of Immunization

The mission of this Division is to promote the prevention of vaccine-preventable diseases in the state's population through the management of immunization programs and initiatives. It implements its efforts through the following programs: 1) Childhood Immunization Program, 2) Perinatal Hepatitis B Program, 3) Adult Immunization Program, and 4) International Travel, Rabies Post-exposure prophylaxis, Outbreak control, and Health Care Worker Immunization Programs. Examples of the Division's specific goals are: 1) Maintain vaccination coverage levels (DTaP, MMR, and Polio) at 95% for children in licensed day care facilities and children in kindergarten through first grade. Vaccination coverage levels for universally recommended vaccines among preschool children are maintained at 90 percent. 2) Reduce Vaccine-Preventable Disease and maintain an active surveillance system. 3) Systematically document, monitor, and report all adverse events following immunization, and 4) Promote, and train providers on compliance.

Other MCH Capacity Discontinued

Over the past few years, the Agency has discontinued programs/services/contracts due to decreased resources or policy changes. These discontinued changes are listed below by year: SFY 2004

1) State-Aid Cancer program, June 2004. //2005//

E. STATE AGENCY COORDINATION

The Department of Health and Environmental Control (DHEC) is a separate state agency from the

Medicaid Agency, Department of Health and Human Services (DHHS), which is a cabinet agency of the Governor. As with the rest of the nation, the relationship between Title V and Medicaid continues to evolve. The relationship has been changing at two levels. At the commissioner's level and using task forces, we have worked together to: 1) recruit health care providers 2) improve reimbursement procedures 3) improve reimbursement options for providers by developing incentives for providing medical homes 4) improving EPSDT 5) expand covered services 6) increase eligibility (most recently via SCHIP) 7) change the image of Medicaid to providers and patients; and 8) develop systems of care.

The SC Medicaid agency initially piloted four PEP (Physician Enhanced Program) initiatives to offer partially capitated services through local pediatric and family practices. Evaluation indicates satisfaction of providers and clients, improved immunization rates, higher EPSDT show rates for appointments, and fewer ER visits*. DHEC provides upon referral, Family Support Services to assist the clients/families in appropriate utilization of primary care and in healthy lifestyles practices. *A study was conducted using all Medicaid claims from 1995-1998, and updated in 1999, for children 1-3 years old. Children in partnership practices were significantly more likely to have had primary care visits and less likely to rely on the emergency room than children in non-partnership practices.

The first Medicaid HMO started taking patients in South Carolina in December 1996. This HMO, Select Health of South Carolina, is still the only Medicaid HMO in the state. They continue to contract with the health department to provide home health services, the postpartum/newborn home visit, family support services, and services to CSHCN Family Support Services (FSS) continue to be a main focus of these core personal preventive services provided to individuals and families. In 2000, we hired a Training Development Director for FSS who has designed a very comprehensive training package, complete with learning modules, exercises, etc. This training has been implemented as a train-the-trainer initiative and is now expanded to include ongoing follow-up through regional trainings with the goal of fully preparing front-line providers in client engagement/assessment, and goal development.

//2004/ In FY 2002, an outcome study was conducted statewide to look at the impact of Family Support Services. The study observed that by the time of closure to FSS, 97% of clients were linked to a medical home and over 84% had achieved or partially achieved success on identified behavioral goals. This year, a customer service survey was conducted of FSS demonstrating that over 90% of the clients who received FSS were very satisfied with the services received. FSS training is ongoing with the June 2003 class being the largest to date. //2004//

//2005/ The Medicaid agency has implemented Managed Care through several products, Disease Management, Health Maintenance Organizations and starting in the fall 2004, a new product entitled 'Primary Care Case Management (PCCM)' in three upstate counties, Anderson, Oconee, and Pickens. The health departments in these counties and the central office are working within and with Medicaid staff to develop the public health role in this product. //2005//

The following represents a summary of the Medicaid contracts, amendment contracts, and other Memoranda of Agreements between DHEC and DHHS.

1) Medicaid Mega Contract (MCH Bureau): DHEC and DHHS continue activities in support of the Medicaid State Plan covered in the Medicaid Mega Contract. Clinical and administrative services are covered and a detailed management plan is monitored on a quarterly basis to ensure progress. The activities of this contract are categorized into four goals:

Goal 1: To increase provision of Medical assistance to Medicaid eligible individuals and potential eligibles including reproductive aged women at or below 185 percent of poverty, infants at or below 185 percent of poverty, children at or below 150 percent of poverty and or children with special health care needs. The first objective under this goal

includes recruitment activities to identify potential eligibles and assist them in becoming eligible for the most appropriate program. All DHEC staff are involved in this effort including outreach workers formally called Family Planning outreach workers. A second objective under Goal 1, in addition to the recruitment activity, is to assist special needs children in the appropriate use of Medicaid services available to them. These objectives are being revised presently to focus recruitment on the Family Planning population and on CSHCN. For children, the primary goal at this time is directed toward improved utilization.

/2004/ Since the Spring of 2002 and throughout 2003, the activities of this goal have been in revision. The DHHS changed the management plan for this goal to move toward enhancing utilization of services by those children already on Medicaid. Priority was put on the Family Planning population for recruitment. //2004//

Goal 2: To assist the Medicaid State Plan in recruiting providers to serve Medicaid recipients. This goal goes hand-in hand with DHEC's desire to promote public/private partnerships to assure medical homes for Medicaid recipients and includes the training of nurses in the private sector in the provision of EPSDT clinical services.

/2004/ As previously stated, budget cuts have negatively impacted on partnerships. In addition, the Medicaid agency has been re-structured several times and joint training, recruitment efforts; ongoing reports to measure success have been put on hold due to staffing changes and shortages at the Medicaid Agency. //2004//

Goal 3: To improve birth outcomes for Medicaid eligible women and infants. The objectives of this goal are carried out through the regional perinatal contracts with the perinatal centers including referral and transport.

/2004/ The management plan for this goal remains unchanged and is important as it provides resources to continue the perinatal regionalization program in SC. //2004//

/2005/ The Caring For Tomorrow's Children Program has been added as a component of this goal. //2005//

Goal 4: To improve health outcomes of Medicaid eligible populations with special health care needs. Activities include the development of a coordinated tertiary hospital/local Medicaid health care service system that targets CSHCN. A second objective includes the development of a comprehensive implementation plan to establish a regional system of care for Medicaid eligible individuals with Sickle Cell Disease.

2) Family Support Services (Across Bureaus): This contract was developed in 1995 in response to the desire to work in partnership with private providers to promote the medical home concept. It is a fee for service contract to provide Family Support Services to the existing Medicaid eligible population, including pregnant women, infants, children, and CSHCN. This contract gives all health districts the opportunity to provide evaluation of the need for FSS, including nursing, social work, psychosocial, nutrition and education services (including treatment and follow-up as needed), to assist families in the appropriate use of primary care and the practice of healthy behaviors. This allows DHEC to provide services to a greater population than is possible with the current population-specific contracts. Districts continue to provide FSS for all populations and for all programs. As noted, FSS has been enhanced through the addition of a comprehensive training program. These services provide an excellent resource to our partnerships with medical providers as they complement and enhance their provision of clinical services.

/2005/ 3) Perinatal Regionalization- these activities are part of the Medicaid Mega Contract and are redundant. Therefore, this section was deleted in 2005. //2005//

4) Clinical and Family Planning Services (Division of WCS): Contract which includes all clinical services for Maternity Care, Family Planning, Family Support Services and the Postpartum Newborn Home Visit.

5) Children's Rehabilitative, Clinical and Care Coordination Services (Division of CSHCN): Provides

medical services to pediatric patients in the CRS or Children's Health clinics, nutrition, psychosocial services, care giver training, and coordination of services for special needs children through CRS and FSS. Occupational and physical therapy, audiology and speech therapy services are also provided through CRS.

6) Purchase and Provision of Hearing Aids and Accessories (Division of CSHCN): Provides for the purchase and provision of hearing aids, hearing aid accessories and coordination of hearing aid repairs for Medicaid eligible children and recipients who are 21 years of age and over and who participate in the DDSN waiver program.

7) Administration and Provision of Orthodontic Services (Division of CSHCN): Provides for the provision and administration of orthodontia services to eligible individuals under the age of 21 who have qualified under the CRS program criteria.

8) High Risk Channeling Project (Division of WCS): Was discontinued as a requirement in 2001. Now, risk screening and risk appropriate care and delivery will be considered best practice without the benefit of a waiver. FSS will continue to be covered based on risks identified.

9) EPSDT Outreach (Division of WCS): An administrative contract to cover outreach services. Focus is on providing medical education relative to the importance of EPSDT, periodic visits, immunizations, etc., to the newly eligible population.

//2005/ This contract was terminated December 2003. These activities have been incorporated into FSS. //2005//

10) Child Health Maintenance (Division of WCS): An administrative contract to provide training for nurses in private or other public provider settings to perform EPSDT appraisals, and as a part of the Mega Contract.

//2004/ All of these classes have been cancelled in the past year due to lack of participation. //2004//

11) MOA for Provision of State Matching funds for Therapeutic Services/Alpha-feto-protein (AFP) tests (Division of CSHCN): Provides state matching funds for physical therapy, occupational therapy, speech therapy, and audiology services to Medicaid eligible individuals sponsored by CRS and BabyNet. Additionally, this MOA provides state match for the increased reimbursement rate for AFP tests.

12) MOA for Provision of State Matching funds for persons with Sickle Cell Disease/Trait and Enhanced Genetic Services (Division of CSHCN): Provides state matching funds for family planning, genetic education and case management services to Medicaid eligible persons with sickle cell disease/trait and enhanced genetic services provided by genetic centers.

DHEC has been working in various ways to partner with the private medical sector in the provision of MCH health services. With the large indigent health service need, it is not possible for federally funded health centers, public hospitals, and the health department to meet all of the need. Based on this, previous Public Health Commissioners Mike Jarrett and Doug Bryant, worked to change the image of the health department from the provider of indigent medical services, to one of participant in a private/public partnership to complement with Family Support Services the medical services provided. To accomplish this change, the agency has had multiple interagency task forces (Obstetrical Task Force, Newborn-Infant Task Force, the State and Regional Perinatal Boards, and a Pediatric

Advisory group), met with state level provider groups, met with local medical groups and community groups, and based on input, modified service operations based on community need. The current DHEC Commissioner, Earl Hunter, chairs the OB Task Force and the Pediatric Advisory Committee, and the Director of DHHS has a Family Practice Advisory Board where DHEC is represented. The agency currently has the following types of relationships with providers and hospitals: 1) contracting for physician services in the health department clinic and/or in their office to provide primary care; 2) contracting for hospital services; 3) contracting along with a hospital for another health agency to

provide services; 4) as an access point to enter prenatal care by being screened and referred to the private sector; 5) out stationing of health department staff in provider's offices who provide case management services, nutrition, social work and health education services, after hours call, home visiting, preventive health services (immunizations, well child assessments such as EPSDT), outreach and anticipatory guidance, and; 6) other special arrangements, such as the medical home project for special needs children.

A pilot project is being developed between DHEC and DHHS to address environmental factors that negatively affect children's health in South Carolina. This pilot is being developed at the request of the Department of CMS in Washington. The environmental factors to be addressed include asthma and asthma triggers, second hand smoke, lead exposure/poisoning and unsafe drinking water and unsanitary sewage disposal.

/2004/This pilot project has been temporarily placed on hold by the Medicaid Agency. Many of the activities developed within this initiative can be incorporated into the provision of FSS. //2004//

Key Resources/Groups Influencing the Provision of MCH Services

Multiple groups affect the provision of MCH Services. The DHEC Commissioner has promoted the building of partnerships between agencies and between private and public sectors as one of the most important initiatives to improve services. This attitude has spread among most groups and agencies providing health services statewide.

The Maternal, Infant, and Child Health (MICH) Council was established by the SC Legislature in 1986 to improve the health status of pregnant women, infants and children. This Council was disbanded in 2001 due to state fiscal constraints. The Council's work continues in small community workgroups and no longer provides a unified statewide presence. Within the private sector, the SC Medical Association (SCMA), the SC Hospital Association (SCHA), the Alliance for SC's Children, Family Connections, as well as the Children's Hospital Collaborative have all been strong partners for promoting improvements in the provision of MCH services.

/2004/ The SC Dental Association and the SC Dental Hygiene Association have become strong partners in the past year. //2004//

The Bureau of MCH, Health Services and all of DHEC, have consistently worked with related federal and state programs to coordinate services for mothers, infants and children. Coordination takes place in various ways, including: administration, planning and policy development, service provision, funding, and evaluation. Public Health levels of infrastructure include statewide, health district, county, service delivery site, and individual patients.

The Bureau of MCH and other Bureaus within Health Services have a strong working relationship with various state agencies. Efforts are underway to improve organizational structures, data systems, and client services through a number of efforts initiated through DHEC and these agencies. Several grant programs, such as SSDI, support an improved framework for service integration. Examples of the plans and activities are:

/2004/ Community and Migrant Health Centers: These two offices are both located within Health Services, and provide an opportunity for direct coordination on specific programs and issues as needed. Where possible, Health Services and Health District staff plan services at the local level with federally funded health centers for both preventive and primary care for pregnant women, infants and children. In addition, Health Services reviews and supports perinatal plans for federally funded health centers. Since 2000, SC has increased from three to seven of our twenty centers having an oral health component. Coordination of service provision varies across centers. //2004//

SC Department of Alcohol and Other Drug Abuse Services (DAODAS): DAODAS is a separate state agency. Coordination of activities takes place on specific issues and/or by program as needed.

SC Department of Disabilities and Special Needs (DDSN): The Division of CSHCN, including

BabyNet, works very closely with DDSN in the coordination of care for children eligible for their respective programs. DDSN has worked closely in the development of the delivery system for infants and toddlers with developmental delays and their families. They are an essential partner in the area of care coordination for children with special needs.

Healthy Start: All three Healthy Start projects functioning in the state have received continued funding. These are:

1. Pee Dee Healthy Start, Inc. This project is the successor to the earlier Pee Dee Healthy Start Project sponsored through the SC United Way. The project is now managed through a consortium with 501.c.3. nonprofit organizational status. Project activities focus on rural outreach with the service area being comprised of Chesterfield, Darlington, Dillon, Marlboro, Marion and Williamsburg counties.
2. Palmetto Healthy Start. This consortium is led by Palmetto Health Alliance (Richland Memorial Hospital). Members of the collaborative include Community Health Partners, Eau Claire Cooperative Health, Richland Community Health Care Association, Inc., Benedict College, the March of Dimes, Richland County Health Department and Richland County Department of Social Services. The project goal is to reduce infant mortality and improve the well being of women, infants, children and families in Richland and Fairfield Counties.
3. Low Country Healthy Start. This project, administered through the SC State Office of Rural Health, is a community-based effort that aims to improve infant mortality and improve pregnancy outcomes in Allendale, Bamberg, Hampton and Orangeburg, all predominantly rural counties. This project has utilized contracts with existing agencies as a primary means of expanding and strengthening resources.

/2004/ The MCH Bureau Director, Sara Balcerek, has initiated regular meetings with the Healthy Start Directors to share information and collaborate on common goals. //2004//

State Child Care and Development Block Grant (CCDBG): SC's Child Care and Development Block Grant are administered through the Bureau of Community Services at the DHHS. The Bureau works closely within DHHS in assuring that assistance is available for low-income families and that plans are developed that assure safe, affordable day care in all areas of the state. DHHS coordinates the delivery of Child Care Development Funds (CCDF) funded childcare services with the SC Department of Social Services (DSS) for children receiving child protective services and children in foster care. In November 2000, DHHS increased the fee scale from 125% to 150% of poverty based on family size to allow clients to receive services and pay minimum co-pay.

/2004/ DHEC no longer has a Healthy Systems Development in Child Care Grant nor the nurse consultant who was providing these services. //2004//

Department of Education (DOE): /2004/ The Division of Women and Children's Services provides consultation to the Department, school nurses, and the Division of Adolescent and School Health in the local school districts. Implementation of programs in the Bureau of Maternal and Child Health, including Women and Children's Services and Children with Special Health Care Needs, involves interface with the DOE. At the state level, interaction primarily involves implementation of five initiatives: 1) School Nurse Program 2) Title V Designation of Schools 3) BabyNet 4) EPSDT Training 5) SC Healthy Schools Project. Please refer back to other sections of the narrative for details. //2004//

Pediatric Emergency Medical System (EMS): Pediatric EMS is coordinated statewide by the Deputy Commissioner area of Health Regulations. Various MCH Divisions work on EMS issues including: maternal and infant transport, local community transportation assessment tool, protocol development, and injury surveillance. Currently, the Division

Director for CSHCN participates in planning through the EMS Advisory Committee. CSHCN staff has also worked closely with EMS staff and tertiary emergency room physicians to develop a portable emergency plan of care for CSHCN.

Standing Advisory Councils/Committees/Task Forces:

Various Standing Advisory Councils/Committees and Task Forces exist in the state; through which planning and interagency work is accomplished to meet the needs of mothers and children in South Carolina. The attached file contains committee examples. NOTE: This list is representative, not

complete.

F. HEALTH SYSTEMS CAPACITY INDICATORS

HSCI 1. The rate of children hospitalized for asthma (ICD-9 codes: 493.0-493.9) per 10,000 children less than five years of age.

/2005/ The 2003 rate of children hospitalized for asthma was 72.3, the third year in a row of increases, 61.5 in 2002 and 58.9 in 2001. During 2003, a new joint initiative between staff from Health Services, Environmental Health, and Environmental Quality and Control of DHEC, Medicaid, and private physicians began a targeted initiative toward children suffering with asthma. The initiative's components included an assessment of the family home environment, participatory guidance concerning environmental triggers and how to decrease their impact, as well as instructions on how to manage asthma preventively. Unfortunately, in 2003, this pilot project was placed on hold by the Medicaid Agency. Many of the activities developed within this initiative were incorporated into the provision of FSS. //2005//

HSCI 2. The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

/2005/ 76.4 percent of Medicaid enrollees less than one year of age received at least one initial periodic screen in 2003. This percentage has been decreasing for the past four years, 77.3 in 2002, 78.2 in 2001, and 78.8 in 2000. Factors that have influenced this percentage are the decreased numbers of children enrolled in Partners for Healthy Children (insurance coverage through regular Medicaid and SCHIP Medicaid expansion), active redetermination process for Medicaid and SCHIP Medicaid, less public health staff and services, and fewer public health partnerships with private physician offices. It is concerning that without some prioritization and re-direction of effort; the participation in well childcare by children will continue to decrease. //2005//

HSCI 3. The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

/2005/ In 2000, 78.3% of SCHIP enrollees less than one year of age received at least one initial periodic screen. Unfortunately, there is no new data for 2001 or 2002 from Medicaid. Only recently has the Medicaid agency been able to differentiate between regular Medicaid and SCHIP enrollees to report separate enrollment and service figures. The state SCHIP program is a Medicaid expansion in our state. Due to the budget shortfalls, the Medicaid agency has implemented an active redetermination process for children and families, co-pays for services (MCH services exempt); and developed over thirty possible actions that could be implemented in the future if the budget is less than necessary to fund current services. //2005//

HSCI 4. The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

/2005/ During 2002, this percentage increased slightly to 84.9 percent of women (15-44) with a live birth having had expected prenatal visits 80 percent or greater. This percentage had been steadily increasing slightly since 1999 (81.3%), 2000 (81.4%), 2001 (83.7%). //2005//

HSCI 5. Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the state.

/2005/ The state is very fortunate in that the MCH Bureau has a wonderful relationship with our vital records office, the state Office of Research and Statistics (ORS), and DHHS (Medicaid Agency). ORS has the legislative responsibility to "host" all state data. DHEC, ORS and DHHS

have a 3-way Memorandum of Agreement (MOA) to share and link data on a request and approval basis of all three agencies. MCH and ORS have a second data sharing MOA that allows the sharing and linking of MCH data with other data by request and approval by ORS.

Comparing the health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations reveals that for 2002, the health status indicators for the Medicaid MCH population are less favorable than the non-Medicaid or all populations. An increased percentage of Medicaid infants are born with a low birth weight (2,500 grams), 11.4 percent verses 8.3 percent for non-Medicaid and 10 percent for all; less infants are born to pregnant women who receive prenatal care beginning in the first trimester, 71.4 percent for Medicaid verses 91.5 percent for non-Medicaid and 80.3 percent for all; and fewer pregnant Medicaid women receive adequate prenatal care as measured by the Kotelchuck Index, 56.4 percent Medicaid verses 94.5 percent for non-Medicaid, and 76 percent for all.

Unfortunately, we were not able to obtain the specific infant death rate for Medicaid and non-Medicaid for 2002. //2005//

HSCI 6. The percent of poverty level for eligibility in the State's Medicaid and S-CHIP programs for infants (0-1), children, and pregnant women.

//2005/ South Carolina's S-CHIP program is a Medicaid expansion. Over the past several years, the state has experienced declining revenues and budgets. This has prevented the state from identifying sufficient state dollars to designate as state match in order to "draw down" federal dollars for Medicaid and/or S-CHIP Medicaid eligibility expansions. The state's Medicaid and S-CHIP Medicaid eligibility for pregnant women and infants remains at 185 % of the federal poverty level (FPL). For children, FPL remains at 150 % even though, in 2000, an expansion was legislatively approved at 165% FPL. At the current time, the state has not maximized its Medicaid or S-CHIP expansion opportunities due to state budgetary constraints. Lastly, the state has not decided to change the SCHIP definition of child to include the interval from conception, therefore missing the opportunity to provide prenatal care to women and their developing infant as early as possible. However, a task force was recently created in the spring of 2004 to discuss and make recommendations concerning the increasing number of undocumented immigrant women who do not have insurance coverage for prenatal care. //2005//

HSCI 7. The percent of EPSDT eligible children aged 6 through 9 who have received any dental services during the year.

//2005/ 55.9 percent of EPSDT eligible children aged 6-9 received any dental services in 2003, an increase from 51.4 in 2002. The Oral Health Division has made great strides in the past year through partnering with the Medicaid agency, private dentists, private dental hygienists, the State Dental School at MUSC, and schools to increase the number of providers, number of children receiving dental services, Medicaid reimbursement rate, and the level of understanding of parents as to the importance of early and preventive oral health services. //2005//

HSCI 8. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs Program.

//2005/ In 2003, the percent of State SSI beneficiaries who received a service from the CRS program decreased to 20.4 from 23.7. This percentage has been decreasing steadily since 2000. Recipients of SSI are referred to BabyNet, Commission for the Blind, Department of Disabilities and Special Needs, Department of Mental Health, DHEC CRS Program, Family Support Services, State Cancer Program and the Ryan White Program. //2005//

HSCI 9A. The ability of States to assure that the Maternal and Child Health program and Title V

agency have access to policy and program relevant information and data.

/2005/ The state MCH staff have developed strong relationships with our state office of vital records and our State Office of Research and Statistics to assist us in ensuring that we have access to relevant information and data. They have recently assisted the Bureau by "cleaning, unduplicating, deidentifying, linking, and matching" our MCH data with other MCH, vital records, and Medicaid data. This process resulted in identifying the WIC data set as being the most complete with the other data sets (Family Planning, Child Health, Immunization) being identified as incomplete and not worthy of linking with other data. Therefore, the linking of MCH data sets across programs is not feasible at this time. The Bureau will reexamine the linking of MCH programmatic data sets after the new automated client data system the Agency is developing.

Several advancements in 2004 will increase the state and Agency data collection and linkage capacity. In January 2004, the state implemented an electronic birth certificate, and during the fall of 2004, the state will implement a new electronic lab data system. These two electronic systems will enable the state to link birth certificates to WIC and to newborn screening. Also, the 2004 state legislature passed legislation to develop and establish a birth defects surveillance system. Implementation planning is beginning for this new system, including seeking funds to support this new program. //2005//

HSCI 9B. The ability of states to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

/2005/ The State Department of Education conducts the YRBS every two years with the 2003 being the most recent year of the survey. The state does not participate every year. MCH has access to this data, however, 2003 data is not available yet. In addition, the SC Tobacco Control Program staff Epidemiologist will be conducting the Youth Tobacco Survey (YTS), which will measure tobacco use behavior among both high school and middle school students. The Oral Health Division is providing data entry services for this project in exchange for the insertion of oral health questions in future surveys. Data for this study is also not available yet. //2005//

HSCI 9C. The ability of States to determine the percent of children who are obese or overweight.

/2005/ The state participates in and has access to health data from the CDC Pediatric Nutrition Surveillance (PedNS) data system. This data set is composed of WIC data only, no other child health or EPSDT data is included. Therefore, this data will only be reflective of a sub-population of the children in our state. //2005//

Note: the info in the following tables is new. It is in a different format because the tables come from the web based application.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The state has identified the MCH public health needs by the levels of the MCH pyramid and they are discussed below. The MCH pyramid is included in the attached file.

Direct Health Care Services

The greatest needs under direct health care services are related to 1) need for increased funding for insurance coverage, and 2) increased number of health care providers to deliver services.

In 2000, the state Legislature approved expansion of income eligibility for the state SCHIP program for children to 165% of the federal poverty level (FPL). This expansion has been postponed because of state budget cutbacks, and remains at 150% of the FPL. The number of families with no health insurance coverage decreased in 2001 due to increased enrollment in Medicaid and the Medicaid expansion through SCHIP. Payment for services for Hispanics whose undocumented status makes them ineligible for Medicaid is an increasing drain on health department resources.

More providers of primary, specialty, and sub-specialty care are needed. The Medicaid program intends to address state budget cutbacks in part by reducing reimbursement to all physicians, a decision that will make recruiting providers for private/public partnerships even more difficult. Rural areas are especially in need of health care providers of all types.

//2005/ The percentage of families and children with out health insurance decreased dramatically in 2002 to 6.9 from 9.9 in 2001 due to the Medicaid expansion through SHCIP. The Medicaid agency has developed a list of over thirty possible actions that could be implemented if program costs continue to increase and the budget does not.//2005//

Enabling Services

Provision of family support services (FSS) through local public/private partnerships has great priority. Staffing of public health nurses, social workers, health educators and dieticians to work with families and patients in both home and community settings must be maintained. The goal of linking all children to medical homes promotes access to primary care as well as helps to decrease disparities in the health status of children of minority races and populations.

Population-Based Services

Population-based services in SC focus on 1) preventive health care programs and 2) educational efforts. Maintaining funding and resources in a climate of budget cutbacks has high priority, i.e., immunizations, newborn home visits, and school health nurses. In addition, addressing priority health issues that greatly affect mortality and morbidity in the total population include:

- Poor nutrition and obesity. The nutritional status of women, infants, children, and youth needs improvement.
- Injuries. Injury rates, especially for motor vehicle crashes, should be monitored to identify problem areas in the state.
- Substance abuse. Efforts to reduce the prevalence of drug and alcohol use, including smoking and smokeless tobacco, especially among adolescents, are needed.
- Unintended pregnancy. A long-standing issue that is often negatively associated with birth outcomes, perinatal health, school readiness, food security and general well being, needs continued focus.

Infrastructure Development

Public health infrastructure must be strengthened in South Carolina. A strong infrastructure is critical in carrying out essential public health services. Public health systems must include state and local public health organizations working in partnership with private entities to assure the public receives essential health services. Much more coordination and collaboration among agencies, public and private service providers, and organizations is needed. Strengthening links between these separate entities will promote better program planning and evaluation, policy development, monitoring and

quality assurance, as well as better health services delivery for all.

B. STATE PRIORITIES

/2004/The monetary, service provider, manpower, health system, and infrastructure needs identified in the five year Comprehensive Needs Assessment detailed in the FFY 2001 application remain very relevant in 2004. The ten state priority needs determined from the five-year Comprehensive Needs Assessment described in the FFY 2001 application have been revised for FFY 2004. Priorities relate to a) preventive and primary care services for pregnant women, mothers, and infants; b) preventive and primary care services for children; and c) services for children with special health care needs. These priority needs are also included on Form 14. //2004//

- Increase access to quality risk appropriate care for women, infants, and children, including CSHCN.
- Improve the nutritional status of women, infants, and children, including CSHCN.
- Increase access to preconceptional and interconceptional care.
- Reduce preventable injuries in the state among the MCH populations.
- Increase access for women, infants, and children, including CSHCN, to enabling, family support services.
- Decrease the use of illegal and legal substances among the MCH populations.
- Increase access to newborn home visits.
- Reduce the percent of births reported to be unintended.
- Improve the quality and availability of health and health education services in school settings.
- Ensure there is a transitional program in place statewide for CSHCN, for those children aging out of the program.

/2005/South Carolina made progress on some of the 18 core and 7 state performance measures this last year. Following is a description of that effort. Explanations are provided for those measures where improvement is needed, as well as those measures that did not have data currently available to measure. Please refer to the Data Forms for specific five-year projections with year-to-year goals for each performance measure for the next five years. //2005//

/2005/ The State Priorities have not been changed for 2005//

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

South Carolina estimates that 99 percent of all newborns are screened for each test based on the number of annual state births. The inability to link State Laboratory newborn blood screening tests with vital records data is the reason this data is an estimate.

b. Current Activities

The state is aware of this limitation and will be implementing a new laboratory data system and an expansion of the newborn screening test panel in the fall of 2004. The new system will enable the linkage of newborn screening data to vital records. Therefore, in the future, we will be able to accurately report this number and not use an estimate.

c. Plan for the Coming Year

This fall, the state will implement the expansion of the newborn screening panel and the new laboratory data system.

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

a. Last Year's Accomplishments

This is a quality assurance measure for the CRS Program; data from CRS record audits are used for this measure, not national SLAITS data. Programmatic data indicates that 83.6 percent of families with special health care needs age 0-18 partnered in decision making at all levels and are satisfied with services they received.

b. Current Activities

CRS records are audited every quarter for assurance of this measure. This is also a measure for the annual CRS Program Assessment that each CRS Coordinator must complete. The program developed, with families, a Comprehensive Assessment and Treatment Plan, that must be completed with and given to families. Parents participate in decision making for the CRS Program through the Parent Advisory Council and various committees. Parents are employed as team members in all 12 public health districts. The Parent Advisory Council publishes a newsletter for families with a circulation of 4000.

c. Plan for the Coming Year

The program will maintain current efforts and is also engaged in developing a parent/consumer survey with the CSHCN Interagency Data Warehouse.

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

a. Last Year's Accomplishments

The state prefers to use data from the CSHCN Data Warehouse for this measure. The last data we have is for 2002. During 2002, a slight drop occurred as only 88.2 percent of Children with Special Health Care Needs (CSHCN) in the State had a medical/health home. The state did not meet the target of 95 percent. This is largely due to attempting to establish the base number of CSHCN in the State and a methodology to define what constitutes a medical home.

b. Current Activities

SC is collaborating with the Office of Research and Statistics, Budget and Control Board (the organization that houses the CSHCN Data Warehouse) to establish the base number of CSHCN in the State. The Medical Home Team is working with physicians to enlist them as medical home providers for CSHCN as well as providing trainings to parents in the importance of proper utilization of the medical home.

c. Plan for the Coming Year

The activities listed in (b) above will continue. We will conduct a survey of CSHCN Families to validate the methodology of identifying the number of CSHCN utilizing the medical home from the data warehouse.

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

a. Last Year's Accomplishments

The state utilizes medical record audits for this data, not national SLAITS data. In 2003, the percentage went down from 91.3 to 88 percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program had a source of insurance for primary and specialty care. We did not meet our goal of 95 percent.

b. Current Activities

The State CSHCN Program identifies children with special health care needs who are potentially Medicaid eligible and refers and assists these children and their families in obtaining Medicaid coverage. The Program maintains linkages with third party insurance carriers and assists families in coordinating coverage for needed medical services. The State CSHCN program has participated in advocating for adequate reimbursement for pediatric sub-specialty providers helping to assure access for children with special health care needs to needed services.

c. Plan for the Coming Year

The State CSHCN Program will continue the activities identified in b) above in the next year.

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

a. Last Year's Accomplishments

This is a quality assurance measure for the CRS Program; data from CRS record audits is used, not national SLAITS data. In 2003, 76.5 percent of families with children with special health care needs age 0 to 18 report the community-based service systems are organized so they can use them easily. This is an increase from 72.1, and almost met our goal of 80 percent.

b. Current Activities

This is also a measure for the annual CRS Program Assessment and an established competency for the CRS Coordinator. The interagency work group for the CSHCN Data Warehouse is also looking at this issue from a utilization and geographic perspective. The CRS Program also provides clinics and itinerant clinics where there is unmet need, develops tertiary partnerships to assure specialty care, and is in the process of developing case management through the medical home sites. The program offers case management through the CRS staff and DHEC Family Support Services.

c. Plan for the Coming Year

The program will also address this measure through the CSHCN Data warehouse parent survey and maintain current efforts.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

The program utilizes reviews of medical records for this data, not national SLAITS data. In previous years, SLAITS was used. Therefore, trends can not be inferred from the three years of data that is reported on the form. In 2003, 90 percent of families interviewed felt they had received services necessary to make transitions to all aspects of life.

b. Current Activities

In 2002, the CRS Program has hired a transition coordinator. She works closely with the CRS Program, Parent Advisory Council, BabyNet, Sickle Cell Foundation, and interagency groups to develop systems for transition. She also serves on the Office of the Governor's transition Work Group. In addition, the Parent Liaison and the Transition Coordinator provide intense training to families, consumers and staff who work with CSHCN. This is also a quality measure for the CRS Program and a measure for the CRS Program Assessment.

c. Plan for the Coming Year

The CRS Program will maintain this effort plus use this measure in the CSHCN Data Warehouse Survey.

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

a. Last Year's Accomplishments

South Carolina continues to achieve very high levels of immunization in its two-year-old population. The latest (Spring 2001) population survey indicated that 87.1 percent of two year olds were fully immunized. The 2002 survey is not available yet, so there is no new data.

b. Current Activities

The state continues to work on the following interrelated strategies:

-enhance the quality and quantity of vaccination delivery services (through increasing access to immunizations in DHEC and non-DHEC clinic and provider sites) and through training for all

immunization providers in the state
-reduce vaccine costs for parents
-increase community participation, education, and partnerships
-improve the monitoring of disease and vaccination coverage
-improve vaccines and vaccine use.

c. Plan for the Coming Year

The target for next year is to maintain at least a 90 percent level through interventions that sustain the ongoing success that the state has had.

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

a. Last Year's Accomplishments

The 2002 rate has decreased for the fourth year in a row to 28.7 percent from 29.9 in 2001. We almost met our goal of 28 percent. Initiatives and activities that contributed to this decrease are increased awareness by teens of the dangers of risk taking behaviors, abstinence education programs, and teen pregnancy prevention councils across the state who, along with other community providers and the local health department do an excellent job of getting the word out. The availability of a broad range of contraceptive methods including depo provera, emergency contraception, the "patch" and other methods also enhance the likelihood that a teen can find something suitable to his/her needs.

b. Current Activities

A statewide effort has been undertaken to evaluate the efficiency of service delivery in DHEC Family Planning clinics. As a result of this evaluation, a full set of recommendations have been made by Health Metrics. One health district has already implemented the recommendations with great success. Show rates have improved from around 40-45% to nearly 90-100% with open access scheduling. Such activities that promote efficiency will also contribute to better customer service.

c. Plan for the Coming Year

The target for HP 2010 at 43.0 has been met. The goal for the state is to continue to improve the teen pregnancy rate so tht the state is ranked in the top 25 states for teen pregnancy rates.

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

a. Last Year's Accomplishments

2003 saw another year with a dramatic increase to 27.4 percent from 9.6 of third grade children who have received protective sealants on at least one permanent molar tooth. This increase is a reflection of the newly established partnership program for school-based dental services.

b. Current Activities

Expansion efforts are currently underway statewide.

c. Plan for the Coming Year

Planned activities for next year will be to work with organized dentistry, hygienists and local schools to expand partnerships to target schools; establish standard forms and evaluation process for all participating providers including data reporting requirements; and work with the Alliance for SC's Children to conduct public awareness campaign on dental sealants and caries prevention.

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

a. Last Year's Accomplishments

Unfortunately, in 2002 the rate increased slightly from 6.3 to 6.9 of deaths to children aged 0-14 caused by motor vehicle crashes per 100,000 children. This increase demonstrates the continued need for education regarding the proper use of child passenger seats as well the need for distribution of child passenger seats for those unable to afford them.

b. Current Activities

The program currently provides:

- parental and community group counseling on child passenger seats
- distribution of child passenger seats
- demonstration and instruction of the proper installation of the various child safety seats (infant, convertible, and booster seats) at various public health events and in four permanent fitting stations in Appalachia III Health District, Upper Savannah Health District, Pee Dee Health District, and Wateree Health District
- instruction about the dynamics of a motor vehicle crash and the potential dangers to children not properly restrained
- training to health districts, partner organizations, and community groups to ensure knowledge and skills to properly restrain children in motor vehicles
- technical assistance to the health districts and the community
- technical assistance to SCPHA bicycle helmet program.

c. Plan for the Coming Year

The program plans to:

- distribute child passenger seats
- establish fitting stations within the Appalachia III, Upper Savannah, Pee Dee and Wateree Health Districts
- conduct a minimum of 24 presentations reaching an estimated 700 people, regarding the

proper use of seatbelts and child restraint devices
-conduct or participate in a minimum of 12 NHTSA Certified Technician classes
-plan and conduct educational activities in support of National Child Passenger Safety Week (February) and Buckle Up America Week (May)
-conduct or participate in a minimum of 36 child safety seat check-up events
-fully participate in the state's Occupant Protection Program throughout the grant period, to include the Fasten for Life mobilizations.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

The state has changed to using PRAMS data to report on this measure and revised previous years data to reflect this as well. The state must use PRAMS data because the breastfeeding data is no longer available from newborn screening data at hospital discharge. In 2001, the percentage increased to 52.7 from 48.1 of infants breastfeed more than one week, exceeding our goal of 50 percent. However, a disparity exists by race with 61.6 percent of white infants verses 34 percent of black infants verses 77.4 percent of other race infants being breastfed. In January, 2004, SC implemented an electronic birth certificate with all 48 birthing hospitals submitting data electronically. As soon as quality assurance measures are satisfactory, SC will use birth certificate data to report on this measure.

Current Activities

Each local health district must designate a staff member as the breastfeeding coordinator. This staff coordinates breastfeeding promotion and support activities. Local health districts also use breastfeeding peer counselors to provide one-on-one support to promote and increase the duration of breastfeeding. All local health districts provide an opportunity for each pregnant woman to attend a breastfeeding nutrition education class. Task appropriate breastfeeding education is provided for WIC health professionals to assure that updated and appropriate breastfeeding education is provided to pregnant and breastfeeding women and appropriate information is provided for breastfed infants. Public Health: Newborn home visits by a nurse, lactation consultant, breastfeeding peer counselor and/or other health care professional will be provided for eligible clients. Due to these follow-up home visits, breastfeeding difficulties may be prevented and/or eliminated thus promoting increases in South Carolina breastfeeding duration rates. Five regional breastfeeding coalitions (Low Country, Midlands, Pee Dee, Piedmont and Trident), as well as the South Carolina Breastfeeding Coalition, will implement activities in the community to promote and support the art and science of breastfeeding. Through education, publicity, recommendation and person-to-person support, the coalition(s) will be instrumental in fomenting social change throughout the state.

Plan for the Coming Year

Activities planned for the upcoming year include:

Expansion of the breastfeeding peer counselor program.

Increase the accuracy of collecting WIC breastfeeding data.

Provide training to district staff including clerical staff that input WIC breastfeeding data.

Provide statewide updates/trainings to district Breastfeeding Coordinators to include: a)working with Hispanic population, b)use of peer counselors to increase breastfeeding rates.

b. Current Activities

Each local health district must designate a staff member as the breastfeeding coordinator. This staff coordinates breastfeeding promotion and support activities. Local health districts also use breastfeeding peer counselors to provide one-on-one support to promote and increase the duration of breastfeeding. All local health districts provide an opportunity for each pregnant woman to attend a breastfeeding nutrition education class. Task appropriate breastfeeding education is provided for WIC health professionals to assure that updated and appropriate breastfeeding education is provided to pregnant and breastfeeding women and appropriate information is provided for breastfed infants. Public Health: Newborn home visits by a nurse, lactation consultant, breastfeeding peer counselor and/or other health care professional will be provided for eligible clients. Due to these follow-up home visits, breastfeeding difficulties may be prevented and/or eliminated thus promoting increases in South Carolina breastfeeding duration rates. Five regional breastfeeding coalitions (Low Country, Midlands, Pee Dee, Piedmont and Trident), as well as the South Carolina Breastfeeding Coalition, will implement activities in the community to promote and support the art and science of breastfeeding. Through education, publicity, recommendation and person-to-person support, the coalition(s) will be instrumental in fomenting social change throughout the state.

c. Plan for the Coming Year

Activities planned for the upcoming year include:

Expansion of the breastfeeding peer counselor program.

Increase the accuracy of collecting WIC breastfeeding data.

Provide training to district staff including clerical staff that input WIC breastfeeding data.

Provide statewide updates/trainings to district Breastfeeding Coordinators to include: a) working with Hispanic population, b) use of peer counselors to increase breastfeeding rates.

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

a. Last Year's Accomplishments

In 2003, the percentage of infants screened for hearing loss before hospital discharge was 98.1 percent of newborns screened for hearing, exceeding the state target of 98.0 and the American Academy of Pediatrics target of 95 percent.

b. Current Activities

Currently, the First Sound Program is refining and improving the Internet data tracking system that was implemented to alleviate the massive paper trail and assist staff to more closely monitor progress towards program goals. The system is housed and maintained on an internal agency application server and stringent measures have been adopted to ensure the system meets HIPPA requirements for patient confidentiality and data integrity. First Sound staff is assisting hospitals and community audiologists to transition from a paper system to the new Internet based, secure, electronic data system. On site training is provided for hospitals and audiologists transmitting data into the First Sound System.

c. Plan for the Coming Year

First Sound staff will continue to visit hospitals and review protocols and procedures for reporting information to First Sound; present information to community and medical providers on the importance of universal newborn hearing screening; develop monitoring and assessment tools to measure screening and evaluation outcomes for newborn hearing screening; and will continue to provide technical assistance as needed to achieve the target goal of 100% of infants screened for hearing loss before hospital discharge in 2004.

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

a. Last Year's Accomplishments

Based on CPS estimates of uninsured in the under 200 percent of poverty population for 2002, 6.9 percent of children were uninsured in the state, exceeding our goal of 12 percent. This percentage is a large decrease from previous years, 9.9 in 2001, 12.7 in 2000, and 13.5 percent in 1999. This significant decrease can be attributed to implementing SCHIP through a Medicaid expansion and districts having worked very hard to outreach and assist families to enroll their children into the Medicaid and SCHIP programs.

Unfortunately, in the past year, the state Medicaid program has had to struggle with increased costs and decreased or flat revenues. The program has:

- terminated the outreach contract with DHEC to do primary outreach to families,
- implemented an active eligibility redetermination process,
- implemented co-pays (MCH populations are exempt), and
- created a list of over 30 actions that could be implemented to decrease costs.

The Medicaid service with the largest cost increase is pharmaceuticals.

We do anticipate that the percentage of uninsured may increase due to implementation of the above actions by Medicaid, changes in the private insurance market, and a struggling economy.

b. Current Activities

The districts continue to concentrate on promoting utilization for children already eligible for Medicaid through the mega Medicaid contract and the provision of Family Support Services.

Starting July 2004, the Medicaid agency will be piloting a new managed care product for children in three upstate counties entitled "Primary Care Case Management(PCCM)". DHEC is working internally and with the Medicaid Agency to assist the two Health Districts affected to transition to this new product. The PCCM product is being designed to support the primary care physician provider and the medical home concept.

c. Plan for the Coming Year

As stated above, the state and districts will be participating in the newest managed care initiative PCCM as well as continue to encourage families and children to enroll in Medicaid and SCHIP. We have projected an increase in the percentage of uninsured children to 10 percent in the future based on the loss of the outreach contract, the funding difficulties the Medicaid agency has and potentially will experience, and the struggling economy.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a*

service paid by the Medicaid Program.

a. Last Year's Accomplishments

Based on estimates provided by the Medicaid agency, and using the latest HCFA available 2082 report, the number of children potentially eligible for a Medicaid service who received a service in 2002 was 83.6 percent. This was a slight increase from 83 percent in 2001.

b. Current Activities

South Carolina is placing tremendous effort on assisting clients to retain and appropriately utilize Medicaid and linking these enrolled children to primary care services. Unfortunately, the number of private/public partnerships has decreased to approximately ??????. This decrease can be partially attributed to the decreased budgets the districts and counties have experienced, increased turnover in public health positions, continuation of a statewide hiring freeze with only a few positions being filled through requested exceptions. Even with these partnerships, there is still a need to continue to provide comprehensive well childcare in some of our county health departments. Most districts have transitioned out of the provision of EPSDT but in ?????? districts EPSDT services, as well as some services to uninsured clients are still provided.

c. Plan for the Coming Year

For 2004 and forward, the target each year remains at 85 percent of potentially Medicaid eligible children will receive a paid Medicaid service. All twelve health districts continue to emphasize private/public partnerships for medical homes for children.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

During 2002, the percent of very low birth weights remained at 1.9, falling short of meeting the target of 1.8. The very low birth weight trend in the state appears to have plateaued. The partnership with the SC March of Dimes to reduce prematurity provides a an opportunity to collaborate with private and public entities to more closely study the data, identify needs and target interventions in SC.

b. Current Activities

Most of the health districts focus on activities that promote access to prenatal care, risk assessment and utilization of supplemental foods (WIC). Several districts have Fetal and Infant Mortality Review teams and utilize information gained from that process to correct systems issues that impact this measure. There is collaboration with Healthy Start projects in selected areas throughout the state as well as the Regional Perinatal Boards and March of Dimes Program Services Committee.

c. Plan for the Coming Year

A primary activity to reduce the percent of VLBW births in SC will be to partner and support the SC March of Dimes Campaign to prevent premature births. SC DHEC will be actively involved

in the development of educational and provider activities to increase awareness of the problem of premature birth. Health departments will incorporate the signs and symptoms of premature labor into their teaching curriculum for prenatal clients as the FIMR process has identified that women often do not know they are experiencing early labor and do not seek care. Also, the partnership with the African Methodist Episcopal Church Minister's Wives and Widows Alliance will continue training to the general community on how to have healthier infants and specifically educate pregnant women about the signs and symptoms of preterm labor.

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

a. Last Year's Accomplishments

During 2002, the rate of youth suicide increased slightly to 6.3 from 6.0 in 2001, exceeding the target of 6.0. It appears that the rate may be becoming stable at this rate. We must also look at the incidents in addition to the rate as the incidence is very low and has been for the past three years. At present, there are no known statewide initiatives that may have contributed to this increase. However, there has been an increase in public awareness messages regarding depression and how to seek help from private behavioral health service providers.

b. Current Activities

Health districts have developed activities, primarily in partnership with the local county mental health centers and schools since 1999. Those activities include staff development, collaboration and coordination with local service agencies including substance abuse treatment centers, and community mental health centers. Health department staff are doing risk assessments of all patients who present for services, including youth, and making referrals to appropriate mental health services as indicated.

c. Plan for the Coming Year

A state wide ten-member interagency suicide prevention task force has been created and SC DHEC is partnering with USC College of Social Work to write a Youth Suicide Prevention grant through the National Institute of Mental Health. Other local efforts will be continued.

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

a. Last Year's Accomplishments

During 2002, the percent of VLBW infants delivered in Level III hospitals increased to 80 from 77.1, exceeding the target of 78. New hospital licensing standards and increased oversight have been effective in reversing the trend with more VLBW infants born in Level III hospitals now than 5 years ago.

b. Current Activities

At the state level, public health is focusing on the issue and identifying strategies to increase the percentage of VLBW births in Level III hospitals. All hospitals are now required by law to complete a form on every very low birth weight infant delivered in their facility and to forward a copy to the Division of Perinatal Systems. An electronic version of this form and an electronic

data base has been created. These forms are being entered into the data base this spring and will be analyzed in the next year to identify opportunities for improvement.

c. Plan for the Coming Year

The VLBW data will be analyzed to identify opportunities for improvement. The form will also be evaluated to determine if it can be revised in order to be submitted as an electronic form complimentary to the electronic birth certificate. All 48 birthing hospitals began submitting electronic birth data in January 2004.

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

a. Last Year's Accomplishments

During 2002, a slight decrease from 78.5 to 77.7 percent all women entered care in the first trimester of pregnancy, the fourth year in a row of decreases.

b. Current Activities

This is a multifaceted problem and requires work on several fronts, including accurate reporting of prenatal care entry on the birth certificate, physicians promoting the first visit during the first trimester, and thirdly, getting information to women of childbearing age regarding the importance of early entry into care. The health districts work regularly with the Regional Systems Developers, hospital vital record clerks, hospital medical records and physicians' offices to monitor the quality of data reported on birth certificates. They also have initiated and/or participated in partnerships with private providers for complementing Family Support Services to be provided to their clients.

c. Plan for the Coming Year

For 2003, the target is 80 percent. District activities planned for the future include increasing participation in pre-conceptual health activities, i.e. risk assessment, smoking cessation, and education regarding STD and vaginal/cervical infections. This also includes provider education related to screening for STDs etc. during pregnancy as well as appropriate treatment. Program consultant staff will offer technical assistance to district staff regarding contributing factors to very low birth weight births and successful strategies for interventions.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed				

with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.

1. Implement the expansion of the newborn screening panel by providing consultation to hospitals, physi	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Implement the updated regulations governing blood specimen storage and use for scientific research.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Maintain and support the patient Advisory Council and employment of the Parent Liaison and 14 Parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue information, advocacy, and education efforts for parents, families and providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work closely with families in developing and implementing treatment plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Develop and administer survey tool with the CSHCN Data Warehouse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Recruit physicians to participate in the expanded medical home model.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Train parents of CSHCN in the importance of utilizing a medical home.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Seek methods of financing Care Coordinators in Medical Homes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Identify, refer, and assist families with children with special health care needs who are Medicaid e	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Advocate for adequate reimbursement for pediatric sub-specialists.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Maintain linkages with third party insurers to maximize coverage for children with special health car	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Continue tertiary and medical home partnership development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop case management efforts through medical home.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Develop and administer survey tool with the CSHCN Data Warehouse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Maintain Transition Coordinator, coordination and training efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work through parents to develop a strong training component for families.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Develop and administer survey tool with the CSHCN Data Warehouse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Maintain vaccination coverage (DTaP, MMR, Polio) at 95% for children in licensed day care facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Vaccination coverage levels for universally recommended vaccines among preschool children are mainta	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Vaccine inforamtion statements (VISs), misconceptions about immunizations and DHEC immunizaton requi	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Reduce Vaccine-Preventable Disease and maintain an active surveillance system.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				

1. Work with the Teen Pregnancy Prevention Campaign, to promote awareness through media campaigns and p	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Initiate a youth development project in at least one county.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Collaborate with the community groups and schools in providing supportive servcies in addition to cl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Work with organized dentistry, hygienists and local schools to expand partnerships to target school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Establish standard forms and evaluation process for all participating providers including data repor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work with the Alliance for SC's Children to conduct public awareness campaign on dental sealants and	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Educate parents regarding correct installation of parent owned child car seats.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Train agency staff and community concerned partners and caregivers about correct installation of child passenger seats.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Participate in statewide and national vehicle occupant safety campaigns.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Participate in health fairs promoting use of child passenger seats.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Distribute childcare seats to health districts.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Expansion of the breastfeeding peer counselor program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Increase the accuracy of collecting WIC breastfeeding data.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide training to district staff including clerical staff that input WIC breastfeeding data.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide statewide updates/trainings to district Breastfeeding Coordinators to include: a)working with Hispanic population, b)use of peer counselors to increase breastfeeding rates.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Visit hospitals to review protocols and procedures for reporting information to First Sound.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Present information to community and medical providers on the importance of universal newborn hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Develop monitoring and assessment tool to measure screening and evaluation outcomes for newborn hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

13) Percent of children without health insurance.				
1. continue to work with the Pediatric Advisory Committee and the state Medicaid agency to promote acce	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Evaluate the impact of the provision of public health servcies on utilization of care for Medicaid a	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Work with the Office of Research and Statistics and the Bureau of Biostatistics to evaluate the exte	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Make partnerships a priority for the MCH population.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide consultation to the health departments to determine what it will take to implement the ongoi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Partner with the SC March of Dimes to develop and implement campaign to prevent premature birth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue partnership with the AME Church to educate and increase awareness about infant health, incl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Health Departments will provide educaion to pregnant clients about the signs and symptoms of prematu	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Continue to work with the newly created State Interagency Suicide Prevention Task Force.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Partner with USC College of Social Work to write a Youth Suicide Prevention grant through NIMH.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Local health department staff will continue to risk assess clients for depression and suicide.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Program staff will continue to monitor where VLBW infants are delivered and work with hospitals to a	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal				

care beginning in the first trimester.				
1. Health departments will provide more risk assessments at the time of positive pregnancy tests and fo	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Through the Caring for Tomorrow's Children Program, the importance of early and continuous prenatal	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of Medicaid newborns in the state receiving a home visit.*

a. Last Year's Accomplishments

This measure is a Direct Health Care Service, and it is classified as a Risk Factor measure. The measure looks at all Medicaid newborns receiving a home visit, regardless of who provides the service. Although newborn home visits are an increasing priority for DHEC, we also have an assurance responsibility to facilitate postpartum newborn home visits regardless of public/private affiliation of the provider. Home visits in South Carolina have been associated with improved postneonatal outcomes. Home visits contain counseling components related to behavior change and the linking of mothers and infants to providers and services. The ultimate goal is to have all newborns in the state receive a newborn home visit, but South Carolina is beginning its focus on the Medicaid population due to the higher prevalence of risk factors associated with poor health outcomes in this population. This measure is directly related to the priority need of increasing access to newborn home visits, and related to increasing access to enabling, family support services, reducing preventable injuries, and increasing access to quality risk-appropriate care. This measure is related to the neonatal, postneonatal, and infant mortality outcome measures. Public Health has continued to provide the majority of postpartum newborn home visits in our state, and all twelve health districts continue to be the primary provider of this service.

In 2003, 50.8 percent of Medicaid newborns in South Carolina received a newborn home visit. The target of 70 percent had been established. This was the second year in a row that it has decreased, 53 percent in 2002, and 60.4 in 2001. Factors that may have contributed to these decreases are the difficulties districts have had with decreased budgets, recruiting and retaining staff, and hiring freezes.

b. Current Activities

Newborn home visits to Medicaid infants is one of the priorities that have been identified by the state. Central office staff are providing consultation and encouragement to districts to continue and expand their capacity to provide newborn home visits.

c. Plan for the Coming Year

South Carolina plans to increase the percent of Medicaid newborns receiving a home visit to 60 percent in 2004, increasing slightly each year to 68 percent in 2008. These increases in services are dependent on adequate funding of the state Medicaid agency (DHHS). The Medical University of SC through a contract has recently evaluated this visit for the Medicaid agency with positive results. Over time, the goal will still be to include all newborns/mothers.

State Performance Measure 2: *Percent of women giving birth with an unintended pregnancy*

a. Last Year's Accomplishments

This measure is a Population Based Health Care Service and is classified as a Risk Factor measure. Unintendedness is associated with poorer birth outcomes and greater risk behaviors by the mother. In 2001, the percentage increased to 48.2 from 47.3 of South Carolina's births are reportedly unintended. This is the second year in a row that it has increased. The state did not meet its target of 48.2 percent. There is no available data for 2002.

This measure is directly related to the priority need of reducing the percentage of births in the State reported to be unintended. This measure is related to the following outcome measures: neonatal, perinatal, postneonatal, infant mortality and reducing the ratio between the Black and White infant mortality rates. All groups of women experience unintended pregnancy. A higher percentage of unintended pregnancies occur in women younger than 20 years of age, not married, Black, Medicaid eligible, and with less than 12 years of education.

b. Current Activities

Local health departments and contracting physicians provide family planning services. There were 79 sites statewide. Many health departments have integrated service delivery, which facilitates meeting the customer's needs for family planning and STD services. Others have worked to prioritize services for teens and post partum women workers to follow up on missed appointments as well as to do case finding in local communities. The Family Planning waiver (reproductive health care services to all women under 185 percent of poverty) is scheduled to be resubmitted to CMS for continuation.

c. Plan for the Coming Year

The target for 2004 and each year forward has been set at 45 percent. In 2003, SC requested Health Metrics, a private company, to conduct an assessment and provide recommendations concerning access, efficiencies, and effectiveness of the program. A list of recommendations was provided that included open access scheduling, focused client education, patient flow, and staffing models.

Implementing Health Metrics recommendations to promote clinic efficiency, reduce wait times, and promote access to quality services in all SC counties; promoting and supporting integration of services within the clinic, focusing education and counseling on client needs, ensuring that all Family Planning clinicians complete the Preventive Health Course, and to encourage the offering of flexible clinic hours to accommodate the varying needs of clients has begun in all health districts as part of a set of priorities initiated by the Division of Women and Children's Services. Staff is in the process of visiting each health district to assist in this implementation. As a result of this implementation, districts are already beginning to see a

significant increase in show rates of clients keeping their appointments.

State Performance Measure 3: *Number of school districts that are designated as Title V Providers. (Revised 2004)*

a. Last Year's Accomplishments

This measure is a Population Based Health Care Service, and is classified as a Capacity measure. This measure is directly related to the priority need of improving the quality and availability of health and health education services in school settings. As of May 2004, 66 of 85 school districts have executed contracts and been trained. In 2003, the SDE established the Office of School Based Finance to assist local school districts in their efforts to earn additional dollars through the Medicaid program.

b. Current Activities

The state level nursing consultants and local health districts continue to work closely with their local school districts to coordinate and provide health education, care coordination, immunizations, oral health, primary care, FSS and linkages with other governmental and non-governmental social service providers. Linkages with the Healthy Schools Office of the Department of Education are being strengthened as well.

c. Plan for the Coming Year

The target for next year is to retain the 66 school districts as designated Title V Providers. Linkages between schools, school nurses, school children and their parents, and primary care and enabling service providers are essential components of successful primary care programs for children. School districts in South Carolina are autonomous, so by necessity this effort will be incremental and slow, but the state is committed to strengthening these linkages in the service system.

State Performance Measure 4: *Percent of Districts with an injury prevention program in place.*

a. Last Year's Accomplishments

This measure is a Population Based Health Care measure, and is classified as a Capacity measure. Although injuries are the number one killer of children in South Carolina, districts and counties are being encouraged to look at other populations including infants and pregnant women. This measure is directly related to the priority need of reducing preventable injuries in the state. The measure is related to the reducing childhood mortality outcome measure. Eleven of twelve districts (91.7%) reported having an injury prevention program in place; a dramatic increase from last year of only nine.

b. Current Activities

Injury prevention continues to be an agency priority given the magnitude of the problem (as it is the leading cause of death of children). Injury prevention is fully incorporated into the Health Services Operational Plan through the activities of the Division of Injury and Violence Prevention (DIVP). The DIVP is currently participating in the development and implementation of the state Unintentional Injury Plan and the state Intentional Injury Plan. Educational

brochures were provided to the public regarding poisoning, drowning, fire safety and prevention of injuries due to car crashes. Fire safety educational materials were also provided to clients through the Postpartum Newborn Home Visit Program as part of a partnership with the South Carolina Residential Fire Injury Prevention Program.

Local fire departments are installing smoke detectors in homes referred by the home visit program in six counties in the state as part of the South Carolina Residential Fire Injury Prevention Program. Public awareness highlighting the injury problem is conducted through media outlets and participation in community events, such as health fairs. DHEC will also take advantage of events to address the major causes of childhood injury. South Carolina plans to use information gained from Child Fatality Review Committees and the Traumatic Brain Injury Surveillance System and the South Carolina Violent Death Review System statewide to determine possible suggestions and strategies for prevention interventions.

c. Plan for the Coming Year

The target for next year is for all districts (13/13 or 100 percent) to report that their injury prevention program is in place.

State Performance Measure 5: *Deleted in 2004: because it became NPM6.*

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 6: *Percent of adolescents who smoke.*

a. Last Year's Accomplishments

This measure is a Population Based Health Care Service, and is classified as a Risk Factor measure. Smoking trends in the teen population have increased steadily over the past decade, and smoking is associated with other risky behaviors. Nearly every adult who smokes (almost 90 percent) took his or her first puff at or before the age of 18. Source: Campaign for Tobacco Free Kids. There was no Tobacco Settlement allocation made for Youth Smoking Prevention programs by the General Assembly for FY '04. Youth Risk Behavior Survey data collected in 2001 indicated that the percentage of youth who reported smoking in the past 30 days was 27.6%. Unfortunately, the YRBS data for 2001 could not be weighted due to sample size insufficiency. Therefore, trends cannot be determined. South Carolina does not have any new data to report on this measure, the YRBS is only conducted every other year. It was conducted during the fall of 2003, but the results are not yet available.

b. Current Activities

DHEC, through the SC Tobacco-Use Prevention and Control Program (SCTCP) conducts outcome-based activities statewide directed at the following four program strategies: prevent youth from initiating tobacco use; promote quitting among youth and adults; eliminate exposure to environmental tobacco smoke; and identify and eliminate health disparities related to tobacco use. The division's public health media efforts include the Rage Against the Haze

campaign, a social marketing effort targeting adolescents. Key components of this effort include an inter-active web-based recruitment and messaging center, establishment of specialized training curricula, targeted media messaging utilizing statewide movie theaters, and localized youth-lead programming.

At the state level, SCTCP partners with the Department of Alcohol and Drug Abuse Services, the SC Department of Education, the three major voluntary health organizations ?American Cancer Society, American Heart Association, American Lung Association, the SC Medical Association, and the SC African-American Tobacco Control Network. At the local level, DHEC district health departments and 12 local tobacco coalitions promote these strategies. At both the state and local level, activities focus on policy change, education, surveillance and evaluation.

c. Plan for the Coming Year

In the coming year, the program will continue to address the four goal areas mentioned above through similar strategies, including community intervention and mobilization, counter-marketing, policy and environmental change, and surveillance and evaluation

State Performance Measure 7: To implement in at least three health districts the comprehensive risk assessment form for prenats presenting to the health department for services. (Revised 2004)

a. Last Year's Accomplishments

This measure has been revised to reflect the priorities for pregnant women, infants and children that the Bureau, Divisions, and Health Districts have begun to identify and implement. The new measure is: To implement in at least three health districts the comprehensive risk assessment form for prenatal clients presenting to the health department for services.

This measure is an Enabling Service and is classified as a Risk Factor measure. Over the last several years, there has been a substantial shift in the provider makeup of prenatal care in the state. DHEC used to provide prenatal care services statewide, but now only provides these services in 2 of 46 counties, with the private medical community now providing the great majority of prenatal care. DHEC has a role and responsibility; however, to provide enabling services in partnership with the medical community, and to assure that risk appropriate care is being provided, regardless of payment source. This measure is related to the priority need of increasing access to quality risk appropriate care for women and infants in the state. The measure is associated with the infant, neonatal, perinatal, post neonatal mortality outcome measures, and to the rate ratio in the IMR outcome measure as well.

In 2003, four districts or 33.3 percent have implemented risk assessments for prenats. This exceeded the goal of 30.1 percent.

b. Current Activities

Staff from several programs in the Bureau have developed priorities and a plan that has the support of upper management. State level staff have provided consultation and encouragement to districts to implement risk assessment of prenats. Districts have been requested to assure that all pregnant women who present to the health department are risk assessed through use of the Prenatal Risk Screening Form, and linked to an OB provider. Part of this initiative will require that appointments be confirmed.

c. Plan for the Coming Year

Planned activities for the next year are to provide consultation and encouragement to the remaining eight districts and to continue to provide technical assistance to the four who have implemented prenatal risk assessments.

State Performance Measure 8: *Deleted in 2003*

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 9: *Maintain continuation rates for DHEC Family Planning clients to at least at 85 percent. (Revised 2004)*

a. Last Year's Accomplishments

This measure has been revised. This revised measure is a Direct Health Care Service and is classified as a Risk Factor measure. Family Planning clients who continue their chosen method of birth control is associated with pregnancies that are desired, better birth outcomes and less health risks for women. This measure is related to the following outcome measures: neonatal, perinatal, postneonatal, infant mortality and reducing the ratio between the Black and White infant mortality rates. In 2003, there was a slight percentage decrease from 87.7 to 86.3 of women served in DHEC's Family Planning clinics who continued their chosen method of birth control.

b. Current Activities

Local health departments and contracting physicians provide family planning services. There were 85 sites statewide. Last year 26 of those sites had extended hours or weekend hours to provide services for those who could not be seen during the routine hours of 8:30 to 5:00 PM. Many health departments have integrated service delivery, which facilitates meeting the customer's needs for family planning and STD services. Others have worked to prioritize services for teens and post partum women workers to follow up on missed appointments as well as to do case finding in local communities. The Family Planning waiver (reproductive health care services to all women under 185 percent of poverty) continues, and has been evaluated. The results documented births averted and substantial cost savings.

Family Planning program staff are currently working with several districts to implement recommendations provided to the state from Health Metrics. Implemented recommendations will increase access to services, offer flexible and timely appointments, open access scheduling, and focused education and counseling.

c. Plan for the Coming Year

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percent of Medicaid newborns in the state receiving a home visit.				
1. Home visits will be a priority in 2004 with follow up provided to assure linkage into primary care f	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Develop and implement the plan for these priorities with counties receiving consultation beginning i	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Identify barriers to implementation and pose solutions in order to assure that implementaiton of the	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Percent of women giving birth with an unintended pregnancy				
1. Implement Health Metrics recommendations to promote clinic efficiency, reduce wait times, and promot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Promote and support integration of services within the clinic.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Family Planning clinics will be encouraged to offer flexible clinic hours to accommodate the varying	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Family Planning clinicians will complete the Preventive Health course.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Number of school districts that are designated as Title V Providers. (Revised 2004)				
1. Provide orientation to all new schoold nurses with helath deparment staff making presentations to pr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide trainings to all Title V designated school districts in order to link				

schools and children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of Districts with an injury prevention program in place.				
1. Provide coordination of health education services related to fire protection in the home through cur	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide coordination for distribution of smoke alarms throughout the App I and Edisto/Savannah Health Districts.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Train agency staff and the general public about correct usage and installation of child car seats.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Provide technical and educational assistance and support.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Continue to participate in national seat belt safety and child car safety seat events	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Continue to distribute child passenger seats throughout the state	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Continue to develop the South Carolina Violent Death Reporting System.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Continue to support and participate in the South Carolina Child Fatality Review Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Continue to collect injury data for analysis through the Traumatic Brain Injury Surveillance Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Participate in the development of the State Intentional Injury Strategic Plan and support the continued development and implementation of the State Unintentional Injury Strategic Plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Deleted in 2004: because it became NPM6.				
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of adolescents who smoke.				
1. Increase the number of African American and Hispanic youth groups who adopt a policy to promote pro-	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Increase the number of public school districts that adopt and enforce a policy prohibiting any use o	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Increase the number of public school districts that adopt and enforce a policy to provide access to	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) To implement in at least three health districts the comprehensive risk assessment form for prenatals presenting to the health department for services. (Revised 2004)				
1. Finalize the plan, develop a revised timeline, develop a baseline of current district activities, an	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Assure that all pregnant women who present to the health department are risk assesed through the use	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Deleted in 2003				
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
9) Maintain continuation rates for DHEC Family Planning clients to at least at 85 percent. (Revised 2004)					
1. Implement Health Metrics recommendations to promote clinic efficiency, reduce wait times, and promot		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Promote and support integration of services within the clinic.		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Family Planning clinics will be encouraged to offer flexible clinic hours to accommodate the varying		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Family Planning clinicians will complete the Preventive Health course.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

NON-DUPLICATION OF MEDICAID PAYMENTS TO SSI RECIPIENTS UNDER 16

//2004/ In SC, services to children under 16 who are receiving Supplemental Security Income are administered by the state Title V program for CSHCN. The program is known as the Supplemental Security Income/Disabled Children's Program (SSI/DGP). Since the enactment of the block grant, the program has been integrated into the community-based services of the CSHCN program. SSI consists primarily of case management services, serving approximately 3,500 children. In those instances where Title XIX does not cover services, procedures are in place to approve services in a manner similar to that of the CSHCN program. Recipients of SSI are also referred to DDSN, School for the Deaf and Blind, Department of Mental Health, and HIV programs. All referrals are through a MOA with each institution. //2004//

EPSDT COORDINATION AND STANDARDS:

//2004/ Assurance is provided so that SC coordinates activities between MCH and the EPSDT Program under Title XIX. DHEC is an EPSDT provider of services to eligible clients. The Division of Women and Children's Services (WCS), in coordination with the health districts, provides approximately 20% of all EPSDT screenings in the state. Other providers include private physicians, federally qualified health centers and hospital outpatient clinics. In situations where Public Health

clinics do not provide the screenings, they are available through private/public partnerships that provide the traditional public health supportive services to complement medical care. WCS is responsible, through contract with Title XIX (Medicaid Agency), for providing outreach education to all new eligibles so that the family is aware of the services to which the child is entitled. Public health nurses provide education and assist families in securing a medical home for the children. Once the children are in a medical home, public health staff, at the local level, continue to support the providers and clients to assure adherence to the medical plan outlined by the primary EPSDT provider.

//2005/ The Outreach contract with Medicaid was terminated in December 2003. The activities are continued through Family Support Services. //2005//

The EPSDT Program in SC follows the periodicity schedule recommended by the American Academy of Pediatrics. WCS was actively involved in the selection of this schedule and was instrumental in providing input into the content of EPSDT screenings. Family Support Services are available as needed by EPSDT clients. //2004//

MEDICAID APPLICANT IDENTIFICATION ASSISTANCE

Assurance is provided that DHEC does coordinate with the Title XIX Agency -SC DHHSS in providing funding, assisting in the eligibility process and the provision of services to Pregnant Women, Infants and Children in the State. SC offers Medicaid to Pregnant Women and Infants up to 185% of poverty and Children ages 1 through age 18 up to 150% of poverty (with the latest SCHIP expansion). SC began Medicaid expansion in October 1987. DHEC uses a number of different approaches to identify and assist Medicaid eligible pregnant women and infants. As indicated below, our methods include coordination with other agencies as well as the private sector.

Through the Medicaid 'Mega' Services contract, paraprofessionals are utilized along with professional staff to recruit potentially eligible individuals into the Medicaid program. Out stationed workers continue to assist with the eligibility process for reproductive aged women.

WIC income guidelines are revised at the same time as Medicaid income guidelines to ensure a coordinated process in identifying those who are Medicaid eligible. When WIC clients are identified as being eligible, appointments are made with the out-stationed Medicaid eligibility workers in the County Health Department, or the County Department of Social Services Office, whichever is applicable. State agencies and the private sector continue to work cooperatively toward the goal of eliminating barriers to Medicaid eligibility which spans the continuum from client identification, assistance with eligibility documentation requirements, eligibility processing at the clinic site, meeting transportation needs, etc., through the process of providing appropriate care or case management. For 2002-2003, swipe card technology will be incorporated to expedite eligibility processing.

//2004/ Swipe card technology was implemented this past year. Clinics now have the additional option of purchasing a swipe card reader that staff can use to determine eligibility. However, this technology has come with additional expenses, such as the need for several machines, each with a secure Internet phone line, and a per utilization charge of \$0.25. The original option of using a 1-800 toll free number is still available. This option has also become costly because it now takes staff approximately 20 minutes to ascertain eligibility status for a client. //2004//

F. TECHNICAL ASSISTANCE

//2004/ South Carolina has not identified any technical assistance needs at this time. //2004//

//2005/ South Carolina has not identified any technical assistance needs at this time. //2005//

V. BUDGET NARRATIVE

A. EXPENDITURES

A. EXPENDITURES

Methodology The DHEC Bureau of Maternal and Child Health based the 1989 Maintenance of Effort on the state expenditure of \$8,425,466.

FY 1994 was the first year the direct state appropriation for MCH services to the Bureau dropped below the 1989 effort level. The expenditures for FY 1994 were \$8,114,682. Therefore, we requested that the 1989 baseline be amended to include expenditures for family planning services. The FY 1989 family planning expenditures were \$3,020,500.

Identification of Maintenance Effort The State of South Carolina documents a total of \$11,445,966 as the 1989 baseline against which future effort is measured. This combines the 1989 state expenditures for maternal and child health services with the Family Planning expenditures. For FY 2003, state appropriations for the Bureau of Maternal and Child Health Divisions of Women and Children's Services, and Children with Special Health Care Needs are expected to be \$10,947,692 (this figure may adjust slightly before the beginning of SFY 2003 due to reappropriations).

Therefore, the total maintenance of effort for FY 2002 is \$ 15,831,667 calculated by combining the state appropriated dollars for Maternity, Child Health and Children with Special Health Care Needs programs of \$10,947,692 with the state appropriated dollars for family planning of \$4,883,975. The State of South Carolina exceeds the 1989 maintenance of effort requirement by \$4,385,701.

//2004/ For FY 2004, state appropriations for the Bureau of Maternal and Child Health Divisions of Women and Children's Services, Perinatal Systems, and Children with Special Health Care Needs are expected to be \$11,787,483. There may be some adjustments in this figure in SFY 2004 due to pending state budget reductions. As of this writing there is a plan to significantly reduce Family Planning state funds to address South Carolina's budget shortfall. If approved, we will only have approximately \$1,000,000 in Family Planning funds toward the maintenance of effort. //2004//

Therefore, the total maintenance of effort for FY 2004 is \$ 12,787,483 calculated by combining the state appropriated dollars for Maternal & Child Health, Perinatal Systems, and Children with Special Health Care Needs programs of \$11,787,483 with the state appropriated dollars for family planning of \$1,000,000. The State of South Carolina exceeds the 1989 maintenance of effort requirement by \$1,341,517. //2004//

//2005/ For FY 2005, state appropriations for the Bureau of Maternal and Child Health Divisions of Women and Children's Services, and Children with Special Health Care Needs are expected to be \$12,061,317.

Therefore, the total maintenance of effort for FY 2005 is \$ 12,061,317 calculated by combining the state appropriated dollars for Maternity, Child Health and Children with Special Health Care Needs programs of \$11,061,317 with the state appropriated dollars for Family Planning of \$1,000,000. The State of South Carolina exceeds the 1989 maintenance of effort requirement by \$615,351. //2005//

Match Title V matching requirements for the FY 2002 grant award of \$11,846,832 (including carry forward funding from FY 2001 of \$402,413) is \$9,186,880. We identify \$9,186,880 of the state allocation of \$10,947,692 in the Divisions of Women and Children's Services and Children with Special Health Care Needs as match with \$1,760,812 as overmatch. In addition, we also identify \$8,557,307 in state appropriated dollars to the counties for MCH programs for a total overmatch of \$10,318,119.

//2004/Title V matching requirements for the FY 200 3 grant award of \$ 12,051,811 (including carry

forward funding from FY 2002 of \$ 945,481) is \$ 9,747,912. We identify our required match of \$9,747,912 from the state allocation in the Divisions of Women and Children's Services and Children with Special Health Care Needs. //2004//

/2005/ Title V matching requirements for the FY 2004 grant award of \$11,952,796 (including carry forward funding from FY 2003 of \$1,703,555) is \$10,242,204. We identify our required match from the state allocation in the Divisions of Women and Children's Services and Children with Special Health Care Needs. //2005//

Fiscal Management Procedures Division of Finance's fiscal management procedures was provided in the FY 1995 MCH Title V Grant Application. Another copy can be provided upon request.

Fair Method of Allocating Grant Funds See the attached file for a description of the method used by South Carolina for allocating its MCH and CRS funds to the public health districts.

B. BUDGET

B. BUDGET

"30-30 Minimum" As required by OBRA '89, South Carolina allocates a minimum of 30% of Federal Block Grant Funds for preventive and primary care services to children, and a minimum of 30% is allocated to children with special health care needs that are part of a system of services which promotes family-centered, community based coordinated care.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.