

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: WV

APPLICATION YEAR: 2005

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

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

### **B. FACE SHEET**

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

### **C. ASSURANCES AND CERTIFICATIONS**

Assurances and Certifications are located at the following address:

Office of Maternal, Child and Family Health  
Room 414  
350 Capitol Street  
Charleston, WV 25301

Contact: Kathy Cummons  
Telephone: (304)-558-7171

### **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**

The Title V Block Grant Application was distributed for public comment as follows: 1) Newspaper ads were run in select papers, announcing the availability of the above documents in draft format at the local Department of Health Human Resources office located in each county seat and at the public library. 2) Five public meetings were held in April and May to secure public input in Parkersburg, Martinsburg, Beckley, Fairmont and Charleston. 3) Copies of the draft, including a public comment form, were also sent to the following: Developmental Disabilities Council, WVU Affiliated Center for Developmental Disabilities (UAP, Social Services (Responsible for IV-B/IV-E, etc.), Office of Behavioral Health Services, Medical Advisory Chairs: Department of OB/GYN - WVU, Department of Pediatrics - Marshall University and Department of Community Medicine - WVU, The Governor's Cabinet on Children and Families, West Virginia Chapter March of Dimes, Family Voices - West Virginia, Interagency Coordinating Council Chair (Part C/IDEA), West Virginia Commission for Deaf and Hard of Hearing, West Virginia Department of Education: Office of Health Schools, Special Education, and The West Virginia Perinatal Task Force.

## **II. NEEDS ASSESSMENT**

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

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

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

Thirty-seven of West Virginia's 55 counties are classified as being medically underserved areas with an additional 12 counties classified as partially underserved. There are 15 counties designated as Health Care Professional Shortage areas with an additional 17 classified as having partial shortages. West Virginia currently has 215 physicians per 100,000 residents as compared to 251 nationally. West Virginia reached its population peak a half century ago with 2,005,552 residents counted in the 1950 census. The state's population has not exceeded the two million mark since then, but has fluctuated between 1.7 and 1.9 million depending on the state's economy. Four of the state's five largest cities have lost population since 1990. Charleston, the state capitol and largest city, and Huntington are the only places with populations exceeding 50,000. Population estimates from the 1990 census show West Virginia among the most racially homogeneous states in the country. Ninety-six percent of our residents are white, with African-Americans accounting for 3.1% of the population, Asian/pacific Islanders for 0.4% and the other races for 0.2%. The 2000 census reported that 95.9% of WV residents are Caucasian, 3.5% Black or African American, .6% American Indian and Alaska Native, 0.7% Asian and 0.3 some other race. The ancestry of the state's population is primarily a combination of Irish and Celtic followed by a broad mixture from other European countries.

West Virginia now has the distinction of having the oldest median age in the nation (38.1 years). West Virginia has the highest median age in the nation at 38.9, and the state's percent of people age 60 and older is ranked second in the nation. Between 1990 and 2000 people 85 and older increased by 24.8%; the number of individuals age 90 and older grew by 41.3%. Although the population has fluctuated between 1.8 and 2.0 million over the last 50 years, the rate of births have declined from 50,000 births in 1950 to 20,000 births in 2001 dropping from a rate of 25.4 births per 1,000 to 11.3 births per 1,000. In 1997 West Virginia saw its first natural decrease, having 137 more deaths in that year than births, the first state in the nation to experience such a phenomenon. This trend has continued through 1998, 1999, 2000 and 2001. Because of its older population, West Virginia ranked 1st among the states in 1998 in the percentage of its residents enrolled in Medicare (18.4%, compared to a national average of 13.9%). Older West Virginians value their independence, self-sufficiency and preservation of the family homestead. This lifestyle is demonstrated by the fact that residents maintain the highest percent of home ownership in the nation at 75.15%. Almost 85% of individuals age 65 and older own their home.

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

According to the West Virginia Bureau of Employment Programs, state unemployment, for all of 2003, stood at 6.1%, slightly above the national average of 6.0%, which was unchanged from the 2002 rate, but up from 4.9% in 2001. In 2001, 48.3% of the state's jobs were filled by women compared to a national average of 48.6%. Also work disability is a significant problem in West Virginia. In 1990, 12.6% of the labor force had a work disability, and 8.4% were prevented from working at all due to a

work disability. The latter figure is twice as high as that for the United States as a whole and the highest among the states.

Because of the loss of higher paying jobs over the past thirty years in West Virginia, there has been a concurrent rise in the state's poverty rate. According to figures supplied by the U.S. Census Bureau and reported in the State Rankings 2002 (published by Morgan Quitno), in 2002 West Virginia continued to rank fifth in the nation at 17.2% of state's residents living in poverty, compared to the national average of 12.4%. In 1999 the median household money income in West Virginia was \$29,696 compared to the national average of \$41,994. Of residents age 65 and older, 17.6% are living below the poverty level, while 23.8% of children age 18 and under are living in poverty. The percent of high school graduates or higher, of the population 24 years and over is 78.8% compared to the National average of 82.6 ranking WV 47th. The Office of Maternal, Child and Family Health (OMCFH) operates in partnership with the federal government and the State's medical community, including private practicing physicians, county health departments, community health centers, hospitals and various community agencies to address West Virginia residents' needs.

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

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

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

On March 19, 2003 ACOG applauded West Virginia lawmakers for their enactment of HB 2122, legislation to address the state's chronic medical liability insurance problems. It is the hope that the passage of HB 2122 will bring vital, immediate relief and keep our doctors doing what they've trained to do--deliver babies.

West Virginia House Bill 2388 established a mandate for the universal testing of newborns for hearing loss. The Newborn Hearing Screening Advisory, as established in statute, has made testing recommendations, developed screening protocols, and assisted the Office of Maternal, Child and Family Health with the development of user friendly education materials for inclusion in hospital birth packets and distribution through the State's perinatal program called Right From The Start. The passage of the West Virginia Birth Score, in this same legislation, further strengthened the State's ability to universally screen all newborns for developmental delay, hearing loss, and conditions that may place infants at risk of death in the first year of life. The original birth score instrument was modified to accommodate hearing screening, so one instrument and one tracking system addresses the mandate. All WV birthing facilities began universal screening effective July 1, 2000. The MCFH Provider Education unit (nurses) visited the State's birthing facilities and offered technical assistance related to operationalizing the initiative.

In 2002, three additional Bills were passed, SB 672 establishing a Birth Defects Surveillance System, HB 216 requiring screening of all children under the age of 72 months for lead poisoning, and HB 3017 requiring the creation of a state oral health program. Although all of these programs existed previously, legislative mandates ensure continuance of these health efforts. The Birth Defects Surveillance Program and the Childhood Lead Screening Program are largely supported by grants from the Centers for Disease Control (CDC). The Birth Defects Surveillance System, received a grant from the CDC to build capacity to extract information directly from the medical records in place of relying solely on birth certificate, abortion and death record information. Rules for The Birth Defects Surveillance Program and The Childhood Lead Poisoning Prevention Program were passed by the 2004 Legislature. The Children's Dentistry Program is largely supported using Title V funds, while TANF funds support dental services to adults who are entering the job market or returning to work.

#### Population

For the sixth year in a row, more state residents died than were born. In 2002, 274 West Virginians were lost to the total population as a result of natural decrease, the excess of deaths over births. The rate of natural decrease was 0.2 persons per 1,000 population. Results from the 2002 Census estimate show an overall decrease (approximately 0.4%) in the state's population since 2000, from 1,808,344 to 1,801,873. This decrease is the result of an overall natural decrease and an excess of outmigration over immigration during that span.

#### Live Births

West Virginia resident live births increased by 295, from 20,430 in 2001 to 20,725 in 2002. The 2002 birth rate of 11.5 per 1,000 population also rose from 11.3 in 2001. The U.S. 2002 birth rate was 13.9 live births per 1,000 population, lower than 2001 (14.1). As the graph below shows, West Virginia's birth rate has been below the national rate since 1980. It has continued its overall decline, interrupted by slight upturns in 1989 through 1991, 1999, and 2002.

The 2002 U.S. fertility rate of 64.8 live births per 1,000 women aged 15-44 was 0.9% lower than the 2001 rate (65.4). West Virginia's fertility rate, however, increased 1.9% from 54.6 in 2001 to 55.6 in 2002. The fertility rate among women aged 20-44, however, was 15.7% lower in the state than in the nation (57.9 vs. 68.7).

The number of births to teenage mothers decreased by 23 (0.9%), from 2,669 in 2001 to 2,646 in 2002. The percentage of total births represented by teenage births decreased from 13.1% in 2001 to 12.8% in 2002. The significantly lower fertility rate among older women, however, resulted in teenage births continuing to constitute a higher proportion of total births than is found nationally (10.8% in 2002).

The percentage of births occurring out of wedlock rose from 2001, and once again nearly one out of every three (32.8%) West Virginia resident births was to an unwed mother. The percentages of white and black births that occurred out of wedlock in West Virginia in 2002 were 31.6% and 72.1%, respectively, compared to 30.9% and 77.1% in 2001. In the United States in 2002, 28.5% of white births and 68.2% of births to black mothers occurred out of wedlock. The percentage of teenage births to unmarried teenage mothers in the state decreased minimally from 71.5% in 2001 to 71.4% in 2002. There were a total of 1,915 low birthweight babies (those weighing less than 2,500 grams or 5 1/2 pounds) born to West Virginia residents in 2002, 9.2% of all births. Of the 1,909 low birthweight infants with known gestational age, 1,307 or 68.5% were preterm babies born before 37 weeks of gestation. (Of all 2002 resident births with a known gestational age, 11.7% were preterm babies.) Of the births with known birthweight, 14.2% of babies born to black mothers and 9.1% of babies born to white mothers were low birthweight. Nationally, 7.7% of all infants weighed less than 2,500 grams at birth in 2002; 6.8% of white infants and 13.3% of black infants were of low birthweight.

Eighty-six percent (86.0%) of West Virginia mothers with known prenatal care began their care during the first trimester of pregnancy, compared to 83.7% of mothers nationwide in 2002. Among those with known prenatal care, 86.4% of the white mothers began care during the first trimester; 75.9% of black mothers did so. (U.S. figures show 85.4% of white mothers and 75.2% of black mothers.) No prenatal care was received by 0.4% of white mothers and by 1.3% of black mothers.

Over one-fourth (26.0%) of the 20,725 births in 2002 were to mothers who smoked during their pregnancies, while 0.4% of births were to women who used alcohol. National figures show that 11.4% of women giving birth reported smoking during pregnancy and 0.8% used alcohol. Of the state mothers who reported smoking during pregnancy, 13.6% of the babies born were low birthweight,

compared to 7.7% for non-smoking mothers. U.S. statistics show 12.2% births to smoking mothers were low birthweight and 7.5% for non-smoking mothers. Nearly thirty percent (29.3%) of 2002 state births were delivered by Cesarean section, compared to a national rate of 26.0%. One or more complications of labor and/or delivery were reported for 32.1% of deliveries in the State in 2002.

#### Deaths

Effective in 1999, the National Center for Health Statistics (NCHS) and World Health Organization (WHO) adopted the 10th revision to the International Classification of Diseases -- now known as ICD-10. This is the first revision since 1979 and includes a more comprehensive classification of causes of death. Previously, all causes of death were coded numerically. Now all causes of death are coded alpha-numerically, allowing many more possible causes (Table 42, pages 95-121). When comparing 1999 deaths to earlier years, differences between ICD-9 coding and ICD-10 coding must be taken into account. Appendix B contains a more detailed explanation of ICD-10, as well as the new selected causes of death listing.

The number of West Virginia resident deaths increased by 21, from 20,978 in 2001 to 20,999 in 2002. The state's crude death rate also increased from 11.6 per 1,000 population in 2001 to 11.7. The average age at death for West Virginians was 72.5 (68.5 for men and 76.4 for women). One hundred and twenty-five West Virginia residents who died in 2002 were age 100 or older. The oldest woman was 109 years old at the time of death, while the oldest man was 107 years old.

Heart disease, cancer, and stroke, the three leading causes of death, accounted for 57.6% of West Virginia resident deaths in 2002. Compared to 2001, the number of state deaths due to heart disease decreased 1.3% while cancer deaths decreased 0.6%. Deaths due to stroke, which surpassed chronic lower respiratory diseases for the first time since 1999, also decreased 2.0%, while chronic lower respiratory disease mortality decreased 4.3%. Diabetes mellitus deaths increased 4.5%, while the number of reported deaths due to pneumonia and influenza decreased substantially (28.2%) from 2001 to 2002. Mortality resulting from accidents increased by 107, from 840 in 2001 to 947 in 2002. Motor vehicle accident deaths continued to number fewer than the 435 deaths in 1993, the year the West Virginia seatbelt law took effect; they increased by 44 (12.0%) from 368 in 2001 to 412 in 2002. Accidental poisoning deaths continued to increase, from 127 in 2001 to 156 in 2002.

Accidents were the leading cause of death for ages one through 44 years. Even with the precipitous drop in motor vehicle accident deaths between 1993 and 1994, such fatalities remained the single leading cause of death for young adults aged 15 through 34, accounting for 27.7% of all deaths for this age group in 2002, compared with 29.1% in 2001. West Virginia's 2002 motor vehicle fatalities included three children under five years of age, compared to eight in 2001.

Suicides decreased by thirteen (290 to 277, or 4.5%) between 2001 and 2002. Male suicides decreased 2.9%, from 245 in 2001 to 238 in 2002; the number of female suicides (39) decreased by six or 13.3% from 2001. Almost seventy percent (69.7%) of all suicide deaths were firearm related - 74.4% of male suicides and 41.0% of female suicides. The average age of death for a suicide victim in 2002 was 45.2 years. While suicide was the 11th leading cause of death overall, it was still the second leading cause of death for ages 15-34. The number of suicides among persons aged 19 and under nearly tripled, from 8 in 2001 to 22 in 2002.

Homicides in West Virginia increased by 31, from 67 in 2001 to 98 in 2002. Sixty-eight (68) of the homicide victims were male, 30 were female. The average age at death for a homicide victim in 2002 was 35.6 years. There were six homicide victims under the age of five in 2002, compared to two in 2001. About two-thirds (66.3%) of 2002 homicide deaths were due to firearms.

#### Years of Potential Life Lost (YPLL)

YPLL is a measure of mortality, calculated as the difference between age 75 (an average life span) and the age at death. Using YPLL before age 75, the sum of YPLL across all causes of death represents the total YPLL for all persons dying before the age of 75. A person dying at the age of 45 would therefore contribute 30 years to the total YPLL ( $75-45=30$ ). YPLL is an important tool in emphasizing and evaluating causes of premature death. In our previous reports, data for YPLL before age 65 were presented.

The YPLL from all causes increased 7.0%, from 152,199 YPLL in 2001 to 162,798 in 2002. The three leading causes of YPLL in 2002 were once again malignant neoplasms (34,978 YPLL), diseases of the heart (27,991 YPLL), and motor vehicle accidents (14,150 YPLL). Combined, these three causes accounted for around half (46.2%) of all years of potential life lost in 2002. In comparison to 2001,

YPLL attributable to malignant neoplasms decreased from 22.8% of the total to 21.5%. YPLL due to diseases of the heart also decreased from 18.2% to 17.2%, but the percentage of total YPLL due to motor vehicle crashes increased, from 8.4% to 8.7%.

### Infant Deaths

Deaths of infants under one year of age rose substantially by 39, from 149 in 2001 to 188 in 2002. West Virginia's infant mortality rate also increased, from 7.3 per 1,000 live births in 2001 to 9.1. The U.S. provisional 2002 infant mortality rate was 7.0, up slightly from 6.9 in 2001.

The state's 2002 white infant mortality rate increased 18.1%, from 7.2 in 2001 to 8.5 in 2002, while the rate for black infants more than doubled (145.2%), from 11.5 to 28.2.

Approximately one in seven (14.4%) infant deaths in 2002 was due to SIDS (sudden infant death syndrome). Twenty percent (20.2%) were the result of congenital malformations, while 51.1% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birthweight (9.6%).

### Neonatal/Postneonatal Deaths

The number of neonatal deaths dropped by only one, from 110 in 2001 to 109 in 2002; the neonatal death rate also decreased from 5.4 deaths among infants under 28 days per 1,000 live births in 2001 to 5.3 in 2002. Neonatal deaths comprised 58.0% of all West Virginia resident infant deaths in 2002, compared to 73.8% in 2001. The rate of postneonatal deaths increased from 1.9 deaths per 1,000 neonatal survivors in 2001 to 3.8 in 2002. The 2002 U.S. neonatal death rate was 4.7, while the postneonatal rate was 2.3 deaths per 1,000 neonatal survivors.

### Fetal Deaths

The 140 resident fetal deaths occurring after 20 or more weeks of gestation reported in 2002 were 13 fewer than 2001 (153). The fetal death ratio also decreased from 7.5 deaths per 1,000 live births in 2001 to 6.8 in 2002. The majority (85.7%) of fetal deaths were due to conditions originating in the perinatal period, including complications of placenta, cord, and membrane (37.1%), maternal conditions (1.4%), maternal complications (12.1%), short gestation and low birthweight (7.1%), and other ill-defined perinatal conditions (18.6%). Congenital malformations accounted for 14.3% of all fetal deaths.

### Marriages

For the second year in a row and following a dramatic increase due to the passage of a new law that became effective June 2, 1999\*, the number of marriages in West Virginia decreased from 14,581 in 2001 to 14,558 in 2002. The marriage rate in 2002 was 8.1 per 1,000 population, same as 2001. The 2001 U.S. provisional rate was 7.9. For all marriages in 2002, the median age for brides was 27 and for grooms 29. For first marriages, the median age for brides was 23 and for grooms was 25. The mode (most frequently reported age) for all marriages as well as first marriages was 22 for brides and 23 for grooms.

### Divorces and Annulments

The number of divorces increased by 21 or 0.2%, from 9,421 in 2001 to 9,442 in 2002. The 2002 rate of 5.2 per 1,000 population was the same as 2001. The 2000 U.S. provisional rate was 4.0 per 1,000 population.

Of the 9,442 divorces in West Virginia in 2002, the median duration of marriage was 7 years. Over half (52.2%) of the divorces involved no children under 18 years of age in the family, while one child was involved in 24.1% of all divorces and two children were involved in 17.4%. Three divorces involved six or more children.

### Summary

The number of West Virginia resident births increased by 295 from 20,430 in 2001 to 20,725 in 2002. West Virginia resident deaths also increased from 20,978 in 2001 to 20,999 in 2002. The number of infant deaths increased by 39, from 149 in 2001 to 188 in 2002. Fetal deaths of 20 or more weeks gestation fell from 153 in 2001 to 140 in 2002. Marriages decreased for the second time in four years,

from 14,581 in 2001 to 14,558 in 2002, while divorces increased by 21, from 9,421 in 2001 to 9,442 in 2002.

\*The new law removed the three-day waiting period for persons aged 18 and older as well as the requirement for a blood test for syphilis.

## **B. AGENCY CAPACITY**

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

We have expanded income eligibility coverage for pregnant women to 185% of the Federal Poverty Level, in response to patient demand, using Title V monies. Although the OMCFH is less and less involved as a health care financier, we continue to provide gap filling services when indicated. At this point, SSI populations have not been enrolled in Medicaid Managed Care (MMC), and we continue to present the case that this population requires services that do not fit well within the traditional medical model. In regards to other programs, we continue to recruit providers and provide training relative to EPSDT, including training for HMO providers. We also have maintained our existing network of outreach workers to encourage families to access primary preventive care, now offered by the HMO's.

The Office of Maternal, Child and Family Health in West Virginia is constituted of five divisions, plus a Quality Assurance/Monitoring Team, Provider Education Unit, Provider Recruitment, and an Administrative Unit (made-up of the Office Director, and Human Resources Coordinator. With the exception of the Division of Children's Specialty Care, the Office of Maternal, Child and Family Health does not deliver direct services but rather designs, oversees and evaluates preventive and primary service systems for West Virginia women and men of reproductive age, infants, children, adolescents, and children with special health care needs. In FY 2000, MCH was assigned responsibility to use TANF dollars for developing dental/vision care for adults transitioning from Welfare to work. Following is a brief description of the Divisions and the programs administered by OMCFH:

Division of Perinatal and Women's Health: Primary and Preventive Services for pregnant women, mothers and infants.

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

Family Planning Program:

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

examination, appropriate laboratory testing, and referral to specialty care, if needed. In addition, voluntary sterilization services are available to low-risk, uninsured female and male clients. Family Planning clinical services are offered statewide through a network of 150 locations in all 55 counties of the State. The sites include county health departments, primary care centers, hospital outpatient centers, private providers, free clinics and university health sites. Medical services, contraceptive and clinical supplies, laboratory services, and client educational materials are purchased, in part, with Title V funds.

In early 2002, the Family Planning Program administration was charged by the leadership of the WV Department of Health and Human Resources with development and implementation of a comprehensive Action Plan to reduce unintended pregnancy and the incidence of out-of-wedlock births. The Administration recognized the impact of unintended pregnancies and unmarried births on multiple DHHR programs, i.e., welfare and social service programs, Medicaid, Child Support Enforcement, etc., and reinforced the role of the FP Program in addressing this issue. In response, the Office developed an Action Plan which linked primary and secondary pregnancy prevention activities with all Bureaus within the Department. The Action Plan is attached.

Adolescent Pregnancy Prevention Initiative:

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

In addition, the APPI assumed a leadership role in the revitalization of the West Virginia State Task Force on Adolescent Pregnancy and Parenting (WVSTFAPP), a member-funded, non-profit organization of volunteers and professionals concerned about the health and well-being of West Virginia's adolescents. The mission of WVSTFAPP is to prevent unintended/uninformed pregnancy and other adverse consequences of adolescent sexual activity. This group reflects ideas and cultural diversity across West Virginia, with multiple State and local agencies, programs and initiatives represented. Local and community leaders are also an active component of the Task Force. This team is working to strengthen school-based teen pregnancy prevention policies and programs already in place.

Right From The Start Project:

The Right From The Start Project (RFTS) provides comprehensive perinatal services to low income women and infants up to one year of age. The project provides the following services: 1) Recruitment of medical practitioners to care for low income, government sponsored populations (Title XIX, Title V). 2) Establishes the expectation that national standards of care (ACOG) will be followed. 3) Recruitment and credentialing of practitioners to care for Medicaid and Title V sponsored obstetrical patients, including the completion of signed contractual agreements that establish expectation for care in accordance with national standards. 3) All participating providers complete signed agreements with OMCFH specific to services/benefits, risk scoring and patient information exchanges. 4) Title V provides financial assistance for obstetrical care for pregnant adolescents ages 19 and under who are not eligible for Medicaid regardless of income 5) Financial assistance for prenatal care for non-citizens. (They may be eligible for Medicaid at the time of delivery as this is considered an emergency situation.) 6) Direct financial assistance for obstetrical care for pregnant women denied Medicaid, but whose income is equal to or less than \$100 per month over 185 percent of the Federal Poverty Level. 7) Limited coverage for prenatal patients who at the time of first prenatal visit have not received a Medicaid card and are subsequently denied, or prenatal patients whose Medicaid coverage is not backdated to cover the first visit. Services may include lab work, the initial prenatal visit, and ultrasound, if necessary. This was the closest we could come to presumptive eligibility. The cost of these services are paid for by the OMCFH using Title V funds. 8) Assistance for patient access to health care and the WIC Program. 9) Care Coordination for Title V and Title XIX obstetrical patients and their infants/children less than one year of age. Care Coordination components include a personalized in-home assessment to identify barriers to health care, an individually designed care plan to meet the patient's needs, community referrals as necessary, follow-up and monitoring. All

pregnant Medicaid and Title V cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation, parenting, nutrition).

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

The Smoking Cessation Program developed by Dr. Richard Windsor was implemented in West Virginia in January 2002, incorporating it into the RFTS Project. This smoking cessation program is called 'SCRIPT'." The WV RFTS 'SCRIPT' uses the existing home visitation network and protocols established in the current Right From The Start Project. Services are provided by registered nurses and licensed social workers throughout West Virginia.

The Access to Rural Transportation (ART) Project, in conjunction with the Office of Family Support, Non-Emergency Medical Transportation Program, administers a statewide system to provide transportation dollars to needy infants and pregnant women prior to the actual medical encounter to ensure access to "medically necessary" care. The ART Project purchased approximately 13,374 transportation services in 1998, 13,009 in 1999, 15,564 in 2000 and 14,921 in 2001.

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

#### Perinatal Outreach Project:

Perinatal education efforts has its origins in the Improved Pregnancy Outcome Projects of the 1970's, which has since been discontinued. The method used for skill enhancement has changed, but the opportunity and need to link tertiary care expertise to community providers remain constant. The original intent of the Perinatal Outreach Project (POP) was to partner with the three tertiary care hospitals in the state in the effort to reduce the infant mortality rate in West Virginia and to build a referral system for high risk pregnant women and infants. The project began in the late 1970's when the neonatal intensive care nurseries were just opening. The Office of Maternal, Child and Family Health supported the purchase of newborn resuscitation and monitoring equipment for community hospitals and funding of the outreach educators in each center. This outreach project was a part of the bigger picture in the statewide system to reduce the high costs associated with care of the high risk newborns and pregnant women. Each tertiary care hospital was assigned a region and was responsible for developing and implementing programs aimed at educating health care providers on the latest medical protocols and to support high risk patient referrals. West Virginia's infant mortality rate has fluctuated over the last ten years, but has continued to decrease since 1997 from 9.5 to 7.6 in 1999. In 2000, our infant mortality rate remained at 7.6. In 2001, our infant mortality rate was 7.3 and in 2002 our infant mortality increased to 9.1.

#### Newborn Hearing Screen:

All children born in WV are screened at birth for the detection of hearing loss. Children who fail the screen are followed and assisted in obtaining further diagnostic services. Children who need hearing aids are assisted by CSHCN.

#### Birth Score:

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

### Breast and Cervical Cancer Screening Program:

The Breast and Cervical Cancer Screening Program (BCCSP) is a major force in the state's cancer and medical community. Implemented in 1991 through a grant from the Centers for Disease Control National Breast and Cervical Cancer Early Detection Program, the program's purpose is to reduce mortality from breast and cervical cancers by establishing, expanding and improving community-based screening services. Many women face economic and geographic barriers that prevent them from participating in a regular program of screening. Components of the program include public and provider education, community assessment, outreach to high-risk populations, surveillance, screening, case management and follow-up services. This program links women who have cancer diagnoses to the Breast and Cervical Cancer Prevention and Treatment Act available under Title XIX with all case management provided by BCCSP staff. On April 1, 2001, WV became one of the first three states to take advantage of the passage of the Breast and Cervical Cancer Treatment Act 2000. This option allows states to provide full Medicaid benefits to uninsured women under age 65 by the BCCSP (Title XV) and in need of treatment.

### Preventive and primary care services for children and adolescents:

#### Division of Infant, Child and Adolescent Health:

The goal of this Division is to promote parent/professional collaboration through parent participation on advisories; develop and issue medical care protocols in collaboration with the medical community to ensure provision of quality community-based services for child populations; and develop patient education and outreach strategies to encourage use of preventive health care.

#### Abstinence Only Education:

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

#### The Adolescent Health Initiative:

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

#### EPSDT/HealthCheck:

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

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

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

The EPSDT Program has an extensive outreach component responsible for meeting federal EPSDT informing, linking and follow-up requirements. Pediatric Program Specialists and Family Outreach

Workers (FOW) are assigned to each region and county to accomplish the outreach activities. FOWs are paraprofessionals, hired and housed in the community in which they live and work. The Program Field Specialists are responsible for provider recruitment, training, technical assistance and all compliance related to monitoring issues.

The Children's Dentistry Program:

Works in concert with other Office of Maternal, Child and Family Health programs, Head Start and the public schools to promote awareness and availability of dental health services as an integral part of preventive, primary health services. Dental health efforts are funded from the Preventive Health Block Grant, Title V, and State appropriation. The program conducts needs assessments, provides fiscal resources to local communities to support learning opportunities for children which encourage behavioral change; i.e., regular check-ups, brushing/flossing, use of mouth guards during sports activities. OMCFH has contracts with local health departments serving 26 counties of the state's 55. These local health departments are responsible for oral health education efforts including working with the public school system. The Office has developed education modules which were approved by the WV Dental Association which are used in public school instruction. This program also supports fluoridation and sealant efforts.

Preventive, primary, and rehabilitative services for Children With Special Health Care Needs:

Division of Children's Specialty Care:

Children with Special Health Care Needs Program:

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

Parent Network Specialists System:

In conjunction with the West Virginia University Center for Excellence in Disabilities (WVUUCED), Title V funds the Parent Network Specialists system. These parent/family advocates participate at all levels of CSC operations, including development of program policy and forms. Seven parents of developmentally disabled children serve an assigned regional area of West Virginia linking families to resources, information and services working through organized parent groups and CSHCN clinic settings.

Systems Point of Entry:

State System's Development Initiative grant monies enabled the Children's Specialty Care system to integrate many activities into a unit now called Systems Point of Entry. Because of its growth, it has become the centralized information, education and referral center for the Office of Maternal, Child and Family Health as well as serving as an intake unit for statewide applications made to CSHCN. Families who are not eligible for CSHCN, or other MCFH services, are attended to using health, education and social service programs external to OMCFH to meet the needs of families.

Toll-free Lines:

In June 2000, the toll-free lines were relocated to the SPE unit allowing for more efficient tracking and monitoring.

#### WV Birth to Three/Part C DEA:

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

#### Genetics Project:

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

#### Division of Research, Evaluation and Planning:

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

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

#### Pregnancy Risk Assessment Monitoring System (PRAMS):

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

#### Sudden Infant Death Syndrome Project:

Collects and reports data regarding the occurrence of SIDS deaths in the State. An Advisory Committee, made up of the medical examiner, medical personnel, a member of the Child Fatality Review Team, clergy, mental health professionals, and parents provide ongoing direction for this Project. When a SIDS death is reported, a local health department nurse is contacted to make a home visit to interview and assess the needs of the parents. Educational and grief information is sent to the family upon request. Training is provided to emergency room personnel, police, and funeral home personnel to sensitize them and offer strategies for responding to families.

#### Newborn Metabolic Screening Project:

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

#### Childhood Lead Poisoning Prevention Project:

A collaborative effort between two Offices in the Bureau for Public Health, OMCFH and Environmental Health, funded by the CDC. An Advisory guides the operation of the Program, assisting the State with determining the extent of childhood lead poisoning in WV. To this end, extensive data gathering and

analysis are routinely distributed. The Office of Environmental Health Services, using its local network of community-based sanitarians, provides assessment of home and environment, for residences of children with elevated blood lead levels. The OMCFH's CLPPP nurses case manage all children with positive BLL of >10mcg. Recent 2002 legislative action has resulted in the mandated screening/assessment of all high risk children under the age of 6 years for lead poisoning.

Quality Assurance/Monitoring Unit:

The OMCFH Quality Assurance Monitoring Team has over 21 years proven experience in conducting on-site clinical review. These reviews occur with every medical provider who contracts with the Office - private physicians, primary care centers, local health departments, hospitals, etc. The reviews are conducted on site and include patient interviews, chart reviews, and provider interviews. Formal reports are submitted to each program. Technical assistance and corrective action plans are the next step in the process.

### **C. ORGANIZATIONAL STRUCTURE**

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

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

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

### **D. OTHER MCH CAPACITY**

In all, there are 239 staff positions in West Virginia's Title V agency. Of these positions 9 are senior management, 39 professionals, 22 medical professionals, 39 para-professionals, 103 clerical workers, 9 technicians, and another 18 professionals under contractual hire.

During Fiscal Years 1997 and 1998, two parent advisors were recruited by the Office of Maternal, Child and Family Health, one as a paid employee and the other as a volunteer. These positions have been maintained, and additional parent-to-parent coordinators located in the community and hired through contract have been increased to four. Parent advisors are often trained alongside our developmental disabilities community related to advocacy, public presentation skills, and public policy development. The parent advisors participate in CSC clinical activities and document activities for inclusion in the medical records. Parent Advisor reports are color coded and used as documentation of additional service needs, such as specific medical information, special consideration requests, etc. CSC funds the Parent Network Specialists system, through a contract with the WVU Center for Excellence in Disabilities. These parent/family advocates participate at all levels of CSC operations (PartC and CSHCN), including development of program policy and forms. During the year 2002, this network was expanded to four (4) parents of developmentally disabled children, each serving a regional area of West Virginia. The goal is to expand to six (6) Parent Network Specialists by 2004. The Children's Reportable Disease Project recruited a parent volunteer for its SIDS Project. The SIDS parent is an active member of the SIDS Advisory Committee and is a parental contact for families who have experienced a recent SIDS death.

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

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

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

PROFESSIONAL EXPERIENCE:

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

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

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

PROFESSIONAL EXPERIENCE:

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

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

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

#### PROFESSIONAL EXPERIENCE:

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

Janet E. Lucas, B.A.--Director, Division of Children's Specialty Care  
EDUCATION:

Bachelor of Arts in English/Social Studies, Marshall University, Huntington, West Virginia  
Post graduate studies, University of Pittsburgh Graduate School of Public and International Affairs,  
Pittsburgh, Pennsylvania.  
Marshall University, Graduate School of Education, Huntington, West Virginia

#### PROFESSIONAL EXPERIENCE:

Director, Children's Specialty Care  
Office of Maternal, Child and Family Health.  
Bureau for Public Health  
Health Planner  
West Virginia Health Care Authority  
Network Coordinator  
Center for Economic Options  
Project Manager  
National Center for Education in Maternal and Child Health  
Administrative Director  
Division of Handicapped Children's Services  
Assistant Administrative Director  
Division of Handicapped Children's Services  
Administrative Assistant  
Office of Child Support Enforcement  
Economic Services Program Coordinator  
West Virginia Department of Health and Human Resources.  
Supervisor  
Eligibility Program, Aid to Disabled and Blind  
Eligibility Specialist III  
Prince William County schools, Manassas, Virginia, Classroom Teacher

Patricia A. Meadows, RN - Director, Perinatal and Women's Health Division  
EDUCATION:

Beckley College, 1981 - 1982  
Bluefield State College, 1982 - 1984 (Associate's Degree in Nursing)  
West Virginia State College, 1998 - 1999 (Bachelor of Arts Degree)  
University of Phoenix, 2001 - 2003 (Master's in Organizational Management)

## PROFESSIONAL EXPERIENCE:

Program Director of Perinatal and Women's Health Division, Office of Maternal, Child and Family Health (2004)

Assistant Administrator, Trauma/Renal/Emergency/Pre-Hospital Services, Charleston Area Medical Center (2000 - 2004)

Program Director, Trauma Service Director, Charleston Area Medical Center (1996 - 1999)

Nurse Manager, Emergency Services, Charleston Area Medical Center, General Division (1991 - 1996)

School Nurse, Johnson County Department of Health, Paintsville, Kentucky (1989 - 1990)

Nurse Manager, Emergency Department, Raleigh General Hospital, West Virginia (1984 - 1989)

## E. STATE AGENCY COORDINATION

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

The Office of Maternal, Child and Family Health has in place many systems that contribute to the early identification of persons potentially eligible for services. These population based systems include birth score, birth defect registry, pregnancy tracking systems, metabolic screening, and most recently, newborn hearing screening. In addition, because we administer the EPSDT Program, children who have conditions that may be debilitating and/or chronic disease, are referred to CSHCN for further evaluation. This connection with EPSDT, which targets some 200,000 eligible children yearly, provides public health with a vehicle for identifying youngsters with problems, knowing that economically disadvantaged children are at increased risk. OMCFH, in an effort to increase public awareness, routinely participates in health fairs and community events. Our toll free lines, established

in 1980, average close to 3,000 calls per month. Each caller receives individualized follow-up to assure the referrals and pertinent information related to the request met their need. Callers are also contacted by an administrative entity within OMCFH to ascertain the caller's satisfaction with our services. This quality assurance monitoring is prepared using random sampling. OMCFH toll free lines always receive accolades. Evaluation materials are on file and available if desired. The population based systems also include blood lead level screening. In this past legislative session SB 216 was passed requiring blood lead screening of all children under the age of six along with SB 672 requiring establishment of a Statewide Birth Defects Surveillance System which was already in existence.

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

#### Agency Partners

- A. 400+ medical contracts with private physicians, community health centers, local health departments and hospital based clinics for the provision of EPSDT.
- B. Birth to Three/Part C provides grants to local entities to act as system point of entry for eligibles.
- C. Memorandum of Understanding with WIC and SSA for referrals as referenced earlier.
- D. Working agreement with the Office of Social Services (Title IVB) for children in state custody to receive enhanced health screens through MCFH's medical provider networks.
- E. Working agreement with the Office of Social Services for interagency training for professionals and para-professionals serving young children-including use of assistive technology and understanding ADA.
- F. Agreements with WVU for genetic services and administration of the Birth Score Project.
- G. 150 agreements statewide with private physicians, community health centers and local health departments for Title X family planning services.
- H. 153 agreements statewide for breast and cervical cancer screening program services.
- I. Agreements with 8 agencies to locally administer the Right From The Start Project and subsequent agreements with multiple agencies to provide direct services to perinatal populations who employ over 233 licensed social workers and nurses.

Other partnerships include\*:

- J. March of Dimes
- K. Developmental Disabilities Council
- L. Medical Advisories for all programs and projects
- M. University Affiliated Program, Consumer Advisory Council membership
- N. Interagency Coordinating Council for Birth to Three/PartC (state statute established).
- O. Department of Education/Healthy Schools
- P. Starting Point Centers (Early Childhood Initiative, initially funded with Carnegie Foundation monies)
- Q. Governor's Cabinet on Children and Families
- R. Head Start
- S. Cancer Coalition (established state statute)
- T. Membership, West Virginia Association of Community Health Centers
- U. WV Commission for the Deaf and Hard of Hearing (Board Member)
- V. Women's Health Advisory Council
- W. Children's Mental Health Collaborative
- X. All Offices within The WV DHHR

\*List is not all inclusive

All agreements and contracts are kept on file with the WVOMCFH.

## F. HEALTH SYSTEMS CAPACITY INDICATORS

Health Systems Capacity Indicators:

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

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

In West Virginia, in 2002, there were 935 hospital discharges for asthma for children under the age of five (5). There is an estimated 12.4% of WV high school children who suffer from asthma according to the Youth Tobacco Survey. Approximately 10.3% of middle school students and 8.8% of high school students had an attack of asthma in the past one year. WV has one of the highest smoking rates nationally and second hand smoke is a known irritant for asthma. In August of 2001, the OMCFH wrote a letter of support for a CDC sponsored grant submitted by the Office of Epidemiology and Health Promotion through their Tobacco Prevention Program. Appropriately so, tobacco monies are also being used to address the environmental factors that increase the risk of developing asthma or exacerbate the disease. The grant was approved to enable the development of a statewide plan to address prevention and treatment of asthma efforts. Although the OMCFH is not the home of the asthma initiative, since it is a disease that affects both children and adults, the OMCFH has a role in prevention via education of parents and children, plus a direct clinical care role which includes: 1) addressing maternal smoking during pregnancy and/or early infancy, and 2) provision of asthma therapy for children to include maintaining pulmonary function, normal activity levels, minimizing emergency room visits and hospitalization, and making available medication to control persistent asthma and "quick relief" medication to treat acute symptoms.

A West Virginia Asthma Coalition was formed with members from public health Offices as well as community physicians and other interested agencies. In the information discovery phase a startling finding was that more students with asthma smoke than those who don't have asthma.

The Coalition's role is one of prevention through education, establishing disease reporting parameters and mechanisms enabling tracking of incidence levels, advocacy for inclusion of benefit coverage across all payors for those affected by the disease, and payment for screening and prevention activities. There also remains the responsibility to assure screening, treatment, etc., is available and accessible to all, an assignment which exceeds the scope of health care financing available to MCFH.

#2--The percent Medicaid enrollees whose age is less than one year who received at least one initial or periodic screening.

The OMCFH administers the mandated Medicaid EPSDT Program (HealthCheck). The HealthCheck Program educates families who receive Medicaid about preventive health care for their children and encourages their participation in the HealthCheck Program while ensuring the following: 1) children are screened/re-screened according to periodicity tables established by the American Academy of Pediatrics; 2) medical problems identified by examination are treated/referred; and 3) children/families receive transportation assistance and help with appointment scheduling. In WV, 95% of children under the age of one (1) who receive Medicaid, receive at least one initial or periodic screening. The HealthCheck Program focuses on recruitment and training of providers to assure compliance with program protocols, and targeted outreach by phone and mail. (see performance measure #8 for additional information).

#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.

As of December 31, 2003, 22,826 children ages 0-18 were covered by SCHIP in WV. It is estimated that 27,000 children in WV are eligible for SCHIP. The WV Healthy Kids Coalition has provided extensive outreach since the inauguration of SCHIP and have enrolled over 40,091 children since its inception. There were 106 children eligible for SCHIP under the age of 1 and 46 received at least one periodic screening or 43%.

#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. West Virginia's perinatal program (RFTS) provides comprehensive maternity care for government sponsored pregnant women whose income is at or below 185% of poverty. These services are paid for by Medicaid and Title V. (Note: Legal aliens and adolescents are also provided coverage using Title V monies.) Medical case management for high risk women and infants is provided to facilitate entry into, and receipt of, appropriate health care for populations who, because of medical conditions/predilections, might otherwise not have appropriate or available care. Components include: 1) intensive outreach statewide to identify pregnant women; 2) operation of statewide toll-free line to link pregnant women to obstetrical services; 3) tracking of positive pregnancy tests by community care providers to link patients to care; in the event this fails, follow-up is provided via phone and/or home visitation; 4) all women are screened for risk conditions; 5) initial prenatal visits, lab, etc is defrayed by Title V, if a woman is pregnant and has no means of paying for health care. The patient is given information on how to access Medicaid, including the opportunity for submission of patient-self-completed Medicaid application including the opportunity to complete an online application.

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

The Children's Dentistry Program (CDP) is a component of the Division of Infant, Child and Adolescent Health and is housed within the OMCFH. Data for 2002 suggests that only 48% of West Virginia Medicaid recipients aged 6-9 received a dental service. In West Virginia, Medicaid child beneficiaries have financial access to dental services, yet most do not routinely seek care. Failure to keep appointments adversely affects willingness of dentists to serve the Medicaid population, thus limiting access. It is clear that public health must facilitate opportunities for youth to access dental care by educating children, youth, and their parents about the importance of oral health. The CDP currently has 17 contracts with local health departments and individuals to offer oral health education to students in public schools. Educators offer information about dental hygiene, the need for preventive dental visits, and the dangers of tobacco use. The CDP, in partnership with county school systems, Head Start agencies, and other community children's programs, are working together to offer a sealant and fluoride rinse program within schools. The CDP contracts with local dentists to purchase all supplies, and perform all billing functions. Payments from existing insurance sources are sufficient to cover operational costs and ultimately improve oral health access. There are significant numbers of West Virginians who do not have a fluoridated water supply. Some of those receive water from public systems. Fluoridation equipment is expensive and supplies are no more than \$3 per customer per year. The savings in future dental caries is 5 to 6 times that amount. For example: For a town the size of New Martinsville (currently not receiving fluoridated water), the annual cost of fluoridation would be \$25,500. If only one cavity is prevented in an entire family, the net savings for the community is \$124,200 annually. The CDP is beginning a project to work with a limited number of local communities and water systems to advocate for fluoridation and to assist communities to be able to obtain fluoridation. A small amount of funding is available to pay for necessary equipment. The Office of Environmental Health Services has been approached as a non-funding partner and is willing to participate. Other funding sources are currently being explored. The infrastructure development will have lasting implications and may be supported through the Governor's Office of Community Development.

The CDP is currently on a pilot project in McDowell County for a school-based dental clinic. The CDP has purchased equipment and supplies for this project. In addition to preventive services, patients will be provided with oral health education materials and referred to local dentists for restorative care when necessary. Two other community health centers in different counties have expressed an interest in replicating this model.

It has long been realized that children with disabilities in West Virginia do not have sufficient access to dental services. The only clinic serving this population is located in Morgantown, WV, in the north central part of the state. CDP is partnering with a community health center to establish a periodic clinic in the southern part of the state to care for children with disabilities.

To design effective health promotion campaigns and materials, we must know what the customer is thinking. The CDP is implementing a research project in conjunction with higher education to learn

more about the attitudes of youth and parents toward dental care, and learn more about the barriers to receiving dental care.

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

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

In CY 2002, 5,197 children/youth were served in 47 specialty care clinics state-wide by 52 participating clinicians. Within the clinic system there were 5,066 visits and 990 diagnostic evaluations were completed. There were 446 transition services to youth ages 14,16,18 and 21. 78.8% of children participating CSHCN are Medicaid beneficiaries. This high percentage is attributed to CSHCN Program's commitment to assisting families with SSI application, the expedited SSA/Disability Determination process, and our attention to obtaining health care financing for this targeted group. For CY 2002 there were 1,376 number of children ages 0-16 who received SSI and also received CSHCN services. As of December 2002 there were 6,880 children in WV under the age of 16 receiving SSI benefits indicating that the CSHCN Program served 20% of WV children under the age of 16 who received SSI benefits.

Children are seen more frequently if medically indicated; consequently, children with cystic fibrosis attended CSHCN clinics more often than children with hearing impairments or those needing eye surgery. Since a child/family may not be equally in need of social service support, the CSHCN Program has developed a mechanism for determining the level of social service need. The determination of client need is a part of the overall child/family assessment which is developed as part of a multi-disciplinary process, with the child/family as the pivotal element.

All children assessed by CSHCN receive evaluation and case management services to facilitate access to alternative systems of care. All children enrolled in CSHCN, Birth to Three (Part C/IDEA), or even our perinatal RFTS Program receive care management and care coordination.

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

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

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

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

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

Within the Population-based Services category, surveys and public forums, the Medley class survey and the Developmental Disabilities Council survey, show that oral health services are cited as the greatest need among adults with disabilities. There is no oral health care financing for adults in that Title XIX does not offer coverage and the previously referenced Pre-employment Project, administered by MCFH is limited to adult populations returning to the work force. Also, even when children have health care financed (Medicaid), there is poor utilization of oral health services. Finally, survey results confirm that vocational transition services are in need of renewed support in West Virginia. Approximately 1/3 of survey responders indicated the need for children to receive transition or vocational planning.

Causes of infant death, low birthweight and maternal smoking must be addressed, specifics developed during a summit of policy makers, medical personnel, etc. in 2000 and again in 2002.

Within the Infrastructure building category, recruitment and retention of qualified medical and other

service delivery personnel in WV must receive priority attention in the future. Projects such as the WV Birth to Three/Part C "REIP" program, which offers student stipends and loan repayment, have proven beneficial in recruiting and retaining specialty therapists across the state. (Similar programs could be utilized across the entire OMCFH population.) Moreover, insurance systems within the state infrastructure require modification to better accommodate children and families in WV. Recognition of CSHCN services to include reimbursement for non-traditional services such as intervention by licensed behaviorist and other professionals must become a priority.

## B. STATE PRIORITIES

Each state performance measure was selected because of the health status of the respective population. For example, we have worked hard for years to assist Title XIX sponsored patients with early entry into prenatal care; however, we still have not achieved the 90% first trimester enrollment goal of Healthy People 2010. Furthermore, WV women continue to smoke during pregnancy and an extraordinary number of WV children are exposed to second hand smoke.

In an effort to improve population-based surveillance systems, WV pursued CDC funding for lead screening of its children. This money was used to build capacity at the State Laboratory including the purchase of a graphite furnace. It was our intention to identify children within the first six months of life who have or are at risk of developmental delays, so the addition of lead screening activities only served to strengthen this population-based surveillance activity. WV also pursued other CDC funding which included enhancing the Birth Defects Surveillance System.

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

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

### Direct and Enabling Services

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

### Population-Based Services

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

### Infrastructure

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

improved availability of obstetrical services.

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

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of 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

Last Year's Accomplishments:

In 2002, 99% of infants born in the state of WV received newborn screening. Although, WV did not require testing for Hemoglobinopathies, in 2002, 65% of the infants born received this test. In conjunction with the Office of Laboratory Services, the Newborn Screening Project ensures that infants are screened for inborn errors of metabolism before hospital discharge. All abnormal test results are followed-up by Office of Maternal, Child and Family Health staff and confirmed abnormalities receive case management, with assistance from the Genetics Program at WVU. The Office of Maternal, Child and Family Health provides, free of charge, regardless of family income, formula for those with confirmed PKU. The OMCFH, using Title V dollars reimburses the State Lab for all newborn screening specimens.

The Pediatric Genetics Program at West Virginia University provides subspecialty clinics throughout the State for children identified with inborn errors of metabolism.

OMCFH staff routinely visits birthing hospitals as a means of identifying and resolving any problems or concerns.

Linkage of data from the State Laboratory and the Project have been reestablished creating a more efficient process.

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

During the first year of collecting test data, 1996, the percentage of tests that had to be repeated was 20.8%. In 2002, the percentage had dropped to 6.0%.

## b. Current Activities

### Current Activities:

West Virginia is only mandated to provide three newborn screening tests, Phenylketonuria (PKU), Congenital Hypothyroidism, and Galactosemia. Sickle Cell Disease testing is based on the physician's or parent's request. In 2002, 65% of the infants born in WV received testing for Sickle Cell Disease. In response to national practice standards, the Bureau for Public Health has recently issued policy requiring testing of all infants for sickle cell disease. Three physicians, at strategic locations statewide, are providing follow-up clinical services for this population and providing consultative services to private providers throughout the state. The OMCFH has assisted the medical community in developing the capacity to provide treatment, genetic testing and follow-up services to the population with positive results for Sickle Cell Disease.

The OMCFH maintains its well-established, positive working relationship with the State Lab, as well as, the private physicians who manage the children diagnosed with inborn errors of metabolism. All children who test positive receive case management from a nurse within the Newborn Screening Program. A referral is made to CSHCN for additional follow-up services. West Virginia is currently working collaboratively with a newborn screening regional initiative to assess capacity and need.

## c. Plan for the Coming Year

### Plan for the Coming Year:

The OMCFH Newborn Screening Program is expanding to screen all infants for Sickle Cell and other Hemoglobinopathies. WV has historically only screened for Hemoglobinopathies upon physician or parent request. Even so, last year we screened 65% of our infants. In order to build capacity to provide treatment for infants who screen positive for Sickle Cell Disease, WVOMCFH is collaborating with three physicians and seeking a fourth, to cover the Eastern Panhandle, to act as consultants and to offer clinical care. These identified medical experts will provide follow-up and treatment and support for the primary provider serving the child. A special clinic has been established in partnership with WVU School of Medicine, Women and Children's Hospital (one of the State's three tertiary care hospitals), and CSHCN to serve this population. The clinics will be held approximately six times per year, and be staffed by social workers and nurses from CSHCN employed by OMCFH.

The WV State Laboratory has contracted with Neometrics to upgrade their newborn screening software capabilities. Their current system is outdated and in jeopardy of crashing. The OMCFH will continue to work with the Office of Laboratory Services to ensure that every newborn in the State is screened for PKU, Galactosemia and Hypothyroidism as well as hemoglobinopathies. Any necessary follow-up will continue to be provided by state office nursing personnel, in collaboration with the child's primary care physician. Children with inborn errors of metabolism will continue to receive special consultation through the West Virginia University, Department of Pediatrics-Genetics Program, as part of a contractual agreement with OMCFH and other medical experts in geographically assigned areas of the state. Title V state office nurses and administrative personnel will also continue to track all medically prescribed food stuffs/formulas and have responsibility for assuring the timely "drop shipment" of formulas to families, in addition to coordination of care between the medical community and the family.

*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

### Last Year's Accomplishments:

Parents or legal guardians are involved in the decision making for their child through the Patient/Family Assessment process and the development of the Patient Care Plan. A multi-disciplinary team approach is used to provide care-planning and care-coordination to CSHCN program participants. The multi-disciplinary team includes the child/parent, physicians, nurses, social workers, therapists, school systems, vendors and community services who are providing care for the child. Team members, led by the CSHCN nurse and/or social worker, collaborate with the child/family in developing an appropriate, comprehensive care plan for the child. During CY 2003, 2812 Patient Care Plans were completed to assure a continuum of comprehensive medical care and transition to adult care as appropriate. Our plans are copied, signed and reviewed with parents. Transition services also involve parents, education specialists and other interested parties. Transition screening tools have been newly developed according to age appropriateness and added as part of the process. Transition services were provided to 393 youth, ages 18 and 21.

## b. Current Activities

### Current Activities:

To include parents' voices and advice on decision making at the administrative level, the CSHCN Medical Advisory Board was reconstituted and expanded to become the more inclusive CSHCN Program Advisory in April 2004. The membership of the Program Advisory was diversified to include adolescents, parents, representatives from state and private agencies, and medical professionals, all of whom have provided or received services through the CSHCN program. The Program Advisory advises the Commissioner of the Bureau for Public Health relating to the care and treatment of children receiving services from CSHCN. The Advisory choose to concentrate their efforts in the area of family-centered care. They plan to: review the recently revised Care Notebook and Resource Guide; develop a training packet for parents on how to best use the Notebook; and work with pediatricians and primary care physicians to encourage the use of the Notebook as a tool in care management for children with special health care needs.

The partnering of parents in decision making at all levels of CSHCN is demonstrated through the participation of Parent Network Specialists (PNS) at all levels of program administration and operation. The PNS system is administered by the Center For Excellence for Disabilities (CED). The PNS serve on the CSHCN Administrative team, and the Policy Committee which revised CSHCN Program Manual. The PNS have direct contact with program participants through clinic attendance and community group presentations. In December 2003, an additional parent was added to the Parent Network Specialist (PNS) system bringing the statewide number of PNS to six. This enhanced the ability to contact families and local parent/professional groups in all 55 counties of West Virginia. During CY 2003, the PNS made 1,321 direct contacts with families of children with special health care needs through home and hospital visits, in addition to clinic sessions. The PNS made 16 presentations to community and educational groups about the CSHCN program services.

The PNS surveyed all CSHCN enrolled families and the families in the PNS data base to determine topics of special interest to parents. The topics identified were the effects of medication, respite care, positive behavior support, guardianship, and funding resources. The survey data was compiled and analyzed by CED. The identified topics were then used in the six regional one-day mini conferences for parents/families of children with special health care needs coordinated by the PNS's during FY 2004. The topics offered were presented by professionals in the field. Attendance at each of the workshops averaged 50 families, nurses, social workers, and other professionals.

Revision and reprinting of the Care Notebook and Resource Manual were completed in March 2004.

### c. Plan for the Coming Year

#### Plan for the Coming Year:

During FY 2005, Patient/Family Assessments and Care Plans will be completed for all program-enrolled children through home visits and/or other face-to-face contacts. Priority will be given to newly enrolled children and to children requiring transition services, pre- and post-surgical care; private duty and intermittent skilled nursing; nutritional assessment; child protective services; technology dependent, and those requested by physicians, clinics, other agencies.

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

#### Last Year's Accomplishments (July 1, 2002-June 30, 2003)

Information about a child's primary care provider (medical home) is gathered by the Systems Point of Entry Unit during initial intake, and by CSHCN staff each time a child presents for service. During CY 2003, 3,513 children who received CSHCN services had an identified primary care practitioner. This represents 69% of children in enrolled and pending status with CSHCN. SPE service coordinators link children without an identified primary care practitioner to the OMCFH administration's Health Check Program, and to local sources for medical care. All children receiving benefits through the WV Medicaid Program are assigned a primary care physician either through the Physician's Assured Access Service (PAAS) Program or through the Medicaid Managed Care program.

During CY 2003, the University Health Associates and the Upper Tract Health Center in the Eastern Panhandle of West Virginia continued the Evaluation and Assessment Clinic at that facility and expanded the model to the Dorothy McCormack Center, Martinsburg, WV. The purpose of this clinic was to provide developmental assessments to determine the need for specialty care for those CSHCN applicants who had questionable diagnosis and/or for whom CSHCN did not have enough specific information to refer for specialty care. These clinics also provided linkages to primary pediatric health care for those children who did not need specialty care, and linked under served areas of the state to facilities for accessing primary care. A total of 27 children were evaluated at the eight clinics held in CY 2003. Of these children, 12 were referred for further specialty evaluation through CSHCN, while those without a CSHCN eligible diagnosis were linked to other sources for follow-up care. Further clinics in the Eastern Panhandle were suspended in December 2003, because of the loss of the Board Certified Family Practitioner for the clinic.

### b. Current Activities

#### Current Activities (July 1, 2003-June 30, 2004)

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

community-based services.

To ascertain the appropriateness of specialty medical care and application of program policy, the CSHCN Medical Associates reviewed case records of enrolled children. The SCHCN Orthopedic Associate reviewed over 1000 records of children being followed for orthopedic care. Similarly, the CSHCN Otolaryngology Associate reviewed 80 records of children followed in the Charleston Plastic Surgery Clinic. During the coming year, the CSHCN Otolaryngology Associate will review the records of all children receiving hearing and Ear, Nose, and Throat services. Additionally the 90 records of children receiving nutritional supplements will be reviewed by the pediatric associate.

### c. Plan for the Coming Year

Plan for the Coming Year (July 1, 2004-June 30, 2005)

The annual review of CSHCN clinic services revealed there should be a limited expansion of clinic services planned during FY 2005. Efforts will continue to expand the development of Evaluation and Assessment Clinics in conjunction with health centers and other providers within the state to expedite the process of providing developmental evaluations for children, and linking children with resources for routine primary care. The program's cooperative efforts with primary care centers will be further strengthened when CSHCN begins holding an orthopedic clinic at the Ritchie Primary Care Center. To provide enhanced services in an under served section of the state, the reestablishment of an ENT clinic is being considered in conjunction with the West Virginia School of Osteopathic Medicine, in Lewisburg, WV.

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

CSHCN will continue to work with the WV Chapter of the American Academy of Pediatrics to inform the medical community about the need for chronic care services for children with special health care needs.

In July 2004, CSHCN will collaborate with another office within the Bureau for Public Health, Office of Nutrition's Special Supplemental Nutrition Program for Women, Infant, Children (WIC) to expand their services to children with special health care needs.

The WV Medicaid Program does not provide coverage of nutritional or feeding supplements taken by mouth. Young adults receiving such supplements lose funding for medically necessary prescribed supplements when the young adult transitions from CSHCN at age 21 years. The CED nutritionist plans to work on the issue of funding formulas for children on feeding tubes. If successful in securing funding, the CED nutritionist will develop a transition program that will target adolescents on feeding tubes when they turn 18, 19 or 20 years old.

CSHCN has worked with OMCFH's Oral Health Program (OHP) and the WV Dental Association to initiate dental clinics for children in the south eastern region of WV. CSHCN will collaborate with the OHP to survey families of children enrolled in CSHCN concerning access to dental care.

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

Last Year's Accomplishments (July 1, 2002-June 30, 2003)

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

During Calendar Year 2003, Systems Point of Entry provided the following activities:

##### 1. 1098 referral services provided:

604 families of children identified on the Birth Registry as having congenital problems received OMCFH program information

404 families identified by the Social Security Administration as approved for Supplemental Security Income (SSI) were offered additional referral services

90 identified by OMCFH Reportable Disease, Newborn, and Lead Screening Programs

##### 2. 2804 applications and informational materials provided:

528 Specialty Care Intake Form (SCIF) applications

267 CHIP applications

449 OBRA applications for Medicaid coverage for pregnancy

1244 brochures/pamphlets distributed

During CY 2003, 79.7 % of children participating in CSHCN were also Medicaid beneficiaries. The increase over last year's percentage is attributed to the continuing commitment of CSHCN to assist families to obtain health care financing through assisting with SSI applications, the expedited SSA/Disability Determination process and CHIP/Medicaid applications.

#### b. Current Activities

Current Activities (July 1, 2003-June 30, 2004)

Efforts to increase access for minority participation in CSHCN and other programs within OMCFH were addressed through the establishment of a clinic for the treatment of Sickle Cell in conjunction with Women and Children's Hospital, Charleston, WV. CSHCN provides the social services component for this clinic as well as a nurse to provide patient education concerning sickle cell and other blood disorders. During CY 2003, 27 children were seen at the three clinics held. Of these children, four applications were taken for CSHCN services, and four children were referred to CSHCN regional team nurses for follow-up contact. Efforts to ensure adequate insurance coverage is a concern in this population.

In cooperation with WV CHIP, CSHCN, Birth to 3 and Right From The Start programs continued efforts to involve the faith-based community in identification and outreach to uninsured and under insured children. A workshop was held in Parkersburg, WV in October 2003, to inform members of local faith-based groups about available services and to recruit volunteers to work within their churches to assist in referring families to potential funding resources. Additional workshops are planned for FY 2005.

### c. Plan for the Coming Year

Plan for the Coming Year (July 1, 2004-June 30, 2005)

Building on outreach efforts for the past year, CSHCN will continue efforts to make potential recipients aware of services available through CSHCN. To expand CSHCN outreach efforts, the DHHR Division of Management Information Systems will identify approved or denied Medicaid beneficiary children (age 0-20) who have a disability. The system will generate a monthly report to use in CSHCN outreach efforts by the Systems Point of Entry unit. The SPE unit will mail these families information about available CSHCN services and care coordination.

*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

Last Year's Accomplishments (July 1, 2002-June 30, 2003):

The OMCFH Quality Assurance and Monitoring Unit monitored 334 (5%) of the total of the customers' call-in contacts received by System Point of Entry for consumer satisfaction. Approximately 20% of these calls were from families of children with special health care needs. Public response to SPE telephone referral and assistance operation continues to be completely positive. Those contacted stated that they were pleased with how they were treated. None indicated dissatisfaction with the services and guidance received.

### b. Current Activities

Current Activities (July 1, 2003-June 30, 2004):

Representatives from CSHCN participated in the 13th Annual Community Connection Conference held at Canaan Valley Resort, Davis, WV, sponsored by the DHHR Family Support Program. This conference brought together families of children and young adults with special needs to discuss topics such as inclusion in the community, self-determination, stress management, and special education. A presentation concerning program services was given, and the CSHCN display was included in the exhibits at the conference.

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

Community-based services were expanded through participation of Children with Special Health Care Needs with West Virginia University Health Associates at Women and Children's Hospital, Charleston, WV, in the FACES clinic, a cranio-facial clinic. This clinic is a multi-disciplinary team effort that involves plastic surgery, orthodontia, dentistry, genetics, audiology, social services and speech therapy. CSHCN provided the social work component for a multi-

disciplinary clinic for the treatment of pediatric craniofacial deformities. In FY 2004, four FACES clinics were held starting in June 2003. CSHCN applications were made for seven of the 33 patients seen by the CSHCN social worker. Home visits were done at the request of the clinic physicians/treatment team for CSHCN enrolled children throughout the state.

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

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

### c. Plan for the Coming Year

Plan for the Coming Year (July 1, 2004-June 30, 2005)

The OMCFH needs assessment is to be done in CY 2005. Additionally the needs assessment will include:

The parent interest survey already completed by CED,

A new parent satisfaction with medical community survey,

A survey of enrolled adolescents' and young adults' knowledge and use of transition services, and

The oral health survey to be completed by the OMCFH Oral Health Program.

Revision of the CSHCN Policy and Procedure Manual was completed February, 2004, and distributed to program staff, DHHR offices, and selected providers in April 2004. All CSHCN forms and correspondence were revised and included in the manual. A complete review of the diagnostic codes for covered medical conditions were done. Program staff and PNS will receive training on new procedures during regional workshops beginning June 2004. The CSHCN Policy and Procedure Manual will be placed on the CSHCN page of the OMCFH web site.

During the coming year, particular efforts will be directed to establishing connections with the system of primary care centers in the state. Efforts will continue to expand the development of Evaluation and Assessment Clinics in conjunction with health centers and other providers within the state to expedite the process of providing developmental evaluations for children, and linking children with resources for routine primary care. The program's cooperative efforts with primary care centers will be further strengthened when CSHCN begins holding an orthopedic clinic at the Ritchie Primary Care Center. The local Shriners chapter will provide volunteer support and refreshments for the children at this clinic. To provide enhanced services in an under served section of the state, the reestablishment of an ENT clinic is being considered in conjunction with the West Virginia School of Osteopathic Medicine, Lewisburg, WV.

In 2004, CSHCN will collaborate with the Bureau for Public Health, Office of Nutrition's Special Supplemental Nutrition Program for Women, Infant, Children (WIC) to expand their services to children with special health care needs. A speaker from CSHCN will provide information about CSHCN at two regional conferences for WIC staff entitled Meeting Unique Needs. A speaker from CSHCN will provide information about CSHCN at two regional conferences for WIC staff entitled Meeting Unique Needs. CSHCN program nurses and social service workers will attend the conferences to provide an opportunity for networking and resource development.

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**

Last Year's Accomplishments (July 1, 2003-June 30, 2003):

Transition services are included as part of the development of the Patient Care Plan completed with youth enrolled in CSHCN and their families. During CY 2003, 2,812 Patient Care Plans were completed. Also, during this period, transition services were provided to 393 youth, age 18 and 21.

**b. Current Activities**

Current Activities (July 1, 2003-June 30, 2004):

On September 29 and 30 2003, the CSHCN Annual Total Staff Conference focused on the adolescent population: their needs, and the services available to them on a local, state and federal level. The program included presentations by a parent of a young adult, an adolescent medical practitioner, a nutritionist, Shriners Hospital representatives, Social Security Administration representatives, and OMCFH program specialists from the Adolescent Health Initiative and the Abstinence Education Project.

Training of nurses and social workers about adolescent transition services was continued through the periodic nurse/social worker staff meetings. Written policy concerning delivery of adolescent transition services was expanded in the CSHCN Program manual released to staff in April 2004. This policy places a higher priority than previously on home and other face-to-face contacts for development of Patient/Family Care Plans for youth in transition. Transition screening tools were developed for use with adolescents age 14, 16 and 17; and with young adults ages 18 and 21. The transition services policy was expanded and included in the revised CSHCN Policy and Procedure Manual along with the transition screening tools.

CSHCN participated in a collaborative effort with the Division of Infant, Children and Adolescent Health, and the West Virginia Commission for National and Community Service, to permit CSHCN young adults to participate in the West Virginia Youth Development Institute. The Institute was held in Charleston, WV, during the week of July 27 - 30, 2003. The Institute presented nationally recognized speakers in the fields of youth developmental assets, volunteers, and community involvement.

For the first time, adolescents were invited to join the expanded CSHCN Program Advisory to offer the perspective of adolescent consumers and a voice to their concerns. These adolescents receive or have received CSHCN services.

**c. Plan for the Coming Year**

Plan for the Coming Year (July 1, 2004-June 30, 2005):

A greater emphasis will be placed on beginning transition services at age 14 and 16. Youth will be included in their care planning teams and be given more responsibility for treatment compliance. In addition to the reports already produced identifying young adults 18 and 21 years, the CSHCN electronic data system will produce reports to identify adolescents 14 and 16 years of age. The feasibility of development of adolescent specialty care clinics for delivery of medical care will continue to be explored. The goal of establishing a CSHCN Youth Advisory will also be explored.

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,*

#### a. Last Year's Accomplishments

While still below the targeted performance objective of 90%, as set by Healthy People 2010, the percentage of children being fully immunized by the age of 2 years has increased substantially over time but has been stagnant over the past few years since 1997. In 1994, the percent of children fully immunized was 66 percent; in 1995, 68 percent; as high as 82.4 in 1998, 82.1 reported for 2001, 83.4 reported for 2002, and 81.8 reported for 2003. The DtaP is the lowest percentage received. The State's Immunization Program is not housed in the Office of Maternal, Child and Family Health, but rather in the Office of Epidemiology and Health Promotion's Division of Surveillance and Disease Control. This program works closely with the State's local health departments, WIC, birthing hospitals, the private practicing medical community, and other early childhood initiatives in an effort to get as many children fully immunized as possible.

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

An OMCFH monitoring team monitors the documented immunizations when monitoring HealthCheck pediatric providers.

The immunization program conducted a 2004 Immunization Kindergarten School Survey in cooperation with the Department of Education, the local Boards of Education, school nurses, principals and secretaries from 60 randomly chosen schools. On-site validation audits were conducted. Sixty schools were randomly selected from the 658 responding public and private schools to receive a Validation Audit, which is conducted to verify the accuracy of the school survey as well as monitor the actual immunization records for correct doses, dose intervals and validity. Only 58 audits were actually conducted because two of the 60 schools selected reported having no new enterers this year.

Of the fifty-eight schools, the Immunization staff reviewed 2,157 kindergarten records and 46 out-of-state first grade transfer records. Results of the audit revealed: 2.86% (63 students) were missing at least one required immunization; 0.82% (18 students) had invalid doses which were counted; 2.04% (45 students) had documentation errors. West Virginia Educational Information System records were reviewed in three schools with a total of 171 records and 7.6% (13 records) contained a documentation/data entry error. Certificates of Immunization were noted in 95 files with 5 (5.2%) containing an invalid physician-documented dose.

#### b. Current Activities

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

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

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

#### c. Plan for the Coming Year

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

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

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

#### a. Last Year's Accomplishments

Last Year's Accomplishments (2003):

Under the administrative direction of the Family Planning Program, the Adolescent Pregnancy Prevention Initiative (APPI) promotes public awareness of adolescent pregnancy prevention and related issues through community education and outreach activities for community groups, schools, health care professionals, parent groups, and businesses.

Community education and outreach activities:

Recognized "National Teen Pregnancy Prevention Month" in May 2003;

Promoted "National Day To Prevent Teen Pregnancy" on May 7, 2003 distributing brochures and posters of "101 Ways Adults Can Prevent Teen Pregnancy";

Conducted a "Mother's Day Too Soon" campaign. Mailed "Mother's Day Too Soon" cards containing information on WV adolescent birth rates and statistics in comparison to United States rates;

Mailed information on "Let's Talk" month in October 2003 to APPI grantees and others on the APPI mailing list;

Observed "Father's Day Too Soon" in June 2003. Mailed "Father's Day Too Soon" cards containing information on WV adolescent birth rates and statistics in comparison to United States rates;

Mailed information on "Let's Talk" month in October 2003;

Revised and released for public distribution the APPI Fact Sheet in April 2003;

Professional Continuing Education Opportunities:

Offered a "Wise Guy's" curriculum train-the-trainer workshop. Training focused on males age 10-19 and their responsibility in reducing dating violence and preventing unintended pregnancy;

Provided training to the Division of Juvenile Justice staff and Salem Industrial Home for Youth, July 15-17, 2003 and September 15-16, 2003. A third training is planned for early 2004;

Offered the "Maltreatment of Adolescents Prior to Pregnancy" (MAPP) curriculum to assist in examining relationships between child maltreatment, later adolescent pregnancy and maltreatment of pregnant adolescents.

WV Dept of Education:

Served as WV member on the State School Board of Education National Healthy Schools network;

Functioned as lead partner with Department of Education/Office Healthy Schools developing strategic plan for improving prevention services.

#### Committees/Task Force/Councils:

Attended National Organization on Adolescent Pregnancy, Parenting and Prevention (NOAPP) conference November 2003;  
Board member and President of WV State Task Force on Adolescent Pregnancy and Parenting;  
WV Abstinence Only Education Advisory Council;  
Team member, National School Boards of Education;  
WV School Based Health Center Network;  
WV School Health Committee;  
WV Parent Education Network;  
Coalition for WV Children;  
Region III Teen Pregnancy Prevention Leadership Group;  
Southeastern Public Health Leadership Team, WV Delegate.

#### Public Awareness/Speaking and Displaying Opportunities:

Presented at 13 WV Schools;  
Presented at 3 state level conferences;  
Displayed on 18 occasions;

#### Clinical Contraceptive Services:

Offered confidential contraceptive health services through the statewide Family Planning Program.

### b. Current Activities

#### Current Activities (2004)

##### Adolescent Pregnancy Prevention Initiative Expansions:

To adequately carry out the goals and objectives of the Adolescent Pregnancy Prevention Initiative work plan, four (4) additional permanent full-time personnel were hired in 2003 to conduct statewide community education and outreach activities on a regional/local level. The new hires were strategically located in community-based settings to have the flexibility of alignment as needs change over time. These 4 Adolescent Pregnancy Prevention Specialists work to increase public awareness of problems associated with early sexual activity and childbearing and are developing, expanding or supporting local teen pregnancy prevention initiatives.

##### Family Planning Program:

Confidential contraceptive services and supplies are available to sexually active adolescents through a network of 145 health care agencies through the statewide Family Planning Program. Participating clinics promote postponement of sexually active, mechanisms to reduce sexual coercion, and provide counseling to sexually active teens regarding the importance of family involvement in sexual decision-making.

### c. Plan for the Coming Year

#### Plan for the Coming Year (10/2004-9/2005):

The Adolescent Pregnancy Prevention Initiative will continue to design and conduct community education and outreach activities to increase public awareness of adolescent pregnancy prevention and related issues for community groups, schools, health care professionals, parent

groups, or businesses;

Address state level issues which impact access to or quality of adolescent pregnancy prevention services; confidentiality and parental consent; transportation, financial or other barriers; school health issues; and local availability of pregnancy prevention services.

Coordinate professional continuing education opportunities related to adolescent pregnancy prevention;

Educate teens and young adult males on personal sexual responsibility;

Coordinate community education activities to promote clinical Family Planning Program

Services for sexually active teens and those not yet sexually active; Conduct presentations and exhibits of educational displays at health fairs, conferences, state fairs, and other public activities; Maintain existing and establish new partnerships and initiate referral patterns with entities serving populations of potential clients; Distribute Family Planning Program promotional products, i.e., brochures, posters, fact sheets, etc;

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

#### a. Last Year's Accomplishments

The Children's Dentistry Project (CDP) is a component of the Division of Infant, Child and Adolescent Health and is housed within the OMCFH. Preliminary data for FY 2003 suggests that only 48% of West Virginia Medicaid recipients ages 6-9 received a dental service. In West Virginia, Medicaid child beneficiaries have financial access to dental services, yet most do not routinely seek care. Failure to keep appointments adversely affects willingness of dentists to serve the Medicaid population, thus limiting access. It is clear that public health must facilitate opportunities for youth to access dental care by educating children, youth, and their parents about the importance of oral health. The overarching goal of Children's Dentistry is to promote the value of oral health, build service capacity throughout the State by providing technical assistance to providers offering direct care, involve advanced education in developing strategies to address professional shortages, and to improve access using CHIP and Medicaid as the health financing component. Program highlights were; 1) Fluoride drops and tablets were dispensed through local health departments, WIC offices and at child care sites by health care providers authorized to dispense fluoride, if the child did not have Medicaid or insurance coverage. Medicaid cardholders needing supplements were given prescriptions for local pharmacy use. 2) Recruited and encouraged licensed dentists and hygienists to provide direct program care for CHIP and Medicaid sponsored children. 3) For FY 2003, 42% of children between the age of 3-20, who were Medicaid beneficiaries, received a dental service as compared to 42% in FY 2002. 4) Provided and approved literature for distribution that addresses oral health needs. Literature and program operational guidance were distributed using the Pediatric Program Specialists who routinely visit the medical practitioners' offices, see reference earlier to field staff under EPSDT. 5) Prepared and distributed a listing of all WV dentists serving children, including those accepting Medicaid reimbursement. This list was distributed to all providers of primary care, school nurses and other relevant personnel. The Children's Dentistry Program also provided literature to the Right From The Start's Regional and Designated Care Coordinators to address dental care for pregnant women and encourage infant teeth care to reduce the incidence of baby bottle tooth decay.

#### b. Current Activities

The CDP currently has 17 contracts with local health departments and individuals to offer oral health education to students in public schools. Educators offer information about dental hygiene, the need for preventive dental visits, and the dangers of tobacco use. The CDP, in partnership with county school systems, Head Start agencies, and other community children's programs, are working together to offer a sealant and fluoride rinse program within schools.

The CDP contracts with local dentists to purchase all supplies, and perform all billing functions. Payments from existing insurance sources are sufficient to cover operational costs and ultimately improve oral health access. There are significant numbers of West Virginians who do not have a fluoridated water supply. Some of those receive water from public systems. Fluoridation equipment is inexpensive and supplies are no more than \$3. per customer per year. The savings in future dental caries is 5 to 6 times that amount. For example: For a town the size of New Martinsville (currently not receiving fluoridated water), the annual cost of fluoridation would be \$35,500. If only one cavity is prevented in an entire family, the net savings for the community is \$124,200 annually. The CDP is beginning a project to work with a limited number of local communities and water systems to advocate for fluoridation and to assist communities to be able to obtain fluoridation. A small amount of funding is available to pay for necessary equipment. The Office of Environmental Health Services has been approached as a non-funding partner and is willing to participate. Other funding sources are currently being explored. This infrastructure development will have lasting implications and may be supported through the Governor's Office of Community Development.

### c. Plan for the Coming Year

The CDP is currently working on a pilot project in McDowell County for a school-based dental clinic. The CDP has purchased equipment and supplies for this project. In addition to preventive services, patients will be provided with oral health education materials and referred to local dentists for restorative care when necessary. Two other community health centers in different counties have expressed an interest in replicating this model. It has long been realized that children with disabilities in West Virginia do not have sufficient access to dental services. The only clinic serving this population is located in Morgantown, WV, in the north central part of the state. CDP is partnering with a community health center to establish a periodic clinic in the southern part of the state to care for children with disabilities. To design effective health promotion campaigns and materials, we must know what the customer is thinking. The CDP is implementing a research project in conjunction with higher education to learn more about the attitudes of youth and parents toward dental care, and learn more about the barriers to receiving dental care.

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

Last Year's Accomplishments:

In October, 1997, the Division of Rehabilitation Services (DRS) received a planning grant from the U.S. Department of Health and Human Services to assess the current Traumatic Brain Injury (TBI) needs and resources; gaps in services and develop a strategic plan for the State. OMCFH and the University Affiliated Programs are all partners in the implementation, which also has a prevention component. The EPSDT Program provides anticipatory guidance to parents about childhood injury that may result in death. The WV Youth Risk Survey information for 1999 reports that 20.7% of WV youth report that they rarely or never use seatbelts. Males were twice as likely not to use seat belts (27.7%) as females (13.1%). The State of West Virginia now has a mandatory seatbelt law, which was strongly advocated for by the Bureau for Public Health and other medical partners.

### b. Current Activities

Current Activities:

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

### c. Plan for the Coming Year

Plan for the Coming Year:

The community-based workforce that administers our Abstinence Education Only Program and another group of partners who administer the Adolescent Health Initiative all work to address the issue of health behaviors. Not every motor vehicle accident is alcohol related but our data tells us many of them are. The Adolescent Health Initiative offers parent/child communication skill building, community development activities that include plans for safe recreation after prom, etc. Helping families to talk with their children about risk behaviors is an essential part of effecting change. The Abstinence Only Effort is focused on a much younger population with the same emphasis about abstaining from alcohol and other risk behaviors. Legislation has passed in WV requiring helmets and seatbelt use. In 2004 the Legislature approved ATV laws requiring the use of helmets. We continue work with Transportation and Traffic Safety to develop materials that are directed to youth. We also are using our existing workforce and partnership network for distribution of this anticipatory guidance.

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

### a. Last Year's Accomplishments

The Pump in Style Breastpump Pilot Project was initiated by WV WIC Program in October, 2001, to test whether using this portable electric, professional-looking breastpump would affect breastfeeding duration with working/schooling WIC mothers. Currently, only 18% of breastfeeding WV WIC mothers continue nursing for at least 5 months. The national Healthy People goal for breastfeeding is that 50% of all babies are breastfeed for at least 6 months. Valley Health Systems-Charleston ( a 330 funded community health center)and Monongalia Health Department WIC Programs led the project. Pump In Style breastpumps, retail value of \$225, were given to 75 working/schooling breastfeeding WIC mothers over a 15 month period - October, 2001 through January, 2003. Twelve mothers in the Charleston area and 5 mothers in the Morgantown area continued to breastfeed after the end of the project period.

Results: Working mothers using the Pump In Style breastpump continued breastfeeding on average of 8 months compared to the general WIC breastfeeding mothers population during the last half of 2001 who continued breastfeeding on average of 4.5 months.

The 2003-2004 Office of Nutrition Services Breastfeeding Initiatives included: 1) Expansion of the WIC Breastfeeding Peer Counselor Services; 2) Elevated staff knowledge so that all WIC staff positions are confident in promoting and supporting breastfeeding by providing a one day training for all clerical, medical and new nutritionists; 3) Ensured program expansion by dedicated planning time for breastfeeding services; and 4) Enhanced breastfeeding support

services by collaborating with physician practices.

A grant has been submitted for the following: The "Using Loving Support to Build a Breastfeeding Friendly Community" will enable the West Virginia WIC Program to increase breastfeeding initiation and duration rates in nine rural counties in southern West Virginia where there are low breastfeeding rates but growing community awareness and support.

#### b. Current Activities

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

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

#### c. Plan for the Coming Year

WIC's goals for nutrition education services for 2004-2005 include: 1) Providing breastfeeding information and education to all pregnant WIC participants and health care professionals which promotes breastfeeding in order to increase the number of babies who are fed breastmilk. 2) Provide post-partum breastfeeding assistance and support which promotes continued breastfeeding throughout the first year of life. Preliminary data indicates that 22.4 of women who initiate breastfeeding are continuing to breastfeed for 6 months or longer. 3) Provide additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physician practices in order to keep mother's breastfeeding longer.

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

#### a. Last Year's Accomplishments

Significant progress has been made in achieving the goals set forth by the HEAR WV Early Hearing Detection and Intervention project since its inception. In 2003, 98% of infant hospital births in WV were screened for hearing loss prior to discharge. West Virginia birthing facilities have been consistent in completing hearing screens and providing opportunities for infants who are missed to be screened prior to one month of age. One and one half a percent (1.5%) of infants who are missed or transferred to other facilities are screened before one month of age. One half a percent (0.5%) of infants were missed because of equipment failure. The HEAR WV Project obtained four portable otoacoustical emissions (OAE) screeners for use by birthing facilities when their equipment is temporarily down. The OAEs are loaned to the facilities as needed and can be available to them in twenty-four hours. In 2003, Newborn Hearing Screening was performed on (21,205) infants. Twenty thousand nine hundred ninety-three (20,993) infants were screened prior to discharge from the birthing facility. Two hundred thirty (230) infants were screened before one month of age. Six hundred thirty (630) infants did not pass the hearing screening prior to discharge. Of these, (405) were rescreened before one month of age and (362) passed. Two hundred sixty-seven (267) infants were referred for diagnostic testing. Of these, 176 passed and 31 were diagnosed with hearing loss. Infants diagnosed with hearing loss were referred to the WV Birth to Three Program for early intervention services. Identified infants were also referred to the Ski\*Hi Parent/Child Program.

Ski\*Hi is a program of the WV School for the Deaf, which provides home-based family education and support for deaf and hard of hearing children and their families. Two hundred eleven (211) infants were enrolled in the Right From The Start (RFTS) Project to assure that the child's hearing screening and other health issues were addressed. Fourteen infants were referred to the Office of Maternal, Child and Family Health, Division of Children's Specialty Care, Children with Special Health Care Needs (CSHCN) Program to facilitate diagnostic evaluation and clinical intervention, which may include hearing amplification.

#### b. Current Activities

In 2003, the HEAR WV Project focused on improving access to appropriate audiological diagnosis and intervention. Eight WV audiologists were provided education and training on diagnostic evaluation through the National Center for Hearing Assessment and Management (NCHAM) diagnostic audiology workshops. Pediatricians and family practitioners were provided an additional resource. Universal Newborn Hearing Screening, Diagnosis, and Intervention "Guidelines for Pediatric Medical Home Providers" were distributed to the provider community to assist medical home providers in directing infants and their families to appropriate hearing evaluation and intervention.

In addition to education and training, the HEAR WV Project is focusing on the establishment of four regional diagnostic centers, fully equipped audiological testing sites, that will provide diagnosis and treatment for infants. High frequency Tympanometry and bone conduction auditory brainstem response (ABR) equipment will be obtained to assure that these facilities have the required technology needed to appropriately assess infant hearing loss.

In past years, the number of newborn hearing cases reported as "lost to follow-up" was of significant concern as was the return rate of follow-up documentation from RFTS Care Coordinators in the field assigned to contact families whose infant did not pass screening or was not screened. In 2003, only 8.5 of infants referred to RFTS for follow-up care coordination were reported as "lost to follow-up. The HEAR WV Project received documentation back on 80% of referred cases. Eleven and one half percent (11.5) of cases were reported as pending audiological evaluation outcome.

West Virginia's newborn hearing screening efforts have been recognized by the World Council on Hearing Health, formerly the National Campaign for Hearing Health. West Virginia has received a grade of "excellent" on the published State report card for the past three years, 2001-2003.

#### c. Plan for the Coming Year

Goals and objectives for the Newborn Hearing Screening Program (HEAR WV) for 2004-2005 include the following:

- 1) 100% of newborns in WV will be screened prior to discharge or before one month of age. Objectives for this goal are: a) Each birthing facility will have two trained staff with competence in screening. b) Parents of infants born at home or in a non-licensed facility will have timely access to screening. c) 90% of WV resident infants born in hospitals closely bordering WV will be tracked.
- 2) 100% of infants requiring audiological follow-up and/or intervention will receive diagnostic evaluation by 3 months of age and be receiving intervention by 6 months of age. Objectives for this goal are: a) 80% of all PCP/medical homes from the 8 RFTS service regions will be provided education about UNHS. b) Coordinate follow-up and data tracking systems.
- 3) 100% of infants referred from screening will receive follow-up and audiological evaluations by a qualified provider. Objectives for this goal are: a) Establish a minimum of one trained audiologist in each of the 8 RFTS regions. b) Provide education and training opportunities for audiologists in infant diagnosis and treatment.
- 4) HEAR WV will improve access and resources to assure that children with hearing loss and their families are linked to community-based, culturally competent support systems. Objectives for this goal are: a) 90% of early intervention and child care professionals will receive education

and training in infant hearing loss. b) Parent information and educational materials will be available in at least two languages other than English. c) Identified infants and their families will be connected with local or regional family-to-family support. d) 90% of identified infants will have access to a full range of communication choices.

5) HEAR WV will provide monitoring, project evaluation and quality assurance data reports to all stakeholders in the project each year. Objectives for this goal are:

a) The project will produce data reports, conduct program monitoring and evaluation quarterly and annually.

The state continues to focus on issues concerning insurance coverage for hearing amplification and the number of legislative mandates establishing expectations for performance with no accompanying money. The establishment of fully equipped diagnostic centers is crucial to improving the continuum of care for identified infants. The HEAR WV Project has completed an assessment of the equipment needs of the eight certified audiologists and requested quotes from manufacturers.

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

#### a. Last Year's Accomplishments

Last Year's Accomplishments:

The Children's Report from the West Virginia Healthcare Survey contains very good news, since a substantial number of our children (93.4%) have health insurance coverage. On any given day, an estimated 6.6 percent of West Virginia's children (28,371) are uninsured.

However, there are several notes of caution in this report. First, an additional 6.6 percent of the State's children are estimated to have insurance that pays only for catastrophic health care costs and so are classified as underinsured. Second, about 14 percent (59,699) of children were uninsured for some period of time during 2001.

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

The Survey provides very good news about West Virginia children's access to health care services. About 93 percent have a usual source of care, mainly at a physician's office or at community and other local health clinics, and about 89 percent of those see the same physician when they go for care. Approximately 96 percent of parents, asked if their child was able to receive needed medical care during the past year, responded in the affirmative. It is not surprising that for 52.6 percent of the children who did not get needed medical care during 2001, the main reason was cost.

#### b. Current Activities

Current Activities:

CHIP enrollment, as of September, 2002, now covers 20,958 children and has expanded to 200% of the Poverty Level. The goal is to cover the 28,271 children believed to be eligible for CHIP. Governor Wise is very supportive of the campaign to sign up eligible children. CHIP has

partnered with clinics across the state encouraging them to distribute applications for CHIP. The WV Primary Care Association received fiscal support to provide community-based outreach for CHIP across the state. Children's Specialty Care, Systems Point of Entry mailed out 328 CHIP applications for FY 2003.

The WV Healthy Kids Coalition, through a group effort with other interested community organizations, such as, The Coalition for WV's Children, WV Primary Care Association, WV Welfare Reform Coalition, WV Hospital Association and the WV Community Voices Partnership proposed recommendations for affordable health coverage for West Virginia's children and families. The proposed recommendations were: 1) Support a \$1 a pack increase in the cigarette tax, 2) Assure affordable health coverage available for all uninsured children, 3) One Name/One Card/One Identity: Create a coordinated West Virginia health insurance program for children, and 4) Explore options for affordable adult coverage.

A well-coordinated system of health care for children should be simple for families to navigate; should employ administrative efficiencies for the State and should allow for automatic transitions from one program to another; and should maximize available funding so that the greatest number of children can be served.

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

### c. Plan for the Coming Year

Plan for the Coming Year:

Family-friendly eligibility and enrollment procedures in both Medicaid and CHIP can increase access to health coverage while improving administrative efficiency. For both programs, some of these family friendly steps include: adopting presumptive eligibility, continuing to simplify the process for renewal of coverage, allowing self-declaration of income, and possible centralizing eligibility determination.

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

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

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

### a. Last Year's Accomplishments

Last Year's Accomplishments:

The proportion of eligible children receiving a service from Medicaid has ranged over the past

several years from a low of 53 percent in 1997 to a high, in 2002, of 95 percent. The EPSDT Program, administered by the Office of Maternal, Child and Family Health, provides dedicated outreach to eligibles in order to encourage participation.

The OMCFH administers the EPSDT Program, and uses the outreach requirement of the federal legislation to encourage families with children to participate in routine, primary preventive care. Our staff, in 2001-2002, initiated 50,000 contacts to families and providers, while our Program Field Specialists exceeded their assignment of two times per year contact with program participating medical providers. The total number of technical assistance trainings face-to-face with the medical community was 1,724.

Infants whose birth was sponsored by Medicaid and served by RFTS was 36% of all Medicaid sponsored births. Approximately 57% of all state births were to Medicaid sponsored women, and all infants born to mothers with Medicaid coverage are eligible for Medicaid for the first year of life. The EPSDT program also works closely with the Office of Social Services in assuring that all children in State custody receive an EPSDT screen within thirty (30) days of placement. Of the 3,336 children served through WV Birth to Three/Part C in fiscal year 2000, 74% were Medicaid recipients.

## b. Current Activities

### Current Activities:

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

Pediatric Program Specialists recruit, orient and provide ongoing technical assistance to EPSDT providers and have been especially active in recruiting additional providers for under served areas. The Pediatric Program has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides EPSDT orientation for HMO providers serving Medicaid enrolled children. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community is presently at capacity. The Program provides ongoing staff development to enhance skills needed to better market the EPSDT Program to both providers and families. Program Specialists, who recruit, train, and provide technical assistance to participating medical providers, have also been active in working with local school systems to increase the number of school based clinics and on site EPSDT evaluations. The number of students using school-based health centers (SBHC) has steadily increased over the past few years. The School-Based Health Center Initiative's goal is to develop a coordinated system of health care for children that increases access to primary and preventive care, especially for students who are uninsured, who lack a medical home, or who are at risk for health problems. During the 2001-2002 school year 72% of the students in schools with a SBHC had written parental consent to receive services from their SBHC. Sixty-three percent of the students registered used their SBHC. Fifteen percent of the students who used their SBHC were without health insurance. Medicaid covered 31% of all users. Five percent of users are covered by CHIP-an increase from 3% last year.

## c. Plan for the Coming Year

### Plan for the Coming Year:

Our goal is to have sufficient resources to meet the medical needs of the state's children. This means we are constantly recruiting licensed medical practitioners to serve children who have health care sponsored by Title XXI or XIX. This fits well into our plan for all the children to have

a medical home, but it also means we must constantly monitor the provider community for medical practitioner and child ratios to assure that any one physician is not becoming overloaded. This is particularly important now that part of the state is involved in Medicaid Managed Care. The practitioner community; that is the managed care provider network, and the people who do government sponsored health care are all one and the same. This state has a limited number of physicians available to provide services. In areas where there are professional medical shortages, we work with the Primary Care Association and the Bureau's Recruitment and Retention Division to have these needs addressed.

The state is fortunate to have over 600 licensed practicing dentists willing to serve children who are Medicaid beneficiaries. We are advocating for the primary care provider/medical home of the child to routinely make referrals to the dentists in the area to assure that the children's oral health needs are met. The state only has 871 licensed practicing dentists and we continue to recruit more to care for CHIP and Medicaid beneficiaries. More than 40% of the Medicaid children between the ages of 3 and 20 are receiving oral health services. All the children under the age of 3 have access to nursing bottle mouth and other anticipatory guidance which is routinely distributed to parents. Given that a significant number of the state's children have access to medical services, the question we want to answer in the future is "why aren't they using it?". This is especially important in oral health and we are in the process of developing a survey that will be used for youth between the ages of 6 and 20.

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

#### a. Last Year's Accomplishments

Last Year's Accomplishments:

While the proportion of very low birth weight live births is higher than the objective set by Healthy People 2010, the proportion is still relatively low. The Office of Maternal, Child and Family Health's perinatal program, Right From The Start, provides pregnancy risk assessments, called Pregnancy Risk Survey Instrument (PRSI), for all income eligible pregnant women. The risk assessments, as well as additional enhanced services, identify and then attempt to educate all pregnant women identified as being at-risk for poor pregnancy outcomes. Pregnant women are routinely referred to WIC and receive in-home nutrition support provided by Right From The Start community-based personnel. Personnel providing RFTS are licensed social workers or registered nurses.

In 1999, there were 278 very low birth weight infants, in 2000, there were 318 and in 2001 there were 332. Further, West Virginia data confirms that very low birthweight infants are born to younger age women, the population that we are focusing on through abstinence education, teen pregnancy prevention, and adolescent asset building.

Birthweight data, by smoking mothers, also confirms a West Virginia problem. In 2000, PRAMS data indicates that 47.38% of mothers who had infants weighing less than 2500 grams smoked 3 months prior to pregnancy. West Virginia has one of the highest rates in the country for mothers who smoke during pregnancy at 24.47%.

The Office of Maternal, Child, and Family Health (OMCFH) of the West Virginia Department of Health and Human Resources (WVDHHR) and West Virginia University (WVU) have finalized a contract and have initiated the Risk Reduction Through Focus on Family Well-Being (HAPI-Helping Appalachian Parents and Infants) Project into the already existing Right From The Start (RFTS) Project of Region VII. Several providers including mental health providers have signed contracts and are participating in the program to provide patient services. The services encompass the RFTS care coordination services provided to eligible pregnant women and infants as per the existing RFTS Project but will expand services to include the preconception phase as well. The HAPI Project focuses on helping women to become healthier before becoming pregnant, encourages spacing of pregnancies, and focuses on mental health issues. In 2003, HAPI Project added child care reimbursement to the list of services offered to women

when they attend their medical appointments. OMCFH, as the subcontractor, has established billing procedures and is currently processing patient services invoices. The long-term goal of the project is to decrease the incidence of low birth weight in WV by reducing recurrent low birth weight. It is our hope that the resulting data from this Project may also show that there is a significant benefit of cost savings through the risk reduction plan for at risk families.

(See Attachments HAPI #1 and HAPI #2)

## b. Current Activities

### Current Activities:

The high incidence of low birthweight is concentrated in a small number of counties. Activities to address this include Right From The Start follow-up to discuss nutrition during pregnancy and enrollment in WIC.

The Perinatal and Women's Services unit has five staff persons solely dedicated to teen pregnancy prevention efforts, as referenced earlier. These efforts include sex education/instruction in partnership with public schools. Planning and spacing for pregnancy seems to be the key to reducing low birth weight incidence.

The Smoking Cessation Program developed by Dr. Richard Windsor was implemented in West Virginia in January 2002 through the Office of Maternal, Child, and Family Health. It was incorporated into the Right From The Start (RFTS) Project and is now known as "The West Virginia Right From The Start 'SCRIPT'".

Our goal is that following full program implementation, Right From the Start will see a reduction in the rate of pregnant smokers participating in the program. The Tobacco Prevention Program education materials and curriculum was purchased to assure that smoking cessation efforts in WV are supportable through research and are considered best practice methods. It is hoped that the implementation of tobacco dependence treatment initiatives will result in improvement for the overall health of individuals, families and infants in West Virginia, and that there will be a considerable reduction in infant mortality and low birth weight incidence.

West Virginia has partnered with hospitals, universities, and private partners to present the issues of preterm births in a Perinatal Summit scheduled for September 2003. This Summit will bring together physician providers, midlevel providers, and community leaders, to address the issues of premature births, diagnosis and management of pre-term labors, the causes and indicators of preterm labors, best practices in prematurity prevention, lifelong health consequences of preterm births, and to develop an action plan to be used in this effort. Community partners will move this action plan to the community level and feed back to the planning committee what has been implemented as a result of the summit.

(See Attachments SCRIPT #1 and Perinatal Summit 2003)

## c. Plan for the Coming Year

### Plan for the Coming Year:

Preterm birth is the leading cause of neonatal mortality in the United States, and preterm labor precedes 40 - 50% of preterm births. Preterm birth accounts for 35% of all U.S. healthcare spending for infants and 10% of all such spending for children. Approximately 467,000 live births annually (11.5% of all live births) occur before term in the United States, and preterm births are responsible for three quarters of neonatal mortality and one-half of long-term neurological impairments in children.

(See Attachment Plan For Coming Year)

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

#### a. Last Year's Accomplishments

Last Year's Accomplishments:

Suicide is the 11th leading cause of death in West Virginia. In 2002, WV had 277 suicides, down from 290 in 2001 of which 193 were caused with firearms. Suicide was the 2nd leading cause of death in 15-24 year olds at a total of 49, up from 20 in 2001, 45 males and 4 females. For the 15-19 year olds, there was a total of 19 suicides, up from 8 in 2001. Ten (10) of these suicides were with firearms, all committed by males.

The Office of Maternal, Child and Family Health's Adolescent Health Initiative provides, through the Adolescent Health Coordinators located throughout the State, increased awareness of adolescent at-risk behaviors leading to injury, disease and death. These Coordinators provide technical assistance to youth leaders and school teachers. Among these at-risk behaviors are those which can lead to suicide. The Coordinators' work activities involve programs and services to reduce adolescent at-risk behavior.

Mental health services expanded this year as a result of major funding from the Sisters of St. Joseph Health and Wellness Foundation and collaboration with the WV Bureau for Behavioral Health. In August 2003, this Foundation awarded grants to seven of the School Based Health Centers (SBHC) for mental health services expansion. These grants will add full time master's level counselor positions at the Pendleton, Riverside, Summersville, Ritchie County and Lincoln County SBHCs; a prevention coordinator/health educator at two Mt. Hope SBHCs, and enhancement of services for the counselor at Rainelle's SBHCs. Two other grants from the Foundation support technical assistance and evaluation of the mental health expansions. The grants also support a study of the feasibility of telemedicine technology for extending needed psychiatric services to students in rural areas. The WV Bureau for Behavioral Health directly funds another three SBHCs for mental health services and indirectly supports the services of a number of community behavioral health centers that collaborate with their local SBHCs.

#### b. Current Activities

Current Activities:

The Department of Health and Human Resources, Office of Community and Rural Health Services has received a grant that will support the development of mental health services for children through their primary care center network. The project is too new to be able to report any detail because it is in the planning phase.

The state has 13 comprehensive behavioral health centers (mental health) available to provide services for the population identified as in need of mental health services. The Comprehensives served 695 children in 9 months, all with substantial impairments. The EPSDT screen contains a behavior assessment instrument used for the populations above age 10 years, and serves as a referral, early identification resource.

For the school year 2002-20023, eighteen (18) of the thirty-four (33) School-Based Health Centers offered behavioral health services to twenty-three (23) schools. There were 5,725 behavioral health visits by 951 students. Depression accounted for 27% of the counseling visits, an increase from 19% from 2001. The average number of visits per user was 5.5. The nation is facing a public crisis in mental healthcare for infants, children, and adolescents. One in ten children and adolescents nationally, suffer from mental illness severe enough to cause impairment. Yet in any given year...about one in five of such children receive specialty mental health services.

#### c. Plan for the Coming Year

## Plan for the Coming Year:

West Virginia was one of three states chosen to participate in the Preventive Services Improvement Initiative (PSII)-a national program to improve the quality of preventive services in school based health centers. Representatives from five (5) teams in WV attended. Based on improvements demonstrated by these five teams, the goals have now been adopted as priorities for all of West Virginia's SBHCs: 1) Increasing the number of comprehensive physical exams, 2) Implementing a system of annual risk assessments, and 3) Improving their clinical and systems practices for intervention, referral, and follow-up.

The Adolescent Health Initiative is a special program, financed solely by Title V, that addresses the most prevalent health risks facing adolescents today by empowering communities and supporting efforts that build resiliency and strengthen families. Our mission is to communicate to all West Virginians that all youth need to be surrounded with networks of individuals and institutions that provide them with support, opportunities, boundaries, and structure. This research-based approach, developed by the SEARCH Institute, has demonstrated these types of efforts increase the likelihood of our youth being empowered to develop commitments, values, competencies, and a positive identity needed to mature into healthy and competent adults.

The primary goal of the Adolescent Health Initiative is to improve the health status, health related behavior, and availability/utilization of preventative, acute, and chronic care services among the adolescent population of West Virginia.

In the coming year, the Adolescent Health Initiative will support the efforts of the Adolescent Health Coordinators to build or support existing community asset teams throughout the State. Adolescent Health Coordinators will lend their services to School Based Health Centers to support the Preventive Services Improvement Initiative.

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

### a. Last Year's Accomplishments

#### Last Year's Accomplishments:

The ultimate goals of Right From the Start are to reduce infant mortality and morbidity, increase birth weight, increase access to prenatal and delivery care that meets nationally recognized standards, increase parenthood preparedness, and to foster home environments that are conducive to healthy childrearing. Besides the above listed activities OMCFH also offers a toll-free phone line statewide for referral, improved access to care and to assist with any questions or problems that patients may encounter.

The Access to Rural Transportation (ART) Project, in conjunction with the Office of Family Support, Non-Emergency Medical Transportation Program, administers a statewide system to provide transportation dollars to needy infants and pregnant women prior to the actual medical encounter to ensure access to "medically necessary" care. There was a total of 9,082 participants who received prenatal and infant services under the RFTS Project. (See graph "Participants in RFTS")

RFTS data from October-December 2003, shows that the average birth weight for infants born to pregnant women who participated in care coordination services was 6.6 lbs. There were only 2.1% very low birth weight infants born to pregnant participants, 7.4% low birth weight, (23.3% were not reported) see pie chart October-December 2003 "Outcome Measures".

The average gestation for a pregnant RFTS client during October-December 2003 was 38.3 weeks.

### b. Current Activities

Current Activities:

The Office of Maternal, Child and Family Health's perinatal program, Right From The Start Project, provides pregnancy risk assessments for all government sponsored pregnant women. Early identification efforts have resulted in increased numbers of very low birth weight infants being delivered at the State's tertiary care facilities. The Office of Maternal, Child and Family Health staff has repeatedly urged all pregnant women, regardless of income, to be risk screened. This has involved meetings with PEIA and the Insurance Commissioner. The lack of birthing facilities in every county creates a reluctance on the part of the State's tertiary care facilities to take marginal risk patients; yet it is impossible to predict every high risk patient/condition.

c. Plan for the Coming Year

Plan for the Coming Year:

Since the 1980's the medical community has been screening prenatal patients to determine those who are at risk. The screening involves not only medical screening but also socio-economic issues as well.

Because WV's health network is predominantly small community hospitals, the relationships between the community medical provider and the tertiary care provider is important. In recognition of this, two of WV's Schools of Medicine, Departments of OB/Gyn serve as expert resources. They maintain ob hotlines so that the physicians in the communities can call in for case consultation. There is also the use of telemedicine, called MDTV. This allows at risk women to be cared for in their home community by a family practice physician with assistance from the Schools. If the patient is medically high risk, the physician at the local community may still provide some limited care for the patient with intermittent visits to the OB/Gyn in the geographical service area. Extremely high risk women would have their deliveries at the tertiary care facility and this would be pre-arranged. So while a community physician may have taken care of a patient to a point, there would intermittent visits with the OB/Gyn at the tertiary care center who would be doing the actual delivery. To assist the patient, there have been maps developed and opportunity to tour the tertiary care facility to become acquainted with the hospital. This is particularly important in WV given our geographical terrain. When the patient is there we also use this time to do her pre-registration. In an ideal situation, an extremely high risk patient might receive all of her prenatal care at the tertiary care site, but being realistic, this sharing of patient care has worked for us for more than 20 years.

We also have supported and facilitated working relationships between the family practitioners who offer ob services and community based ob/gyns. The process is very similar to the one described above, the exception being the ob/gyn in the local community supports his medical colleague through the care of a patient that is at moderate risk. In this instance, the patient may be able to deliver in a community hospital with the ob/gyn serving as the practitioner. These decisions are precipitated by medical indicators. Because we are sensitive to the state's geography, we've tried to think of every contingency including offering transportation monies to the pregnant woman to allow her to make these travel accommodations. Our RFTS network provides teaching instruction so that the woman will know when she is in labor and who to call in the event of an emergency.

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

a. Last Year's Accomplishments

Last Year's Accomplishments:

To increase the number of women receiving prenatal care during their first trimester of pregnancy, the Office of Maternal, Child and Family Health's Right From The Start Project provides comprehensive perinatal services to low income women, including direct financial assistance for adolescents and non-citizens who are ineligible for Medicaid, but whose income is equal to or less than 185 percent of the Federal Poverty Level; limited coverage for prenatal patients who at the time of first prenatal visit have not received a Medicaid card and are subsequently denied, or prenatal patients whose Medicaid coverage is not backdated to cover the first visit and initial laboratory services. Adolescents age 19 years and under are automatically eligible for financial assistance under Title V for medically indigent prenatal services regardless of income. In FY 1999, approximately 50% of all pregnant women in the State received some direct service from this Project. In FY 2000, approximately 47% of all pregnant women in the State received some direct service from this Project. In 2003, 5,652 prenatals enrolled in RFTS.

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

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

## b. Current Activities

### Current Activities:

The Family Planning Program provides free pregnancy testing at all sites in an effort to improve early identification and referral of pregnant women into care. Women who have positive pregnancy tests completed at one of our 150 sites statewide are immediately assisted with completing a shortened Medicaid application, linked to a physician, with initial care cost defrayed by Title V, etc., if they do not have health care financing.

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

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

## c. Plan for the Coming Year

### Plan for the Coming Year:

West Virginia has done a good job of getting their pregnant women into early care. The Perinatal Program, Right From The Start Project (RFTS) provides comprehensive perinatal services to low income women and infants up to one year of age. The project provides the following services: 1) Recruitment of medical practitioners to care for low income, government sponsored populations (Title XIX, Title V). 2) Recruitment and credentialing of practitioners to care for Medicaid and Title V sponsored obstetrical patients, including the completion of signed contractual agreements that establish expectation for care in accordance with national

standards. 3) All participating providers complete signed agreements with OMCFH specific to services/benefits, risk scoring and patient information exchanges. 4) Direct financial assistance for obstetrical care for pregnant adolescents ages 19 and under who are not eligible for Medicaid.

5) Provides financial assistance for pregnant adolescents ages 19 and under regardless of income. 6) Direct financial assistance for prenatal care for non-citizens. (They may be eligible for Medicaid at the time of delivery as this is considered an emergency situation). 7) Direct financial assistance for obstetrical care for pregnant women denied Medicaid, but whose income is equal to or less than \$100 per month over 185 percent of the Federal Poverty Level.

8) Limited coverage for prenatal patients who at the time of first prenatal visit have not received a Medicaid card and are subsequently denied, or prenatal patients whose Medicaid coverage is not backdated to cover the first visit. The services may include lab work, the initial prenatal visit, and ultrasound, if necessary. This was the closest we could come to presumptive eligibility. The cost of these services are paid for by the OMCFH using Title V funds. 9) Assistance for patient access to health care and the WIC Program. Coordination of medical care for Title V and Title XIX obstetrical patients and their infants/children less than one year of age. Coordination components include a personalized in-home assessment to identify barriers to health care, an individually designed care plan to meet the patient's needs, community referrals as necessary, follow-up and monitoring. 10) All pregnant Medicaid and Title V cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation, parenting, nutrition).

In 2003, there were 458 approvals for obstetrical care services, paid under Title V, and 136 denials who were over income.

**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. All abnormal test results are followed by OMCFH case management.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The pediatric genetics program at WVU provides five subspecialty clinics throughout WV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. An active advisory committee was re-established to assist with policy and program development.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. The NBS Project staff work collaboratively with the State Lab to ensure screening before discharge.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Formula for PKU patients is provided free of charge, regardless of income, by OMCFH.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Linkage of data between OMCFH and the State Lab has been reestablished creating efficiency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. The Bureau issued policy requiring universal testing of all infants for				

Hemoglobinopathies.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Formal relationships have been developed with Schools of Medicine to assure availability of medical experts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. Collaboration with Marshall University funding the Parent Network Specialists as parent advocates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The Center For Excellence In Disabilities conducts a Parent Network satisfaction survey.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. The OMCFH/Monitoring Quality Assurance unit conducts call-backs to determine satisfaction.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Parents are involved in the development of individual care plans with CSHCN and school systems.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Parents participate in policy making for the CSHCN Program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Care Notebook and Resource Manual were revised for distribution to families and applicants.	<input type="checkbox"/>	<input checked="" 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. Intake information captures medical home information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. CSHCN information is shared with the child's primary medical provider.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Systems Point of Entry Program assists CSHCN participants to find a medical provider.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. All infants identified by the Birth Defect Registry are contacted to determine health needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Appropriateness of specialty medical care reviewed by CSHCN Medical Associates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Nutritional assessments available to CSHCN children through Center for Excellence in Disabilities contract.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Primary care (medical home) information included in CSHCN Patient/Assessment and Care Plan.	<input type="checkbox"/>	<input checked="" 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. All children/families are assisted with accessing health care financing.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Children from families without coverage are referred to local DHHR offices in their county.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Staff of OMCFH programs are trained on eligibility requirements for accessing government programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Families are provided guidance as to specific information required to apply for assistance.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Denied Medicaid or CHIP applications with income at or below 185% FPL receive CSHCN if eligible.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Systems Point of Entry provides referrals to alternative resources when indicated.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. System Point of Entry staff keep up to date on available resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Currently 96.3% of all children have health care coverage.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Children who have chronic debilitating conditions have access to CSHCN.	<input type="checkbox"/>	<input checked="" 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. Parents participate in policy and procedures development for Part C and CSHCN.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Collaboration with Medicaid to optimize resources and plan efficient use of funds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. CSHCN works with the Children With Disabilities Community Support Program to expedite services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CSHCN collaborates with other OMCFH programs to coordinate needed services efficiently.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. CSC Director participates on Medicaid policy committee sharing input from families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Parents and CSHCN staff take part in mini conferences coordinated by the Parent Network Specialists.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. CSHCN Program Advisory includes youth, parents and providers of services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. Transition services are provided by CSHCN to all program participants.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Formalized working relationship agreements are used to transition youth for career counseling.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. CSHCN nurses and social workers receive training in provision of adolescent transition services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Adolescent Transition Screening Tools were developed for use in care coordination with adolescents and young adults.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. CSHCN expanded services to the adolescent population, including transition services for youth 14 to 21 years.	<input type="checkbox"/>	<input checked="" 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. Need for immunizations is promoted by RFTS, WIC and other public health programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The EPSDT Program encourages providers to offer immunizations as part of health care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. An OMCFH monitoring team monitors the documented immunizations of HealthCheck clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. The RFTS Project collects data on whether or not infant participants (who are up to 12 months) are up to date on immunizations.	<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

8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Provided confidential contraceptive services through the FP Program to 18,218 sexually active teens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Recognized and promoted "National Day To Prevent Teen Pregnancy" and "National Teen Pregnancy Prevention Month" (May 2003).	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Conducted "Mother's Day Too Soon" and Observed "Father's Day Too Soon" campaigns to increase public awareness of the incidence of teen pregnancy in WV.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Promoted "Let's Talk" month (October 2003); Free resources to encourage parent/child communication about sexuality.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Offered "Wise Guys" workshop (April 2003) regarding young male responsibility in preventing unintended pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provided 2 "Wise Guys" trainings to Division of Juvenile Justice staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. "Maltreatment of Adolescents Prior to Pregnancy" curriculum was presented to 3 agencies to examine child maltreatment and later teen pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Worked with Dept of Ed/Office of Healthy Schools to develop strategic plan to reduce sexual risk behaviors among students. Presented at 13 WV School and state level conferences on the topic of teen pregnancy prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Provided confidential contraceptive services through the Family Planning Program to 18,218 sexually active teens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Hired 4 new staff in 2003 to conduct community education and outreach activities on a regional/local level.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. Dentists receive fiscal support from OMCFH to apply sealants.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Medicaid and CHIP policy support the application of sealants at urging of OMCFH.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Program provides preventive guidance regarding oral hygiene and good dental practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. EPSDT provides dental examination and referrals if needed.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The Dental Program provides grade-specific oral health education modules to all public schools.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. The EPSDT Program provides preventive guidance to parents regarding childhood injuries.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. All women participants in the OMCFH programs receive benefits of breast-feeding information.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The WIC Program strongly supports and promotes breast-feeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. RFTS collects data on prenatals who are breast-feeding at hospital discharge, and how many continue to breast-feed at case closure.	<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
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. All WV birthing facilities are screening infants for hearing loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Infants identified with a hearing loss are referred to the CSHCN Program.	<input type="checkbox"/>	<input checked="" 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
<b>13) Percent of children without health insurance.</b>				
1. All children referred to OMCFH programs are assessed for eligibility for Medicaid and CHIP.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. All EPSDT participating providers are monitored as to the availability of CHIP applications.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The Systems Point of Entry Project (SPE) within OMCFH provides CHIP applications to families.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The SPE assists with OBRA applications for Medicaid coverage for pregnancy.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Medicaid and CHIP have resulted in more WV children having access to health coverage.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. CHIP applications are routinely distributed by EPSDT staff during provider site visits.	<input type="checkbox"/>	<input checked="" 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
<b>14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.</b>				
1. The OMCFH administers the EPSDT Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The EPSDT Program provides dedicated outreach workers to encourage participation.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Approximately 57% of all births in WV are sponsored by Medicaid covering the infant for a year.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The EPSDT works closely with the Office of Social Services to assure EPSDT screens for kids in State custody.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Children in State custody receive a screen within thirty days of placement.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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. OMCFH participates in the low-birthweight education planning for the annual Summits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The Right From the Start Program addresses smoking and nutrition issues for pregnant women. ('SCRIPT')	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. OMCFH partners with community health organizations to improve public education efforts.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. RFTS collects info on the number of very low, low, and normal birth weights.	<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"/>
<b>NATIONAL PERFORMANCE MEASURE</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. The OMCFH's Adolescent Health Initiative provides awareness of adolescent at-risk behaviors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. In 2001, 18 out of the thirty-three school-based health centers offered Mental Health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Children's Mental Health has adopted the Columbia Teen Screening to identify suicide risk.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The EPSDT screen contains a behavior assessment instrument used for age 16 and above.	<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"/>
<b>NATIONAL PERFORMANCE MEASURE</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. The OMCFH's perinatal program, Right From The Start (RFST) provides pregnancy risk assessments.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. OMCFH advocates that all pregnant women to be screened for high risk.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

3. OMCFH fiscally supports training teams to encourage early screening and referral.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. The WV RFTS 'SCRIPT' educates, supports, and assists pregnant women to quit or lower # cigarettes per day.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. RFTS case managers educate women on risk factors for high risk and/or low birth weight infants.	<input type="checkbox"/>	<input checked="" 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. Free pregnancy testing is available at 150+ sites statewide.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Women who have a positive pregnancy test are assisted with securing health care coverage.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Adolescents age 19 years and under are automatically eligible for OMCFH financial assistance.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Early Prenatal care is strongly encouraged and supported through all family planning efforts.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The OMCFH partners with The March of Dimes to provide education targeting early prenatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. The OMCFH supports efforts to develop capacity in physician shortage areas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Provided free pregnancy testing at 145 Family Planning Program Sites.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. The OMCFH partners with Health Promotion, Tobacco Prevention Project, to educate and support pregnant women in smoking cessation and/or reduction.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. The OMCFH partners with the local DHHRs to encourage them to refer pregnant women who are denied Medicaid coverage. for obstetrical care services consideration.	<input type="checkbox"/>	<input checked="" 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 age appropriate children (ages 6 months through 6 years) screened for blood lead.*

##### a. Last Year's Accomplishments

Childhood Lead Poisoning and Prevention Project (CLPPP) and Research, Evaluation and Planning Division staff developed and continued to refine an active surveillance system with all laboratories for mandatory reporting of blood lead testing results to the Office of Maternal, Child and Family Health. These population-based surveillance activities are coordinated with the EPSDT pediatric field staff as a part of medical provider orientation, monitoring and technical assistance.

The CLPPP provided a strong educational/technical assistance program to elementary schools, and child care service sites, including Head Start and EPSDT providers on a statewide basis, targeting high risk counties. In addition to these efforts, public presentations have occurred at forums made available by local church groups and through parent advisories of agencies responsible for children's health services and/or child care. In 2003, the OMCFH Provider Education Specialist made presentations and provided educational displays at public health fairs reaching at least 2,400 persons, mostly in the high risk areas.

The CLPPP works with local health departments and the Office of Environmental Health Services to implement a community-level case management system which relies on both local health department nurses and sanitarians.

The CLPPP investigated the filter-paper specimen submission method which was using a few drops of blood from an already scheduled finger stick making it less painful to collect the sample. Some providers are now using this method.

An agreement was entered into with an area WIC office, serving multiple counties, to use the first two drops of blood, from the already scheduled iron sufficiency test, to test for blood lead levels. This agreement was an effort to screen high risk children targeted in a high risk area. SB 216 passed last year mandating universal blood lead screening, following CDC protocol, for all children under the age of 6. The legislative rules were worked on in 2002 and submitted in 2003 for the universal lead screening law to go in effect in 2004.

The number and percent of children 0 to 72 months of age screened for elevated blood lead levels was the highest in 2002. Children receiving Medicaid benefits had a prevalence rate of 15 per 1000 for elevated blood lead levels, while non-Medicaid eligible children had a prevalence rate of 9 per 1,000.

## b. Current Activities

According to the 2000 Census, 75.2% of occupied housing units within WV are owned by the occupant, ranking number two in the nation. Also according to the 2000 Census, 41% of all WV housing was built before 1960. Twenty-seven percent of the occupied pre-1960 housing is renter-occupied and 73% is owner occupied, compared to 66% nationally. Because WV is predominantly a rural state, many homes have been passed down from generation to generation and are mortgage free. The older housing is either renovated or not upgraded and maintained and a little over 3% of WV housing lacks complete plumbing.

West Virginia continues to collaborate with the EPSDT Program to screen all children for lead poisoning who are eligible for Medicaid. Information on prevention of lead poisoning is distributed through the EPSDT workforce to participant's parents and to all medical practitioners serving children. The CLPPP continues to maintain strong relationships with the Division of Environmental Health and the local health departments in providing environmental assessments in homes where children with increased blood lead levels live. All children identified with increased blood lead levels > or equal to 10ug/dl are referred to CSHCN. The CLPPP maintains a strong educational component reaching over 2,400 parents, child care workers, care givers, physicians, nurses and social workers through a myriad of presentations and displays. Educational and screening efforts are targeted in higher risk areas and populations.

WV continues an agreement with a higher risk area WIC program to screen for elevated blood lead levels when the child is scheduled for iron deficiency testing. This eliminates the need for an additional finger stick and ensures screening of a high risk population.

Although WV only has a moderately high prevalence rate, ranking 40th in the nation, Senate Bill Number 216 was passed in January 2002 requiring systematic screening of children for early identification and prevention of lead poisoning in children 0-72 months of age. The rules and regulations specific to this legislation were submitted and screening was defined as assessment of high risk instead of a blood test in the 2004 legislative session.

In an effort to target CDC funds to higher prevalence states, WV lost almost half of the CDC grant funds for the CLPPP beginning in 2004. CDC is requesting States to eliminate lead poisoning in children by 2009 when they want to cease giving grant dollars. We have

submitted our screening and elimination plans which includes targeting the nine (9) highest counties at risk to screen for blood lead levels. Included in our submitted budget was a plan to train risk assessors to perform housing assessments reaching across the state.

### c. Plan for the Coming Year

West Virginia requested \$380,468 to continue and improve efforts at identifying and eradicating childhood lead poisoning in the state. However, only \$200,000 was awarded. Activities to be supported by this CDC grant were to focus on increasing screening, testing, case management, data integrity capabilities, and the current efforts that are underway in West Virginia: underwriting appropriate environmental assessments, educating health professionals and the public on issues related to blood lead poisoning, monitoring screening rates and prevalence of lead poisoning in overall age appropriate children, as well as in Medicaid eligible children, strengthening surveillance activities by improving completeness, accuracy and timeliness of data, geo-targeting program activities in identified problem areas, improving CLPPP database standards for inclusion of the data in the National CBLS database, and applying epidemiological methodology to identify and provide appropriate services to lead poisoned children. West Virginia's project, although housed and managed in the Office of Maternal, Child and Family Health, represents a concerted collaborative effort among a number of state agencies and offices throughout West Virginia. With a loss of \$180,000. the OMCFH will continue to provide quality services for the State, but will use Title V dollars to provide case management and educational activities. The CDC award will focus on surveillance and elimination activities.

West Virginia screened 12,139 children in 2002 or 9.9% of children age 0-72months of age. The average yearly screening rate is 7.7%. WV continues to encourage screening for increased blood lead levels in all children under 72 months of age.

WV continues to support aggressive educational efforts in those areas and/or counties with higher prevalence and risk. The nurse educator in 2002 made presentations to over 2,500 parents and professionals and set up displays offering information for 7 booth opportunities. To strengthen the CLPPP efforts a planning and advisory component involving families, environmental health, local health departments, the private practicing community, epidemiology, WIC and health promotion to assist in providing direction for this program. Membership from HUD and Department of Education will be sought this year to secure additional areas of expertise for the advisory council.

## State Performance Measure 2: *Percent of women $\geq$ 18 receiving a Pap smear within the preceding three years.*

### a. Last Year's Accomplishments

Last Year's Accomplishments:

IN CY 2003, the Family Planning Program provided Pap smears for 42,886 low-income, uninsured women receiving contraceptive services;

In April 2003, the Family Planning Program released a Policy Update regarding revised guidelines for management of Pap smear results. These guidelines reflected Bethesda system 2001 terminology for reporting results of cervical cytology and American Society of Colposcopy and Cervical Pathology (ASCCP) management guidelines and follow-up recommendations.

During CY 2002, the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP) provided 12,940 Pap smears. The 2000 Behavior Risk Factors Surveillance System (BRFSS) (West Virginia did not have information on women's health in 2001) reported that 95.3% of West Virginia women have had a Pap smear. Additionally, 2000 BRFSS data

indicated that 3.6% of women aged 18-36, 6.0% of women aged 40-49, 3.2% of women aged 50-59, and 4.3% of women aged 60-64 reported that it had been three years since their last Pap smear. During this time period the Program reached approximately 25% of all eligible women within the state. A cervical cancer over-screening report was developed as a guide to ensure that providers and the Program are in compliance with the CDC's cervical cancer screening policy which states that women who have received 3 consecutive normal Pap smears within 5 years cannot be rescreened for 3 years through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Data from April 1, 2002 through September 30, 2002 indicated a never or rarely percentage of 24.9%. The WVBCCS, celebrated Cervical Cancer Awareness Month by offering Free Pap Smear Days in various locations around the state. During these activities, women in the community who could not afford a Pap smear were encouraged to visit the participating clinic and enroll in the Program. If the women were not eligible for the WVBCCS, they still received a free Pap smear. Pap smears for non-eligible women were donated by the WVBCCS's contracted cytological laboratory.

## b. Current Activities

### Current Activities:

Pap smears are recommended for all Family Planning Program clients on initial and annual exams, with repeat or follow-up Pap smears, as clinically indicated.

According to the 2002 BRFSS, 95.6% of West Virginia women surveyed aged > 18 have had a Pap smear. During CY 2003, WVBCCS provided 10,674 Pap smears on Program eligible women between the ages of 25 and 64, which resulted in the diagnosis of five cases of invasive cervical cancer. The Centers for Disease Control and Prevention (CDC) reported that between January 1, 2003 and June 30, 2003, 23.8% of new Program enrollees were never or rarely screened for cervical cancer (3.8% above CDC's mandated > 20%). Never or rarely screened refers to women who have never had a Pap smear or have had a Pap smear, but the procedure was performed five or more years ago.

The Program is offered in all of West Virginia's fifty-five counties and cervical screening services are provided to eligible women through a network of 164 county health departments, primary care centers, hospital outpatient clinics and free clinics. The WVBCCS also has seventy-one colposcopy providers located throughout the state.

Program staff continues to serve on the West Virginia Comprehensive Cancer Control Coalition's Steering Committee and attend quarterly meetings. Staff also serve as subcommittee chairs and help plan quarterly meetings.

Current activities for the grant year include the distribution of a quarterly provider report, the implementation of HPV testing for all clients receiving a liquid based Pap test with a result of ASCUS, providing case management services for all women in need of follow-up services, conducting outreach campaigns during Cervical Cancer Awareness Month (Free Pap Smear Days), providing Spanish language cervical cancer materials for applicable providers, identification of trends/discrepancies of WVBCCS cervical cancer state at final diagnosis, identification of high cervical cancer incidence areas, determine causes related to unsatisfactory Pap smears, and begin to identify cervical cancer screening barriers utilizing qualitative research methodology. Staff members of several committees including the CDC's Science and Epidemiology Committee and the Chronic Disease Directors (CDD) Genetics Planning Committee.

## c. Plan for the Coming Year

### Plans for the Coming Year:

Continue to recommend Pap smears for all Family Planning Program clients on initial and annual exams, with repeat or follow-up Pap smears, as clinically indicated.

The WVBCCSPP will continue to provide quality cervical cancer screening services to its eligible population which includes low-income, uninsured or underinsured, older women, minorities, and women who live in rural areas. The Program also has a special focus on never or rarely screened women and women who partner with women. It is estimated that the Program will provide approximately 11,000 Pap smears during FY 2004-2005. Complete and timely follow-up services and case management will continue to be a key factor in serving West Virginia's eligible population as well as continued public education and outreach activities to increase cervical cancer awareness. Pap smear results will be reported in accordance with Bethesda 2001 terminology and the Program will continue to implement and monitor cervical cancer screening to ensure its compliance with the CDC's cervical cancer screening policy. All women with a liquid based Pap smear result of ASCUS or negative for intraepithelial lesion or malignancy will receive HPV testing. Innovative strategies will still be used to reach the never or rarely screened population. Staff will represent the Program both locally and nationally as members of the West Virginia Comprehensive Cancer Control Coalition, CDC Science and Epidemiology Committee, and CDC Genetics Planning Committee.

**State Performance Measure 3: *Percent of women >= 50 years of age receiving a mammogram within the preceding two years.***

**a. Last Year's Accomplishments**

The WVBCCSPP provided 10,423 screening mammograms and 16,386 clinical breast examinations (CBE). Sixty cases of invasive breast cancer were also discovered as a result of screening services provided through the WVBCCSPP. The 2000 BRFSS reported that 90.6% of West Virginia women aged 50-59 have had a mammogram and 87.9% of women aged 60-64 have had a mammogram.

Breast Cancer Awareness Month Activities were conducted during October 2002. Over 3,841 participated in these activities statewide. Ten Walks for Women...Take a Step Against Breast Cancer, were held in thirty-three counties with over 1,270 people participating. Program staff also served on the Susan G. Komen Breast Cancer Foundation Ancillary Board and participated in the Susan G. Komen Drive for the Cure.

**b. Current Activities**

Current WVBCCSPP data for CY 2003 indicates that the Program has performed 10,078 screening mammograms, 14,507 CBEs and diagnosed fifty-nine cases of invasive breast cancer. Behavioral Risk Factors Surveillance System data for 2002 stated that 15.0% of women aged 50-59 and 13.7% of women aged 60-64 had not had a mammogram in two years. Additionally, 12.1% of women 50-59 and 13.7% of women 60-64 had not had a CBE in two years.

The Program is offered in all of West Virginia's fifty-five counties and breast screening services are provided to eligible women through a network of 164 county health departments, primary care centers, hospital outpatient clinics, and free clinics. The WVBCCSPP currently has eighty-two mammography providers and thirty-seven fine needle aspiration (FNA) providers located throughout the state.

The WVBCCSPP has developed and implemented a four-hour MammaCare training curriculum aimed at teaching individuals how to perform CBEs using the MammaCare method. Two staff members became certified Breast Health Specialists in June 2003. Activities were conducted in all of West Virginia's fifty-five counties during October 2003 in celebration of Breast Cancer Awareness Month. Activities included "Ten Walks for Women...Take a Step Against Breast Cancer", exhibitions, and a Think Pink luncheon to raise money for the Diagnostic and Treatment Fund. The Program will also begin offering Spanish language breast cancer

materials.

### c. Plan for the Coming Year

The WVBCSP anticipates providing over 10,000 screening mammograms and over 14,000 CBEs during FY 2004-2005. The Program will continue to provide quality breast cancer screening services to the eligible populations of West Virginia women. Case management services and timely follow-up will remain an integral part of the WVBCSP. Efforts will continue to be focused on providing mammograms to women aged fifty and older, including the identification and monitoring of invasive breast cancer cases in women > 50 years of age. MammaCare training sessions will continue to be held regionally throughout West Virginia. Breast Cancer Awareness Month activities will continue to be sponsored around the state by the WVBCSP.

## State Performance Measure 4: *Percent of women receiving first trimester prenatal care whose prenatal care is being paid for by Medicaid.*

### a. Last Year's Accomplishments

Last Years Accomplishments:

While 83 percent of all pregnant women in the State received first trimester prenatal care in CY 2001, a substantially lower proportion, 77.1%, of women whose prenatal care is being paid for by Medicaid received first trimester prenatal care. Nevertheless, trend data indicate that the proportion of such women has increased steadily over the years. Contributing to this substantial increase is the State's Right From The Start Project (see National Core Performance Measure 18), and free pregnancy testing offered by Family Planning, referenced earlier. In addition to first trimester prenatal care being a factor associated with intendedness of pregnancy, payor source for deliveries is as well. Women who access medical care, but have no source of coverage at the initial visit are referred to OMCFH by the medical community for care management. Also referenced earlier, OMCFH serves as the initial payor for the patient's preliminary care, while exploring all health financing options. PRSI data 48 % of RFTS pregnant women received 1st trimester prenatal care.

### b. Current Activities

Current Activities:

West Virginia's perinatal program, Right From The Start (RFTS), is administered by the OMCFH. Core components of care coordination and enhancement services reinforce the positive effect of medical care on the health and well-being of mothers and infants. Increasing access to prenatal and delivery care that meets nationally recognized standards is the goal of this program.

RFTS focuses on coordination of medical care for Title V and Title XIX obstetrical patients and their infants/children less than one year of age. Coordination components include a personalized in-home assessment to identify barriers to health care, an individually designed care plan to meet the patient's needs, community referrals as necessary, follow-up and monitoring. All pregnant Medicaid and Title V cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation, parenting, nutrition).

RFTS has continued to provide statewide presentations which explain the process of referrals into RFTS and Obstetrical Care Services. The Right From The Start Project has developed a Power Point presentation outlining the benefits and protocols of the Project for the purposes of education and to promote RFTS among the local Department's of Health and Human Services

staff. The presentation details and clarifies the referral process, eligibility requirements, and the case management services provided to eligible pregnant women and their infants. The presentation is designed to encourage early prenatal/infant referral to RFTS and to increase awareness of the variety of services offered. The RFTS Regional Care Coordinator (RCC) also attends the training sessions and is introduced as the contact person for follow up on referrals or for additional questions. The RCC will then follow up with the obstetrical care providers to refresh their knowledge of the referral process.

In 2003, the RFTS Project has provided this presentation to staff from several county DHHR offices. RFTS presentations are planned for DHHR staff in additional counties in 2004. The presentations have provided RFTS with positive feedback about the Project, provided a forum for policy updates, questions, and answers, and an opportunity for the Regional Care Coordinators to establish rapport or build on their current relationship with local DHHR offices.

### c. Plan for the Coming Year

Plan for the Coming Year:

The OMCFH will continue to advocate for Medicaid coverage of pregnant women and continue to support the availability of free pregnancy test sites through Family Planning. OMCFH will continue to support reform in malpractice insurance to assure availability of providers (access).

Through the Family Planning Program, with verification of pregnancy, the OMCFH ensures the patient has located a prenatal care provider, and (if medically indigent) has been provided a shortened Medicaid application and an agency referral to WIC.

## State Performance Measure 5: *Percent of unintended pregnancies.*

### a. Last Year's Accomplishments

Last Year's Accomplishments:

West Virginia's fertility rate decreased 2.2% from 55.8 in 2000 to 54.6 in 2001.

In CY 2003, the Family Planning Program provided comprehensive reproductive health services to 64,203 unduplicated clients, an increase of nearly 4% from CY 2002. The methods of contraception for these clients included the following:

CY 2002	CY 2003
Oral Contraceptives 34,610 (56.1%)	33,092 (51.5%)
Intrauterine Device 232 (0.38%)	255 ( 0.4%)
Diaphragm 78 (0.12%)	81 ( 0.1%)
Foam/Condom 8,576 (13.9%)	8,899 (13.9%)
Natural Family Planning 684 ( 1.1%)	771 ( 1.2%)
Norplant Contraceptive Implant 26 ( 0.1%)	13 ( 0.1%)
Depo-Provera Injection 8,538 (13.8%)	9,001 ( 14%)
No Method 8,126 (13.1%)	8,337 (12.9%)
Other 0 ( 0%)	0 ( 0%)
Patch Not Available 3,303 ( 5.1%)	
Sterilization 440 (0.7%)	451 ( 0.8%)
TOTAL: 61,743	64,203

In CY 2003, the Family Planning Program continued financial support for female and male sterilization procedures, with 330 female and 121 male procedures, for a total of 451 sterilizations;

Family Planning provider training and staff development courses, sponsored in whole or in part by TRAINING 3 included the following:

"Understanding Cervical Cytology and the Management of Abnormal Paps"

March 14, 2003 Charleston, WV (80 participants)

April 22, 2003 Morgantown, WV (53 participants)

"Reproductive Health Update"

June 23, 2003 Beckley, WV (30 participants)

June 30, 2003 Morgantown, WV (44 participants)

"Working With Teens: Creating a Teen Friendly Environment"

October 16, 2003 Charleston, WV (30 participants)

"New Developments: Diagnosis, Treatment and Counseling of STD's and HIV"

November 19, 2003 Charleston, WV (51 participants)

Ortho TriCyclen Lo, a new oral contraceptive, was added to the formulary in March 2003. The Family Planning Program effort makes thousands of people with low incomes aware of the availability of Family Planning Program services as brochures are mailed to individuals over the age of 16 who had been clients of WV WORKS (TANF), School Clothing Allowance, Food Stamps, Medicaid, TRIP, Low Income Energy Assistance and Emergency Assistance. In 2003, 17,355 brochures were mailed.

## b. Current Activities

Current Activities:

For FY 2003-2004 (7/1/03-6/30/2004), the Family Planning Program contracted with one hundred (100) delegate agencies, representing one-hundred forty-five (145) clinic sites for the provision of comprehensive family planning services. Five (5) of these service sites, known as "Special Agreement" clinics, provide family planning services for their enrolled populations, i.e., university/college student health centers and a Job Corps Center;

Client education and counseling on reproductive anatomy/physiology and contraceptive methods is provided in accordance with the Family Planning Program Guidelines, 2001 as evidenced by medical record audits completed by the OMCFH Quality Assurance and Monitoring Team and site reviews conducted by the Family Planning Program Specialists. A targeted emphasis on the requirements for detailed client education and counseling has been reflected in positive audit results which have indicated more thorough documentation of services provided.

## c. Plan for the Coming Year

Plans for the Coming Year:

Maintain Memorandum of Understanding with 145 existing delegate agencies/clinics to deliver clinical Family Planning Program services;

Provide client education and counseling on reproductive anatomy/physiology and use of contraceptive methods consistent with Family Planning Program Guidelines, 2001;

Provide confidential medical and laboratory services and contraceptive methods to enrolled clients, consistent with Family Planning Program Guidelines, 2001;

Monitor and evaluate the cost-effectiveness of new contraceptive methods, alternative contraceptive products/formulations and treatment modalities for possible addition to the Family Planning Program formulary:

- a. Vaginal Contraceptive Ring (NuvaRing)
- b. Mirena IUD
- c. Seasonale oral contraceptive
- d. Alternative oral contraceptive formulations

Provide surgical sterilization services for female and male clients (as funding permits) in accordance with Family Planning Program Guidelines, 2001;

To improve access, recruit additional health care agencies and private providers for participation in the program (as funding permits);

Coordinate STD services in Family Planning clinics with the WV STD Program to assist with client testing, treatment, partner referrals, and Disease Investigation Specialist (DIS) tracking services.

### State Performance Measure 6: *The incidence of young women 15-19 years of age who have contracted Chlamydia.*

#### a. Last Year's Accomplishments

Chlamydia positivity in Family Planning Program clients increased 0.1% in female clients from 2001-2002, but decreased by 1% in male clients. Overall, Chlamydia positivity decreased by 0.9%.

#### Last Year's Accomplishments:

The Family Planning Program continued to offer STD counseling, education, screening, diagnosis, and treatment activities. Testing and treatment of chlamydia, gonorrhea, and syphilis are available for established Family Planning clients. In January 2003, the Family Planning Program distributed summaries of 2002 Sexually Transmitted Diseases (STD) Treatment Guidelines, published by the WV Bureau for Public Health, Division of Surveillance and Disease Control and the Centers for Disease Control and Prevention. Providers were encouraged to place the laminated documents in their exam rooms for reference in the treatment of STDs.

#### Chlamydia Screening, Diagnosis, and Treatment:

Through the Region III Infertility Prevention Project (IPP), 35,750 Chlamydia tests were completed for Family Planning clients in CY 2002, with a 2.3% positivity for females and a 10.9% positivity for males. In 2002, Chlamydia increased by 0.1% for females statewide, as compared to the number of positive reports received in 2001, although positivity for males decreased by 1%. Approximately 97% of all women in Family Planning clinics diagnosed with Chlamydia received treatment, as confirmed by WV DIS staff.

#### Participation in Region III Chlamydia Advisory Committee:

In 2002-2003, Jackie Newson, Family Planning Specialist, continued active participation in the Region III IPP Advisory Committee, serving as a voting member of the full committee, in addition to participation on the Clinical and Program Management Subcommittee. Ms. Newson transferred employment in mid-2003, so an alternative representative for the Advisory Committee was needed. Anne Williams, Family Planning Director and Stephanie Thorn, Family

Planning Specialist, attended the November 2003 Advisory Committee meeting with Stephanie Thorn assigned responsibility for continued participation on the Committee, effective immediately following the meeting.

#### STD Educational/Training Program:

With changing trends in research and treatment of STDs and HIV, it is important for family planning staff to stay up to date. In cooperation with TRAINING 3 and the WV STD Program, the Family Planning Program offered a course, "New Developments: Diagnosis, Treatment and Counseling on STDs and HIV" (November 19, 2003, Charleston, WV). This course provided Family Planning staff with new information about the most common STDs likely to be encountered in the clinic setting, as well as HIV. Participants were informed of local resources available to clients diagnosed with STD and HIV. Speakers for the course included Dr. Anne Rompalo, Associate Professor of John Hopkins University School of Medicine; Terry Hogan, Director of Region III STD/HIV Prevention Training Center, and Greg Moore, Assistant Director of the WV STD/HIV/AIDS Program

#### b. Current Activities

##### Current Activities:

##### Male Expansion Project:

The Family Planning Program continues to work with the WV Sexually Transmitted Disease Program in the Region III Infertility Prevention Project (IPP) Male Services Expansion (2002-2004). Given the problem of reinfection in women and factors involved in not reaching males, a Male Demonstration Project has been on-going throughout 2002-2004 in juvenile detention centers, school based health centers, and selected Special Agreement sites. The APTIMA Combo II Assay (the urine test for Chlamydia) has been used to determine positivity for asymptomatic men. Three thousand (3000) men will be tested, with possible changes in test technology or equipment resulting from this Demonstration Project. Upon completion and following data review, results may indicate a need for urine-based Chlamydia screening in all FP and STD clinics;

##### Coordination with WV STD Program:

The Family Planning Program administration works collaboratively with the WV Sexually Transmitted Disease Program to assure high quality general STD/HIV education and counseling services. The Family Planning and STD Programs worked closely to facilitate STD counseling, screening, and treatment of women not served through the STD clinic system. The Family Planning Program provides initial diagnosis and treatment of STDs; For continuing treatment, partner follow-up, or HIV testing, clients are referred to the STD Program for services. WV STD Program Disease Intervention staff (DIS) also provide partner notification, testing, and treatment services on request from Family Planning clinics.

#### c. Plan for the Coming Year

##### Plan for the Coming Year:

Coordinate STD services in FP clinics with the WV STD Program to assist with client testing, treatment, partner referrals, and Disease Investigative Specialist (DIS) tracking services;

Work collaboratively with partners from the STD Program, WV Office of Laboratory Services and the Region III Infertility Prevention Project to evaluate and update the WV Chlamydia Screening Protocols;

Collaborate with STD Program to consider modification of WV Chlamydia Screening Protocols to rescreen positive clients 4-6 months post treatment, in accordance with CDC STD

Treatment Guidelines, 2002;

Collaborate with STD Programs to consider modification of WV Chlamydia Screening Protocols to revise age parameters for screening criteria (change from <30 years of age to <25 years of age);

Participate in WV STD Program urine-based Chlamydia screening project targeted to high-risk male population (juvenile detention centers, prisons, special agreement sites) to distribute FP Program brochures, clinic directories and materials.

## State Performance Measure 7: *The percent of women not smoking during pregnancy.*

### a. Last Year's Accomplishments

Last Years Accomplishments:

According to West Virginia Vital Statistics, West Virginia pregnant women smoking rate for 2002 - 26% - U.S. Rate - 11.4%. West Virginia still has the highest smoking rate for pregnant women in the United States. The Right From The Start (RFTS) Project has obtained past data from the Birth Score Office which shows that many counties in West Virginia have a self-reported rate of between 30 to 57% among Medicaid mothers who smoked during pregnancy. If the self-reported rate is this high, one can only imagine the confirmed rate. This creates an enormous health problem for the State of West Virginia which impacts not only the developing infant but the pregnant woman, their children, and other exposed family and friends, not to mention the impact on the health care community. Pregnant women participating in the Right From The Start Project have a high incidence of smoking during pregnancy. To address this issue RFTS has adopted an intense smoking cessation initiative. The program was developed by Dr. Richard Windsor who has successfully implemented the program recently in Alabama. The Smoking Cessation Program developed by Dr. Richard Windsor was implemented in West Virginia in January 2002, through the Office of Maternal, Child, and Family Health. It was incorporated into the RFTS Project and is now known as "The West Virginia Right From The Start 'SCRIPT'". The WV RFTS 'SCRIPT' uses the existing home visitation network and protocols already established in the current RFTS Project. RFTS Project services are provided to pregnant women and infants by registered nurses and licensed social workers throughout West Virginia who are known as Designated Care Coordinators (DCCs) Beginning in January 2002, specific areas of West Virginia were chosen to participate in two Natural History Studies based on the largest concentration of pregnant smokers. The purpose of the two Natural History Studies was to document the number of new Medicaid obstetrical patients who were smokers, to biochemically confirm self-reported smoking status, to establish the natural quit rate during pregnancy, and to document the relapse rate of women reporting they had quit on their own since becoming pregnant. Natural History Study Number One was conducted in six of the eight RFTS regions in West Virginia. One hundred seventy-four (174) pregnant women were enrolled in Natural History Study Number One and approximately 74 (42.8%) of these women were self-reported smokers. In the West Virginia counties who participated in Natural History Study Number One, data suggested that self-reported smoking rates among pregnant women ranged from 25 to 58.8%. 2002 RFTS data shows that the 3 top risk factors identified on the PRSI are #1 Partner smokes, #2 Client smokes, #3 Alcohol use.

### b. Current Activities

Current Activities:

Natural History Study Number Two was conducted in the late summer of 2002 and provided

pregnant smokers with interventions which were new to the RFTS Project. The interventions are those currently recognized as best practice methods and are advised for use in tobacco dependence treatment. These new interventions are the use of the 5 A's which are Ask, Advise, Assess, Assist, and Arrange. The RFTS DCCs provided education and support to pregnant smokers who desired to quit using the 5 A's along with the educational patient handbook, "A Pregnant Woman's Guide to Quit Smoking", and the video "Commit To Quit During Pregnancy and Beyond." The pregnant smokers were tested initially for the level of Carbon Monoxide(CO) in their body by the use of a breathalyzer on the first home visit by the RFTS DCC. After the initial test, they were tested again approximately four (4) weeks later following the tobacco dependence treatment education process. Patients could also be tested as often as they requested during that time period. The training for these new interventions was provided to all RFTS staff statewide in March of 2002 by Dr. Richard Windsor and the West Virginia Office of Maternal, Child and Family Health (OMCFH) Perinatal Services Director, Jeannie Clark. A final document of the results of the "Formative Evaluation of the WV RFTS SCRIPT' has been developed by Dr. Richard Windsor and includes analysis of data gathered during the Natural History studies. These studies collected data regarding the prevalence of smoking among WV pregnant women and the effects of the newly implemented interventions among the study participants. Initial data collected in the Natural History Studies suggested, through the use of Carbon Monoxide (CO) testing of the pregnant smokers, that the smoking rate among WV RFTS study participants may be as high as 46%. (See Attachment)

### c. Plan for the Coming Year

Plan for the Coming Year:

The WV RFTS 'SCRIPT' Program is now up and running statewide and includes all regions of West Virginia. Educational tools such as videos, CO monitors, smoking cessation guides, and smoking cessation incentives are available to the Right From The Start DCCs for use in the smoking cessation effort. All of the RFTS DCCs have received initial training in the tobacco dependence effort to provide pregnant women with best practice smoking cessation methods. Additional training is still ongoing for the DCCs and plans are being developed for future training to continually be updated so that all providers are competent to provide best practice tobacco dependence treatment to all participating pregnant smokers. RFTS Regional Care Coordinators are now beginning to provide 'SCRIPT' education to other prenatal care providers who are contracted to provide obstetrical services through the OMCFH.

Of great concern to the RFTS Project staff is the fact that the majority of pregnant smokers who successfully stop smoking during pregnancy relapse in the immediate postpartum period. The RFTS Project sees the need to more aggressively address this issue in the future. Addressing this issue is critical in order to prevent long term maternal health complications and prevent second hand smoke exposure among infants. Since the pregnant woman is covered by the RFTS Project and eligible for services for only sixty (60) days postpartum, this issue presents a major challenge to the RFTS DCCs.

Data is now being collected through the OMCFH on all pregnant smokers who are participating in the Right From The Start Project. Revisions have been completed to the database which will now allow accurate data collection for the project. The goal of the RFTS Project is to see a reduction in the rate of pregnant smokers in the State of West Virginia due to the efforts of the 'SCRIPT' Program. Through the funding provided by the Tobacco Prevention grant, educational materials and curriculum have been obtained which have been proven to be effective in assisting with smoking cessation through research and are considered best practice methods. Through the implementation of these tobacco dependence treatment initiatives, the overall health of individuals, families and infants can be improved, and West Virginia can see a reduction in poor pregnancy outcomes, infant mortality, prematurity and low birth weight rates.

State Performance Measure 8: *The percentage of eligible children receiving EPSDT services.*

a. Last Year's Accomplishments

Last Years Accomplishments:

HealthCheck is West Virginia's name for the mandated pediatric Medicaid program, Early and Periodic screening, Diagnosis and Treatment (EPSDT). Over 200,000 Medicaid-approved children in West Virginia have been eligible to participate in the HealthCheck program for the past three years. EPSDT's promise to children eligible for Medicaid is the provision of preventive health exams and treatment of all medical conditions discovered during the exams free of charge. In FY 2001 and FY 2002, EPSDT utilization was at 50%. EPSDT Family Outreach Workers, located in nine regions of the State inform parents and care-takers of Medicaid eligible children about EPSDT services and encourage them to use the EPSDT services for preventive health. A Program Specialist is assigned to each region and provides recruitment and orientation of new EPSDT providers, and provides technical assistance, orientation of new staff members, an Annual Review of all EPSDT program requirements, and a minimum of two site visits each fiscal year for all existing EPSDT providers.

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

A new Program Operations Manual for EPSDT outreach was issued in CY 2002. The new manual is used as a tool to ensure standardized outreach activities statewide.

b. Current Activities

Current Activities:

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

c. Plan for the Coming Year

Plan for the Coming Year:

The EPSDT Program will continue to be operated by the OMCFH through a contractual

arrangement with the Bureau of Medical Services and renegotiated every year. EPSDT has contracted with the Health Maintenance Organizations (HMO) to provide outreach services for their child beneficiaries to encourage their participation in EPSDT. A new HMO is entering the State by January 2004 and EPSDT hopes to contract with them as well. EPSDT providers plan to continue offering EPSDT services in the School-Based Health Centers as a way to be more accessible and useful for those children who may not otherwise receive services due to restricted access. EPSDT has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides EPSDT orientation for HMO providers serving Medicaid enrolled children. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community often lacks capacity in some areas of the state.

**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 age appropriate children (ages 6 months through 6 years) screened for blood lead.				
1. Multiple educational presentations delivered at community/ parent meetings in high risk areas.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Annual inservices are offered to medical professionals on importance of screening.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The CLPPP has a strong relationship with the Office of Environmental Services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The CLPPP offers case management services to children identified with increased blood lead.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The CLPPP partners with WIC to increase blood lead screening in a high risk area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. An Epidemiological Snapshot is created annually to provide current information to providers.	<input type="checkbox"/>	<input checked="" 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 >= 18 receiving a Pap smear within the preceding three years.				
1. OMCFH houses the Breast and Cervical Cancer Screening Program (BCCSP).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. BCCSP offers education, assessment, outreach, surveillance, case management and follow-up services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Screenings are provided statewide through contractual agreements.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Breast and cervical cancer screening and family planning is offered statewide in all 55 counties.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. WV participates in the Breast and Cervical Treatment Act.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. WV provides full Medicaid benefits to uninsured women under age 65 identified by the BCCSP, as having cancer of the breast or of the cervix.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Provided Pap smears to 42,886 low-income, uninsured Family Planning Program clients receiving contraceptive services.	<input type="checkbox"/>	<input checked="" 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) Percent of women >= 50 years of age receiving a mammogram within the preceding two years.				
1. WV took advantage of the Breast and Cervical Treatment Act.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. WV provides full Medicaid benefits to uninsured women under age 65 identified by the BCCSP, as having cancer of the breast or of the cervix.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. BCCSP offers education, assessment, outreach, surveillance, case management and follow-up services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Breast and cervical cancer screening and referral is offered statewide.	<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"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of women receiving first trimester prenatal care whose prenatal care is being paid for by Medicaid.				
1. The OMCFH's perinatal program RFTS, provides comprehensive perinatal services to low income pregnant women and infants up to age 1 year.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Adolescents age 19 years and under are automatically eligible regardless of income.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The OMCFH ensures information about the need for early and continuous care is provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Shortened Medicaid eligibility forms improve access to care by providing source of payment.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The OMCFH resources pay for the initial visits for any medically indigent women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The OMCFH works with Divisions of Primary Care and Recruitment to develop capacity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

7. All DHHR local offices have been linked to MCFH toll-free lines for referrals for care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. RFTS staff providing inservice statewide on process of OMCFH and RFTS eligibility.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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
5) Percent of unintended pregnancies.				
1. The OMCFH has a strong Family Planning Program offering free contraceptive care to low income.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. OMCFH uses PRAMS data to follow the trends and recruits additional health care agencies and private providers for participaton in the FP Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Maintain agreements with 145 clinic network providers to deliver statewide Family Planning Program services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The Abstinence Program targets children ages 9-14 to discourage sexual activity.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Evaluate cost-effectiveness of new contraceptive methods, alternative contraceptive products and treatment medications.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Intensive community education and outreach activities for prevention of unintended pregnancies.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Adolescent Pregnancy Prevention Initiative discourages use of drugs and alcohol as prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Providing confidential medical and laboratory services and free contraceptive methods as well as providing client education/counseling on pregnancy/STD prevention and use of contraceptive methods for enrolled clients.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Provide confidential medical and laboratory services and free contraceptive methods to enrolled clients.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Provide surgical sterilization services for female and male clients (as funding permits).	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The incidence of young women 15-19 years of age who have contracted Chlamydia.				
1. The Family Planning Program monitors the incidence of chlamydia.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. The Family Planning Program provides chlamydia tests for females ages 15-19.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Women in Family Planning clinics receive risk reduction counseling relative to chlamydia.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. All Family Planning Program clients with positive results are treated free of charge.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Family Planning staff serve on the Region III Chlamydia Advisory Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide STD counseling/education, testing and treatment services in				

145 Family Planning Program clinics.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Work with STD Program to enhance partner referrals and Disease Investigative Specialist (DIS) tracking services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Work with STD Program to revise WV Chlamydia Screening Protocols age parameters from <30 yrs to <25 yrs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Work with STD Program on urine-based Chlamydia Screening project targeted to high-risk male populations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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) The percent of women not smoking during pregnancy.				
1. Implemented the Smoking Cessation Program developed by Dr. Richard Windsor in Jan.,2002. (SCRIPT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The WV 'SCRIPT' uses the existing home visitation network and protocols in the RFTS Project.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The effects of smoking during pregnancy are distributed to all women in the OMCFH programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. SCRIPT mandated to be provided to all RFTS participants by DCCs 10/1/2003.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Information collected in OMCFH Research Division's Tobacco Screening databases.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. All pregnant RFTS smokers/former smokers are offered CO Testing.	<input type="checkbox"/>	<input checked="" 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) The percentage of eligible children receiving EPSDT services.				
1. EPSDT works with the Office of Social Services to ensure foster care children receive care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. EPSDT Outreach Workers inform parents and caretakers of EPSDT services and encourage use.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Thirty School Based Health Centers provide EPSDT services.	<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"/>

## E. OTHER PROGRAM ACTIVITIES

The Office of Maternal and Child Health, since the 1980's, has contracted for the provision of direct health care. These contractual relationships include private sector physicians, university-medical school partners, hospitals, community health centers, and local health departments. All services are formally contracted with established performance standards portrayed in the written provider-OMCFH agreement. The exception to this format is CSHCN, which was, until the late 1980's, administered by the former Human Services arm of the now Department of Health and Human Resources organization. This unit has maintained its direct service responsibility because of the scarcity of pediatric and pediatric sub-specialty providers in certain geographical areas of the State.

The program receives referrals from multiple sources. However, as the State has developed and improved population-based surveillance systems, more and more youngsters have been referred, as a result of the birth defect registry, birth score, blood lead testing, newborn hearing screening and metabolic screening. It is also important to note that the State's universal risk scoring of infants, called birth score, was modified several years ago to assure the identification of infants with or at risk of developmental delay. These children are referred to the MCFH administered Birth to Three Program/Part C IDEA. In addition, MCFH administers EPSDT, again with direct care through community provider partnerships, but we do have access to information on each child, enabling us to identify youngsters with chronic or disabling conditions for referral to CSHCN. The primary care physicians are encouraged to refer children to CSHCN, and are routinely visited by Pediatric field staff who serve as technical resources to the medical community.

All children assessed by CSHCN receive evaluation and case management services to facilitate access to alternative systems of care. All children enrolled in CSHCN, Birth to Three (Part C IDEA), or even our perinatal RFTS program receive case management and care coordination. Children participating in Special Health Care Needs Program access Medicaid, at a rate of 78.6%. This high percentage is attributed to CSHCN commitment to assist families with SSI applications, the expedited SSA/Disability Determination process, and our attention to obtaining health care financing for this targeted group.

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

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

The OMCFH continues to provide monies for maintenance of a data repository which keeps current health, social, and community information by county and by type of service statewide. This data repository, linked to MCFH via modem, is used to access information for client specific questions, received on the MCFH toll-free lines. As previously discussed, MCFH has well used toll-free lines which are monitored by independent reviewers. All calls, unless client refuses, are followed up by letter. We also maintain resource information on a variety of topics enabling us to respond to specific concerns such as "my child is bed wetting," "I have a breast lump," "I've missed my period," and "Johnny won't eat". MCFH program information is also available via Web access with multiple links to access informational guidance on a variety of topics.

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

## **F. TECHNICAL ASSISTANCE**

There were a total of 1,808 low birthweight babies (those weighing less than 2,500 grams or 5 1/2 pounds) born to West Virginia residents in 2001, representing 8.8% of all births. Of the 1,802 low birthweight infants with known gestational age, 1,235 or 68.5% were preterm babies born before 37 weeks of gestation. (Of all 2001 resident births with a known gestational, 11.2% were preterm babies.) In 2000, 8.4% of resident infant births were low birthweight and 65.1% were preterm babies born before 37 weeks of gestation. (Of all 2000 resident births with a known gestational age, 10.9% were preterm babies.) In 1999, 8% of resident births were low birthweight with 13.5% preterm. Over one-fourth of the births in each of these years was to a mother who smoked during her pregnancy. Each of these years smoking mothers while pregnant has increased as well. Interestingly enough, infants born to mothers who received 1st trimester care was above the national average and continued to increase for each of these years. (A chart comparing National and State information for these three years is attached.) Over eighty-six percent (86.5%) of West Virginia mothers with known prenatal care began their care during the first trimester of pregnancy, compared to 83.4% of mothers nationwide. West Virginia has a strong prenatal program and has implemented the smoking cessation program developed by Richard Windsor with the goal of reducing the number of pregnant women who smoke. With one of the highest smoking rates in the nation for smoking pregnant women and our low birthweight continuing to rise, West Virginia would like technical assistance to examine our systems and identify strategies to positively impact the low birthweight incidence. The legislative session in 2003 mandated an increase of \$.50 per pack on cigarettes with a two-fold goal. One was to reduce smoking in WV and the other was to raise revenue.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

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

### **B. BUDGET**

The Office of Maternal, Child and Family Health has done a good job of leveraging resources. The Block Grant Title V, serves as the foundation but the Office also administers Title X Family Planning; Title XV Breast and Cervical Cancer Screening Program; Part C DEA; Childhood Lead Prevention Program, CDC funded; EPSDT, funded by Title XIX; Children with Special Health Care Needs, funded by Title XIX and Title V; Birth Defects Surveillance, funded by CDC; and PRAMS, funded by CDC. All of these funding streams augment what is purchased with Title V monies. Like many states across the country, Title V has moved away from the sole focus of purchasing or providing individual health services and has placed most of our attention and fiscal resources on developing a system of care. For example, because the state had high incidences of neural tube defect and other congenital anomalies, the OMCFH approached the WVU School of Medicine to develop satellite clinics providing genetics counseling and screening. Although the medical expertise came from the WVU School of Medicine, the funding to make these services more accessible throughout the state came from Title V. These clinics serve everyone, not just persons who have government sponsored health care. Because WV has a median income of \$27,000 for a family of four, the need for services has been great but our resources have been limited. The State Legislature routinely supports Maternal and Child Health, but over the years this commitment has not kept pace with the demand for services and escalating cost. This is largely attributable to the fact that as Medicaid expansions occurred and the CHIP program was introduced, there was an assumption by members of the State Legislature that Maternal and Child Health would not need as many resources. We have attempted to educate the Legislature explaining to them that while these alternate health financing strategies have come into being, the MCH monies are needed to improve the quality of services rendered and improve the availability of care. Like states across the country, WV does not have enough money to fund all the many things that we would like to have for our citizens. For example, several years ago newborn hearing screening legislation was passed but there was no accompanying state appropriation. What was obvious to us was that while there was a commitment to identify children who needed intervention, be it hearing aids or whatever, there was no consideration given to the fact that there has to be a mechanism for identifying the children, tracking the children, and making sure the intervention occurred, all of which costs money. MCFH staff argued this to no avail, so we were very pleased to be a recipient of the Title V monies to support this project. It is true that Medicaid and some insurers would offset the cost of the newborn hearing screening services, but there was no way to individually bill and recover monies necessary for the population-based tracking and surveillance that was necessary...no insurances or Medicaid pay for this activity.

In order to be good stewards of the system, the OMCFH provides leadership for much of the health care services provided in the state. Medicaid, CHIP and others are purchasers, but the OMCFH and its staff recruit the clinicians, establish the care protocols, monitor provider behavior, offer skill building opportunities, etc. all using the resources identified above to improve WV's health care system. The WV OMCFH administers EPSDT on behalf of Medicaid and has done so for approximately 30 years. The Medicaid Bureau supports the program by paying for the individual health services that the children access. The OMCFH develops, distributes, and purchases anticipatory guidance which is used by the participating providers. We also are responsible for bringing together members of the medical community to provide guidance as it relates to child health, not just EPSDT, but Newborn Hearing, Children with Special Health Care Needs, Birth Defects, Lead, etc. We use many of the programs cited to identify children who are ultimately referred to CSHCN. The CSHCN Program, financed under Medicaid and Title V, not only serve children who have diagnosed chronic and debilitating conditions but provides free assessment for children referred by their primary care/medical home. To be sure that we are meeting the demand and have an opportunity for early identification of children with chronic or debilitating conditions, we are offering assessment clinics in our most rural parts of the state. All of these efforts are our commitment to primary and preventive care of the state's

children and ultimately have a tie-in to CSHCN when indicated.

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

## **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.