WEST VIRGINIA
SECRETARY OF STATE
NATALIE E. TENNANT
ADMINISTRATIVE LAW DIVISION

Form #2

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2010 JUN 23 PM 1:25

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: DHHR - Bureau for Public Health TITLE NUMBER: 64

RULE TYPE: Legislative CITE AUTHORITY: WV Code §§16-1-4 and 16-4E-4.

AMENDMENT TO AN EXISTING RULE: YES ____ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 97

TITLE OF RULE BEING PROPOSED: MATERNAL RISK SCREENING

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON July 23, 2010 AT 12:00 noon ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS:

Ann A. Goldberg, Director
~~Public Health Regulations~~
Bureau for Public Health
350 Capitol Street, Rm 702
Charleston, WV 25301
304 558-0035 Phone
304 558-1035 FAX
ann.a.goldberg@wv.gov

Anne Williams, Director
~~Divn of P & Women's Hlth~~
Bureau for Public Health
350 Capitol Street, Rm 427
Charleston, WV 25301
304 558-5388 phone
304 558- 7164 FAX
anne.a.williams@wv.gov

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.

Patsy A Hardy
Authorized Signature

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

FISCAL NOTE FOR PROPOSED RULES

Rule Title: **64CSR97 Maternal Risk Screening**

Type of Rule: **X** Legislative _____ Interpretive _____ Procedural

Agency: **Health and Human Resources**

Address: **1900 Kanawha Blvd. East**

Bldg. 3, Room 206

Charleston, WV 25305

Phone Number: **304-558-2971** Email: **Ann.A.Goldgerg@wv.gov**

Fiscal Note Summary

Summarize in a clear and concise manner what effect this measure will have on costs and revenues of state government.

The proposed rule develops and establishes the requirements for health care practitioners to use a uniform maternal risk screening tool. It makes the risk screening tool available to all medical providers and it requires that the information obtained remain confidential. There is no cost associated with this proposed rule.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

Effect of Proposal	Fiscal Year		
	2010 Increase/Decrease (use"-")	2011 Increase/Decrease (use"-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	0	0	0
Personal Services			
Current Expenses			
Repairs and Alterations			
Equipment			
Other			
2. Estimated Total Revenues			

3. Explanation of above estimates (including long-range effect):

Please include any increase or decrease in fees in your estimated total revenues.

Memorandum

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

Date: 6-23-10

Agency: Department of Health and Human Resources

Authorized Representative: Patsy A. Hardy
Cabinet Secretary

64CSR97, Legislative Rule
Maternal Risk Screening
WV DHHR/ Bureau for Public Health
Office of Maternal, Child and Family Health

BRIEF SUMMARY

This rule establishes the Advisory Council on Maternal Risk screening and requires the Council to develop a screening tool to help identify women at risk for preterm birth or other high-risk conditions during pregnancy. It makes the risk screening tool available to all medical providers, requires them to use the screening tool and that the information obtained remain confidential and not be disclosed.

STATEMENT OF CIRCUMSTANCES

In passing the Uniform Maternal Screening Act in 2009 the legislature mandated that a rule be proposed for legislative approval. This filing is responsive to that mandate.

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period; Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: JUNE 2010

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM:(*Agency Name, Address & Phone No.*) Ann Goldberg
Bureau for Public Health
350 Capitol Street, Rm 702
Charleston, WV 25301
304 558-2971 phone
304 558-1035 fax

LEGISLATIVE RULE TITLE:
MATERNAL RISK SCREENING, 64CSR97

1. Authorizing statute(s) citation
WV Code §§16-1-4 and 16-4E-4.

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

b. What other notice, including advertising, did you give of the hearing?

c. Date of Public Hearing(s) ***or*** Public Comment Period ended:

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached _____ No comments received _____

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

f. **Name, title, address and <u>phone/fax/e-mail numbers</u>** of agency person(s) to receive all *written correspondence* regarding this rule: (Please type)

Ann A Goldberg
350 Capitol St. Rm. 702
Charleston, WV 25301
304 558 - 2971 phone
304 558-1035 fax
ann.a.goldberg@wv.gov

g. **<u>IF DIFFERENT</u> FROM ITEM 'f'**, please give **Name, title, address and phone number(s)** of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

Anne Williams, Interim Director
Office of Maternal Child and Family Health
350 Capitol Street, Room 427
Charleston, WV 25301
304 558-5388 phone
304 558-7164 fax
anne.a.williams@wv.gov

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

b. Date of hearing or comment period:

From June 2010 to July 2010

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

n/a

d. Attach findings and determinations and reasons:

Attached n/a

TITLE 64
LEGISLATIVE RULE
BUREAU FOR PUBLIC HEALTH

SERIES 97
MATERNAL RISK SCREENING

§64-97-1. General.

1.1. Scope -- This rule further implements the Uniform Maternal Screening Act by setting forth responsibilities of the advisory council created in the Act; developing and establishing the requirement for health care practitioners to use a uniform maternal risk screening tool; and providing for the confidentiality of the tool. This rule should be read in conjunction with WV Code §16-4E-1, et seq. The WV Code is available in public libraries and on the Legislature's web page, http://www.legis.state.wv.us/.

1.2. Authority -- WV Code §§16-1-4 and 16-4E-4.

1.3. Filing Date --

1.4. Effective Date --

§64-97-2. Application.

2.1. Application -- This rule applies to all health care providers offering maternity services.

2.2. Enforcement -- This rule is enforced by the Office of Maternal, Child and Family Health in the Bureau for Public Health.

§64-97-3. Definitions.

3.1. Maternal Risk Screening - Screening conducted by physicians, midwives and other qualified health care practitioners to discover at-risk and high-risk pregnancies.

3.2. Maternal Risk Screening Advisory Council - A multidisciplinary group of professionals including representatives from public health and the medical community all with an interest in improving pregnancy outcomes.

§64-97-4. Responsibilities of Maternal Risk Screening Advisory Council.

4.1. The Maternal Risk Screening Advisory Council shall exercise the following responsibilities:

4.1.a. Meet at least annually;

4.1.b. Offer expert advice to the Office of Maternal, Child and Family Health to gain a better understanding of at-risk and high-risk conditions that are most frequently observed and to develop methodology to address these concerns;

4.1.c. Develop a uniform maternal risk screening tool to identify risk conditions that contribute to adverse pregnancy outcomes and review the tool at least annually to offer suggested revisions based upon current medical knowledge;

4.1.d. Develop, in conjunction with the Office of Maternal, Child and Family Health, a statistical matrix to measure incidence of high-risk and at-risk pregnancies for planning purposes by public health officials; and

4.1.e. Develop methods to collect evidence based data reported to the Office of Maternal, Child and Family Health needed to track at-risk and high-risk women.

§64-97-5. Applicability of the Screening Tool.

5.1. The maternal risk screening tool has been developed by the advisory council. It is attached to the end of this rule. All health care providers offering maternity services shall be required to use this maternal risk screening tool in their initial examination of all pregnant women.

5.2. The health care provider shall notify the woman of any high-risk condition which has been identified along with any appropriate referral.

5.3. The health care provider shall report the results to the Bureau for Public Health, Office of Maternal, Child and Family Health by FAX (304) 957-0176.

§64-97-6. Confidentiality.

6.1. The uniform maternal risk screening tool shall be confidential and shall not be released or disclosed to anyone for any reason other than data analysis of high-risk and at-risk pregnancies and for planning purposes by public health officials.

6.2. Proceedings, records and opinions of the advisory council are confidential and are not subject to discovery, subpoena or introduction into evidence in any civil or criminal proceeding. Nothing in this subsection is to be construed to limit or restrict the right to discover or use in any civil or criminal proceeding anything that is available from another source and entirely independent of the proceedings of the advisory council.

6.3. Members of the advisory council may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting of the council. Nothing in this subsection may be construed to prevent a member of the advisory council from testifying to information obtained independently of the council or which is public information.

WEST VIRGINIA
PRENATAL RISK SCREENING INSTRUMENT

Name: Last	First	MI	Date of Birth:	Age:	Social Security #:
Address: Street	City	Zip Code	County of Residence:	Telephone #:	Alternate #:

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
(Check all that apply)

U.S. Citizen: ☐ Yes ☐ No

Married: ☐ Yes ☐ No

Insurance Source: ☐ Health Insurance ☐ No Insurance ☐ Medicaid #_____

Date of 1st Prenatal Visit: (MM/DD/YYYY): _____

Current Weight (lbs): _____

Height (Ft-inches): _____

BMI: _____

Blood Pressure: ☐☐☐ / ☐☐☐

Obstetrical History:
Gravida ☐☐ Para ☐☐☐☐☐☐
T P SAB EAB L

LMP (MM/DD/YYYY): _____

EDC (MM/DD/YYYY): _____

Date of Last Delivery: _____

Type of Delivery:
1st Trimester ☐Miscarriage ☐Abortion
2nd Trimester ☐Miscarriage ☐Abortion
☐Preterm Birth ☐Term Birth

Oral Health:

	Yes	No
Sensitive/Bleeding Gums	☐	☐
Loose/Broken/Decayed Teeth	☐	☐
Dental visit within the last year	☐	☐

	Yes	No
Do you intend to breastfeed?	☐	☐
Are you currently breastfeeding?	☐	☐

Pregnancy Risk Factors:	Current Preg. Y	Current Preg. N	Prior Preg. Y	Prior Preg. N
Previous Cesarean Section	na	na	☐	☐
Low Birth Weight (<2500gm)	na	na	☐	☐
Gestational Diabetes	☐	☐	☐	☐
PIH/Preeclampsia	☐	☐	☐	☐
Placental Abruption	☐	☐	☐	☐
Placenta Previa	☐	☐	☐	☐
Cervical Incompetence	☐	☐	☐	☐
Abdominal Surgery	☐	☐	☐	☐
Opioid Replacement Treatment	☐	☐	☐	☐
Asst Reproductive Technology	☐	☐	☐	☐
Fetal Reduction	☐	☐	☐	☐
Macrosomia	☐	☐	☐	☐
IUGR	☐	☐	☐	☐
Oligo/Polyhydramnios	☐	☐	☐	☐
Abnormal Amniocentesis	☐	☐	☐	☐
Abnormal AFP	☐	☐	☐	☐
Maternal Fetal Infection	☐	☐	☐	☐
Obesity	☐	☐	☐	☐
Rh Negative	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐
Hepatitis C	☐	☐	☐	☐
Group B Strep	☐	☐	☐	☐
Pyelonephritis	☐	☐	☐	☐
History of PROM	na	na	☐	☐
Previous Stillbirth	na	na	☐	☐

Other/Unlisted Risk Factor: _____

Advanced Maternal Age: ☐Yes ☐No
Bleeding during current pregnancy:
Trimester: ☐ 1st ☐ 2nd ☐ 3rd ☐ No

Family History:	Current Preg. Y	Current Preg. N	Prior Preg. Y	Prior Preg. N	Family History Y	Family History N
Multiple Gestation	☐	☐	☐	☐	☐	☐
Fetal Genetic/Structural Abnormalities	☐	☐	☐	☐	☐	☐

Psychosocial Risk Factors:	Yes	No
Disabled	☐	☐
Unemployed/Inadequate Income	☐	☐
Husband/Partner Unemployed	☐	☐
Homeless	☐	☐
Unstable Housing	☐	☐
Education <12 years	☐	☐
Currently in Foster Care	☐	☐
Inadequate Transportation	☐	☐
Inadequate Social Support	☐	☐
Unplanned Pregnancy	☐	☐
Nutritional Concerns	☐	☐
Eating Disorder	☐	☐
Domestic Violence	☐	☐
Difficulty with Reading & Understanding	☐	☐
Internet Access	☐	☐

Medical Conditions:	Yes	No	On Meds		Yes	No	On Meds
High Blood Pressure	☐	☐	☐	STD	☐	☐	☐
Kidney Disease	☐	☐	☐	Seizures	☐	☐	☐
Diabetes	☐	☐	☐	Other	☐	☐	☐
Asthma	☐	☐	☐				
Heart Condition	☐	☐	☐				
Thyroid Disease	☐	☐	☐				

Environmental Risk Factors:	Yes	No
Lead: House Built before 1978	☐	☐
Viral: Cats or Birds in Home	☐	☐
Tobacco: 2nd or 3rd Hand Smoke	☐	☐

Reasons for Late Entry into Prenatal Care:	Yes		Yes
Does not apply	☐	Financial	☐
Insurance Enrollment Delay	☐	Child Care Issues	☐
Unaware of Importance of PNC	☐	Access to pregnancy testing	☐
Couldn't find a health provider	☐	Transportation	☐
Abortion desired/unsuccessful	☐	Other: _____	

Have either of your parents had a problem with drugs or alcohol?	Yes ☐	No ☐
Has your partner had a problem with drugs or alcohol?	Yes ☐	No ☐
Have you had a problem with drugs or alcohol in the past?	Yes ☐	No ☐
Have you used drugs or alcohol during this pregnancy?	Yes ☐	No ☐
Have you ever smoked cigarettes? Yes ☐ No ☐	I quit (when) _____	
Do you currently smoke cigarettes? Yes ☐ No ☐	If yes, # of cigarettes per day: _____	Does your partner smoke? Yes ☐ No ☐
Have you ever been a victim of abuse or violence?	Yes ☐	No ☐
Has your partner's anger ever worried or scared you?	Yes ☐	No ☐
Have you ever felt down or hopeless?	Yes ☐	No ☐
Have you lost interest in things you used to do for fun?	Yes ☐	No ☐

Provider Name & Title:	Provider Telephone#:	Date:

I am interested in further follow-up. I give my consent for necessary referrals to be made. I understand that my participation in any referral services is voluntary and that all information provided will be held strictly confidential.

Patient Name (print):	Patient Signature:	Date:

PLEASE COMPLETE AND FAX TO (304) 957-0176